PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION FOR

TRI-COUNTY SCHOOLS INSURANCE GROUP (TCSIG) EMPLOYEE HEALTH CARE PLAN

Effective January 1, 2021

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INTRODUCTION

This document is a description of Tri-County Schools Insurance Group (TCSIG) Employee Health Care Plan (the Plan). No oral interpretations can change this Plan. The Plan described is designed to protect Plan Participants against certain catastrophic health expenses.

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

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

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

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

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

No action at law or in equity shall be brought to recover under any section of this Plan until the appeal rights provided have been exercised and the Plan benefits requested in such appeals have been denied in whole or in part.

A Member may not assign or transfer any benefits or rights that arise under the Plan or applicable law to any other person, including a healthcare provider, and any purported assignment or transfer is void. This includes (but is not limited to) an attempted assignment or transfer of claims for payment of benefits, breach of fiduciary duty, penalties or any other claim or remedy. For convenience, the Plan may pay any undisputed benefit directly to the healthcare provider, but this is not a waiver of this anti-assignment provision and does not make the healthcare provider an assignee or confer any other rights on the provider. Similarly, the Plan recognizes an authorized representative for purposes of the Plan's claims and appeal procedures, but the authorized representative is not an assignee and has no derivative rights with respect to the claim. However, this anti-assignment provision will not apply (1) to an assignment of a Covered Person's rights to the Plan or the Plan Administrator, or (2) to the extent required under Medicaid laws.

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

It is the intent of this Plan and the Plan Administrator to comply with all applicable Federal and State laws and regulations. In the event of non-compliance with any such law or regulation, the Plan Document will be deemed amended to comply with said law or regulation as of its effective date, and the remainder of the Plan Document will remain in full force and effect. Similarly, in the event a law or regulation applicable to this Plan becomes effective after the initial effective date of this Plan Document, said law or regulation will be deemed included in this Plan Document as of its effective date and without the necessity of an amendment to this Plan Document.

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

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

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

TCSIG deems all Employee Groups to be eligible to participate in the Plan. However, it is at the discretion of each Employer to determine which Employee Groups shall be eligible to participate in this Plan. Coverage for eligible Employee Groups shall begin as determined by the written policies of the Employer but no sooner than the first of the month following the date of employment.

As specified in the Eligibility section of this Plan, family members are eligible for Dependent coverage under the Plan, and their coverage will usually begin at the same time as the Employee's coverage. (See Eligibility, Funding, Effective Date and Termination Provisions.)

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

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

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

Cost of Coverage. The participating Employers shall maintain discretion as to whether or not an Employee Group shall contribute toward the cost of coverage under this Plan. The same rate structure, i.e., composite or tiered, shall apply for all active Employees in a group. Retirees shall be placed on the tiered rate structure or may be placed, with their Employer's approval, on a composite rate if they enroll two or more Dependents and their former, active group is also composite. If a Retiree enrolls in both Medicare Parts A and B, TCSIG may provide a reduced contribution schedule, provided the Plan is secondary payer to Medicare. Individuals who continue their coverage under the Continuation of Coverage provision may be required to pay the entire cost of that coverage, plus an additional fee as allowed by Federal law.

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

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

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

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

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

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

Applicable Law. This Plan is not a plan of insurance. This Plan is a self-funded governmental group health plan which, for the most part, is exempt from the requirements of ERISA (the Employee Retirement Income Security Act).

However, governmental plans are not automatically excluded from the following amendments to ERISA: The Health Insurance Portability and Accountability Act (HIPAA), the Mental Health Parity and Addiction Equity Act (MHPAEA), the Newborns and Mothers Health Protection Act (NMHPA), and the Women's Health and Cancer Rights Act (WHCRA). To be exempt from certain requirements of these laws, the Plan must make an affirmative written election to be excluded. Such election must be filed with the Centers for Medicare and Medicaid Services (CMS) prior to the beginning of each Plan Year, with notice provided to each Plan participant. Unless such written election is filed, and participant notices are made, this Plan intends to fully comply with the above-stated federal laws.

Mental Health Parity Opt-Out. Tri-County Schools Insurance Group (TCSIG) has elected to exempt **Premier Plus, Premier, Standard, Basic, and HDHP** from parity in the application of certain limits to mental health benefits and to allow first dollar benefits for outpatient services without having a Deductible requirement.

Tri-County Schools Insurance Group already provides significant mental health benefits which are reviewed annually and adjusted as necessary to meet the needs of our members. Changing outpatient benefits and requiring a Deductible or payment of a Coinsurance percentage would in many cases be a barrier to receiving needed care. Outpatient and Inpatient limits may be subject to case management/alternative treatment review on a case-by-case basis.

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

Tri-County Schools Insurance Group complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

Tri-County Schools Insurance Group does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Tri-County Schools Insurance Group:

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

2. Provides free language services to people whose primary language is not English, such as: Qualified interpreters; Information written in other languages.

If you need these services, contact Tri-County Schools Insurance Group.

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

Tri-County Schools Insurance Group
400 Plumas Boulevard, Suite 210
Yuba City, CA 95991
Phone Number: 530-822-5299
Fax Number: 530-822-5284
Email address: Lynn Whitlock at: lynn@tcsig.com; or Marisa Garramore at: Marisa@tcsig.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Tri-County Schools Insurance Group is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the OCR Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

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

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

SCHEDULE OF BENEFITS

Verification of Eligibility 800-442-7247

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

MEDICAL BENEFITS

All benefits described in this Schedule are percentages paid by the plan and are subject to the exclusions and limitations described more fully herein including, but not limited to, the Plan Administrator's determination that: care and treatment is Medically Necessary; that charges are based on the Reasonable and Allowed amounts; that services, supplies and care are not Experimental and/or Investigational. The meanings of these capitalized terms are in the Defined Terms section of this document.

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

Note: The following services must be precertified or reimbursement from the Plan may be reduced.

(1) All inpatient Hospital and Skilled Nursing Facility stays.
(2) Facility based Treatment for Mental or Nervous Disorders or Substance Abuse.
(3) Home Health Care.
(4) All Organ and Tissue Transplants, peripheral stem cell replacement and similar procedures.
(5) Infusion Therapy that includes Specialty Drugs in the specialty pharmacy program, and related services (for each Course of Therapy) in any setting, including, but not limited to: Physician's office, infusion center, outpatient Hospital or clinic, or your home or other residential setting.
(6) Certain surgical, diagnostic procedures, Durable Medical Equipment over $2,000 and/or prosthetics wherever rendered as specified by Anthem Blue Cross. For a list of current procedures, please contact Anthem Blue Cross toll free at (800) 274-7767.
(7) Chiropractic Care after 12 visits and for children under the age of 18. Precertification for this is handled by PhysMetrics.

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

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

The Plan is a plan which contains a Network Provider Organization.

PPO name: Refer to your medical identification card for the name and phone number of the Network Provider.

This Plan has entered into an agreement with certain Hospitals, Physicians and other health care providers, which are called Network Providers. Because these Network Providers have agreed to charge reduced fees to persons covered under the Plan, the Plan can afford to reimburse a higher percentage of their fees.

If the Plan generally requires or allows the designation of a primary care provider, a Covered Person has the right to designate any primary care provider who is a Network Provider and who is available to accept the Covered Person. For children, a Covered Person may designate a pediatrician as the primary care provider if the pediatrician is a Network Provider and is available to accept the child as a patient. A Covered Person does not need prior authorization from the Plan, a primary care provider, or any other person in order to obtain access to obstetrical or gynecological care from a health care professional who specializes in obstetrics or gynecology and who is a Network Provider. However, the health care professional may be required to comply with certain Plan procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals.

Therefore, when a Covered Person uses a Network Provider, that Covered Person will receive better benefits from the Plan than when a Non-Network Provider is used. It is the Covered Person's choice as to which Provider to use. Terms of agreements that allow the Plan access to Network Providers and other discounts may differ from provisions of the Plan and will be honored by the Plan as required.

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

If a Covered Person has no choice of Network Providers in the specialty that the Covered Person is seeking within the PPO service area.

If a Covered Person has a Medical Emergency requiring immediate care.

If a Covered Person has no choice of a Network Provider and receives services by a Non-Network Provider at a network facility

Covered Persons who do not have access to PPO Providers within fifty (50) miles by the shortest route to a PPO Provider from the Covered Person's residence or employment site. If the Covered Person travels to an area that has PPO Providers, the Covered Person must use the PPO Providers to receive the PPO level of benefits. This fifty (50) mile provision does not apply to Inpatient, residential Treatment Centers and day Treatment Centers for Mental Health Disorders/Chemical Dependency services.

Additional information about this option, including any rules that apply to designation of a primary care provider, as well as a list of Network Providers, will be given to Plan Participants, at no cost, and updated as needed. This list will include providers who specialize in obstetrics or gynecology.

Deductibles/Copayments payable by Plan Participants

PPO Plans

Deductibles/Copayments are dollar amounts that the Covered Person must pay before the Plan pays.

A deductible is an amount of money that is paid once a Calendar Year per Covered Person. Typically, there is one deductible amount per Plan and it must be paid before any money is paid by the Plan for any Covered Charges. On the first day of each Calendar Year, a new deductible amount is required. However, Covered Charges incurred in, and applied toward the deductible in the last three months of the Calendar Year will be applied to the deductible in the next Calendar Year as well as the current Calendar Year.

A copayment is the amount of money that is paid each time a particular service is used. Typically, there may be copayments on some services and other services will not have any copayments.

High Deductible Health Plan (HDHP) with Health Saving Account (HSA Plan)

Copayments and Deductibles are dollar amounts that the Covered Person must pay before the Plan pays. See the Schedule of Benefits for details.

A deductible is an amount of money that is paid once a Calendar Year per Covered Person or Family Unit. On the first day of each Calendar Year, a new deductible amount is required.

For family coverage, the Plan will begin to pay Covered Charges when the entire family deductible has been met. However, the Plan will begin to pay the Covered Charges of an individual family member who has met the individual deductible, even if the family deductible has not been met.

For single coverage, the Covered Person must meet the individual deductible before any money is paid by the Plan for any Covered Charge.

A copayment is the amount of money that is paid each time a particular service is used. Typically, there may be copayments on some services and other services will not have any copayments. Copayments apply only after the deductible has been satisfied.

MEDICAL BENEFITS SCHEDULE
BASIC PLAN

COVERED CHARGES	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
DEDUCTIBLE, PER CALENDAR YEAR - Network and Non-Network Deductibles are combined.		
Per Covered Person	$1,000	$2,000
Per Family Unit	$2,000	$4,000
MAXIMUM OUT-OF-POCKET AMOUNT, PER CALENDAR YEAR - Network and Non-Network Out-of-Pocket amounts are combined and are separate from the Prescription Drug Out-of-Pocket maximum.		
Per Covered Person	$5,000	$10,000
Per Family Unit	$10,000	$20,000
The Plan will pay the designated percentage of Covered Charges until out-of-pocket amounts are reached, at which time the Plan will pay 100% of the remainder of Covered Charges for the rest of the Calendar Year unless stated otherwise.		
The following charges do not apply toward the out-of-pocket maximum and are never paid at 100%. Amounts over the Reasonable and Allowed amounts Cost containment penalties Prescription Drugs		
COVERED CHARGES		
Note: The maximums listed below are the total for Network and Non-Network expenses. For example, if a maximum of 60 days is listed twice under a service, the Calendar Year maximum is 60 days total which may be split between Network and Non-Network providers.		
Percentage Payable – unless otherwise stated.	70% after deductible	50% after deductible
Abortion	70% after deductible	50% after deductible
Acupuncture	70% deductible waived	50% after deductible
Ambulance Service	70% deductible waived	70% deductible waived 50% after deductible for Non-emergent transportation
Autism Spectrum Disorders		
Initial Office Visit to diagnose and Medication Management	100% after $20 copayment deductible waived	50% after deductible
Mental Health Psychotherapy	Not covered	Not covered
Habilitative Therapy	Not covered	Not covered
Applied Behavioral Analysis Therapy	Not covered	Not covered
Biofeedback	70% after deductible	50% after deductible
Birthing Center	70% after deductible	50% after deductible
Contraceptive Methods	100% deductible waived in accordance with PPACA	50% after deductible
CT Scans, MRI and PET Scans	70% after deductible	50% after deductible
Diabetes Supplies/Equipment	70% after deductible	50% after deductible
Durable Medical Equipment	70% after deductible	50% after deductible
Emergency Room Visit – Including professional services	70% after $50 copayment deductible waived Copayment waived if admitted	70% after $50 copayment deductible waived Copayment waived if admitted
Habilitative therapy – includes physical, and occupational therapy, and speech pathology	70% after deductible 20 combined visits Calendar Year maximum	50% after deductible 20 combined visits Calendar Year maximum
Home Health Care	70% after deductible 100 visits Calendar Year maximum	50% after deductible 100 visits Calendar Year maximum

COVERED CHARGES	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
Hospice Care	70% after deductible	50% after deductible
Bereavement	70% after deductible $25 per visit maximum paid amount 4 visits Calendar Year maximum	50% after deductible $25 per visit maximum paid amount 4 visits Calendar Year maximum
Respite Care	70% after deductible Limited to 5 consecutive days	50% after deductible Limited to 5 consecutive days
Hospital Services		
Inpatient - the semiprivate room rate	70% after deductible	50% after deductible
Ambulatory/Outpatient Surgery Facilities	70% after deductible	50% after deductible
Outpatient Services	70% after deductible	50% after deductible
Jaw Joint Conditions / Temporomandibular Joint Syndrome (TMJ)	Covered same as any illness	Covered same as any illness
Lab & X-ray	70% after deductible	50% after deductible
LiveHealth Online – Medical	100% deductible waived	Not covered
Behavioral Health	100% after $20 copayment deductible waived	Not covered
Mental Disorders and Substance Abuse		
Inpatient, Partial Hospitalization, and Residential treatment - the facility's semiprivate room rate	70% after deductible 100 days Calendar Year maximum	Not covered
Outpatient	70% after deductible	Not covered
Office Setting	100% after $20 copayment deductible waived	50% after deductible
Organ Transplants – for recipient and donor.	Covered same as any illness	Covered same as any illness
Physician Services		
Inpatient visits	70% after deductible	50% after deductible
Office visits	100% after $20 copayment deductible waived	50% after deductible
Office Visit Services – including Minor Surgery, Lab, X-ray, and Supplies	70% after deductible	50% after deductible
Surgery (Inpatient and Outpatient)	70% after deductible	50% after deductible
Assistant Surgeon and Anesthesiologists	70% after deductible	50% after deductible
Allergy Injections and Serum	70% after deductible	50% after deductible
Allergy Testing	70% after deductible	50% after deductible
Pre-Admission Testing	70% after deductible	50% after deductible
Pregnancy	Covered same as any illness	Covered same as any illness
Preventive Care – Services as defined by the Patient Protection Affordable Care Act (PPACA) for Network and Non-Network Providers.		
Routine Well Care – All ages	100% deductible waived	50% after deductible
NOTE: Cost sharing (deductibles, copayments, and coinsurance) will be waived for FDA-approved COVID-19 vaccines for Network and Non-Network providers.		

COVERED CHARGES	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
Prosthetics	70% after deductible	50% after deductible
Breast prosthesis – external prosthesis	70% after deductible One every 36 months	50% after deductible One every 36 months
Support garment	70% after deductible Limited to 2 in a 6 month period Up to maximum paid of $50 each	50% after deductible Limited to 2 in a 6 month period Up to maximum paid of $50 each
Rehabilitation – includes Physical, and Occupational Therapies	70% after deductible Limited to 1 treatment per day per therapy	50% after deductible Limited to 1 treatment per day per therapy
NOTE: Inpatient rehabilitation services must begin within 14 days after discharge from a hospital confinement of at least 3 consecutive days.		
Speech therapy	70% after deductible	50% after deductible
Skilled Nursing Facility – the facility's semiprivate room rate	70% after deductible 100 days Calendar Year maximum	50% after deductible 100 days Calendar Year maximum
Spinal Manipulation Chiropractic – only provided through PhysMetrics	100% after $20 copayment deductible waived Limited to 1 visit per day 12 visits Calendar Year maximum	100% deductible waived $10 maximum paid per visit Limited to 1 visit per day 12 visits Calendar Year maximum
NOTE: Pre-certification by PhysMetrics required after 12 visits. All visits for minor dependents up to age 18 must be pre-certified. Claims must be submitted to PhysMetrics.		
X-rays	70% after deductible $100 maximum paid per Calendar Year	50% after deductible $100 maximum paid per Calendar Year
Telemedicine	100% deductible waived	50% after deductible
Travel Expenses – Refer to Travel to Center of Excellence under Covered Charges.		
Accommodations, and Travel – must use TCSIG Center of Excellence	70% after deductible $10,000 Lifetime maximum paid per Covered Person	
NOTE: Transportation and lodging for the Covered Person and one companion. If the Covered Person receiving care is a minor, then reasonable and necessary costs for transportation and lodging may be allowed for two companions. Ground transportation is covered when facility is 75 miles or more from place of residence. Coach airfare is covered when facility is 300 miles or more from place of residence. Lodging is limited to one room, double occupancy.		
Meals – must use TCSIG Center of Excellence	100% deductible waived $50 maximum paid per day per person Maximum is included in $10,000 Lifetime maximum paid for Accommodations and Travel	
NOTE: Meals for Covered Person and one companion. If the Covered Person receiving care is a minor, then reasonable and necessary costs for meals may be allowed for two companions.		
Urgent Care		
Office visit	100% after $20 copayment deductible waived	50% after deductible
All other services	70% after deductible	50% after deductible
Voluntary Sterilization		
Female	100% deductible waived in accordance with PPACA	50% after deductible
Male	70% after deductible	50% after deductible
Wigs – after chemotherapy or radiation therapy	70% after deductible $250 Lifetime maximum paid	50% after deductible $250 Lifetime maximum paid

It is the intent of this Plan to comply with all Federal mandates, for so long as they remain in effect and provide for the screening and testing of patients for COVID-19 as set forth below.

Cost sharing (deductibles, copayments and coinsurance) will be waived for medically necessary screening and testing for FDA-approved COVID-19 including hospital, emergency department, urgent care, and provider office visits, including telehealth where the purpose of the visit is to be screened and/or tested for COVID-19 for Network and Non-Network providers. The screening services are included without cost share even if the visit does not result in an order or administration of the COVID-19 test.

PREMIER PLUS PLAN

COVERED CHARGES	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
DEDUCTIBLE, PER CALENDAR YEAR - Network and Non-Network Deductibles are combined.		
Per Covered Person	$75	$150
Per Family Unit	$150	$300
MAXIMUM OUT-OF-POCKET AMOUNT, PER CALENDAR YEAR - Network and Non-Network Out-of-Pocket amounts are combined and are separate from the Prescription Drug Out-of-Pocket maximum.		
Per Covered Person	$475	$950
Per Family Unit	$950	$1,900
The Plan will pay the designated percentage of Covered Charges until out-of-pocket amounts are reached, at which time the Plan will pay 100% of the remainder of Covered Charges for the rest of the Calendar Year unless stated otherwise.		
The following charges do not apply toward the out-of-pocket maximum and are never paid at 100%. Amounts over the Reasonable and Allowed amounts Cost containment penalties Prescription Drugs		
COVERED CHARGES		
Note: The maximums listed below are the total for Network and Non-Network expenses. For example, if a maximum of 60 days is listed twice under a service, the Calendar Year maximum is 60 days total which may be split between Network and Non-Network providers.		
Percentage Payable – unless otherwise stated.	80% after deductible	60% after deductible
Abortion	80% after deductible	60% after deductible
Acupuncture	80% deductible waived	60% after deductible
Ambulance Service	80% deductible waived	80% deductible waived 60% after deductible for Non-emergent transportation
Autism Spectrum Disorders		
Initial Office Visit to diagnose and Medication Management	100% after $10 copayment deductible waived	60% after deductible
Mental Health Psychotherapy	Not covered	Not covered
Habilitative Therapy	Not covered	Not covered
Applied Behavioral Analysis Therapy	Not covered	Not covered
Biofeedback	80% after deductible	60% after deductible.
Birthing Center	80% after deductible	60% after deductible
Contraceptive Methods	100% deductible waived in accordance with PPACA	60% after deductible
CT Scans, MRI and PET Scans	80% after deductible	60% after deductible
Diabetes Supplies/Equipment	80% after deductible	60% after deductible
Durable Medical Equipment	80% after deductible	60% after deductible
Emergency Room Visit – Including professional services	80% after $50 copayment deductible waived Copayment waived if admitted	80% after $50 copayment deductible waived Copayment waived if admitted
Habilitative therapy – includes physical, and occupational therapy, and speech pathology	80% after deductible 20 combined visits Calendar Year maximum	60% after deductible 20 combined visits Calendar Year maximum
Home Health Care	80% after deductible 100 visits Calendar Year maximum	60% after deductible 100 visits Calendar Year maximum

COVERED CHARGES	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
Hospice Care	80% after deductible	60% after deductible
Bereavement	80% after deductible $25 per visit maximum paid amount 4 visits Calendar Year maximum	60% after deductible $25 per visit maximum paid amount 4 visits Calendar Year maximum
Respite Care	80% after deductible Limited to 5 consecutive days	60% after deductible Limited to 5 consecutive days
Hospital Services		
Inpatient - the semiprivate room rate	80% after deductible	60% after deductible
Ambulatory/Outpatient Surgery Facilities	80% after deductible	60% after deductible
Outpatient Services	80% after deductible	60% after deductible
Jaw Joint Conditions / Temporomandibular Joint Syndrome (TMJ)	Covered same as any illness	Covered same as any illness
Lab & X-ray	80% after deductible	60% after deductible
LiveHealth Online – Medical	100% deductible waived	Not covered
Behavioral Health	100% after $10 copayment deductible waived	Not covered
Mental Disorders and Substance Abuse		
Inpatient, Partial Hospitalization, and Residential treatment - the facility's semiprivate room rate	80% after deductible 100 days Calendar Year maximum combined	Not covered
Outpatient	80% after deductible	Not covered
Office Setting	100% after $10 copayment deductible waived	60% after deductible
Organ Transplants – for recipient and donor.	Covered same as any illness	Covered same as any illness
Physician Services		
Inpatient visits	80% after deductible	60% after deductible
Office visits	100% after $10 copayment deductible waived	60% after deductible
Office Visit Services – including Minor Surgery, Lab, X-ray, and Supplies	80% after deductible	60% after deductible
Surgery (Inpatient and Outpatient)	80% after deductible	60% after deductible
Assistant Surgeon and Anesthesiologists	80% after deductible	60% after deductible
Allergy Injections and Serum	80% after deductible	60% after deductible
Allergy Testing	80% after deductible	60% after deductible
Pre-Admission Testing	80% after deductible	60% after deductible
Pregnancy	Covered same as any illness	Covered same as any illness
Preventive Care – Services as defined by the Patient Protection Affordable Care Act (PPACA) for Network and Non-Network Providers.		
Routine Well Care – All ages	100% deductible waived	60% after deductible
NOTE: Cost sharing (deductibles, copayments, and coinsurance) will be waived for FDA-approved COVID-19 vaccines for Network and Non-Network providers.		

COVERED CHARGES	NETWORKPROVIDERS	NON-NETWORK PROVIDERS
Prosthetics	80% after deductible	60% after deductible
Breast prosthesis – external prosthesis	80% after deductible One every 36 months	60% after deductible One every 36 months
Support garment	80% after deductible Limited to 2 in a 6 month period Up to maximum paid of $50 each	60% after deductible Limited to 2 in a 6 month period Up to maximum paid of $50 each
Rehabilitation – includes Physical, and Occupational Therapies	80% after deductible Limited to 1 treatment per day per therapy	60% after deductible Limited to 1 treatment per day per therapy
NOTE: Inpatient rehabilitation services must begin within 14 days after discharge from a hospital confinement of at least 3 consecutive days.		
Speech therapy	80% after deductible	60% after deductible
Skilled Nursing Facility – the facility's semiprivate room rate	80% after deductible 100 days Calendar Year maximum	60% after deductible 100 days Calendar Year maximum
Spinal Manipulation Chiropractic – only provided through PhysMetrics	100% after $20 copayment deductible waived Limited to 1 visit per day 12 visits Calendar Year maximum	100% deductible waived $10 maximum paid per visit Limited to 1 visit per day 12 visits Calendar Year maximum
NOTE: Pre-certification by PhysMetrics required after 12 visits. All visits for minor dependents up to age 18 must be pre-certified. Claims must be submitted to PhysMetrics.		
X-rays	80% after deductible $100 maximum paid per Calendar Year	60% after deductible $100 maximum paid per Calendar Year
Telemedicine	100% deductible waived	60% after deductible
Travel Expenses – Refer to Travel to Center of Excellence under Covered Charges.		
Accommodations, and Travel – must use TCSIG Center of Excellence	80% after deductible $10,000 Lifetime maximum paid per Covered Person	
NOTE: Transportation and lodging for the Covered Person and one companion. If the Covered Person receiving care is a minor, then reasonable and necessary costs for transportation and lodging may be allowed for two companions. Ground transportation is covered when facility is 75 miles or more from place of residence. Coach airfare is covered when facility is 300 miles or more from place of residence. Lodging is limited to one room, double occupancy.		
Meals – must use TCSIG Center of Excellence	100% deductible waived $50 maximum paid per day per person Maximum is included in $10,000 Lifetime maximum paid for Accommodations and Travel	
NOTE: Meals for Covered Person and one companion. If the Covered Person receiving care is a minor, then reasonable and necessary costs for meals may be allowed for two companions.		
Urgent Care		
Office visit	100% after $10 copayment deductible waived	60% after deductible
All other services	80% after deductible	60% after deductible
Voluntary Sterilization		
Female	100% deductible waived in accordance with PPACA	60% after deductible
Male	80% after deductible	60% after deductible
Wigs – after chemotherapy or radiation therapy	80% after deductible $250 Lifetime maximum paid	60% after deductible $250 Lifetime maximum paid

It is the intent of this Plan to comply with all Federal mandates, for so long as they remain in effect and provide for the screening and testing of patients for COVID-19 as set forth below.

Cost sharing (deductibles, copayments and coinsurance) will be waived for medically necessary screening and testing for FDA-approved COVID-19 including hospital, emergency department, urgent care, and provider office visits, including telehealth where the purpose of the visit is to be screened and/or tested for COVID-19 for Network and Non-Network providers. The screening services are included without cost share even if the visit does not result in an order or administration of the COVID-19 test.

PREMIER PLAN

COVERED CHARGES	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
DEDUCTIBLE, PER CALENDAR YEAR - Network and Non-Network Deductibles are combined.		
Per Covered Person	$500	$1,000
Per Family Unit	$1,000	$2,000
MAXIMUM OUT-OF-POCKET AMOUNT, PER CALENDAR YEAR - Network and Non-Network Out-of-Pocket amounts are combined and are separate from the Prescription Drug Out-of-Pocket maximum.		
Per Covered Person	$2,500	$5,000
Per Family Unit	$5,000	$10,000
The Plan will pay the designated percentage of Covered Charges until out-of-pocket amounts are reached, at which time the Plan will pay 100% of the remainder of Covered Charges for the rest of the Calendar Year unless stated otherwise.		
The following charges do not apply toward the out-of-pocket maximum and are never paid at 100%. Amounts over the Reasonable and Allowed amounts Cost containment penalties Prescription Drugs		
COVERED CHARGES		
Note: The maximums listed below are the total for Network and Non-Network expenses. For example, if a maximum of 60 days is listed twice under a service, the Calendar Year maximum is 60 days total which may be split between Network and Non-Network providers.		
Percentage Payable – unless otherwise stated.	90% after deductible	70% after deductible
Abortion	90% after deductible	70% after deductible
Acupuncture	90% deductible waived	70% after deductible
Ambulance Service	90% deductible waived	90% deductible waived 70% after deductible for Non-emergent transportation
Autism Spectrum Disorders		
Initial Office Visit to diagnose and Medication Management	100% after $15 copayment deductible waived	70% after deductible
Mental Health Psychotherapy	Not covered	Not covered
Habilitative Therapy	Not covered	Not covered
Applied Behavioral Analysis Therapy	Not covered	Not covered
Biofeedback	90% after deductible	70% after deductible
Birthing Center	90% after deductible	70% after deductible
Contraceptive Methods	100% deductible waived in accordance with PPACA	70% after deductible
CT Scans, MRI and PET Scans	90% after deductible	70% after deductible
Diabetes Supplies/Equipment	90% after deductible	70% after deductible
Durable Medical Equipment	90% after deductible	70% after deductible
Emergency Room Visit – Including professional services	90% after $50 copayment deductible waived Copayment waived if admitted	90% after $50 copayment deductible waived Copayment waived if admitted
Habilitative therapy – includes physical, and occupational therapy, and speech pathology	90% after deductible 20 combined visits Calendar Year maximum	70% after deductible 20 combined visits Calendar Year maximum
Home Health Care	90% after deductible 100 visits Calendar Year maximum	70% after deductible 100 visits Calendar Year maximum

COVERED CHARGES	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
Hospice Care	90% after deductible	70% after deductible
Bereavement	90% after deductible $25 per visit maximum paid amount 4 visits Calendar Year maximum	70% after deductible $25 per visit maximum paid amount 4 visits Calendar Year maximum
Respite Care	90% after deductible Limited to 5 consecutive days	70% after deductible Limited to 5 consecutive days
Hospital Services		
Inpatient – the semiprivate room rate	90% after deductible	70% after deductible
Ambulatory/Outpatient Surgery Facilities	90% after deductible	70% after deductible
Outpatient Services	90% after deductible	70% after deductible
Jaw Joint Conditions / Temporomandibular Joint Syndrome (TMJ)	Covered same as any illness	Covered same as any illness
Lab & X-ray	90% after deductible	70% after deductible
LiveHealth Online – Medical	100% deductible waived	Not covered
Behavioral Health	100% after $15 copayment deductible waived	Not covered
Mental Disorders and Substance Abuse		
Inpatient, Partial Hospitalization, and Residential treatment - the facility's semiprivate room rate	90% after deductible 100 days Calendar Year maximum combined with partial hospitalization	Not covered
Outpatient	90% after deductible	Not covered
Office Setting	100% after $15 copayment deductible waived	70% after deductible
Organ Transplants – for recipient and donor	Covered same as any illness	Covered same as any illness
Physician Services		
Inpatient visits	90% after deductible	70% after deductible
Office visits	100% after $15 copayment deductible waived	70% after deductible
Office Visit Services – including Minor Surgery, Lab, X-ray, and Supplies	90% after deductible	70% after deductible
Surgery (Inpatient and Outpatient)	90% after deductible	70% after deductible
Assistant Surgeon and Anesthesiologists	90% after deductible	70% after deductible
Allergy Injections and Serum	90% after deductible	70% after deductible
Allergy Testing	90% after deductible	70% after deductible
Pre-Admission Testing	90% after deductible	70% after deductible
Pregnancy	Covered same as any illness	Covered same as any illness
Preventive Care – Services as defined by the Patient Protection Affordable Care Act (PPACA) for Network and Non-Network Providers.		
Routine Well Care – All ages	100% deductible waived	70% after deductible
NOTE: Cost sharing (deductibles, copayments, and coinsurance) will be waived for FDA-approved COVID-19 vaccines for Network and Non-Network providers.		

COVERED CHARGES	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
Prosthetics	90% after deductible	70% after deductible
Breast prosthesis – external prosthesis	90% after deductible One every 36 months	70% after deductible One every 36 months
Support garment	90% after deductible Limited to 2 in a 6 month period Up to maximum paid of $50 each	70% after deductible Limited to 2 in a 6 month period Up to maximum paid of $50 each
Rehabilitation – includes Physical, and Occupational Therapies	90% after deductible Limited to 1 treatment per day per therapy	70% after deductible Limited to 1 treatment per day per therapy
NOTE: Inpatient rehabilitation services must begin within 14 days after discharge from a hospital confinement of at least 3 consecutive days.		
Speech therapy	90% after deductible	70% after deductible
Skilled Nursing Facility – the facility's semiprivate room rate	90% after deductible 100 days Calendar Year maximum	70% after deductible 100 days Calendar Year maximum
Spinal Manipulation Chiropractic – only provided through PhysMetrics	100% after $20 copayment deductible waived Limited to 1 visit per day 12 visits Calendar Year maximum	100% deductible waived $10 maximum paid per visit Limited to 1 visit per day 12 visits Calendar Year maximum
NOTE: Pre-certification by PhysMetrics required after 12 visits. All visits for minor dependents up to age 18 must be pre-certified. Claims must be submitted to PhysMetrics.		
X-rays	90% after deductible $100 maximum paid per Calendar Year	70% after deductible $100 maximum paid per Calendar Year
Telemedicine	100% deductible waived	70% after deductible
Travel Expenses – Refer to Travel to Center of Excellence under Covered Charges.		
Accommodations, and Travel – must use TCSIG Center of Excellence	90% after deductible $10,000 Lifetime maximum paid per Covered Person	
NOTE: Transportation and lodging for the Covered Person and one companion. If the Covered Person receiving care is a minor, then reasonable and necessary costs for transportation and lodging may be allowed for two companions. Ground transportation is covered when facility is 75 miles or more from place of residence. Coach airfare is covered when facility is 300 miles or more from place of residence. Lodging is limited to one room, double occupancy.		
Meals – must use TCSIG Center of Excellence	100% deductible waived $50 maximum paid per day per person Maximum is included in $10,000 Lifetime maximum paid for Accommodations and Travel	
NOTE: Meals for Covered Person and one companion. If the Covered Person receiving care is a minor, then reasonable and necessary costs for meals may be allowed for two companions.		
Urgent Care		
Office visit	100% after $15 copayment deductible waived	70% after deductible
All other services	90% after deductible	70% after deductible
Voluntary Sterilization		
Female	100% deductible waived in accordance with PPACA	70% after deductible
Male	90% after deductible	70% after deductible
Wigs – after chemotherapy or radiation therapy	90% after deductible $250 Lifetime maximum paid	70% after deductible $250 Lifetime maximum paid

It is the intent of this Plan to comply with all Federal mandates, for so long as they remain in effect and provide for the screening and testing of patients for COVID-19 as set forth below.

Cost sharing (deductibles, copayments and coinsurance) will be waived for medically necessary screening and testing for FDA-approved COVID-19 including hospital, emergency department, urgent care, and provider office visits, including telehealth where the purpose of the visit is to be screened and/or tested for COVID-19 for Network and Non-Network providers. The screening services are included without cost share even if the visit does not result in an order or administration of the COVID-19 test.

STANDARD PLAN

<table>
<tr><th>COVERED CHARGES</th><th>NETWORK PROVIDERS</th><th>NON-NETWORK PROVIDERS</th></tr>
<tr><td colspan="3">DEDUCTIBLE, PER CALENDAR YEAR - Network and Non-Network Deductibles are combined.</td></tr>
<tr><td>Per Covered Person</td><td>$750</td><td>$1,500</td></tr>
<tr><td>Per Family Unit</td><td>$1,500</td><td>$3,000</td></tr>
<tr><td colspan="3">MAXIMUM OUT-OF-POCKET AMOUNT, PER CALENDAR YEAR - Network and Non-Network Out-of-Pocket amounts are combined and are separate from the Prescription Drug Out-of-Pocket maximum.</td></tr>
<tr><td>Per Covered Person</td><td>$3,500</td><td>$7,000</td></tr>
<tr><td>Per Family Unit</td><td>$7,000</td><td>$14,000</td></tr>
<tr><td colspan="3">The Plan will pay the designated percentage of Covered Charges until out-of-pocket amounts are reached, at which time the Plan will pay 100% of the remainder of Covered Charges for the rest of the Calendar Year unless stated otherwise.</td></tr>
<tr><td colspan="3">The following charges do not apply toward the out-of-pocket maximum and are never paid at 100%.

Amounts over the Reasonable and Allowed amounts
Cost containment penalties
Prescription Drugs</td></tr>
<tr><td colspan="3">COVERED CHARGES</td></tr>
<tr><td colspan="3">Note: The maximums listed below are the total for Network and Non-Network expenses. For example, if a maximum of 60 days is listed twice under a service, the Calendar Year maximum is 60 days total which may be split between Network and Non-Network providers.</td></tr>
<tr><td>Percentage Payable – unless otherwise stated.</td><td>80% after deductible</td><td>60% after deductible</td></tr>
<tr><td>Abortion</td><td>80% after deductible</td><td>60% after deductible</td></tr>
<tr><td>Acupuncture</td><td>80% deductible waived</td><td>60% after deductible</td></tr>
<tr><td>Ambulance Service</td><td>80% deductible waived</td><td>80% deductible waived
60% after deductible for Non-emergent transportation</td></tr>
<tr><td colspan="3">Autism Spectrum Disorders</td></tr>
<tr><td>Initial Office Visit to diagnose and Medication Management</td><td>100% after $20 copayment deductible waived</td><td>60% after deductible</td></tr>
<tr><td>Mental Health Psychotherapy</td><td>Not covered</td><td>Not covered</td></tr>
<tr><td>Habilitative Therapy</td><td>Not covered</td><td>Not covered</td></tr>
<tr><td>Applied Behavioral Analysis Therapy</td><td>Not covered</td><td>Not covered</td></tr>
<tr><td>Biofeedback</td><td>80% after deductible</td><td>60% after deductible</td></tr>
<tr><td>Birthing Center</td><td>80% after deductible</td><td>60% after deductible</td></tr>
<tr><td>Contraceptive Methods</td><td>100% deductible waived
in accordance with PPACA</td><td>60% after deductible</td></tr>
<tr><td>CT Scans, MRI and PET Scans</td><td>80% after deductible</td><td>60% after deductible</td></tr>
<tr><td>Diabetes Supplies/Equipment</td><td>80% after deductible</td><td>60% after deductible</td></tr>
<tr><td>Durable Medical Equipment</td><td>80% after deductible</td><td>60% after deductible</td></tr>
<tr><td>Emergency Room Visit – Including professional services</td><td>80% after $50 copayment deductible waived
Copayment waived if admitted</td><td>80% after $50 copayment deductible waived
Copayment waived if admitted</td></tr>
<tr><td>Habilitative therapy – includes physical, and occupational therapy, and speech pathology</td><td>80% after deductible
20 combined visits Calendar Year maximum</td><td>60% after deductible
20 combined visits Calendar Year maximum</td></tr>
<tr><td>Home Health Care</td><td>80% after deductible
100 visits Calendar Year maximum</td><td>60% after deductible
100 visits Calendar Year maximum</td></tr>
</table>

COVERED CHARGES	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
Hospice Care	80% after deductible	60% after deductible
Bereavement	80% after deductible $25 per visit maximum paid amount 4 visits Calendar Year maximum	60% after deductible $25 per visit maximum paid amount 4 visits Calendar Year maximum
Respite Care	80% after deductible Limited to 5 consecutive days	60% after deductible Limited to 5 consecutive days
Hospital Services		
Inpatient – the semiprivate room rate	80% after deductible	60% after deductible
Ambulatory/Outpatient Surgery Facilities	80% after deductible	60% after deductible
Outpatient Services	80% after deductible	60% after deductible
Jaw Joint Conditions / Temporomandibular Joint Syndrome (TMJ)	Covered same as any illness	Covered same as any illness
Lab & X-ray	80% after deductible	60% after deductible
LiveHealth Online – Medical	100% deductible waived	Not covered
Behavioral Health	100% after $20 copayment deductible waived	Not covered
Mental Disorders and Substance Abuse		
Inpatient, Partial Hospitalization, and Residential treatment - the facility's semiprivate room rate	80% after deductible 100 days Calendar Year maximum combined with partial hospitalization	Not covered
Outpatient	80% after deductible	Not covered
Office Setting	100% after $20 copayment deductible waived	60% after deductible
Organ Transplants – for recipient and donor.	Covered same as any illness	Covered same as any illness
Physician Services		
Inpatient visits	80% after deductible	60% after deductible
Office visits	100% after $20 copayment deductible waived	60% after deductible
Office Visit Services – including Minor Surgery, Lab, X-ray, and Supplies	80% after deductible	60% after deductible
Surgery (Inpatient and Outpatient)	80% after deductible	60% after deductible
Assistant Surgeon and Anesthesiologists	80% after deductible	60% after deductible
Allergy Injections and Serum	80% after deductible	60% after deductible
Allergy Testing	80% after deductible	60% after deductible
Pre-Admission Testing	80% after deductible	60% after deductible
Pregnancy	Covered same as any illness	Covered same as any illness
Preventive Care – Services as defined by the Patient Protection Affordable Care Act (PPACA) for Network and Non-Network Providers.		
Routine Well Care – All ages	100% deductible waived	60% after deductible
NOTE: Cost sharing (deductibles, copayments, and coinsurance) will be waived for FDA-approved COVID-19 vaccines for Network and Non-Network providers.		
Prosthetics	80% after deductible	60% after deductible
Breast prosthesis – external prosthesis	80% after deductible One every 36 months	60% after deductible One every 36 months
Support garment	80% after deductible Limited to 2 in a 6 month period Up to maximum paid of $50 each	60% after deductible Limited to 2 in a 6 month period Up to maximum paid of $50 each

COVERED CHARGES	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
Rehabilitation – includes Physical, and Occupational Therapies	80% after deductible Limited to 1 treatment per day per therapy	60% after deductible Limited to 1 treatment per day per therapy
NOTE: Inpatient rehabilitation services must begin within 14 days after discharge from a hospital confinement of at least 3 consecutive days.		
Speech therapy	80% after deductible	60% after deductible
Skilled Nursing Facility – the facility's semiprivate room rate	80% after deductible 100 days Calendar Year maximum	60% after deductible 100 days Calendar Year maximum
Spinal Manipulation Chiropractic – provided through PhysMetrics	100% after $20 copayment deductible waived Limited to 1 visit per day 12 visits Calendar Year maximum	100% deductible waived $10 maximum paid per visit Limited to 1 visit per day 12 visits Calendar Year maximum
NOTE: Pre-certification by PhysMetrics required after 12 visits. All visits for minor dependents up to age 18 must be pre-certified. Claims must be submitted to PhysMetrics.		
X-rays	80% after deductible $100 maximum paid per Calendar Year	60% after deductible $100 maximum paid per Calendar Year
Telemedicine	100% deductible waived	60% after deductible
Travel Expenses – Refer to Travel to Center of Excellence under Covered Charges.		
Accommodations, and Travel – must use TCSIG Center of Excellence	80% after deductible $10,000 Lifetime maximum paid per Covered Person	
NOTE: Transportation and lodging for the Covered Person and one companion. If the Covered Person receiving care is a minor, then reasonable and necessary costs for transportation and lodging may be allowed for two companions. Ground transportation is covered when facility is 75 miles or more from place of residence. Coach airfare is covered when facility is 300 miles or more from place of residence. Lodging is limited to one room, double occupancy.		
Meals – must use TCSIG Center of Excellence	100% deductible waived $50 maximum paid per day per person Maximum is included in $10,000 Lifetime maximum paid for Accommodations and Travel	
NOTE: Meals for Covered Person and one companion. If the Covered Person receiving care is a minor, then reasonable and necessary costs for meals may be allowed for two companions.		
Urgent Care		
Office visit	100% after $20 copayment deductible waived	60% after deductible
All other services	80% after deductible	60% after deductible
Voluntary Sterilization		
Female	100% deductible waived in accordance with PPACA	60% after deductible
Male	80% after deductible	60% after deductible
Wigs – after chemotherapy or radiation therapy	80% after deductible $250 Lifetime maximum paid	60% after deductible $250 Lifetime maximum paid

It is the intent of this Plan to comply with all Federal mandates, for so long as they remain in effect and provide for the screening and testing of patients for COVID-19 as set forth below.

Cost sharing (deductibles, copayments and coinsurance) will be waived for medically necessary screening and testing for FDA-approved COVID-19 including hospital, emergency department, urgent care, and provider office visits, including telehealth where the purpose of the visit is to be screened and/or tested for COVID-19 for Network and Non-Network providers. The screening services are included without cost share even if the visit does not result in an order or administration of the COVID-19 test.

PRESCRIPTION DRUG BENEFIT SCHEDULE
FOR BASIC, PREMIER PLUS, PREMIER AND STANDARD PPO PLANS

Please contact the Prescription Drug Administrator for additional information.

PRESCRIPTION DRUG BENEFIT		
MAXIMUM OUT-OF-POCKET AMOUNT PER CALENDAR YEAR - The maximum out-of-pocket expense for Prescription Drug benefits includes copayments and is separate from the Medical Out-of-Pocket maximum.		
	NETWORK	**NON-NETWORK**
Per Covered Person	$1,000	Not Applicable
Per Family Unit	$2,000	Not Applicable
Pharmacy Option (31 Day Supply)		
Generic Drugs	$5 copayment	Prescriptions are only covered at participating pharmacies
Formulary Brand Name Drugs	25% to a maximum of $35 copayment	Prescriptions are only covered at participating pharmacies
Non-Formulary Brand Name Drugs	45% to a maximum of $70 copayment	Prescriptions are only covered at participating pharmacies
Pharmacy Option (90 Day Supply)		
Generic Drugs	$10 copayment	Prescriptions are only covered at participating pharmacies
Formulary Brand Name Drugs	$50 copayment	Prescriptions are only covered at participating pharmacies
Non-Formulary Brand Name Drugs	$90 copayment	Prescriptions are only covered at participating pharmacies
Mail Order Option (90 Day Supply)		
Generic Drugs	$10 copayment	Not Applicable
Formulary Brand Name Drugs	$50 copayment	Not Applicable
Non-Formulary Brand Name Drugs	$90 copayment	Not Applicable
Refer to the Prescription Drug Section for details on the Prescription Drug benefit.		

Should the Covered Person request a brand name drug when the generic is available, and the Physician has NOT provided evidence of medical necessity, the Covered Person will be liable for the difference between the brand name and the generic in addition to the brand name Copay.

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

MEDICAL BENEFITS SCHEDULE
CONSUMER DRIVEN HEALTH PLAN (HDHP)

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

COVERED CHARGES	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
DEDUCTIBLE, PER CALENDAR YEAR - Network and Non-Network Deductibles are combined. The Medical Deductible is combined with the Prescription Drug Deductible.		
Single Coverage	$1,500	$3,000
Family Unit - aggregate	$3,000	$6,000
No benefits will be paid for any member of a Family Unit until the Family Unit deductible has been met regardless of the number of participants it takes to meet the family deductible.		
MAXIMUM OUT-OF-POCKET AMOUNT, PER CALENDAR YEAR - Network and Non-Network Out-of-Pocket amounts are combined. The Medical Out-of-Pocket maximum is combined with the Prescription Drug Out-of-Pocket maximum.		
Single Coverage	$5,000	$10,000
Family Unit	$10,000	$20,000
The Plan will pay the designated percentage of Covered Charges until out-of-pocket amounts are reached. The Family out-of-pocket includes an embedded out-of-pocket whereby once an individual reaches the single coverage out-of-pocket, the Plan will pay 100% of the remainder of Covered Charges for that individual for the rest of the Calendar Year unless stated otherwise. Once the Family out-of-pocket is reached, the Plan will pay 100% of the remainder of Covered Charges for the entire family for the rest of the Calendar Year unless stated otherwise.		
The following charges do not apply toward the out-of-pocket maximum and are never paid at 100%. Amounts over the Reasonable and Allowed amounts Cost containment penalties		
COVERED CHARGES		
Note: The maximums listed below are the total for Network and Non-Network expenses. For example, if a maximum of 60 days is listed twice under a service, the Calendar Year maximum is 60 days total which may be split between Network and Non-Network providers.		
Percentage Payable – unless otherwise stated.	50% after deductible	40% after deductible
Abortion	50% after deductible	40% after deductible
Acupuncture	50% after deductible	40% after deductible
Ambulance Service	50% after deductible	50% after deductible 40% after deductible for Non-emergent transportation
Autism Spectrum Disorders		
Initial Office Visit to diagnose and Medication Management	50% after deductible	40% after deductible
Mental Health Psychotherapy	Not covered	Not covered
Habilitative Therapy	Not covered	Not covered
Applied Behavioral Analysis Therapy	Not covered	Not covered
Biofeedback	50% after deductible	40% after deductible
Birthing Center	50% after deductible	40% after deductible
Contraceptive Methods	100% deductible waived in accordance with PPACA	40% after deductible
CT Scans, MRI and PET Scans	50% after deductible	40% after deductible
Diabetes Supplies/Equipment	50% after deductible	40% after deductible

COVERED CHARGES	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
Durable Medical Equipment	50% after deductible	40% after deductible
Emergency Room Visit – Including professional services	50% after deductible	50% after deductible
Habilitative therapy – includes physical, and occupational therapy, and speech pathology	50% after deductible 20 combined visits Calendar Year maximum	40% after deductible 20 combined visits Calendar Year maximum
Home Health Care	50% after deductible 100 visits Calendar Year maximum	40% after deductible 100 visits Calendar Year maximum
Hospice Care	50% after deductible	40% after deductible
Bereavement	50% after deductible $25 per visit maximum paid amount 4 visits Calendar Year maximum	40% after deductible $25 per visit maximum paid amount 4 visits Calendar Year maximum
Respite Care	50% after deductible Limited to 5 consecutive days	40% after deductible Limited to 5 consecutive days
Hospital Services		
Inpatient - the semiprivate room rate	50% after deductible	40% after deductible
Ambulatory/Outpatient Surgery Facilities	50% after deductible	40% after deductible
Outpatient Services	50% after deductible	40% after deductible
Jaw Joint Conditions / Temporomandibular Joint Syndrome (TMJ)	50% after deductible	40% after deductible
Lab & X-ray	50% after deductible	40% after deductible
LiveHealth Online – Medical and Behavioral Health	50% after deductible	Not covered
Mental Disorders and Substance Abuse		
Inpatient, Partial Hospitalization, and Residential treatment - the facility's semiprivate room rate	50% after deductible 100 days Calendar Year maximum combined	Not covered
Outpatient	50% after deductible	Not covered
Office Setting	50% after deductible	40% after deductible
Organ Transplants – for recipient and donor.	Covered same as any illness	Covered same as any illness
Physician Services		
Inpatient visits	50% after deductible	40% after deductible
Office visits	50% after deductible	40% after deductible
Office Visit Services – including Minor Surgery, Lab, X-ray, and Supplies	50% after deductible	40% after deductible
Surgery (Inpatient and Outpatient)	50% after deductible	40% after deductible
Assistant Surgeon and Anesthesiologists	50% after deductible	40% after deductible
Allergy Injections and Serum	50% after deductible	40% after deductible
Allergy Testing	50% after deductible	40% after deductible

COVERED CHARGES	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
Pre-Admission Testing	50% after deductible	40% after deductible
Pregnancy	50% after deductible	40% after deductible
Preventive Care – Services as defined by the Patient Protection Affordable Care Act (PPACA) for Network and Non-Network Providers.		
Routine Well Care – All ages	100% deductible waived	40% after deductible
NOTE: Cost sharing (deductibles, copayments, and coinsurance) will be waived for FDA-approved COVID-19 vaccines for Network and Non-Network providers.		
Prosthetics	50% after deductible	40% after deductible
Breast prosthesis – external prosthesis	50% after deductible One every 36 months	40% after deductible One every 36 months
Support garment	50% after deductible Limited to 2 in a 6 month period Up to maximum paid of $50 each	40% after deductible Limited to 2 in a 6 month period Up to maximum paid of $50 each
Rehabilitation – includes Physical, and Occupational Therapies	50% after deductible Limited to 1 treatment per day per therapy	40% after deductible Limited to 1 treatment per day per therapy
NOTE: Inpatient rehabilitation services must begin within 14 days after discharge from a hospital confinement of at least 3 consecutive days.		
Speech therapy	50% after deductible	40% after deductible
Skilled Nursing Facility – the facility's semiprivate room rate	50% after deductible 100 days Calendar Year maximum	40% after deductible 100 days Calendar Year maximum
Spinal Manipulation Chiropractic – provided through PhysMetrics	50% after deductible Limited to 1 visit per day 12 visits Calendar Year maximum	40% after deductible $10 maximum paid per visit Limited to 1 visit per day 12 visits Calendar Year maximum
NOTE: Pre-certification by PhysMetrics required after 12 visits. All visits for minor dependents up to age 18 must be pre-certified. Claims must be submitted to PhysMetrics.		
X-rays	50% after deductible $100 maximum paid per Calendar Year	40% after deductible $100 maximum paid per Calendar Year
Telemedicine	50% after deductible	40% after deductible
Travel Expenses – Refer to Travel to Center of Excellence under Covered Charges.		
Accommodations, and Travel – must use TCSIG Center of Excellence	50% after deductible $10,000 Lifetime maximum paid per Covered Person	
NOTE: Transportation and lodging for the Covered Person and one companion. If the Covered Person receiving care is a minor, then reasonable and necessary costs for transportation and lodging may be allowed for two companions. Ground transportation is covered when facility is 75 miles or more from place of residence. Coach airfare is covered when facility is 300 miles or more from place of residence. Lodging is limited to one room, double occupancy.		
Meals – must use TCSIG Center of Excellence	100% after deductible $50 maximum paid per day per person Maximum is included in $10,000 Lifetime maximum paid for Accommodations and Travel	
NOTE: Meals for Covered Person and one companion. If the Covered Person receiving care is a minor, then reasonable and necessary costs for meals may be allowed for two companions.		
**Urgent Care - ** includes physician services	50% after deductible	40% after deductible

COVERED CHARGES	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
Voluntary Sterilization		
Female	100% deductible waived in accordance with PPACA	40% after deductible
Male	50% after deductible	40% after deductible
Wigs – after chemotherapy or radiation therapy	50% after deductible $250 Lifetime maximum paid	40% after deductible $250 Lifetime maximum paid

It is the intent of this Plan to comply with all Federal mandates, for so long as they remain in effect and provide for the screening and testing of patients for COVID-19 as set forth below.

Cost sharing (deductibles, copayments and coinsurance) will be waived for medically necessary screening and testing for FDA-approved COVID-19 including hospital, emergency department, urgent care, and provider office visits, including telehealth where the purpose of the visit is to be screened and/or tested for COVID-19 for Network and Non-Network providers. The screening services are included without cost share even if the visit does not result in an order or administration of the COVID-19 test.

PRESCRIPTION DRUG BENEFIT SCHEDULE
FOR CONSUMER DRIVEN HEALTH PLAN (HDHP)

Please contact the Prescription Drug Administrator for additional information.

PRESCRIPTION DRUG BENEFIT		
	NETWORK	**NON-NETWORK**
DEDUCTIBLE, PER CALENDAR YEAR – The Prescripton Drug Deductible is combined with the Medical Deductible.		
Single Coverage	$1,500	Not Applicable
Per Family Unit	$3,000	Not Applicable
MAXIMUM OUT-OF-POCKET AMOUNT PER CALENDAR YEAR - The maximum out-of-pocket expense for Prescription Drug benefits is combied with the Medical Out-of-Pocket maximum.		
Single Coverage	$5,000	Not Applicable
Per Family Unit	$10,000	Not Applicable
Pharmacy Option (31 Day Supply)		
Generic Drugs	50% coinsurance after deductible	Prescriptions are only covered at participating pharmacies
Formulary Brand Name Drugs	50% coinsurance after deductible	Prescriptions are only covered at participating pharmacies
Non-Formulary Brand Name Drugs	50% coinsurance after deductible	Prescriptions are only covered at participating pharmacies
Specialty Drugs	50% coinsurance after deductible	Prescriptions are only covered at participating pharmacies
Mail Order Option or Retail Pharmacy (90 Day Supply) Note that not all Specialty Drugs are available with a 90-day Retai pharmacy supply, and special pricing may apply.		
Generic Drugs	50% coinsurance after deductible	Not Applicable
Formulary Brand Name Drugs	50% coinsurance after deductible	Not Applicable
Non-Formulary Brand Name Drugs	50% coinsurance after deductible	Not Applicable
Specialty Drugs	50% coinsurance after deductible	Prescriptions are only covered at participating pharmacies
Refer to the Prescription Drug Section for details on the Prescription Drug benefit.		

Should the Covered Person request a brand name drug when the generic is available, and the Physician has NOT provided evidence of medical necessity, the Covered Person will be liable for the difference between the brand name and the generic in addition to the brand name Copay.

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

ELIGIBILITY, FUNDING, EFFECTIVE DATE AND TERMINATION PROVISIONS

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

ELIGIBILITY

Eligible Classes of Employees. All Active Employees, who qualify under one of the classes below, and Retired Employees.

New Hires:

- Regular Full-Time Employees: Employees designated by the Employer as Regular Full-Time Employees who are scheduled to work at least 20 hours per week. Coverage for Regular Full-Time Employees becomes effective as determined by the written policies of the Employer, but not sooner than the first day of the month following the date of employment nor can the Waiting Period exceed 90 calendar days.

- Contracted certified (academic) Employees: is a contracted certified (academic) Employee with 50% or greater full-time equivalent workload. Employees becomes effective as determined by the written policies of the Employer, but not sooner than the first day of the month following the date of employment nor can it exceed the Waiting Period.

Each Employer has the discretion to determine which Employee Groups are eligible to participate in the Plan.

Eligible Employees of a new Employer of TCSIG who are Actively at Work and were covered under the Prior Plan of the new Employer will be eligible for the benefits under this Plan on their effective date with TCSIG. Any waiting period previously satisfied under the prior health plan will be applied toward satisfaction of the Waiting Period of this Plan. In the event that a new Employer did not have a health plan, all eligible Employees will be eligible on the date of their effective date with TCSIG.

- Subject to the Employer's bargaining agreement(s) or policies, Retired Employees may be eligible to participate in the Plan provided:

  (a) they are eligible for pension benefits from the Public Employees' Retirement System (P.E.R.S.), the State Teachers' Retirement System (S.T.R.S.), or other recognized public Employee retirement system, and

  (b) they were covered under a TCSIG Plan on the date immediately prior to retirement.

  Retired Employees are considered part of the Employee Group they were in just prior to retirement.

- Eligibility for active elected officials is at the option of each Employer. Retired elected officials who have completed one or more terms of office shall be eligible for coverage under this Plan provided:

  (a) the Employer has a policy that allows Retired elected officials to participate as an eligible group,

  (b) they were covered under a TCSIG Plan on the date immediately prior to retirement, and

  (c) Retired elected officials are considered part of the Employee Group they were in just prior to retirement. If the Employer elects to provide coverage to active or Retired elected officials, all Plan provisions shall apply.

An Employee's status as a Full-Time or Part-Time Employee will be determined on the basis of the average number of hours worked during an initial or standard measurement period, as applicable, as established by the Plan in accordance with applicable law. The Employee's eligibility (or lack of eligibility) for Plan coverage on the

basis of his or her Full-Time or Part-Time status will extend through the stability period established by the Plan in accordance with applicable law. In calculating the average hours worked, the Plan will count hours paid and hours for which the Employee is entitled to payment (such as paid holidays, vacation, pay, etc.). An Employee's status as a Full-Time or Part-Time Employee will be determined on the basis of the Employer's standard employment practices.

Contact the Human Resources Department for additional information.

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

(1) A covered Employee's Spouse.

The term "Spouse" shall mean the person with whom the covered Employee has established a valid marriage under applicable State law but does not include common law marriages. The term "Spouse" shall include an individual of the same sex as the covered employee, if they were legally married under the laws of a State or other foreign or domestic jurisdiction. The Plan Administrator may require documentation proving a legal marital relationship.

The term "Spouse" shall also mean the person who is currently registered with the Employer as the Domestic Partner of the Employee, this includes opposite sex and same sex couples. An individual is a Domestic Partner of an Employee if that individual and the Employee meet each of the following requirements:

(a) The Employee and individual are 18 years of age or older and are mentally competent to enter into a legally binding contract.

(b) The Employee and the individual are not married to anyone.

(c) The Employee and the individual are not related by blood to a degree of closeness that would prohibit legal marriage between individuals of the opposite sex in the state in which they reside.

(d) The Employee and the individual share the same principal residence(s), the common necessities of life, the responsibility for each other's welfare, are financially interdependent with each other and have a long-term committed personal relationship in which each partner is the other's sole domestic partner. Each of the foregoing characteristics of the domestic partner relationship must have been in existence for a period of at least twelve (12) consecutive months and be continuing during the period that the applicable benefit is provided. The Employee and the individual must have the intention that their relationship will be indefinite.

(e) The Employee and the individual have common or joint ownership of a residence (home, condominium, or mobile home), motor vehicle, checking account, credit account, mutual fund, joint obligation under a lease for their residence or similar type ownership.

To obtain more detailed information or to apply for this benefit, the Employee must contact the Plan Administrator, Tri-County Schools Insurance Group (TCSIG), 400 Plumas Boulevard, Suite 210, Yuba City, California, 95991, 866-822-5299.

In the event the domestic partnership is terminated, either partner is required to inform Tri-County Schools Insurance Group (TCSIG) of the termination of the partnership.

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

(2) A covered Employee's Child(ren).

An Employee's "Child" includes his natural child, child for whom the Employee is the legal guardian, stepchild, adopted child, or a child placed with the Employee for adoption. An Employee's Child will

be an eligible Dependent until reaching the limiting age of 26, without regard to student status, marital status, financial dependency or residency status with the Employee or any other person. When the child reaches the applicable limiting age, coverage will end on the last day of the child's birthday month.

The phrase "placed for adoption" refers to a child whom a person intends to adopt, whether or not the adoption has become final, who has not attained the age of 18 as of the date of such placement for adoption. The term "placed" means the assumption and retention by such person of a legal obligation for total or partial support of the child in anticipation of adoption of the child. The child must be available for adoption and the legal process must have commenced.

Any child of a Plan Participant who is an alternate recipient under a qualified medical child support order shall be considered as having a right to Dependent coverage under this Plan.

A participant of this Plan may obtain, without charge, a copy of the procedures governing qualified medical child support order (QMCSO) determinations from the Plan Administrator.

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

(3) A Child who has a physical and/or mental disability that existed prior to age twenty-six (26) and continues to the present time shall remain eligible for coverage provided:

(a) The Child is unmarried; and

(b) The Child is incapable of self-sustaining employment due to mental and/or physical disability; and

(c) The Child is principally dependent upon the Employee for support and maintenance. (Named as an exemption on the Employee's most current Federal Income Tax Return. Proof may be required.); and

(d) The Dependent must have been covered under the Plan before attaining the limiting age in order to be eligible for continued coverage. A disability is a physical and/or mental impairment that prevents or interferes with normal functions, activities or achievement. Proof of incapacitation must be provided at the Employee's expense within thirty-one (31) days of the Child's twenty-sixth (26) birthday and thereafter as requested by TCSIG or the Claims Administrator, but not more than once every two (2) years.

Eligibility may not be continued beyond the earliest of the following:

(a) Cessation of the disability;

(b) Failure to furnish any required proof of mental and/or physical disability or to submit to any required examination.

Eligible Dependents do not include:

(a) Children of a Dependent Child.

(b) Dependents who are, or become, a full-time member of the armed forces of any country.

(c) Grandchildren or foster Children, unless legally adopted and/or ward.

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

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

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

FUNDING

Cost of the Plan. The participating Employers shall maintain discretion as to whether or not an Employee Group shall contribute toward the cost of coverage under this Plan. The same rate structure (i.e., composite or tiered) shall apply for all Employees in an Employee Group.

All covered Retirees age sixty-five (65) and older who are eligible for Medicare Part A must enroll in Medicare A and B. If any retired Covered Person is eligible for Medicare Parts A and B and fails to enroll, benefits will be paid as though he had enrolled. If the Employer elects Retirees to be eligible to participate, contributions may be Retiree or Employer paid at the discretion of the Employer. Retirees shall be placed on the tiered rate structure or may be placed, with their Employer's approval, on a composite rate if they enroll two or more dependents and their former, active group is also composite. If a Retiree enrolls in both Medicare Parts A and B, TCSIG may provide a discounted contribution schedule, provided the Plan is secondary payer to Medicare.

ENROLLMENT

Enrollment Requirements. An Employee must enroll for coverage by filling out and signing an enrollment application along with the appropriate payroll deduction authorization. The covered Employee is required to enroll each Dependent for coverage.

Enrollment Requirements for Newborn Children.

A newborn child of a covered Employee who has Dependent coverage is not automatically enrolled in this Plan. If the newborn child is not enrolled in this Plan on a timely basis, as defined in the section "Timely Enrollment" following this section, there will be no payment from the Plan and the parents will be responsible for all costs.

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

TIMELY OR LATE ENROLLMENT

(1) **Timely Enrollment** - The enrollment will be "timely" if the completed form is received by the Plan Administrator no later than 31 days after the person becomes eligible for the coverage, either initially or under a Special Enrollment Period.

If two Employees who are covered under the Plan are the parents of children who are covered under the Plan, and the Employee who is covering the Dependent children terminates coverage, the Dependent coverage may be continued by the other covered Employee with no Waiting Period as long as coverage has been continuous.

(2) **Late Enrollment** - An enrollment is "late" if it is not made on a "timely basis" or during a Special Enrollment Period. Late Enrollees and their eligible Dependents who are not eligible to join the Plan during a Special Enrollment Period may join only during open enrollment.

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

The time between the date a Late Enrollee first becomes eligible for enrollment under the Plan and the first day of coverage is not treated as a Waiting Period. Coverage begins on the date determined by TCSIG.

SPECIAL ENROLLMENT RIGHTS

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

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

The Special Enrollment rules are described in more detail below. To request Special Enrollment or obtain more detailed information of these portability provisions, contact the Plan Administrator, Tri-County Schools Insurance Group (TCSIG), 400 Plumas Boulevard, Suite 210, Yuba City, California, 95991, 866-822-5299.

SPECIAL ENROLLMENT PERIODS

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

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

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

(b) If required by the Plan Administrator, the Employee stated in writing at the time that coverage was offered that the other health coverage was the reason for declining enrollment.

(c) Either (i) the other coverage was COBRA coverage and the COBRA coverage was exhausted, or (ii) the other coverage was not COBRA coverage, and the coverage was terminated as a result of loss of eligibility for the coverage or because employer contributions towards the coverage were terminated. Coverage will begin the day immediately following the date other coverage terminates.

(d) The Employee or Dependent requests enrollment in this Plan not later than 31 days after the date of exhaustion of COBRA coverage or the termination of non-COBRA coverage due to loss of eligibility or termination of employer contributions, described above. Coverage will begin the day immediately following the date other coverage terminates.

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

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

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

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

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

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

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

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

(b) A person becomes a Dependent of the Employee through marriage, registration of domestic partnership, birth, adoption or placement for adoption,

then the Dependent may be enrolled under this Plan. If the Employee is not enrolled at the time of the event, the Employee must enroll under this Special Enrollment Period in order for his eligible Dependents to enroll. In the case of the birth or adoption of a child, the Spouse or Domestic Partner of the covered Employee may be enrolled as a Dependent of the covered Employee if the Spouse or Domestic Partner is otherwise eligible for coverage.

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

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

(a) in the case of marriage, as of the date of marriage, or in the case of domestic partner relationship, on the date of registration of the domestic partner relationship; or

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

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

The monthly contribution for coverage will not be pro-rated for any portion of a month. If coverage for a newly acquired dependent begins before the 16th of the month, the new increased premium will be charged for the entire month. If not, the premium will be increased the first of the following month.

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

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

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

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

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

STATUS CHANGE

(1) For Employee's who have an employment status change with the Employer, coverage will be effective on the first of the month following receipt of written application for enrollment and any required contribution.

(2) If an Employee is removed from Active Employment due to total disability, the Employer shall notify TCSIG the same business day of the action.

Upon approval by TCSIG, enrollment changes requested by an Employer under a collective bargaining agreement.

Once enrolled in the Plan, **it is the responsibility of the Employee to notify the Employer** of any change in eligibility of Dependents including the birth of a Child that is to be covered and adding or deleting any other Dependents.

EFFECTIVE DATE

Active Employee Requirement.

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

Effective Date of Dependent Coverage. A Dependent's coverage will take effect on the day that the Eligibility Requirements are met; the Employee is covered under the Plan; and all Enrollment Requirements are met.

TERMINATION OF COVERAGE

The Employer or Plan has the right to rescind any coverage of the Employee and/or Retiree and/or Dependents for cause, making a fraudulent claim or an intentional material misrepresentation in applying for or obtaining coverage, or obtaining benefits under the Plan. The Employer or Plan may either void coverage for the Employee and/or covered Retirees and/or covered Dependents for the period of time coverage was in effect, may terminate coverage as of a date to be determined at the Plan's discretion, or may immediately terminate coverage. If coverage is to be terminated or voided retroactively for fraud or misrepresentation, the Plan will provide written notice at least 30 days in advance of such action. The Employer will refund all contributions paid for any coverage rescinded; however, claims paid will be offset from this amount. The Employer reserves the right to collect

additional monies if claims are paid in excess of the Employee's and/or Retiree's and/or Dependent's paid contributions.

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

(1) The date the Plan is terminated.

(2) The last day of the calendar month in which the covered Employee ceases to be in one of the Eligible Classes. This includes death or termination of Active Employment of the covered Employee. (See the section entitled Continuation Coverage Rights under COBRA.) It also includes an Employee on disability, leave of absence or other leave of absence, unless the Plan specifically provides for continuation during these periods.

(3) The last day of the month in which any required contributions have been made on the Employee’s behalf.

(4) The date the Employee becomes a full-time, active member of the armed forces of any country, other than scheduled drills or other training not exceeding one month in any Calendar Year.

(5) The first day an Employee fails to return to work following an approved Leave of Absence.

(6) If an Employee commits fraud, makes an intentional misrepresentation of material fact in applying for or obtaining coverage, or obtaining benefits under the Plan, or fails to notify the Plan Administrator that he or she has become ineligible for coverage, then the Employer or Plan may either void coverage for the Employee and covered Dependents for the period of time coverage was in effect, may terminate coverage as of a date to be determined at the Plan's discretion, or may immediately terminate coverage. If coverage is to be terminated or voided retroactively for fraud or misrepresentation, the Plan will provide written notice at least 30 days in advance of such action.

Employees whose contract expires with the close of the current school year may be covered until the beginning of the following school year at the discretion of the Employer.

Leave Of Absence. If an Employee is absent from work because of an approved extended Leave of Absence due to Illness or Injury, coverage may be considered to continue until terminated by the Employer, but for no longer than twelve (12) months following the calendar month in which the absence started, provided the Employer and/or Employee makes the required contributions.

If an Employee is absent from work because of an approved sabbatical Leave of Absence, coverage may be considered to continue until terminated by the Employer, but for no longer than twelve (12) months following the calendar month in which the absence started, provided the Employer and/or Employee makes the required contributions.

If an Employee is absent from work because of an approved temporary Leave of Absence, coverage may be considered to continue until terminated by the Employer, but for no longer than twelve (12) months following the calendar month in which the leave started, provided the Employer and/or Employee makes the required contributions.

The Break in Coverage provision below shall not apply to an Employee returning to work from an approved leave under the Family Medical Leave Act.

All employees who were on the Plan effective January 1, 2021 will remain eligible for continued enrollment on the Plan despite any actively-at-work or minimum-hour requirements during the time that:

(1) the Employee is on furlough or reduced hours furlough with an offer of medical benefits; or

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

Continuation During Family and Medical Leave. Regardless of the established leave policies mentioned above, this Plan shall at all times comply with the Family and Medical Leave Act, as amended, and as promulgated in regulations issued by the Department of Labor, as well as any state employment regulations which require additional periods of leave and are applicable to the Plan Sponsor.

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

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

Break In Coverage. A break in coverage occurs whenever an Employee remains employed by the Employer, but coverage under the Plan terminates for either the Employee or Dependents. After a break in coverage, the Employee and/or Dependents may only re-enroll in the Plan during the annual open enrollment, unless there is a status change. (Refer to Status Change.)

If the Employee fails to make the required contributions, coverage shall terminate the last day of the month in which contributions were made. When coverage terminates, the Break in Coverage provision shall apply.

Reinstatement. If an Employee terminates employment with the Employer and coverage under the Plan ceases, the Employee will be subject to all Plan provisions as a new Employee if the break in service exceeds thirteen (13) weeks or twenty-six (26) weeks from an educations organization. However, if the Employee is returning to work directly from COBRA coverage, this Employee does not have to satisfy any employment waiting period.Retirees and Retired elected officials and any Dependents of Retirees and Retired elected officials that discontinue coverage cannot re-enroll in this Plan. The Break in Coverage provision shall not apply.

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

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

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

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

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

(3) An exclusion or Waiting Period may not be imposed in connection with the reinstatement of coverage upon reemployment if one would not have been imposed had coverage not been terminated because of service. However, an exclusion or Waiting Period may be imposed for coverage of any Illness or Injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of uniformed service.

If the Employee wishes to elect this coverage or obtain more detailed information, contact the Plan Administrator Tri-County Schools Insurance Group (TCSIG), 400 Plumas Boulevard, Suite 210, Yuba City, California, 95991, 866-822-5299. The Employee may also have continuation rights under USERRA. In general, the Employee must meet the same requirements for electing USERRA coverage as are required under COBRA continuation coverage requirements. Coverage elected under these circumstances is concurrent, not cumulative. The Employee may elect USERRA continuation coverage for the Employee and their Dependents. Only the Employee has election rights. Dependents do not have any independent right to elect USERRA health plan continuation.

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

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

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

(3) The date a covered Spouse loses coverage due to loss of eligibility status. (See the section entitled Continuation Coverage Rights under COBRA.)

(4) Coverage in which the Qualified Dependent ceases to meet the applicable eligibility requirements. (See the section entitled Continuation Coverage Rights under COBRA.)

(5) Coverage will end on the last day of the month in which the Child ceases to meet the applicable eligibility requirements. (See the section entitled Continuation Coverage Rights under COBRA.)

(6) The last day of the month in which any required contribution have been made on his behalf.

(7) The date the Employee requests that Dependents' coverage be terminated The date the Employee requests that Dependents' coverage be terminated.

(8) If a Dependent commits fraud or makes an intentional misrepresentation of material fact in applying for or obtaining coverage, or obtaining benefits under the Plan, or fails to notify the Plan Administrator that he or she has become ineligible for coverage, then the Employer or Plan may either void coverage for the Dependent for the period of time coverage was in effect, may terminate coverage as of a date to be determined at the Plan's discretion, or may immediately terminate coverage. If coverage is to be terminated or voided retroactively for fraud or misrepresentation, the Plan will provide written notice at least 30 days in advance of such action.

Survivors's Benefits. Subject to the terms and conditions in effect for each Employer, surviving Dependents may be eligible to continue coverage under the Plan after the death of the Employee. Survivors' benefits shall be continued after the Employee's death while contributions are continued, if required. Surviving spouse and Dependents shall be considered part of the Employee Group they were in just prior to becoming eligible for survivors' benefits.

However, coverage shall not be continued beyond the earliest of the following occurrences:

(1) The date the Employer terminates the Plan and offers no other group health plan.

(2) Termination of Dependent coverage under this Plan.

(3) The end of the period for which contributions (if required) have been paid.

(4) When the surviving spouse remarries.

(5) When the surviving spouse becomes eligible for any other group health coverage.

(6) When the Child ceases to meet the eligibility requirements or becomes eligible for other group health coverage.

Survivor benefits may be provided under this Plan to an Employee's Child who is born after the Employee's death, as long as coverage for the Employee's other Dependents is being continued under this Section.

For the purposes of filing a claim and payment of claims, the Employee's spouse, if living will be considered as the Employee, otherwise the Child (or the legal guardian) claiming benefits will be so considered.

This Section will not apply to a Dependent for whom a greater period of coverage is provided elsewhere in this Plan.

OPEN ENROLLMENT

The annual open enrollment is to allow Employees, Retirees, and their eligible Dependents who are currently enrolled in a TCSIG medical benefits plan the opportunity to enroll in any TCSIG medical plan offered by their Employer. In addition, Employees may enroll their eligible Dependents who are not currently enrolled under a TCSIG plan. Retirees and Retired elected officials and any Dependents of Retirees and Retired elected officials that discontinue coverage cannot re-enroll in this Plan unless they continue to be enrolled as a dependent under their spouse's TCSIG medical plan. The period of the annual open enrollment and the Effective Date of coverage after open enrollment shall be determined by TCSIG. Enrollment is for a period of twelve (12) months subject to the Plan provisions. Participation by individual Employers in the annual open enrollment shall be at the sole discretion of each Employer.

MEDICAL BENEFITS

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

DEDUCTIBLE – PPO Plans

Deductible Amount. This is an amount of Covered Charges for which no benefits will be paid. Before benefits can be paid in a Calendar Year a Covered Person must meet the deductible shown in the Schedule of Benefits.

Deductible Three Month Carryover. Covered Charges incurred in, and applied toward the deductible in the last three months of the Calendar Year will be applied toward the deductible in the next Calendar Year.

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

Deductible For A Common Accident. This provision applies when two or more Covered Persons in a Family Unit are injured in the same accident.

These persons need not meet separate deductibles for treatment of injuries incurred in this accident; instead, only one deductible for the Calendar Year in which the accident occurred will be required for them as a unit for expenses arising from the accident.

DEDUCTIBLE – High Deductible Health Plan (HDHP) with Health Saving Account (HSA PLAN)

Single Deductible. The Calendar Year Deductible is the amount of Covered Expense which the Covered Person incurs and pays Out-of-pocket during each Calendar Year before any Benefit Percentage applies for services and supplies rendered. Charges which are not covered under the Plan, or charges which exceed the Reasonable and Allowable Amount for the service or supply rendered may not be used to satisfy the Deductible.

Family Deductible. If in any Calendar Year covered members of a family shall have cumulatively incurred sufficient Covered Expenses to satisfy the Deductible specified, the Deductible shall be deemed to be satisfied for all covered members of the family in that Calendar Year.

Deductible Three Month Carryover. In order to maintain the Internal Revenue Service (IRS) qualification for federal exemption of associated health savings accounts, the carryover of prior year last quarter Deductible expenses is not allowed.

Deductible expense shall only apply in the Calendar Year in which it occurred.

This Plan will provide credit for any Deductible and Benefit Percentage satisfied under a prior TCSIG Plan in the same Benefit Plan Year. If this Plan's Calendar Year Deductible and/or Coinsurance are greater than the prior TCSIG Plan, the Covered Person must satisfy the remaining Deductible and/or Coinsurance requirement of this Plan.

BENEFIT PAYMENT

Each Calendar Year, benefits will be paid for the Covered Charges of a Covered Person that are in excess of the deductible and any copayments. Payment will be made at the rate shown under reimbursement rate in the Schedule of Benefits. No benefits will be paid in excess of the Maximum Benefit Amount or any listed limit of the Plan.

OUT-OF-POCKET LIMIT – PPO PLANS

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

When a Family Unit reaches the out-of-pocket limit, Covered Charges for that Family Unit will be payable at 100% (except for any charges excluded, as shown on the Schedule of Benefits) for the rest of the Calendar Year. Covered Charges for an individual family member who meets the individual out-of-pocket limit before the out-of-pocket limit for the Family Unit is met will be covered at 100% (except for any charges excluded as shown in the Schedule of Benefits) for the rest of the Calendar Year.

OUT-OF-POCKET LIMIT – High Deductible Health Plan (HDHP) with Health Saving Account (HSA PLAN)

After the Covered Person has paid an amount equal to the Out-of-pocket expense the Plan shall pay one hundred percent (100%) of Covered Expenses for the remainder of the Calendar Year, subject to the limitations below.

When a Family Unit reaches the out-of-pocket limit, Covered Charges for that Family Unit will be payable at 100% (except for any charges excluded, as shown on the Schedule of Benefits) for the rest of the Calendar Year. Covered Charges for an individual family member who meets the individual out-of-pocket limit before the out-of-pocket limit for the Family Unit is met will be covered at 100% (except for any charges excluded as shown in the Schedule of Benefits) for the rest of the Calendar Year.

If any part of the Out-of-pocket expense limit has been paid under the prior TCSIG Plan, the Out-of-pocket expense limit of this Plan shall be reduced by that amount.

COVERED CHARGES

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

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

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

Charges for an Intensive Care Unit stay are payable.

(2) **Coverage of Pregnancy.** The charges for the care and treatment of Pregnancy are covered the same as any other Sickness.

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

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

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

(b) the confinement starts within 14 days of a Hospital confinement of at least 3 days; and

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

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

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

If the Covered Person is discharged from the Skilled Nursing Facility and again becomes an Inpatient in such facility within fourteen (14) days of the original discharge, it is considered one (1) period of confinement.

The Plan shall cover up to the lesser of the facility's regular daily Semiprivate rate or fifty percent (50%) of the most common daily Semiprivate rate of the Hospital in which most recently confined.

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

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

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

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

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

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

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

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

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

Benefit payment for nursing, home health aide and therapy services is subject to the Home Health Care limit shown in the Schedule of Benefits.

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

(7) **Hospice Care Services and Supplies.** Charges for hospice care services and supplies are covered only when the attending Physician has diagnosed the Covered Person's condition as being terminal, determined that the person is not expected to live more than six months and placed the person under a Hospice Care Plan.

Covered Charges for Hospice Care Services and Supplies are payable as described in the Schedule of Benefits.

Respite care under the Hospice program is a short-term Inpatient stay in a facility. The Inpatient confinement gives temporary relief, a respite, to the person who regularly assists with home care. Each Inpatient respite care stay is limited as shown in the Medical Benefits Schedule.

Bereavement counseling services by a licensed social worker or a licensed pastoral counselor for the patient's immediate family (covered Spouse and/or other covered Dependents). Bereavement services must be furnished within three months after the patient's death.

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

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

(b) **Acupuncture therapy**. Charges for acupuncture therapy rendered by an M.D., D.O., D.C. or Licensed Acupuncturist for treatment of chronic pain associated with migraines, arthritis, neuritis, sprains or strains.

(c) Local Medically Necessary professional land or air **ambulance** service. 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.

(d) **Anesthetic**; oxygen; blood and blood derivatives that are not donated or replaced; intravenous injections and solutions. Administration of these items is included.

(e) **Biofeedback.** Following appropriate diagnostic alternatives and documented failure of conventional medical evaluation, biofeedback may be considered Medically Necessary in the treatment of the following conditions: chronic pain, organic muscle abnormalities, chronic anorectal dysfunction associated with incontinence and constipation, chronic pelvic muscular dysfunction associated with urinary incontinence and Raynaud's phenomenon. All other uses of biofeedback are considered Experimental and are not a Covered Expense.

(f) **Cardiac rehabilitation** as deemed Medically Necessary provided services are rendered (a) under the supervision of a Physician; (b) in connection with a myocardial infarction, coronary occlusion or coronary bypass surgery; and (c) in a Medical Care Facility as defined by this Plan.

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

(h) **Christian Science services.** Services rendered in accordance with the healing practices of Christian Science (except those rendered primarily for rest or spiritual guidance):

(i) Present treatment and absent treatment by a Christian Science Practitioner subject to the same terms and conditions as if such charges had been made by a Physician;

(ii) Room and Board during Confinement for healing purposes in a Christian Science Sanatorium subject to the same terms and conditions as if such charges had been incurred in a Hospital;

(iii) Private duty nursing services by a Christian Science Nurse subject to the same terms and conditions as if such charges had been made by a Registered Nurse (R.N.).

(i) Routine patient care charges for **Clinical Trials.** Coverage is provided only for routine patient care costs for a Qualified Individual in an approved clinical trial for treatment of cancer or other life-threatening disease or condition. For these purposes, a Qualified Individual is a Covered Person who is eligible to participate in an approved clinical trial according to the trial protocol with respect to the treatment of cancer or another life-threatening disease or condition, and either: (1) the referring health care professional is a Network Provider and has concluded that the individual's participation in such trial would be appropriate; or (2) the Covered Person provides medical and scientific information establishing to the satisfaction of the Plan Administrator that the individual's participation in such trial would be appropriate. Coverage is not provided for charges not otherwise covered under the Plan, and does not include charges for the drug or procedure under trial, or charges which the Qualified Individual would not be required to pay in the absence of this coverage.

(j) Initial **contact lenses** or glasses required for treatment of keratoconus or glaucoma or following cataract surgery..

(k) Medical facility, anesthesia charges or any fees associated with **Dental Care** treatment that is determined to be medically necessary will be covered under the medical plan. Following are some examples of medical necessity:

(i) The patient is a child (up to 6 years old) with a dental condition that requires repairs of significant complexity (e.g., multiple restorations, pulpal therapy, extractions);

(ii) Patients with certain physical, intellectual or medically compromising conditions (e.g., mental retardation, cerebral palsy, epilepsy, cardiac problems, hyperactivity verified by appropriate medical documentation);

(iii) Extremely uncooperative, fearful, unmanageable, anxious or uncommunicative patients with substantial dental needs and no expectation that behavior will improve soon;

(iv) Patients with dental restorative or surgical needs for whom local anesthesia is ineffective (such as due to acute infection, anatomic variations or allergy);

(v) Patients who have sustained extensive orofacial or dental trauma, for which treatment under local anesthesia would be ineffective or compromised.

(l) Rental of **durable medical or surgical equipment** if deemed Medically Necessary. These items may be bought rather than rented, with the cost not to exceed the fair market value of the equipment at the time of purchase. Repair or replacement will be covered only when required due to growth or development of a dependent child, or deterioration from normal wear and tear if recommended by the attending physician.

(m) **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 Covered Person.

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 Covered Person'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.

(n) **Genetic testing.** The following tests are covered when physician-ordered and medically necessary or preventive:

- **(i)** laboratory tests for the diagnosis or treatment of a physician-diagnosed symptomatic illness in the Covered Person who is tested;
- **(ii)** procedures to determine if a fetus has chromosomal abnormalities that indicate the presence of a genetic disease or disorder and limited to those obtained through amniocentesis, chorionic villus sampling (CVS), fetoscopy and alpha-fetoprotein (AFP) analysis in pregnant women;
- **(iii)** multi-gene panel testing for the detection of the BRCA-1 or BRCA-2 gene in persons over age 18 with a family history of breast or ovarian cancer; and
- **(iv)** phenylketonuria (PKU) testing in newborns.

(o) **Habilitative therapy.** Covered Expenses include physical therapy, occupational therapy and speech pathology**.** These services could also include devices that are provided for a person to attain, maintain, or prevent deterioration of a skill or function never learned or acquired due to a disabling condition. <u>These services when provided for autism spectrum disorder are not a covered benefit.</u> This benefit is separate from Rehabilitation services.

(p) **Hearing Device.** Charges for cochlear implants, bone-anchored hearing aid, auditory brainstem implant, or any other surgically implantable device to correct hearing loss or surgery to implant such a device.

(q) **Home Infusion Therapy.** Subject to Pre-certification. Failure to obtain Pre-certification may result in a reduction of benefits.

Home infusion therapy Provider services are subject to Pre-certification to determine medical necessity. The following services and supplies when provided by a home infusion therapy Provider in the home for the intravenous administration related to Illness or Injury, chemotherapy, antibiotic therapy, aerosol therapy, tocolytic therapy, special therapy, intravenous hydration, or pain management:

- **(i)** Medication, ancillary medical supplies and supply delivery (not to exceed a fourteen (14) day supply); however, medication which is delivered but not administered is not covered;
- **(ii)** Pharmacy compounding and dispensing services (including pharmacy support) for intravenous solutions and medications;
- **(iii)** Hospital and home clinical visits related to the administration of infusion therapy, skilled nursing services including those provided for: (a) patient or alternative care giver training; and (b) visits to monitor the therapy;
- **(iv)** Rental and purchase charges for Durable Medical Equipment; maintenance and repair charges for such equipment;
- **(v)** Laboratory services to monitor the patient's response to therapy regimen.

(r) Medically Necessary services for care and treatment of **jaw joint conditions, including Temporomandibular Joint syndrome (TMJ)**.

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

(t) Treatment of **Mental Disorders and Substance Abuse** is payable as shown in the Medical Benefits Schedule.

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

Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth.

Emergency repair due to Injury to sound natural teeth and treatment is completed within six (6) months after the Injury.

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

Excision of benign bony growths of the jaw and hard palate.

External incision and drainage of cellulitis.

Incision of sensory sinuses, salivary glands or ducts.

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

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

(v) **Occupational therapy** by a licensed therapist. Therapy must be ordered by a Physician, result from an Injury or Sickness and improve a body function. Covered Charges do not include recreational programs, maintenance therapy or supplies used in occupational therapy.

(w) **Organ transplant** limits. Charges otherwise covered under the Plan that are incurred for the care and treatment due to an organ or tissue transplant are subject to these limits:

The transplant must be performed to replace an organ or tissue.

Charges for obtaining donor organs or tissues are Covered Charges under the Plan when the recipient is a Covered Person. When the donor has medical coverage, his or her plan will pay first. The benefits under this Plan will be reduced by those payable under the donor's plan. Donor charges include those for:

evaluating the organ or tissue;

removing the organ or tissue from the donor; and

transportation of the organ or tissue from within the United States and Canada to the place where the transplant is to take place.

If the recipient is covered under this Plan, eligible medical expenses incurred by the recipient shall be considered for benefits.

If the donor is covered under this Plan, eligible medical expenses incurred by the donor shall be considered for benefits provided the recipient is also covered under this Plan. Eligible medical expenses incurred by each person shall be treated separately for each person. (If the recipient is not covered by this Plan, the donor expenses shall not be covered by this Plan.)

Expenses incurred by the donor, who is not ordinarily covered under this Plan according to eligibility requirements, shall be Covered Expenses to the extent that such expenses are not payable by any other form of health coverage, including any government plan or individual policy of health coverage, and provided the recipient is covered under this Plan. The donor's expense shall be applied to the recipient's Maximum Benefit. In no event will benefits be payable in excess of the Maximum Benefit still available to the recipient.

Covered Expenses of the donor which are incurred as the direct result of and within three (3) months of the transplant shall be considered expenses incurred by the donor to the extent that benefits are not provided under any other group health plan. Any fee or charge made by the donor for such organ(s) shall not be considered a covered medical expense.

The Reasonable and Allowable Amount for securing an organ from a cadaver or tissue bank, including the surgeon's charge for removal of the organ and a Hospital's charge for storage or transportation of the organ shall be considered a Covered Expense.

(x) **Physical therapy** must be administered in strict accordance with the referring Physician's orders regarding type of therapy, frequency and duration. The condition treated must also be established as one which receives substantial benefit from short-term therapy.

(y) **Podiatry services.** Covered Expenses shall include surgical podiatry services, including incision and drainage of infected tissues of the foot, removal of lesions of the foot, removal or debridement of infected toenails, surgical removal of nail root, and treatment of fractures or dislocations of bones of the foot.

(z) Routine **Preventive Care.** Covered Charges under Medical Benefits are payable for routine Preventive Care as described in the Schedule of Benefits. Standard Preventive Care shall be provided as required by applicable law if provided by a Network Provider. Standard Preventive Care for adults includes services with an "A" or "B" rating from the United States Preventive Services Task Force. Examples of Standard Preventive Care include:

- Screenings for: breast cancer, cervical cancer, colorectal cancer, high blood pressure, Type 2 Diabetes Mellitus, cholesterol, and obesity.
- Immunizations for adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention; and
- Additional preventive care and screening for women provided for in the guidelines supported by the Health Resources and Services Administration, including the following:
  -Breastfeeding support, supplies, and counseling.
  -Gestational diabetes screening.

Standard Preventive Care includes women's contraceptives, sterilization procedures, and counseling.

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

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

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

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

- Immunizations for children and adolescents recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. These may include:
  - -Diphtheria,
  - -Pertussis,
  - -Tetanus,
  - -Polio,
  - -Measles,
  - -Mumps,
  - -Rubella,
  - -Hemophilus influenza b (Hib),
  - -Hepatitis B,
  - -Varicella.
- Preventive care and screenings for infants, children and adolescents as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration

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

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

(aa) The initial purchase, fitting and repair of fitted **prosthetic devices** which replace body parts.

(bb) **Reconstructive Surgery.** Correction of abnormal congenital conditions and reconstructive mammoplasties will be considered Covered Charges.

This mammoplasty coverage will include reimbursement for:

(i) reconstruction of the breast on which a mastectomy has been performed,

(ii) surgery and reconstruction of the other breast to produce a symmetrical appearance, and

(iii) coverage of prostheses and physical complications during all stages of mastectomy, including lymphedemas,

in a manner determined in consultation with the attending Physician and the patient.

(cc) **Speech therapy** by a licensed therapist. Therapy must be ordered by a Physician and follow either: (i) surgery for correction of a congenital condition of the oral cavity, throat or nasal complex (other than a frenectomy) of a person; (ii) an Injury; or (iii) a Sickness.

(dd) **Spinal Manipulation services** by a health care provider acting within the scope of his or her license.

(ee) **Sterilization** procedures for men and women, excluding reversals.

(ff) **Surcharges**. Any excise tax, sales tax, surcharge, (by whatever name called) assessed by a governmental entity for services, supplies and/or treatments rendered by a professional Provider; Physician; Hospital; facility or any other health care Provider.

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

(hh) **Tobacco Cessation Programs** shall be covered with no cost sharing as a Standard Preventive Care benefit if provided by Network Providers.

(ii) **Travel to Center of Excellence.** The Plan will cover the cost of reasonable and necessary travel costs when you get prior approval and need to travel more than 75 miles from your permanent home to reach a Center of Excellence (COE) where a covered expense will be performed (Refer to Defined Terms, Centers of Excellence.) Help with travel costs includes transportation to and from the Center of Excellence, and lodging and meals for the Covered Person and one companion. If the Covered Person receiving care is a minor, then reasonable and necessary costs for transportation, lodging and meals may be allowed for two companions. Itemized receipts for transportation, lodging and meal costs must be submitted in a form satisfactory to the Claims Administrator. Call the Claims Administrator for complete information.

The Plan will provide benefits for lodging, transportation and other reasonable expenses up to the current limits set forth in the Internal Revenue Code when authorized in advance by the Claims Administrator.

Covered expenses include:

(i) Ground transportation to and from the hospital when it is 75 miles or more from your place of residence.

(ii) Coach airfare to and from the hospital when it is 300 miles or more from your residence.

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

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

Non-Covered expenses include, but are not limited to:

(i) Child care,

(ii) Mileage within the city where the Center of Excellence is located,

(iii) Rental cars, buses, taxis, rideshare or shuttle service, except as specifically approved by the Plan

(iv) Administrator,

(v) Frequent Flyer miles,

(vi) Coupons, Vouchers, or Travel tickets,

(vii) Prepayments or deposits,

(viii) Services for a condition or procedure not listed under the Definition of Centers of Excellence,

(ix) Phone calls,

(x) Laundry,

(xi) Postage,

(xii) Entertainment,

(xiii) Travel costs for donor companion/caregiver, and

(xiv) Return visits for the donor for a treatment of an illness found during the evaluation.

The Plan Administrator shall determine what Network Centers of Excellence are to be used and the following list of Centers shall be updated periodically:

Provider Name	**Condition/procedure**
Adventist Health Coon Joint Replacement Institute	Knee & hip joint replacement
UC Davis	Severe burns, Stevens Johnson syndrome
UCSF Transgender Care	Transgender health
California Pacific Medical Center	Adult organ transplant: Heart, Kidney, Kidney/Liver, Kidney/Pancreas, Liver, Pancreas
UCSF Benioff Children's Hospital	Pediatric organ transplant: Blood/Marrow, Kidney, Kidney/Liver, Liver
UCSF Medical Center	Adult organ transplant: Blood/Marrow, Heart, Heart/Lung, Kidney, Kidney/Liver, Kidney/Pancreas, Liver, Lung, Pancreas
Lucile Packard Children's Hospital at Stanford	Pediatric organ transplant: Blood/Marrow, Heart, Kidney, Kidney/Liver, Liver
Stanford Health Care	Adult organ transplant: Blood/Marrow, Heart, Heart/Lung, Kidney, Kidney/Liver, Liver, Lung

Travel expenses are covered when the Covered Person utilizes a Center of Excellence for conditions/procedures listed above.

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

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

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

The benefit is limited to charges for routine well-baby nursery care for the newborn child while Hospital confined as a result of the child's birth.

Charges for covered routine nursery care will be applied toward the Plan of the covered parent, provided the newborn child is enrolled on a timely basis.

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

under Federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Charges for Routine Physician Care. The benefit is limited to the charges for routine well-baby care made by a Physician for pediatric visits to the newborn child while Hospital confined as a result of the child's birth.

Charges for covered routine Physician care will be applied toward the Plan of the covered parent, provided the newborn child is enrolled on a timely basis.

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

(kk) Charges associated with the initial purchase of a **wig after chemotherapy or radiation therapy.**

Charges for wig after chemotherapy or radiation therapy are subject to the limits as described in the Schedule of Benefits.

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

COST MANAGEMENT SERVICES

Cost Management Services Phone Number

Please refer to the Employee ID card for the Cost Management Services phone number.

The provider, patient or family member must call this number to receive certification of certain Cost Management Services. This call must be made prior to the admission or prior to services being rendered or within 48 hours after a Medical Emergency, or the next business day.

Any costs incurred because of reduced reimbursement due to failure to follow cost management procedures will not accrue toward the 100% maximum out-of-pocket payment.

UTILIZATION REVIEW

Utilization review is a program designed to help ensure that all Covered Persons receive necessary and appropriate health care while avoiding unnecessary expenses.

The program consists of:

(a) Precertification of the Medical Necessity for the following non-emergency services before Medical and/or Surgical services are provided:

- **(i)** All inpatient Hospital and Skilled Nursing Facility stays.
- **(ii)** Facility based Treatment for Mental or Nervous Disorders or Substance Abuse.
- **(iii)** Home Health Care.
- **(iv)** All Organ and Tissue Transplants, peripheral stem cell replacement and similar procedures.
- **(v)** Infusion Therapy that includes Specialty Drugs in the specialty pharmacy program, and related services (for each Course of Therapy) in any setting, including, but not limited to: Physician's office, infusion center, outpatient Hospital or clinic, or your home or other residential setting.
- **(vi)** Certain surgical, diagnostic procedures, Durable Medical Equipment over $2,000 and/or prosthetics wherever rendered as specified by Anthem Blue Cross. For a list of current procedures, please contact Anthem Blue Cross toll free at (800) 274-7767.
- **(vii)** Chiropracatic Care after 12 visits and for children under the age of 18. Precertification for this is handled through PhysMetrics.

(b) Retrospective review of the Medical Necessity of the listed services provided on an emergency basis;

(c) Concurrent review, based on the admitting diagnosis, of the listed services requested by the attending Physician; and

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

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

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

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

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

Here's how the program works.

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

The utilization review program is set in motion by a telephone call from, or on behalf of, the Covered Person. Contact the utilization review administrator at the telephone number on your ID card **at least 3 days before** services are scheduled to be rendered with the following information:

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

If there is an **emergency** admission to the Medical Care Facility, the patient, patient's family member, Medical Care Facility or attending Physician must contact the utilization review administrator **within 48 hours** of the first business day after the admission.

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

If the Covered Person does not receive precertification as explained in this section, the benefit payment may be reduced by 50%.

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

If the attending Physician feels that it is Medically Necessary for a Covered Person to receive additional services or to stay in the Medical Care Facility for a greater length of time than has been precertified, the attending Physician must request the additional services or days.

SECOND AND/OR THIRD OPINION PROGRAM

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

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

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

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

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

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

PREADMISSION TESTING SERVICE

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

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

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

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

Covered Charges for this testing will be payable as shown in the Medical Benefits Schedule if tests show the condition requires medical treatment prior to Hospital confinement or the Hospital confinement is not required.

OUTPATIENT SURGERY

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

Charges for covered surgical procedures, when such procedures are performed on an outpatient rather than an inpatient basis, will be paid as shown in the Medical Benefits Schedule.

CASE MANAGEMENT

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

TCSIG may arrange for review and/or case management services from a professional organization qualified to perform such services. Case management may apply to inpatient hospital, residential treatment and partial hospitalization. The TCSIG Executive Committee or its designated representative shall have the right to alter or waive the normal provisions of the Plan when it is reasonable to expect a cost-effective result while maintaining the quality of care.

A case manager consults with the patient, the family and the attending Physician in order to develop a plan of care for approval by the patient's attending Physician and the patient. This plan of care may include some or all of the following:

- personal support to the patient;
- contacting the family to offer assistance and support;
- monitoring Hospital or Skilled Nursing Facility;
- determining alternative care options; and
- assisting in obtaining any necessary equipment and services.

Case Management occurs when this alternate benefit will be beneficial to both the patient and the Plan.

The case manager will coordinate and implement the Case Management program by providing guidance and information on available resources and suggesting the most appropriate treatment plan. The Plan Administrator, attending Physician, patient and patient's family must all agree to the alternate treatment plan.

Once agreement has been reached, the Plan Administrator will direct the Plan to cover Medically Necessary expenses as stated in the treatment plan, even if these expenses normally would not be paid by the Plan. Unless specifically provided to the contrary in the Plan Administrator's instructions, reimbursement for expenses incurred in connection with the treatment plan shall be subject to all Plan limits and cost sharing provisions.

Note: Case Management is a voluntary service. There are no reductions of benefits or penalties if the patient and family choose not to participate.

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

DEFINED TERMS

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

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

Allowable charge is a charge which is either the network Provider's reduced fee or the Reasonable and Allowed amount for a service or supply.

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

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

(1) Federally-Funded Trials—The study or investigation is approved or funded (which include funding through in-kind contributions) by one or more of the following:

- **(a)** The National Institutes of Health;
- **(b)** The Centers for Disease Control and Prevention;
- **(c)** The Agency for Health Care Research and Quality;
- **(d)** The Centers for Medicare & Medicaid Services;
- **(e)** Cooperative group or center of any of the entities described in **(a)** through **(d)** or the Department of Defense or Department of Veterans Affairs; or
- **(f)** A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.

(2) The study or investigation is conducted under an investigational new drug application reviewed by the Food and Drug Administration.

(3) The study or investigation is a drug trial that is exempt from having such an investigational new drug application.

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

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

Brand Name means a trade name medication.

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

Center(s) of Excellence. Center(s) of Excellence shall mean medical care facilities that have met stringent criteria for quality care in the specialized procedures. The Centers have exceptional experience and outcomes in performing certain procedures.

Christian Science Nurse. A Christian Science Nurse who is listed in the issue of the Christian Science Journal in effect at the time treatment and services are rendered.

Christian Science Practitioner. A Christian Science Practitioner who is listed in the issue of the Christian Science Journal in effect at the time treatment and services are rendered.

Christian Science Sanatorium. A facility accredited by the Department of Care of the First Church of Christ Scientist in Boston, Massachusetts at the time treatment and services are rendered.

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

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

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

Custodial Care is care provided primarily to meet 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 administration of medicine which is usually self-administered or any other care which does not require continuing services of medical personnel.

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

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

Emergency Services means a medical screening examination (as required under Section 1867 of the Social Security Act (EMTALA)) within the capability of the Hospital emergency department, including routine ancillary services, to evaluate a Medical Emergency and such further medical examination and treatment as are within the capabilities of the staff and facilities of the Hospital and required under EMTALA to stabilize the patient.

Employee means a person who is classified by his Employer as an Active, common law employee.

For the purpose of this document, the term "Employee" shall include all eligible Retirees, Retired elected officials, Employees under continuation of coverage, and Employee Groups.

Employee Group is any group defined under existing applicable collective bargaining law. The elected officials (e.g., Board), superintendent, management Employees, confidential Employees, classified Employees, certified (academic) Employees and Retirees will always be considered individual Employee Groups even when an Employer has no organized bargaining groups.

Employer is Tri-County Schools Insurance Group (TCSIG).

Essential Health Benefits include, to the extent they are covered under the Plan, ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

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

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

Formulary means a list of prescription medications of safe, effective therapeutic drugs specifically covered by this Plan.

Gender identity disorder (GID), also known as Gender Dysphoria, is a formal diagnosis used by psychologists and Physicians to describe people who experience significant dysphoria (discontent) with the sex they were assigned at birth and/or the gender roles associated with that sex.

Gender transition is the process of changing one's outward appearance, including physical sex characteristics, to accord with his or her actual gender identity.

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

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

Habilitation/Habilitative services. Health care services that help a person keep, learn or improve skills and functioning for daily living which may include physical therapy, occupational therapy, and speech language pathology. These services when provided for autism spectrum disorder are not a covered benefit.

HIPAA shall mean the Health Insurance Portability and Accountability Act of 1996, as amended.

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

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

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

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

Hospice Agency is an agency or organization providing a specialized form of interdisciplinary health care that provides palliative care (pain control and symptom relief) and alleviates the physical, emotional, social, and spiritual discomforts of a terminally ill person, as well as providing supportive care to the primary caregiver and the patient's family. A hospice must be: currently licensed as a hospice pursuant to Health and Safety Code section 1747 or a licensed home health agency with federal Medicare certification pursuant to Health and Safety Code section 1726 and 1747.1.

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

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

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

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

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

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

Infertility means incapable of producing offspring.

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

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

Investigational procedures (Investigational) are those:

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

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

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

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

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

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

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

Late Enrollee means a Plan Participant who enrolls under the Plan other than during the first 30-day period in which the individual is eligible to enroll under the Plan or during a Special Enrollment Period.

Legal Guardian means a person recognized by a court of law as having the duty of taking care of the person and managing the property and rights of a minor child.

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

Medical Emergency means a medical condition manifesting itself by acute symptoms of sufficient severity including severe pain such that a prudent layperson with average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in (1) serious jeopardy to the health of an individual (or, in the case of a pregnant woman, the health of the woman or her unborn child), (2) serious impairment to body functions, or (3) serious dysfunction of any body organ or part. A Medical Emergency

includes such conditions as heart attacks, cardiovascular accidents, poisonings, loss of consciousness or respiration, convulsions or other such acute medical conditions.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Partial Hospitalization shall mean medically directed intensive, or intermediate short-term mental health and Substance Abuse treatment, for a period of less than twenty-four (24) hours but more than four (4) hours in a day in a licensed or certified facility or program.

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

Physician means a Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Doctor of Podiatry (D.P.M.), Doctor of Chiropractic (D.C.), Audiologist, Licensed Professional Counselor, Physiotherapist, Psychiatrist, Psychologist (Ph.D.), Dentist (D.D.S.) (D.M.D., Optometrist (O.D.), a dispensing optician, and any other practitioner of the healing arts who is licensed and regulated by a state or federal agency and is acting within the scope of his or her license.

Plan means Tri-County Schools Insurance Group (TCSIG) Employee Health Care Plan, which is a benefits plan for certain Employees of Tri-County Schools Insurance Group (TCSIG) and is described in this document.

Plan Participant shall mean any Employee, Dependent, Retiree, active elected officials and retired elected officials who are eligible for benefits (and enrolled) under the Plan.

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

Practioner is a Physician or person acting within the scope of applicable state licensure/certification requirements and holding the degree of Certified Nurse Midwife (C.N.M.), Certified Registered Nurse Anesthetists (C.R.N.A.), Registered Nurse (R.N.), Licensed Practical Nurse (L.P.N.), Registered Physical Therapist (P.T. or R.P.T.), Licensed Acupuncturist, Physician's Assistant, Registered or Certified Respiratory Therapist, Occupational Therapist, Speech Therapist, Speech Pathologist, Masters prepared Social Worker (M.S.W.), a Clinical Social Worker (C.S.W. or L.C.S.W.), a Marriage, Family and Child Counselor (M.F.C.C.), Marriage Family Therapist (M.F.T.), Christian Science Practitioner, or Nurse Practitioner.

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

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

Reasonable and Allowed is the maximum amount payable by the Plan for a service, supply and/or treatment that is considered a Covered Expense. The Reasonable and Allowable Amount is the *lesser of*:

(1) The charge made by the Provider that furnished the care, service or supply;

(2) The negotiated amount established by discounting or negotiated arrangement;

(3) The reasonable and customary charge for the same treatment, service or supply furnished in the same geographic area by a Provider of like service of similar training and experienced as further described below; or

(4) An amount equivalent to the following:

- **(a)** For Inpatient or Outpatient facility claims, an amount equivalent to 140% of the Medicare equivalent allowable amount;

- **(b)** For Physician or other Provider claims, an amount equivalent to 120% of the Medicare equivalent allowable amount.

The reasonable and customary charge referenced above in #3 shall mean an amount equivalent to the lesser of a commercially available database or such other cost or quality-based reimbursement methodologies as may be available and adopted by the Plan from time to time. If there is insufficient information submitted for a given procedure, the Plan will determine the Reasonable and Allowed Amount based upon charges made for similar services. Determination of the reasonable and customary charge will consider the nature and severity of the condition being treated, medical complications or unusual circumstances that require more time, skill or experience, and the cost and quality data for that Provider.

The term ‘geographic area’ shall be defined as a metropolitan area, zip code, state or such greater area as is necessary to obtain a representative cross-section of Providers, persons, or organizations rendering such treatment, service or supply for which a specific charge is made.

For Covered Expenses rendered by a Physician, Hospital or other Provider in a geographic area where applicable law dictates the maximum amount that can be billed by the rendering Provider, the Reasonable and Allowed Amount shall mean the amount established by the applicable law for the Covered Expense.

The Plan Administrator or its designee has the ***ultimate discretionary authority*** to determine the Reasonable and Allowed Amount, including establishing the negotiated terms of a Provider arrangement as the Reasonable and Allowed Amount even if such negotiated terms do not satisfy the lesser of test described above.

Retired Employee is an Employee, as defined by the Employer’s bargaining agreement(s) or policies, who is receiving pension benefits from the Public Employees’ Retirement System (P.E.R.S.) or the State Teachers’ Retirement System (S.T.R.S.) and who, on the date immediately prior to retirement, was covered by a TCSIG medical Plan.

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

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

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

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

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

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

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

PLAN EXCLUSIONS

Note: Exclusions related to Prescription Drugs are shown in the Prescription Drug Plan. Contact your Prescription Drug Administrator for additional information.

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

(1) **Alcohol.** Services, supplies, care or treatment to a Covered Person for an Injury or Sickness which occurred as a result of that Covered Person's illegal use of alcohol. The responding officer's determination of inebriation will be sufficient for this exclusion, but is not required. The Plan may rely on any information contained in the medical records, traffic collision report, toxicology report, or other documentary evidence. Expenses will be covered for Injured Covered Persons other than the person illegally using alcohol and expenses will be covered for Substance Abuse treatment as specified in this Plan. This exclusion does not apply if the Injury resulted from an act of domestic violence or a medical (including both physical and mental health) condition.

(2) **Attention Deficit Disorders.** Charges for services, supplies or treatment for attention deficit disorders, hyperkinetic syndromes, behavior or conduct disorders, development delay, hyperactivity, learning disorders, mental retardation, autistic disease or hospitalization for environmental change. However, the initial examination, office visit, initial diagnostic testing to determine the Illness and the attention deficit disorders medications and the medication management charges shall be a Covered Expense.

(3) **Birth control.** Over-the-counter birth control devices, contraceptives or medications used for contraceptive purposes.

(4) **Complications of non-covered treatments.** Care, services or treatment required as a result of complications from a treatment not covered under the Plan are not covered.

(5) **Cosmetic Procedures.** Any surgery or procedure, the primary purpose of which is to improve or change the appearance of any portion of the body, but which does not restore bodily function, correct a disease state, or improve a physiological function. Cosmetic Procedures include cosmetic surgery, reconstructive surgery, pharmacological services, nutritional regimens or other services for beautification, or treatment relating to the consequences of, or as a result of, Cosmetic Surgery (including reimplantation). This exclusion includes, but is not limited to, surgery to correct gynecomastia and breast augmentation procedures, and otoplasties. This exclusion does not apply to surgery to restore function if the body area has been altered by injury, disease, trauma, congenital/developmental anomalies, or previous covered therapeutic processes.

(6) **Custodial care.** Services or supplies provided mainly as a rest cure, maintenance, Custodial Care or domiciliary care consisting chiefly of room and board.

(7) **Diabetes education.**

(8) **Educational or vocational testing.** Services for educational or vocational testing or training.

(9) **Excess charges.** The part of an expense for care and treatment of an Injury or Sickness that is in excess of the Reasonable and Allowed amount.

(10) **Exercise programs.** Exercise programs for treatment of any condition, except for Physician-supervised cardiac rehabilitation, occupational or physical therapy if covered by this Plan.

(11) **Experimental / Investigational or not Medically Necessary.** Care and treatment that is either Experimental/Investigational or not Medically Necessary. This exclusion shall not apply to routine patient costs to the extent that the cost is for a Qualified Individual who is a participant in an approved clinical trial with respect to the treatment of cancer or another life-threatening disease or condition. The Plan shall not deny, limit or impose additional conditions on routine patient costs for items and services furnished in connection with participation in the clinical trial.

The following are not included as routine patient costs:

(a) The investigational item, device, or service itself;

(b) 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; or

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

This provision does not require the Plan to pay charges for services or supplies that are not otherwise Covered Charges (including, without limitation, charges which the Qualified Individual would not be required to pay in the absence of this coverage) or prohibit the Plan from imposing all applicable cost sharing and reasonable cost management provisions. For these purposes, a Qualified Individual is a Covered Person who is eligible to participate in an approved clinical trial according to the trial protocol with respect to the treatment of cancer or another life-threatening disease or condition, and either: (1) the referring health care professional is a Network Provider and has concluded that the individual's participation in such trial would be appropriate; or (2) the Covered Person provides medical and scientific information establishing that the individual's participation in such trial would be appropriate.

(12) **Eye care.** Radial keratotomy or other eye surgery to correct refractive disorders. Also, routine eye examinations, including refractions, lenses for the eyes and exams for their fitting. This exclusion does not apply to aphakic patients and soft lenses or sclera shells intended for use as corneal bandages or as may be covered under the well adult or well child sections of this Plan.

(13) **Foot care.** Treatment of weak, strained, flat, unstable or unbalanced feet, metatarsalgia or bunions (except open cutting operations), and treatment of corns, calluses or toenails (unless needed in treatment of a metabolic or peripheral-vascular disease).

(14) **Foot orthotics.** Charges in connection with over-the-counter foot orthotics or arch supports.

(15) **Foreign travel.** Care, treatment or supplies out of the U.S. if travel is for the purpose of obtaining medical services.

(16) **Functional medicine.** Services for functional medicine are excluded unless obtained from Best Life Medical Center in Rocklin, California. Services obtained from another provider, including one that participates in the medical network are **not covered**.

Covered expenses are limited to the following:

(a) Initial consult with Dr. Christopher Campbell and subsequent follow-up visits, including nutritional counseling; and

(b) Laboratory tests required to determine endocrine and hormone function; metabolic or nutritional deficiencies; and immunological tolerance.

(17) **Government coverage.** Care, treatment or supplies furnished by a program or agency funded by any government. This exclusion does not apply to Medicaid or when otherwise prohibited by applicable law.

(18) **Hair loss.** Care and treatment for hair loss including wigs, hair transplants or any drug that promises hair growth, whether or not prescribed by a Physician, except for wigs after chemotherapy or radiation therapy or when due to a medical condition.

(19) **Hearing aids and exams.** Charges for services or supplies in connection with hearing aids or exams for their fitting, except as may be covered under the well adult or well child sections of this Plan.

(20) **Hospital employees.** Professional services billed by a Physician or nurse who is an employee of a Hospital or Skilled Nursing Facility and paid by the Hospital or facility for the service.

(21) **Illegal acts.** Charges for services received as a result of Injury or Sickness occurring directly or indirectly, as a result of the Covered Person's commission of or attempt to commit a Serious Illegal Act, or a riot or public disturbance. For purposes of this exclusion, the term "Serious Illegal Act" shall mean any act or series of acts that, if prosecuted as a criminal offense, a sentence to a term of imprisonment in excess of one year could be imposed. It is not necessary that criminal charges be filed, or, if filed, that a conviction result, or that a sentence of imprisonment for a term in excess of one year be imposed for this exclusion to apply. Proof beyond a reasonable doubt is not required. This exclusion does not apply if the Injury or Sickness resulted from an act of domestic violence or a medical (including both physical and mental health) condition.

(22) **Illegal drugs or medications.** Services, supplies, care or treatment to a Covered Person for Injury or Sickness resulting from that Covered Person's voluntary taking of or being under the influence of any controlled substance, drug, hallucinogen or narcotic not administered on the advice of a Physician. Expenses will be covered for Injured Covered Persons other than the person using controlled substances and expenses will be covered for Substance Abuse treatment as specified in this Plan. This exclusion does not apply if the Injury resulted from an act of domestic violence or a medical (including both physical and mental health) condition.

(23) **Immunizations** and inoculations for foreign travel.

(24) **Infertility.** Care, supplies, services and treatment for infertility, except for diagnostic services rendered for infertility evaluation.

In vitro fertilization, artificial insemination, induced ovarian hyperstimulation, or embryonic implantation procedures, and other direct attempts to induce Pregnancy are not covered.

(25) **Marital or pre-marital counseling.** Care and treatment for marital or pre-marital counseling.

(26) **Naturopathy.** Charges for naturopathy, homeopathy treatment or drugs, hypnotism, massage therapy, unless under course of treatment rendered by chiropractor or physical therapist. or aversion therapy.

(27) **No charge.** Care and treatment for which there would not have been a charge if no coverage had been in force.

(28) **Non-compliance.** All charges in connection with treatments or medications where the patient either is in non-compliance with medical orders issued while an inpatient at, or is discharged against medical advice from a Hospital or Skilled Nursing Facility.

(29) **Non-emergency Hospital admissions.** Care and treatment billed by a Hospital for non-Medical Emergency admissions on a Friday or a Saturday. This does not apply if surgery is performed within 24 hours of admission.

(30) **No obligation to pay.** Charges incurred for which the Plan has no legal obligation to pay.

(31) **No Physician recommendation.** Care, treatment, services or supplies not recommended and approved by a Physician; or treatment, services or supplies when the Covered Person is not under the regular care of a Physician. Regular care means ongoing medical supervision or treatment which is appropriate care for the Injury or Sickness.

(32) **Not specified as covered.** Non-traditional medical services, treatments and supplies which are not specified as covered under this Plan.

(33) **Nutritional counseling.**

(34) **Obesity.** Screening and counseling for obesity will be covered to the extent required under Standard Preventive Care. Other care and treatment of obesity, weight loss or dietary control whether or not it is, in any case, a part of the treatment plan for another Sickness is excluded. Specifically excluded are charges for bariatric surgery, including but not limited to, gastric bypass, stapling and intestinal bypass, and lap band surgery, including reversals. Medically Necessary surgical and non-surgical charges for Morbid Obesity are not covered.

(35) **Occupational.** Care and treatment of an Injury or Sickness that is occupational -- that is, arises from work for wage or profit including self-employment. This exclusion may apply even if the expenses for the illness or injury are not paid by Worker's Compensation or similar employer's liability insurance.

(36) **Orthopedic shoes.** Charges for orthopedic shoes (except when they are an integral part of a leg brace), shoe inserts, orthotic appliances or other supportive devices.

(37) **Orthotics.** Charges in connection with orthotics.

(38) **Personal comfort items.** Personal comfort items or other equipment, such as, but not limited to, air conditioners, air-purification units, over-the-counter humidifiers, electric heating units, orthopedic mattresses, blood pressure instruments, scales, elastic bandages or stockings, nonprescription drugs and medicines, and first-aid supplies and nonhospital adjustable beds.

(39) **Plan design excludes.** Charges excluded by the Plan design as mentioned in this document.

(40) **Private duty nursing.** Charges in connection with care, treatment or services of a private duty nurse.

(41) **Relative giving services.** Professional services performed by a person who ordinarily resides in the Covered Person's home or is related to the Covered Person as a Spouse, parent, child, brother or sister, whether the relationship is by blood or exists in law.

(42) **Services before or after coverage.** Care, treatment or supplies for which a charge was incurred before a person was covered under this Plan or after coverage ceased under this Plan.

(43) **Sexual dysfunction.** Charges for services, supplies or treatment, including medications, implants, hormone therapy, Surgery, medical or psychiatric treatment or charges in connection with sexual dysfunction or inadequacies. Erectile dysfunction medications are a covered benefit.

(44) **Surgical sterilization reversal.** Care and treatment for reversal of surgical sterilization for men and women.

(45) **Surrogacy and surrogate mother.** Charges associated with surrogacy, a method of reproduction whereby a woman agrees to become pregnant and deliver a child for a contracted party.

(46) **Travel or accommodations.** Charges for travel or accommodations, whether or not recommended by a Physician, except for ambulance charges and organ transplants and certain procedures as described in Travel to Center of Excellence in the Covered Charges section.

(47) **Virtual scans.** Virtual physical (full-body CAT scan), CT body scanning, coronary artery scoring, high resolution-low dose lung screening, full body screening, brain scan, vital views and full body scans or similar named scans will not be a Covered Expense.

Scans ordered/referred by a Physician for an active Diagnosis that requires this type of scan will be a Covered Expense.

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

PRESCRIPTION DRUG BENEFITS

Pharmacy Drug Charge

Participating pharmacies have contracted with the Plan to charge Covered Persons reduced fees for covered Prescription Drugs.

Copayments

The copayment is applied to each covered pharmacy drug or mail order drug charge and is shown in the schedule of benefits. The copayment amount is not a Covered Charge under the medical Plan. Any one pharmacy prescription is limited to a 31-day supply. A 90 day supply is available at contracting pharmacies. Any one mail order prescription is limited to a 90-day supply. The maximum Out-of-Pocket expense for Prescription Drug benefits includes copayments.

Contact the Prescription Drug Administrator for information regarding non-participating pharmacy benefits or benefits at a participating pharmacy when the Covered Person's ID card is not used.

Mail Order Drug Benefit Option

The mail order drug benefit option is available for maintenance medications (those that are taken for long periods of time, such as drugs sometimes prescribed for heart disease, high blood pressure, asthma, etc.). Because of volume buying, the mail order pharmacy is able to offer Covered Persons significant savings on their prescriptions.

Covered Prescription Drugs

(1) Drugs prescribed by a Physician that require a prescription either by federal or state law. This includes oral contraceptives unless otherwise specifically excluded, but excludes any drugs stated as not covered under this Plan.

(2) All compounded prescriptions containing at least one prescription ingredient in a therapeutic quantity.

(3) Insulin and other diabetic supplies when prescribed by a Physician. Other injectables are not covered.

Limits To This Benefit

This benefit applies only when a Covered Person incurs a covered Prescription Drug charge. The covered drug charge for any one prescription will be limited to:

(1) Refills only up to the number of times specified by a Physician.

(2) Refills up to one year from the date of order by a Physician.

Expenses Not Covered

This benefit will not cover a charge for any of the following:

(1) **Administration.** Any charge for the administration of a covered Prescription Drug.

(2) **Appetite suppressants.** A charge for appetite suppressants, dietary supplements or vitamin supplements, except for prenatal vitamins requiring a prescription or prescription vitamin supplements containing fluoride.

(3) **Consumed on premises.** Any drug or medicine that is consumed or administered at the place where it is dispensed.

(4) **Devices.** Devices of any type, even though such devices may require a prescription. These include (but are not limited to) therapeutic devices, artificial appliances, braces, support garments, or any similar device.

(5) **Drugs used for cosmetic purposes.** Charges for drugs used for cosmetic purposes, such as anabolic steroids, Retin A or medications for hair growth or removal.

(6) **Experimental.** Experimental drugs and medicines, even though a charge is made to the Covered Person.

(7) **FDA.** Any drug not approved by the Food and Drug Administration.

(8) **Growth hormones.** Charges for drugs to enhance physical growth or athletic performance or appearance.

(9) **Immunization.** Immunization agents or biological sera, except as may be required under Standard Preventive Care.

(10) **Impotence.** A charge for impotence medication.

(11) **Infertility.** A charge for infertility medication.

(12) **Injectable.** A charge for hypodermic syringes and/or needles, injectables or any prescription directing administration by injection (other than for insulin).

(13) **Inpatient medication.** A drug or medicine that is to be taken by the Covered Person, in whole or in part, while Hospital confined. This includes being confined in any institution that has a facility for the dispensing of drugs and medicines on its premises.

(14) **Investigational.** A drug or medicine labeled: "Caution - limited by federal law to investigational use".

(15) **Medical exclusions.** A charge excluded under Medical Plan Exclusions.

(16) **No charge.** A charge for Prescription Drugs which may be properly received without charge under local, state or federal programs.

(17) **No prescription.** A drug or medicine that can legally be bought without a written prescription. This does not apply to injectable insulin or to over the counter drugs that are prescribed by a Physician as required for Standard Preventive Care.

(18) **Refills.** Any refill that is requested more than one year after the prescription was written or any refill that is more than the number of refills ordered by the Physician.

HOW TO SUBMIT A CLAIM

Benefits under this Plan shall be paid only if the Plan Administrator decides in its discretion that a Covered Person is entitled to them.

When a Covered Person has a Claim to submit for payment that person must:

(1) Obtain a Claim form from the Personnel Office, Human Resources Office or the Plan Administrator.

(2) Complete the Employee portion of the form. ALL QUESTIONS MUST BE ANSWERED.

(3) Have the Physician complete the provider's portion of the form.

(4) For Plan reimbursements, attach bills for services rendered. ALL BILLS MUST SHOW:

- Name of Plan
- Employee's name
- Name of patient
- Name, address, telephone number of the provider of care
- Diagnosis
- Type of services rendered, with diagnosis and/or procedure codes
- Date of services
- Charges

(5) Send the above to the Claims Administrator at this address:

HealthComp Administrators
P. O. Box 45018
Fresno, California 93718-5018
800-442-7247

WHEN CLAIMS SHOULD BE FILED

Claims should be filed with the Claims Administrator within 90 days of the date charges for the services were incurred. Benefits are based on the Plan's provisions at the time the charges were incurred. Claims filed later than that date may be declined or reduced unless:

(a) it's not reasonably possible to submit the claim in that time; and

(b) the claim is submitted within one year from the date incurred. This one year period will not apply when the person is not legally capable of submitting the claim.

The Claims Administrator will determine if enough information has been submitted to enable proper consideration of the claim. If not, more information may be requested from the claimant. The Plan reserves the right to have a Plan Participant seek a second medical opinion.

FOREIGN CLAIMS

In the event a Covered Person incurs a Covered Expense in a foreign country, the Covered Person shall be responsible for providing the following to the Claims Administrator before payment of any benefits due are payable:

(a) The claim form, Provider invoice and any other documentation required to process the claim must be submitted in the English language.

(b) The charges for services must be converted into dollars at the conversion rate applicable as of the date of service.

(c) A current conversion chart validating the conversion from the foreign country's currency into dollars.

CLAIMS PROCEDURE

Following is a description of how the Plan processes claims for benefits and reviews the appeal of any claim that is denied. The terms used in this section are defined below.

A "Claim" is defined as any request for a Plan benefit, made by a claimant or by a representative of a claimant, which complies with the Plan's reasonable procedure for submitting claims and making benefit claims determinations.

A "Claim" does not include a request for a determination of an individual's eligibility to participate in the Plan.

If a Claim is denied, in whole or in part, or if Plan coverage is rescinded retroactively for fraud or misrepresentation, the denial is known as an "Adverse Benefit Determination."

A claimant has the right to request a review of an Adverse Benefit Determination. This request is an "Appeal." If the Claim is denied at the end of the Plan's internal Appeal process, as described below, the Plan's final decision is known as a "Final Adverse Benefit Determination." For certain types of Claims, the claimant has the right to request an independent external review of the Final Adverse Benefit Determination. The External Review procedures are described below.

The Claims and the Appeal procedures are designed to ensure that claimants are not unduly inhibited from making Claims; that claimants may appoint an authorized representative in accordance with Plan rules; that determinations will be made in accordance with the Plan documents and that Plan provisions are applied consistently. This means, among other things, that Claims and Appeals will be decided in a manner designed to ensure the independence and impartiality of the persons involved in making these decisions.

A claimant must follow all Claims and Appeal procedures both internal and external, before he or she can file a lawsuit. However, this rule may not apply if the Plan Administrator has not complied with the procedures described in this Section. If a lawsuit is brought, it must be filed within two years after the final determination of an Appeal.

The Plan may offer additional voluntary appeal and/or mandatory arbitration procedures other than those described here. If applicable, the Plan will not assert that a claimant has failed to exhaust administrative remedies for failure to use the voluntary procedures; any statute of limitations or other defense based on timeliness is tolled during the time a voluntary appeal is pending; and the voluntary process is available only after exhaustion of the appeals process described in this section. If mandatory arbitration is offered by the Plan, the arbitration must be conducted instead of the appeal process described in this section, and the claimant is not precluded from challenging the decision under ERISA section 501(a) or other applicable law.

Any of the authority and responsibilities of the Plan Administrator under the Claims and Appeal Procedures or the External Review Process, including the discretionary authority to interpret the terms of the Plan, may be delegated to a third party. If you have any questions regarding these procedures, please contact the Plan Administrator.

There are different kinds of Claims and each one has a specific timetable for each step in the review process. Upon receipt of the Claim, the Plan Administrator must decide whether to approve or deny the Claim. The Plan Administrator's notification to the claimant of its decision must be made as soon as practical and not later than the time shown in the timetable. However, if the Claim has not been filed properly, or if it is incomplete, or if there are other matters beyond the control of the Plan Administrator, the claimant may be notified that the period for providing the notification will need to be extended. If the period is extended because the Plan Administrator

needs more information from the claimant, the claimant must provide the requested information within the time shown on the timetable. Once the Claim is complete, the Plan Administrator must make its decision as shown in the timetable. If the Claim is denied, in whole or in part, the claimant has the right to file an Appeal. Then the Plan Administrator must decide the Appeal and, if the Appeal is denied, provide notice to the claimant within the time periods shown on the timetable. The time periods shown in the timetable begin at the time the Claim or Appeal is filed in accordance with the Plan's procedures. Decisions will be made within a reasonable period of time appropriate to the circumstances, but within the maximum time periods listed in the timetables below. Unless otherwise noted, "days" means calendar days.

The definitions of the types of Claims are:

Urgent Care Claim

A Claim involving Urgent Care is any Claim for medical care or treatment where the Plan conditions receipt of benefits, in whole or in part, on approval in advance of obtaining the care or treatment, and using the timetable for a non-urgent care determination could seriously jeopardize the life or health of the claimant; or the ability of the claimant to regain maximum function; or in the opinion of the attending or consulting Physician, would subject the claimant to severe pain that could not be adequately managed without the care or treatment that is the subject of the Claim. The Urgent Care Claim rules do not apply to claims involving urgent care where Plan benefits are not conditioned on prior approval. These claims are subject to the rules on Post-Service Claims described below.

A Physician with knowledge of the claimant's medical condition may determine if a Claim is one involving Urgent Care. The Claims Administrator will defer to the attending provider's determination that the Claim involves Urgent Care. If there is no such Physician, an individual acting on behalf of the Plan applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine may make the determination.

In the case of a Claim involving Urgent Care, responses must be made as soon as possible consistent with the medical urgency involved, and no later than the following times:

Notification to claimant of Claim determination	72 hours
Insufficient information on the Claim, or failure to follow the Plan's procedure for filing a Claim:	
Notification to claimant, orally or in writing	24 hours
Response by claimant, orally or in writing	48 hours
Benefit determination, orally or in writing	48 hours
Notification of Adverse Benefit Determination on Appeal	72 hours

If there is an Adverse Benefit Determination on a Claim involving Urgent Care, a request for an expedited Appeal may be submitted orally or in writing by the claimant. All necessary information, including the Plan's benefit determination on review, may be transmitted between the Plan and the claimant by telephone, facsimile, or other similarly expeditious method. Alternatively, the claimant may request an expedited review under the External Review Process.

Concurrent Care Claims

A Concurrent Care Claim is a special type of Claim that arises if the Plan informs a claimant that benefits for a course of treatment that has been previously approved for a period of time or number of treatments is to be reduced or eliminated. In that case, the Plan must notify the claimant sufficiently in advance of the effective date of the reduction or elimination of treatment to allow the claimant to file an Appeal. This rule does not apply if benefits are reduced or eliminated due to Plan amendment or termination. A similar process applies for Claims based on a rescission of coverage for fraud or misrepresentation.

In the case of a Concurrent Care Claim, the following timetable applies:

Notification to claimant of benefit reduction	Sufficiently prior to scheduled termination of course of treatment to allow claimant to appeal
Notification to claimant of rescission	30 days
Notification of determination on Appeal of Claims involving Urgent Care	24 hours (provided claimant files Appeal more than 24 hours prior to scheduled termination of course of treatment)
Notification of Adverse Benefit Determination on Appeal for non-Urgent Claims	As soon as feasible, but not more than 30 days
Notification of Adverse Benefit Determination on Appeal for Rescission Claims	30 days

Pre-Service Claim

A Pre-Service Claim means any Claim for a benefit under this Plan where the Plan conditions receipt of the benefit, in whole or in part, on approval in advance of obtaining medical care. These are, for example, Claims subject to pre-certification. Please see the Cost Management section of this booklet for further information about Pre-Service Claims.

In the case of a Pre-Service Claim, the following timetable applies:

Notification to claimant of Benefit Determination (whether or not adverse)	15 days
Extension due to matters beyond the control of the Plan	15 days
Insufficient information on the Claim:	
Notification of	15 days
Response by claimant	45 days
Notification, orally or in writing, of failure to follow the Plan's procedures for filing a Claim	5 days
Notification of Adverse Benefit Determination on Appeal	15 days per benefit appeal

Post-Service Claim

A Post-Service Claim means any Claim for a Plan benefit that is not an Urgent Care Claim or a Pre-Service Claim; in other words, a Claim that is a request for payment under the Plan for medical services already received by the claimant.

In the case of a Post-Service Claim, the following timetable applies:

Notification to claimant of Adverse Benefit Determination	30 days
Extension due to matters beyond the control of the Plan	15 days
Extension due to insufficient information on the Claim	15 days
Response by claimant following notice of insufficient information	45 days
Notification of Adverse Benefit Determination on Appeal	30 days per benefit appeal

Notice to claimant of Adverse Benefit Determinations

If a Claim is denied in whole or in part, the denial is considered to be an Adverse Benefit Determination. Except with Urgent Care Claims, when the notification may be oral followed by written or electronic notification within three days of the oral notification, the Plan Administrator shall provide written or electronic notification of the Adverse Benefit Determination. The notice will state in a culturally and linguistically appropriate manner and in a manner calculated to be understood by the claimant:

(1) Information sufficient to allow the claimant to identify the Claim involved (including date of service, the healthcare provider, and the claim amount, if applicable), and a statement that the diagnosis code and treatment code and their corresponding meanings will be provided to the claimant as soon as feasible upon request.

(2) The specific reason or reasons for the adverse determination, including the denial code and its corresponding meaning, and a description of the Plan's standard, if any, that was used in denying the Claim. In the case of a Final Adverse Benefit Determination, the description must include a discussion of the decision.

(3) Reference to the specific Plan provisions on which the determination was based.

(4) A description of any additional material or information necessary for the claimant to perfect the Claim and an explanation of why such material or information is necessary.

(5) A description of the Plan's internal and external Appeal procedures. This description will include information on how to initiate the Appeal and the time limits applicable to such procedures.

(6) If the Adverse Benefit Determination was based on an internal rule, guideline, protocol, or other similar criterion, the specific rule, guideline, protocol, or criterion will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol, or criterion was relied upon in making the Adverse Benefit Determination and a copy will be provided free of charge to the claimant upon request.

(7) If the Adverse Benefit Determination is based on the Medical Necessity or Experimental or Investigational treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, will be provided. If this is not practical, a statement will be included that such explanation will be provided free of charge, upon request.

(8) Information about the availability of and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under applicable federal law to assist individuals with the internal claims and appeals and external review process.

Appeals

When a claimant receives notification of an Adverse Benefit Determination, the claimant generally has 180 days following receipt of the notification in which to file a written request for an Appeal of the decision. However, for Concurrent Care Claims, the Claimant must file the Appeal prior to the scheduled reduction or termination of treatment. For a claim based on rescission of coverage, the claimant must file the Appeal within 30 days. A claimant may submit written comments, documents, records, and other information relating to the Claim.

The Plan Administrator shall provide the claimant, as soon as possible and sufficiently in advance of the time within which a final determination on Appeal is required to allow the claimant time to respond, any new or additional evidence that is relied upon, considered or generated by or at the direction of the Plan. This evidence shall be provided free of charge.

A document, record, or other information shall be considered relevant to a Claim if it:

(1) was relied upon in making the benefit determination;

(2) was submitted, considered, or generated in the course of making the benefit determination, without regard to whether it was relied upon in making the benefit determination;

(3) demonstrated compliance with the administrative processes and safeguards designed to ensure and to verify that benefit determinations are made in accordance with Plan documents and Plan provisions have been applied consistently with respect to all claimants; or

(4) constituted a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit.

The period of time within which a benefit determination on Appeal is required to be made shall begin at the time an Appeal is filed in writing in accordance with the procedures of the Plan. This timing is without regard to whether all the necessary information accompanies the filing.

Before the Plan Administrator issues its Final Adverse Benefit Determination based on a new or additional rationale, the claimant must be provided, free of charge, with a copy of the rationale. The rationale must be provided as soon as possible and sufficiently in advance of the time within which a final determination on Appeal is required to allow the claimant time to respond. If it is impossible under the circumstances to give the claimant a reasonable time to respond, the period for issuing the Final Adverse Benefit Determination will be delayed until the claimant has a reasonable opportunity to respond. After the claimant responds, or if the claimant fails to do so, the Plan Administrator will issue its Final Adverse Benefit Determiantion as soon as reasonably possible, taking into account the medical exigencies.

The review shall take into account all comments, documents, records, and other information submitted by the claimant relating to the Claim, without regard to whether such information was submitted or considered in the initial benefit determination. The review will not afford deference to the initial Adverse Benefit Determination and will be conducted by a fiduciary of the Plan who is neither the individual who made the adverse determination nor a subordinate of that individual.

If the determination was based on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is Experimental, Investigational, or not Medically Necessary or appropriate, the fiduciary shall consult with a health care professional who was not involved in the original benefit determination. This health care professional will have appropriate training and experience in the field of medicine involved in the medical judgment. Additionally, medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the initial determination will be identified.

If the Appeal of a Claim is denied, in whole or in part, the Plan Administrator shall provide written notification of the Adverse Benefit Determination on Appeal. The notice will state, in a culturally and linguistically appropriate manner and in a manner calculated to be understood by the claimant:

(1) Information sufficient to allow the claimant to identify the Claim involved (including date of service, the healthcare provider, and the claim amount, if applicable), and a statement that the diagnosis code and treatment code and their corresponding meanings will be provided to the claimant as soon as feasible upon request.

(2) The specific reason or reasons for the adverse determination, including the denial code and its corresponding meaning, and a description of the Plan's standard, if any, that was used in denying the Claim.

(3) Reference to the specific Plan provisions on which the determination was based.

(4) A description of any additional material or information necessary for the claimant to perfect the Claim and an explanation of why such material or information is necessary.

(5) A description of the Plan's internal and external review procedures and the time limits applicable to such procedures.

(6) A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim.

(7) If the Adverse Benefit Determination was based on an internal rule, guideline, protocol, or other similar criterion, the specific rule, guideline, protocol, or criterion will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol, or criterion was relied upon in making the Adverse Benefit Determination and a copy will be provided free of charge to the claimant upon request.

(8) If the Adverse Benefit Determination is based on the Medical Necessity or Experimental or Investigational treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, will be provided. If this is not practical, a statement will be included that such explanation will be provided free of charge, upon request.

(9) Information about the availability of and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under applicable federal law to assist individuals with the internal claims and appeals and external review process.

If the claimant disagrees with the Adverse Benefit Determination on Appeal, he or she may file a request for a second level of Appeal. This request must be made in writing within 180 days following receipt of the Adverse Benefit Determination on Appeal. The claimant may submit written comments, documents, records, and other information relating to the Claim. The second level of review will be conducted, and written notification of the decision, shall be made in accordance with all of the procedures that apply to the first level of review. If the Claim is denied in whole or in part after this second level of Appeal, the written notification describing the Adverse Benefit Determination is the Final Adverse Benefit Determination.

EXTERNAL REVIEW PROCESS

If a claimant receives a Final Adverse Benefit Determination under the Plan's internal Claims and Appeals Procedures, he or she may request that the Claim be reviewed under the Plan's External Review process. For requests made on or after September 20, 2011, the External Review process is available only where the Final Adverse Benefit Determination is denied on the basis of (1) a medical judgment (which includes but is not limited to, Plan requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit; eligibility for a reasonable alternative under a wellness program; or application of nonquantitative treatment limitations), (2) a determination that a treatment is experimental or investigational, or (3) a rescission of coverage. The request for External Review must be filed in writing within four (4) months after receipt of the Final Adverse Benefit Determination.

The Plan Administrator will determine within five days of receipt whether the Claim is eligible for review under the External Review process. This determination is based on the criteria described above and whether:

(1) The claimant is or was covered under the Plan at the time the Claim was made or incurred;

(2) The denial relates to the claimant's failure to meet the Plan's eligibility requirements;

(3) The claimant has exhausted the Plan's internal Claims and Appeal Procedures; and

(4) The claimant has provided all the information required to process an External Review.

Within one business day after completion of this preliminary review, the Plan Administrator will provide written notification to the claimant of whether the claim is eligible for External Review.

If the request for review is complete but not eligible for External Review, the Plan Administrator will notify the claimant of the reasons for its ineligibility. The notice will include contact information for the Employee Benefits Security Administration at its toll free number (866-444-3272).

If the request is not complete, the notice will describe the information needed to complete it. The claimant will have 48 hours or until the last day of the 4 month filing period, whichever is later, to submit the additional information.

If the request is eligible for the External Review process, the Plan will assign it to a qualified independent review organization ("IRO"). The IRO is responsible for notifying the claimant, in writing, that the request for External Review has been accepted. The notice should include a statement that the claimant may submit in writing, within 10 business days, additional information the IRO must consider when conducting the review. The IRO will share this information with the Plan. The Plan may consider this information and decide to reverse its denial of the Claim. If the denial is reversed, the External Review process will end.

If the Plan does not reverse the denial, the IRO will make its decision on the basis of its review of all of the information in the record, as well as additional information where appropriate and available, such as:

(1) The claimant's medical records;

(2) The attending health care professional's recommendation;

(3) Reports from appropriate health care professionals and other documents submitted by the plan or issuer, claimant, or the claimant's treating provider;

(4) The terms of the Plan;

(5) Appropriate practice guidelines;

(6) Any applicable clinical review criteria developed and used by the Plan; and

(7) The opinion of the IRO's clinical reviewer.

The IRO must provide written notice to the Plan and the claimant of its final decision within 45 days after the IRO receives the request for the External Review. The IRO's decision notice must contain:

(1) A general description of the reason for the External Review, including information sufficient to identify the claim;

(2) The date the IRO received the assignment to conduct the review and the date of the IRO's decision;

(3) References to the evidence or documentation the IRO considered in reaching its decision;

(4) A discussion of the principal reason(s) for the IRO's decision;

(5) A statement that the determination is binding and that judicial review may be available to the claimant; and

(6) Contact information for any applicable office of health insurance consumer assistance or ombudsman established under the PPACA.

Generally, a claimant must exhaust the Plan's Claims and Procedures in order to be eligible for the External Review process. However, in some cases the Plan provides for an expedited External Review if:

(1) The claimant receives an Adverse Benefit Determination that involves a medical condition for which the time for completion of the Plan's internal Claims and Appeal Procedures would seriously jeopardize the claimant's life or health or ability to regain maximum function and the claimant has filed a request for an expedited internal review; or

(2) The claimant receives a Final Adverse Benefit Determination that involves a medical condition where the time for completion of a standard External Review process would seriously jeopardize the claimant's life or health or the claimant's ability to regain maximum function, or if the Final Adverse Benefit Determination concerns an admission, availability of care, continued stay, or health care item or service for which the claimant received emergency services, but has not been discharged from a facility.

Immediately upon receipt of a request for expedited External Review, the Plan must determine and notify the claimant whether the request satisfies the requirements for expedited review, including the eligibility requirements for External Review listed above. If the request qualifies for expedited review, it will be assigned to an IRO. The IRO must make its determination and provide a notice of the decision as expeditiously as the claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited External Review. If the original notice of its decision is not in writing, the IRO must provide written confirmation of the decision within 48 hours to both the claimant and the Plan.

COORDINATION OF BENEFITS

Coordination of the benefit plans. Coordination of benefits sets out rules for the order of payment of Covered Charges when two or more plans -- including Medicare -- are paying. When a Covered Person is covered by this Plan and another plan, or the Covered Person's Spouse is covered by this Plan and by another plan or the couple's Covered children are covered under two or more plans, the plans will coordinate benefits when a claim is received.

The plan that pays first according to the rules will pay as if there were no other plan involved. The secondary and subsequent plans will pay the balance due up to 100% of the total Allowable Charges.

Benefit plan. This provision will coordinate the medical benefits of a benefit plan. The term benefit plan means this Plan or any one of the following plans:

(1) Group or group-type plans, including franchise or blanket benefit plans.

(2) Blue Cross and Blue Shield group plans.

(3) Group practice and other group prepayment plans.

(4) Federal government plans or programs. This includes, but is not limited to, Medicare and Tricare.

(5) Other plans required or provided by law. This does not include Medicaid or any benefit plan like it that, by its terms, does not allow coordination.

(6) No Fault Auto Insurance, by whatever name it is called, when not prohibited by law.

Allowable Charge. For a charge to be allowable it must be a Negotiated or Reasonable and Allowed amount and at least part of it must be covered under this Plan.

In the case of HMO (Health Maintenance Organization) or other in-network only plans: This Plan will not consider any charges in excess of what an HMO or network provider has agreed to accept as payment in full. Also, when an HMO or network plan is primary and the Covered Person does not use an HMO or network provider, this Plan will not consider as an Allowable Charge any charge that would have been covered by the HMO or network plan had the Covered Person used the services of an HMO or network provider.

In the case of service type plans where services are provided as benefits, the reasonable cash value of each service will be the Allowable Charge.

Automobile limitations. When medical payments are available under vehicle insurance, the Plan shall pay excess benefits only, without reimbursement for vehicle plan deductibles. The Plan shall always be considered the secondary carrier regardless of the individual's election to file a claim under PIP (personal injury protection) coverage with the auto carrier.

Benefit plan payment order. When two or more plans provide benefits for the same Allowable Charge, benefit payment will follow these rules:

(1) Plans that do not have a coordination provision, or one like it, will pay first. Plans with such a provision will be considered after those without one.

(2) Plans with a coordination provision will pay their benefits up to the Allowable Charge:

> **(a)** The benefits of the plan which covers the person directly (that is, as an employee, member or subscriber) ("Plan A") are determined before those of the plan which covers the person as a dependent ("Plan B").
>
> **(b)** The benefits of a benefit plan which covers a person as an Employee who is neither laid off nor retired are determined before those of a benefit plan which covers that person as a laid-off or Retired Employee. The benefits of a benefit plan which covers a person as a

Dependent of an Employee who is neither laid off nor retired are determined before those of a benefit plan which covers a person as a Dependent of a laid off or Retired Employee. If the other benefit plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule does not apply.

(c) The benefits of a benefit plan which covers a person as an Employee who is neither laid off nor retired or a Dependent of an Employee who is neither laid off nor retired are determined before those of a plan which covers the person as a COBRA beneficiary.

(d) When a child is covered as a Dependent and the parents are not separated or divorced, these rules will apply:

(i) The benefits of the benefit plan of the parent whose birthday falls earlier in a year are determined before those of the benefit plan of the parent whose birthday falls later in that year;

(ii) If both parents have the same birthday, the benefits of the benefit plan which has covered the parent for the longer time are determined before those of the benefit plan which covers the other parent.

(e) When a child's parents are divorced or legally separated, these rules will apply:

(i) This rule applies when the parent with custody of the child has not remarried. The benefit plan of the parent with custody will be considered before the benefit plan of the parent without custody.

(ii) This rule applies when the parent with custody of the child has remarried. The benefit plan of the parent with custody will be considered first. The benefit plan of the stepparent that covers the child as a Dependent will be considered next. The benefit plan of the parent without custody will be considered last.

(iii) This rule will be in place of items (i) and (ii) above when it applies. A court decree may state which parent is financially responsible for medical and dental benefits of the child. In this case, the benefit plan of that parent will be considered before other plans that cover the child as a Dependent.

(iv) If the specific terms of the court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child shall follow the order of benefit determination rules outlined above when a child is covered as a Dependent and the parents are not separated or divorced.

(v) For parents who were never married to each other, the rules apply as set out above as long as paternity has been established.

(f) If there is still a conflict after these rules have been applied, the benefit plan which has covered the patient for the longer time will be considered first. This includes situations in which a person who is covered as a dependent child under one benefit plan is also covered as a dependent spouse under another benefit plan. When there is a conflict in coordination of benefit rules, the Plan will never pay more than 50% of Allowable Charges when paying secondary.

(g) Dual TCSIG Plan. If both spouses are employed by the same Employer or by separate participating Employers of TCSIG, and are covered as participants, these provisions will apply for all covered family members in the same manner as if the spouses were covered under two different plans.

(3) Medicare will pay primary, secondary or last to the extent stated in federal law. If a Plan Participant is Medicare entitled this Plan will base its payment upon benefits that would have been paid by

Medicare under Parts A, and B, regardless of whether or not the person was enrolled under any of these parts. The Plan Administrator will make this determination based on the information available through CMS. If CMS does not provide sufficient information to determine the amount Medicare would pay, the Plan Administrator will make reasonable assumptions based on published Medicare fee schedules.

(4) If a Plan Participant is under a disability extension from a previous benefit plan, that benefit plan will pay first and this Plan will pay second.

(5) The Plan will pay primary to Tricare and a State child health plan to the extent required by federal law.

Claims determination period. Benefits will be coordinated on a Calendar Year basis. This is called the claims determination period.

Right to receive or release necessary information. To make this provision work, this Plan may give or obtain needed information from another insurer or any other organization or person. This information may be given or obtained without the consent of or notice to any other person. A Covered Person will give this Plan the information it asks for about other plans and their payment of Allowable Charges.

Facility of payment. This Plan may repay other plans for benefits paid that the Plan Administrator determines it should have paid. That repayment will count as a valid payment under this Plan.

Right of recovery. This Plan may pay benefits that should be paid by another benefit plan. In this case this Plan may recover the amount paid from the other benefit plan or the Covered Person. That repayment will count as a valid payment under the other benefit plan.

Further, this Plan may pay benefits that are later found to be greater than the Allowable Charge. In this case, this Plan may recover the amount of the overpayment from the source to which it was paid.

THIRD PARTY RECOVERY PROVISION

RIGHT OF SUBROGATION AND REFUND

When this provision applies. The Covered Person may incur medical or dental charges due to Injuries which may be caused by the act or omission of a Third Party. In such circumstances, the Covered Person may have a claim for payment of the medical or dental charges. Accepting benefits under this Plan for those incurred medical or dental expenses automatically assigns to the Plan any rights the Covered Person may have to Recover payments from any Third Party or any other insurer or source, including but not limited to, “first party” underinsured or uninsured motorist coverage, worker’s compensation, crime victim restitution funds, medical or disability payments, homeowner's plan, renter's plan, medical malpractice plan, or any other liability plan or any other source of coverage.

This Subrogation right allows the Plan to pursue any claim which the Covered Person has against any Third Party, or insurer, whether or not the Covered Person chooses to pursue that claim. The Plan may make a claim directly against the Third Party or insurer, but in any event, the Plan has a lien on any amount Recovered by the Covered Person whether or not designated as payment for medical expenses. This lien shall remain in effect until the Plan is repaid in full.

The Plan Administrator retains sole, full and final discretionary authority to construe, apply, and interpret the language of this provision, to determine all questions of fact and law arising under this provision, and to administer the Plan’s subrogation and reimbursement rights. The Plan Administrator also retains the right to delegate this discretionary authority to the Claims Administrator without notice.

The payment for benefits received by a Covered Person under the Plan shall be made in accordance with the assignment of rights by or on behalf of the Covered Person as required by Medicaid.

In any case in which the Plan has a legal liability to make payments for benefits received by a Covered Person, to the extent that payment has been made through Medicaid, the payment for benefits under the Plan shall be made in accordance with any state law that has provided that the state has acquired the rights of the Covered Person to the payments of those benefits.

The Covered Person:

(1) automatically assigns to the Plan his or her rights against any Third Party or insurer when this provision applies; and

(2) must repay to the Plan the benefits paid on his or her behalf out of the Recovery made from the Third Party or insurer.

Amount subject to Subrogation or Refund. The Covered Person agrees to recognize the Plan's right to Subrogation and Refund. These rights provide the Plan with a 100%, first dollar priority over any and all Recoveries and funds paid by a Third Party or insurer to a Covered Person relative to the Injury or Sickness, including a priority over any claim for non-medical or dental charges, attorney fees, or other costs and expenses, even if the Covered Person’s Recovery is less than the amount claimed, and, as a result, the Covered Person is not made whole. The Covered Person further specifically agrees and acknowledges that the “made whole doctrine” and “common fund” doctrine are completely abrogated under this Plan, and will not affect the Plan’s right to 100% Subrogation or Refund for any and all benefits paid. The Plan shall have an equitable lien which supersedes all common law or statutory rules, doctrines, and laws of any state prohibiting assignment of rights which interfere with or compromise in any way the Plan’s equitable subrogation lien. Accepting benefits under this Plan for those incurred medical or dental expenses automatically assigns to the Plan any and all rights the Covered Person may have to recover payments from any responsible third party or insurer. Further, accepting benefits under this Plan for those incurred medical or dental expenses automatically assigns to the Plan the Covered Person's Third Party Claims and/or the Covered Person’s claims under any other policy of insurance or other coverage.

Notwithstanding its priority to funds, the Plan's Subrogation and Refund rights, as well as the rights assigned to it, are limited to the extent to which the Plan has made, or will make, payments for medical or dental charges as well as any costs and fees associated with the enforcement of its rights under the Plan. The Plan reserves the

right to be reimbursed for its court costs and attorneys' fees if the Plan needs to file suit in order to Recover payment for medical or dental expenses from the Covered Person.

When a right of Recovery exists, the Covered Person will execute and deliver all required instruments and papers as well as doing whatever else is needed to secure the Plan's right of Subrogation as a condition to having the Plan make payments. In addition, the Covered Person will do nothing to prejudice the right of the Plan to Subrogate.

Failure by the Covered Person(s) and/or his attorney to comply with any of these requirements may, at the Plan's discretion, result in forfeiture of payment by the Plan of medical benefits and any funds or payments due under this Plan may be withheld until the Covered Person(s) satisfies his or her obligation.

Conditions Precedent to Coverage. The Plan shall have no obligation whatsoever to pay medical or dental benefits to a Covered Person if a Covered Person refuses to cooperate with the Plan's reimbursement and Subrogation rights or refuses to execute and deliver such papers as the Plan may require in furtherance of its reimbursement and Subrogation rights. Further, in the event the Covered Person is a minor, the Plan shall have no obligation to pay any medical or dental benefits incurred on account of Injury or Sickness caused by a responsible Third Party until after the Covered Person or his authorized legal representative obtains valid court recognition and approval of the Plan's 100%, first dollar reimbursement and Subrogation rights on all Recoveries, as well as approval for the execution of any papers necessary for the enforcement thereof, as described herein.

Defined terms: "Covered Person" means anyone covered under the Plan, including minor dependents.

"Recover," "Recovered," "Recovery" or "Recoveries" means all monies paid to the Covered Person or his designee by way of judgment, settlement, or otherwise to compensate for all losses caused by the Injury or Sickness, whether or not said losses reflect medical or dental charges covered by the Plan. "Recoveries" further includes, but is not limited to, recoveries for medical or dental expenses, attorneys' fees, costs and expenses, pain and suffering, loss of consortium, wrongful death, lost wages and any other recovery of any form of damages or compensation whatsoever.

"Refund" means repayment to the Plan for medical or dental benefits that it has paid toward care and treatment of the Injury or Sickness.

"Subrogation" means the Plan's right to pursue and place a lien upon the Covered Person's claims for medical or dental charges against the other person.

"Third Party" means any Third Party including another person or a business entity.

Rights of Plan Administrator. The Plan Administrator has a right to request reports on and approve of all settlements.

CONTINUATION OF COVERAGE

Government entities are subject to the continuation of coverage provisions of the Public Health Services Act which essentially duplicates the provisions of the Consolidated Omnibus-Budget Reconciliation Act (COBRA). The following is intended to comply with the Public Health Services Act.

The coverage which may be continued under this provision consists of health coverage. It does not include life insurance benefits, Accidental death and dismemberment benefits, or income replacement benefits. Health coverage includes medical benefits as provided under the Plan.

Qualifying Events. Under this provision, the following Covered Persons whose coverage would otherwise end may continue coverage under the Plan:

(1) Covered Dependents of a covered Employee who dies.

(2) A covered Employee and his covered Dependents upon the Employee's termination of employment (other than termination for gross misconduct) or whose work hours have been reduced to less than the minimum required for coverage under the Plan.

(3) A covered spouse (and any affected covered Dependents) upon divorce or legal separation.

(4) Covered Dependents of a covered Employee whose termination from the Plan is due to the covered Employee becoming eligible for benefits under Medicare.

(5) A covered Dependent Child who attains the maximum age at which Dependent Children may be covered under the Plan, or otherwise becomes ineligible under the Plan's terms.

(6) A covered Retiree and their covered beneficiaries whose benefits were substantially reduced within one year of the Employer filing for Chapter 11 bankruptcy.

(7) The last day of a leave under the Family Medical Leave Act.

(8) The call-up of reservist in the United States military or National Guard to active duty.

Notification Requirements.

(1) When eligibility for continuation of coverage results from a spouse being divorced or legally separated from a covered Employee or a Child's attainment of the maximum age for coverage under the Plan, the Employee or Dependent must notify the Employer of that event within sixty (60) days of the event. **Failure to provide notification to the Employer will result in the person forfeiting their right to continued coverage.**

(2) The Employer must submit such notice to TCSIG or its designated representative within thirty (30) days of receipt.

(3) Within fourteen (14) days of receiving notice, TCSIG or its designated representative shall advise the Employee or Dependent of his or her rights to continue coverage.

(4) After receiving notice, the Employee or Dependent has sixty (60) days to decide whether to elect continued coverage. This sixty (60) day period begins on the later of:

> **(a)** The date coverage under the Plan would otherwise end; or
>
> **(b)** The date the person receives the notice from TCSIG or its designated representative of his or her rights to continuation of coverage.

If the Employee or Dependent chooses to have continuation of coverage, he must advise TCSIG or its designated representative in writing of this choice. TCSIG or its designated representative must receive this

written notice no later than the last day of the sixty (60) day period. If the election is mailed, the election must be postmarked on or before the last day of the sixty (60) day period.

(5) Within forty-five (45) days after the date the person notifies TCSIG or its designated representative that he has chosen continuation of coverage, the person must pay the initial premium. The initial payment shall be the amount needed to provide coverage from the date continued benefits begin to the date that the election was made. Thereafter, premiums for the continued coverage are to be paid monthly, and are due in advance, on the first day each month.

(6) The Employee, Dependent or their designated representative must pay the premium for the coverage being continued.

Family Members Acquired During Continuation. A spouse or Dependent Child newly acquired during continuation of coverage is eligible to be enrolled as a Dependent. The standard enrollment provision of the Plan applies to enrollees during continuation of coverage. A Child born to or placed for adoption with the covered Employee during the period of continuation of coverage shall be eligible for an extension of continuation of coverage due to a second qualifying event. A Child born to or placed for adoption with the former spouse of a covered Employee shall not be eligible for the extension of continuation of coverage due to a second qualifying event. The Plan shall provide a special thirty (30) day enrollment period to enroll such Child (ren).

Subsequent Qualifying Events. Once covered under continuation of coverage, it is possible for a second qualifying event to occur, including:

(1) Death of an Employee.

(2) Divorce or legal separation from an Employee.

(3) Employee's entitlement to Medicare.

(4) Child's loss of Dependent status.

If one of these subsequent qualifying events occurs, a Dependent may be entitled to a second continuation period. This period will in no event continue beyond thirty-six (36) months from the date of the first qualifying event.

Except as specified in Family Members Acquired During Continuation above, only a person covered prior to the original qualifying event is eligible for the second continuation period as the result of a subsequent qualifying event. A Dependent acquired during continuation of coverage is not eligible to continue coverage as the result of a subsequent qualifying event.

For example: (1) Continuation may begin due to termination of employment. During the continuation, if a Child reaches the upper age limit of the Plan, the Child is eligible for a second continuation period. This second continuation would end no later than thirtysix (36) months from the date of the first qualifying event, (i.e., the termination of employment). (2) An Employee terminates and elects continuation of coverage for himself and his spouse. They would be allowed continuation of coverage for up to eighteen (18) months. If during the eighteen (18) months, the Employee becomes entitled to Medicare, the spouse would be eligible for additional continuation up to a total of thirty-six (36) months from the date of the first qualifying event.

When Continuation Of Coverage Begins. When continuation of coverage is elected, and the premium paid, coverage is reinstated back to the date of the loss of coverage, so that no break in coverage occurs. However, for an Employee on an approved leave under the Family Medical Leave Act, continuation of coverage shall begin on the last day of the leave. Coverage for Dependents acquired and properly enrolled during the continuation period begins in accordance with the enrollment provisions of the Plan.

End Of Continuation. Continuation shall end on the earliest of the following dates:

(1) Eighteen (18) months from the date continuation began for an Employee whose coverage ended because of a reduction of hours or termination of employment.

(2) Thirty-six (36) months from the date continuation began for Dependents whose coverage ended because of the death of the Employee, divorce or legal separation from the Employee, or the attainment of the maximum age of eligibility by a Dependent.

(3) The end of the period for which premium is paid if the Covered Person fails to make a premium payment on the date specified by TCSIG.

(4) The date coverage under this Plan ends and the Employer offers no other group health benefit plan.

(5) The date the Covered Person becomes entitled to Medicare.

(6) The date the Covered Person becomes covered under any other group health plan.

(7) In the case of bankruptcy proceeding, the period until the death of the Retiree, and widows or widowers of Retirees who died before the Employer's bankruptcy are entitled to lifetime continuation of coverage. However, if a Retiree dies after the Employer's bankruptcy, the surviving spouse and Dependent Children may only elect an additional thirty-six (36) months of continuation of coverage after the death.

In the event an Employer terminates its participation in this Plan, all persons under continuation of coverage through that Employer shall transfer to the Employer's new plan, and continuation of coverage under this Plan shall cease.

Extension For Disabled Individuals. Continuation of coverage may extend from eighteen (18) months to twenty-nine (29) months if the qualified beneficiary receives a determination from the Social Security Administration that the person was disabled at the time of the qualifying event, or within sixty (60) days of the qualifying event. The disabled person and the family members who were covered prior to the qualifying event are eligible for up to twenty-nine (29) months of continuation of coverage. In order to be eligible for the additional eleven (11) month extension, the qualified beneficiary must submit proof of the determination of disability by the Social Security Administration to TCSIG or the Claims Administrator within the initial eighteen (18) month continuation of coverage period and no later than sixty (60) days after the Social Security Administration's determination. Extended coverage will end the month that begins thirty (30) days after the person is no longer considered disabled.

RESPONSIBILITIES FOR PLAN ADMINISTRATION

PLAN ADMINISTRATOR. Tri-County Schools Insurance Group (TCSIG) Employee Health Care Plan is the benefit plan of Tri-County Schools Insurance Group (TCSIG), the Plan Administrator, also called the Plan Sponsor. An individual or committee may be appointed by Tri-County Schools Insurance Group (TCSIG) to be Plan Administrator and serve at the convenience of the Employer. If the Plan Administrator or a committee member resigns, dies or is otherwise removed from the position, Tri-County Schools Insurance Group (TCSIG) shall appoint a new Plan Administrator as soon as reasonably possible.

The Plan Administrator shall administer this Plan in accordance with its terms and establish its policies, interpretations, practices, and procedures. It is the express intent of this Plan that the Plan Administrator shall have maximum legal discretionary authority to construe and interpret the terms and provisions of the Plan, to make determinations regarding issues which relate to eligibility for benefits, to decide disputes which may arise relative to a Plan Participant's rights, and to decide questions of Plan interpretation and those of fact relating to the Plan. The decisions of the Plan Administrator will be final and binding on all interested parties.

DUTIES OF THE PLAN ADMINISTRATOR.

(1) To administer the Plan in accordance with its terms.

(2) To interpret the Plan, including the right to remedy possible ambiguities, inconsistencies or omissions.

(3) To decide disputes which may arise relative to a Plan Participant's rights.

(4) To prescribe procedures for filing a claim for benefits and to review claim denials.

(5) To keep and maintain the Plan documents and all other records pertaining to the Plan.

(6) To appoint a Claims Administrator to pay claims.

(7) To delegate to any person or entity such powers, duties and responsibilities as it deems appropriate.

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

CLAIMS ADMINISTRATOR IS NOT A FIDUCIARY. A Claims Administrator is **not** a fiduciary under the Plan by virtue of paying claims in accordance with the Plan's rules as established by the Plan Administrator.

FORCE MAJEURE. Should the performance of any act required by the Plan be prevented or delayed by reason of any act of nature, strike, lock-out, labor troubles, restrictive governmental laws or regulations, or any other cause beyond a party's control, the time for the performance of the act will be extended for a period equivalent to the period of delay, and non-performance of the act during the period of delay will be excused. In such an event, however, all parties will use reasonable efforts to perform their respective obligations under the Plan.

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

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

(1) **General.** The Plan shall not disclose Protected Health Information to any member of the Employer's workforce unless each of the conditions set out in this HIPAA Privacy section is met. "Protected Health Information" shall have the same definition as set out in the Privacy Standards but generally shall mean individually identifiable health information about the past, present or future physical or

mental health or condition of an individual, including genetic information and information about treatment or payment for treatment.

(2) **Permitted Uses and Disclosures.** Protected Health Information disclosed to members of the Employer's workforce shall be used or disclosed by them only for purposes of Plan administrative functions. The Plan's administrative functions shall include all Plan payment and health care operations. The terms "payment" and "health care operations" shall have the same definitions as set out in the Privacy Standards, but the term "payment" generally shall mean activities taken with respect to payment of premiums or contributions, or to determine or fulfill Plan responsibilities with respect to coverage, provision of benefits, or reimbursement for health care. "Health care operations" generally shall mean activities on behalf of the Plan that are related to quality assessment; evaluation, training or accreditation of health care providers; underwriting, premium rating and other functions related to obtaining or renewing an insurance contract, including stop-loss insurance; medical review; legal services or auditing functions; or business planning, management and general administrative activities. However, Protected Health Information that consists of genetic information will not be used or disclosed for underwriting purposes.

(3) **Authorized Employees.** The Plan shall disclose Protected Health Information only to members of the Employer's workforce who are designated and are authorized to receive such Protected Health Information, and only to the extent and in the minimum amount necessary for these persons to perform duties with respect to the Plan. For purposes of this HIPAA Privacy section, "members of the Employer's workforce" shall refer to all employees and other persons under the control of the Employer.

(a) **Updates Required.** The Employer shall amend the Plan promptly with respect to any changes in the members of its workforce who are authorized to receive Protected Health Information.

(b) **Use and Disclosure Restricted.** An authorized member of the Employer's workforce who receives Protected Health Information shall use or disclose the Protected Health Information only to the extent necessary to perform his or her duties with respect to the Plan.

(c) **Resolution of Issues of Noncompliance.** In the event that any member of the Employer's workforce uses or discloses Protected Health Information other than as permitted by the Privacy Standards, the incident shall be reported to the privacy official. The privacy official shall take appropriate action, including:

(i) Investigation of the incident to determine whether the breach occurred inadvertently, through negligence, or deliberately; whether there is a pattern of breaches; and the degree of harm caused by the breach;

(ii) Applying appropriate sanctions against the persons causing the breach, which, depending upon the nature of the breach, may include, oral or written reprimand, additional training, or termination of employment;

(iii) Mitigating any harm caused by the breach, to the extent practicable; and

(iv) Documentation of the incident and all actions taken to resolve the issue and mitigate any damages.

(4) **Certification of Employer.** The Employer must provide certification to the Plan that it agrees to:

(a) Not use or further disclose the Protected Health Information other than as permitted or required by the Plan documents or as required by law;

(b) Ensure that any agent or subcontractor, to whom it provides Protected Health Information received from the Plan, agrees to the same restrictions and conditions that apply to the Employer with respect to such information;

(c) Not use or disclose Protected Health Information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Employer;

(d) Report to the Plan any use or disclosure of the Protected Health Information of which it becomes aware that is inconsistent with the uses or disclosures hereunder or required by law;

(e) Make available Protected Health Information to individual Plan members in accordance with Section 164.524 of the Privacy Standards;

(f) Make available Protected Health Information for amendment by individual Plan members and incorporate any amendments to Protected Health Information in accordance with Section 164.526 of the Privacy Standards;

(g) Make available the Protected Health Information required to provide any accounting of disclosures to individual Plan members in accordance with Section 164.528 of the Privacy Standards;

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

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

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

The following members of Tri-County Schools Insurance Group (TCSIG)'s workforce are designated as authorized to receive Protected Health Information from Tri-County Schools Insurance Group (TCSIG) Employee Health Care Plan ("the Plan") in order to perform their duties with respect to the Plan: Privacy Officer and other individuals trained and authorized by the Privacy Officer to receive Protected Health Information.

COMPLIANCE WITH HIPAA ELECTRONIC SECURITY STANDARDS. Under the Security Standards for the Protection of Electronic Protected Health Information (45 CFR Part 164.300 et. seq., the "Security Standards"), the Employer agrees to the following:

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

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

(3) The Employer shall ensure that reasonable and appropriate security measures are implemented to comply with the conditions and requirements set forth in Compliance With HIPAA Privacy Standards provisions (3) Authorized Employees and (4) Certification of Employers described above.

FUNDING THE PLAN AND PAYMENT OF BENEFITS

The cost of the Plan is funded as follows:

For Employee and Dependent Coverage: The participating Employers shall maintain discretion as to whether or not an Employee Group shall contribute toward the cost of coverage under this Plan. The same rate structure (i.e., composite or tiered) shall apply for all Employees in an Employee Group.

The level of any Employee contributions will be set by the Plan Administrator. These Employee contributions will be used in funding the cost of the Plan as soon as practicable after they have been received from the Employee or withheld from the Employee's pay through payroll deduction.

Benefits are paid directly from the Plan through the Claims Administrator.

PLAN IS NOT AN EMPLOYMENT CONTRACT

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

CLERICAL ERROR

Any clerical error by the Plan Administrator or an agent of the Plan Administrator in keeping pertinent records or a delay in making any changes will not invalidate coverage otherwise validly in force or continue coverage validly terminated. An equitable adjustment of contributions will be made when the error or delay is discovered.

If, an overpayment occurs in a Plan reimbursement amount, the Plan retains a contractual right to the overpayment. The person or institution receiving the overpayment will be required to return the incorrect amount of money. In the case of a Plan Participant, the amount of overpayment may be deducted from future benefits payable.

GENERAL PLAN INFORMATION

TYPE OF ADMINISTRATION

The Plan is a self-funded group health Plan and the administration is provided through a Third Party Claims Administrator. The funding for the benefits is derived from the funds of the Employer and contributions made by covered Employees. The Plan is not insured.

PLAN NAME

Tri-County Schools Insurance Group (TCSIG) Employee Health Care Plan

PLAN NUMBER:

Basic Plan: 503
Premier Plus Plan: 509
Premier Plan: 504
Standard Plan: 505
High Deductible Health Plan (HDHP): 701

TAX ID NUMBER: 68-0279058

PLAN EFFECTIVE DATE: September 1, 1983

PLAN YEAR ENDS: June 30

EMPLOYER INFORMATION

Tri-County Schools Insurance Group (TCSIG)
400 Plumas Boulevard, Suite 210
Yuba City, California 95991
866-822-5299

PLAN ADMINISTRATOR

Tri-County Schools Insurance Group (TCSIG)
400 Plumas Boulevard, Suite 210
Yuba City, California 95991
530-822-5299

CLAIMS ADMINISTRATOR

HealthComp Administrators
P. O. Box 45018
Fresno, California 93718-5018
800-442-7247

Tri-County Schools Insurance Group (TCSIG)
GROUP HEALTH PLAN AMENDMENT # 1
To the January 1, 2021 Plan Document

This amendment is attached to and made a part of the Tri-County Schools Insurance Group Employee Health Care Plan. Amendment # 1 is effective on the below dates and reflects the following changes:

EFFECTIVE JULY 1, 2022

- Add language below for Specialty Drugs and the Cost Relief Program.

PRESCRIPTION DRUG BENEFIT SCHEDULE
FOR BASIC, PREMIER PLUS, PREMIER AND STANDARD PPO PLANS

Please contact the Prescription Drug Administrator for additional information.

PRESCRIPTION DRUG BENEFIT		
MAXIMUM OUT-OF-POCKET AMOUNT PER CALENDAR YEAR - The maximum out-of-pocket expense for Prescription Drug benefits includes copayments and is separate from the Medical Out-of-Pocket maximum.		
	NETWORK	**NON-NETWORK**
Per Covered Person	$1,000	Not Applicable
Per Family Unit	$2,000	Not Applicable
Pharmacy Option (31 day supply)		
Generic Drugs	$5 copayment	Prescriptions are only covered at participating pharmacies
Preferred Brand Name Drugs	25% to a maximum of $35 copayment	Prescriptions are only covered at participating pharmacies
Non-Preferred Brand Name Drugs	45% to a maximum of $70 copayment	Prescriptions are only covered at participating pharmacies
Pharmacy Option (90 day supply)		
Generic Drugs	$10 copayment	Prescriptions are only covered at participating pharmacies
Preferred Brand Name Drugs	$50 copayment	Prescriptions are only covered at participating pharmacies
Non-Preferred Brand Name Drugs	$90 copayment	Prescriptions are only covered at participating pharmacies
Mail Order Option (90 day supply)		
Generic Drugs	$10 copayment	Not Applicable
Preferred Brand Name Drugs	$50 copayment	Not Applicable
Non-Preferred Brand Name Drugs	$90 copayment	Not Applicable
Specialty Drugs (maximum 30 day supply)		
Obtained through the IngenioRx Cost Relief Program	No charge	Not Applicable

PRESCRIPTION DRUG BENEFIT		
Specialty Drugs, continued (maximum 30 day supply)		
Unavailable through the IngenioRx Cost Relief Program • Preferred Brand Name	25% to a maximum of $35 copayment	Not Available
• Non-Preferred Brand Name	45% to a maximum of $70 copayment	
Voluntary opt out of IngenioRx Cost Relief Program • Preferred Brand Name	30% coinsurance	Not Available
• Non-Preferred Brand Name	45% coinsurance	
NOTE: Specialty Drugs are only available from the Specialty Pharmacy and you will not be able to obtain them at a Retail Pharmacy or through the Home Delivery (Mail Order) Pharmacy. Your medication may be available through the IngenioRX Cost Relief program. The list of prescription drugs covered by the IngenioRX Cost Relief Program may be updated periodically by the Plan. For additional information contact IngenioRX at 877-638-4008. If you are eligible for the IngenioRX Cost Relief Program and choose to opt out, you will be subject to the Specialty Drug Coinsurance.		
Refer to the Prescription Drug Section for details on the Prescription Drug benefit.		

Should the Covered Person request a brand name drug when the generic is available, and the Physician has NOT provided evidence of medical necessity, the Covered Person will be liable for the difference between the brand name and the generic in addition to the brand name Copay.

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

It is agreed that these changes shall be an amendment to the Tri-County Schools Insurance Group (TCSIG) Employee Health Care Plan, and shall become a part of the Plan, but shall not otherwise vary, alter or extend the terms of the Plan.

Dated on this 17th day of June, 2022.

Tri-County Schools Insurance Group (TCSIG)

By: Ryan J. Robison
(Signature of person authorized to make this change)

By: RYAN J. ROBISON, President TCSIG BOARD
(Print signature name and title of person authorized to make this change)