

PORTERVILLE UNIFIED SCHOOL DISTRICT

BENEFIT DOCUMENT & SUMMARY PLAN DESCRIPTION

OF THE SELF-FUNDED

MEDICAL, PRESCRIPTION AND DENTAL BENEFITS

BENEFIT SUMMARIES ARE ALSO INCLUDED FOR THE FOLLOWING
INSURED BENEFITS OF THE PLAN

VISION, LIFE AND DISABILITY

RESTATED EFFECTIVE: MARCH 1, 2009

REVISED EFFECTIVE: JANUARY 2011

REVISED EFFECTIVE: MARCH 16, 2011 – NEW HEALTH CARE REQUIREMENTS

FINAL REVISIONS: FEBRUARY 15, 2012

Contract Administrator:

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IMPORTANT INFORMATION

WHO TO CONTACT FOR ADDITIONAL INFORMATION

A Plan participant can obtain additional information about coverage of a specific drug, treatment, procedure, preventive service, etc. from the office that handles claims on behalf of the Plan (the "Contract Administrator"). See the first page of the **General Plan Information** section for the name, address and phone number of the Contract Administrator.

THE NEWBORNS AND MOTHERS HEALTH PROTECTION ACT

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean delivery. 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).

THE WOMEN'S HEALTH AND CANCER RIGHTS ACT

Under Federal law, group health plans must include coverage for the following post-mastectomy services and supplies when provided in a manner determined in consultation between the attending physician and the patient: (1) reconstruction of the breast on which a mastectomy has been performed, (2) surgery and reconstruction of the other breast to produce symmetrical appearance, (3) breast prostheses, and (4) physical complications of all stages of mastectomy, including lymphedemas.

Plan participants must be notified, upon enrollment and annually thereafter, of the availability of benefits required due to the Women's Health and Cancer Rights Act (WHCRA).

DEFINITIONS

Some of the terms used in this document begin with a capital letter. These terms have special meanings and are included in the **Definitions** section. When reading this document, it will be helpful to refer to this section. Becoming familiar with the terms defined therein will give you a better understanding of the benefits and provisions.

NOTICE OF RIGHT TO RECEIVE A CERTIFICATE OF CREDITABLE COVERAGE

Under the Health Insurance Portability and Accountability Act of 1996 (commonly known as HIPAA), an individual has the right to receive a certificate of prior health coverage, called a "certificate of creditable coverage" or "certificate of group health plan coverage," from the Plan Sponsor or its delegate. If Plan coverage or COBRA continuation coverage terminates (including termination due to exhaustion of all lifetime benefits under the Plan), the Plan Sponsor will automatically provide a certificate of creditable coverage. The certificate is provided at no charge and will be mailed to the person at the most current address on file. A certificate of creditable coverage will also be provided, on request, in accordance with the law (i.e., a request can be made at any time while coverage is in effect and within twenty-four (24) months after termination of coverage). Written procedures for requesting and receiving certificates of creditable coverage are available from the Plan Sponsor.

UTILIZATION MANAGEMENT PROGRAM

The Plan includes a **Utilization Management Program** as described below. The purpose of the program is to encourage Covered Persons to obtain quality medical care while utilizing the most cost efficient sources.

PRE-SERVICE REVIEW REQUIREMENTS

The Plan Sponsor has contracted with an independent organization to provide pre-service review. The name and phone number of the organization is shown on the Employee's coverage identification card.

Compliance Procedures – Prior to any non-emergency Inpatient Hospital admission or Outpatient or in-office surgery or invasive diagnostic procedure where the cost is expected to exceed \$250 or prior to beginning a program of home health care, the Covered Person or someone acting on his behalf must contact the Utilization Management Organization for pre-service review and authorization. In the case of an emergency admission or procedure, contact must occur no later than the first working day following the admission or procedure.

If, in the opinion of the patient's Physician, it is necessary for the patient to be hospitalized for a longer time than initially authorized, the Physician may request that additional days be authorized by contacting the Utilization Management Organization no later than the last authorized day.

NOTES: Pre-service review will not be required for an Inpatient admission for Pregnancy delivery that does not exceed 48 hours following a normal vaginal delivery or 96 hours following a cesarean section delivery. However, if/when the Pregnancy confinement for the mother or newborn is expected to exceed these limits, pre-service review for such extended confinement is required.

See "Transplant-Related Expenses in the **Eligible Medical Expenses** section for prior approval requirements that apply to a proposed transplant procedure.

Penalty for Non-Compliance - If the above pre-service review requirements are not completed or if the Covered Person remains in the Hospital beyond the number of days initially authorized, the Plan's benefit percentage for Eligible Expenses will be 60%. In the case of a Hospital admission, this reduced percentage will apply to Hospital expenses. In the case of an Outpatient surgery or invasive diagnostic procedure, this reduced percentage will apply to all services rendered at the time of the procedure. In the case of home health care, this reduced percentage will apply to all related services and supplies.

Any additional share of expenses that becomes the Covered Person's responsibility for failure to comply with these requirements will not be considered eligible medical expenses and thus will not apply to any deductibles, coinsurance or out-of-pocket maximums of the Plan.

See "Pre-Service Claims" in the **Claims Procedures** section for more information, including information on appealing an adverse decision (i.e. a benefit reduction) under this program.

NOTE: The Plan will not reduce or deny a claim for failure to obtain a prior approval under circumstances that would make obtaining pre-service review impossible or where application of the pre-service review process could seriously jeopardize the life or health of the patient (e.g., the patient is unconscious and is in need of immediate care at the time medical treatment is required).

MORE INFORMATION ABOUT PRE-SERVICE REVIEW

It is the **Employee's or Covered Person's responsibility** to make certain that the compliance procedures of this program are completed. To minimize the risk of reduced benefits, an Employee should contact the review organization to make certain that the facility or attending Physician has initiated the necessary processes.

Pre-service review and authorization is **not a guarantee of coverage**. The **Utilization Management Program** is designed ONLY to determine whether or not a proposed setting and course of treatment is Medically Necessary and appropriate. Benefits under the Plan will depend upon the person's eligibility for coverage and the Plan's limitations and exclusions. Nothing in the **Utilization Management Program** will increase benefits to cover any confinement or service that is not Medically Necessary or that is otherwise not covered under the Plan.

MEDICAL BENEFIT SUMMARY - CERTIFICATED

(This schedule applies to Certificated Employees and their eligible and enrolled Dependents)

SCHEDULE OF MEDICAL BENEFITS

MAXIMUM LIFETIME BENEFIT	NO LONGER APPLICABLE	
CALENDAR YEAR DEDUCTIBLES		
Individual Deductible	\$300 Effective January 1, 2011	
Family Maximum Deductible	\$900 Effective January 1, 2011	
<p><u>Individual Deductible</u> - The Individual Deductible is an amount a Covered Person must contribute each year toward payment of eligible medical expenses. The deductible usually applies before the Plan begins to provide benefits.</p> <p><u>Family Maximum Deductible</u> - If \$900 in eligible medical expenses is incurred collectively by family members during a Calendar Year and is applied toward Individual Deductibles, the Family Maximum Deductible is satisfied. A "family" includes a covered Employee and his covered Dependents.</p> <p><u>Deductible Carry-Over</u> - Eligible Expenses incurred in the last 3 months of a Calendar Year and applied toward that year's Deductible can be carried forward and applied toward the person's Deductible for the next Calendar Year, provided the Deductible amount is satisfied during a period of 12 consecutive months. This carry-over allowance does not apply to the family maximum deductible.</p> <p><u>Common Accident Provision</u> - If 2 or more Covered Persons who are members of the same family are injured in the same accident, only 1 Individual Deductible will be taken from the total eligible medical expenses incurred as the result of such accident during the Calendar Year in which the accident occurred.</p>		
OUT-OF-POCKET MAXIMUMS		
Individual Out-of-Pocket Maximum (Co-Insurance)	\$400	
Family Out-of-Pocket Maximum (Co-Insurance)	\$700	
<p><u>Individual Out-of-Pocket Maximum</u> - Except as noted, a Covered Person will not be required to pay more than \$400 in any Calendar Year toward his share of Eligible Expenses that are not paid by the Plan. Once he has paid his out-of-pocket maximum, his Eligible Expenses will be paid at 100% for the balance of the Calendar Year. * Benefit reduced to 50% for Non-PPO (Anthem Blue Cross) Members.</p> <p><u>Family Out-of-Pocket Maximum</u> - Except as noted, a covered family (Employee and his Dependents) will not be required to pay more than \$700 in any Calendar Year toward their Eligible Expense obligations. Once the family has paid their out-of-pocket maximum, their Eligible Expenses will be paid at 100% for the balance of the Calendar Year.</p> <p>NOTE: The out-of-pocket maximums do not apply to or include:</p> <ul style="list-style-type: none"> Amounts applied or paid to satisfy any Deductible or Co-Pay requirements; Eligible Expenses that are paid at 50%, such as Non-PPO (Anthem Blue Cross) Member Providers ; Expenses that become the Covered Person's responsibility for failure to comply with the requirements of the Utilization Management Program), and are therefore paid at 60%. 		
Accident-Related Expense, up to \$500	-0-†	100%†
<p>The \$500 benefit for accident-related expenses is available only for expenses incurred within 3 months after the date of the accident. Other expenses will be covered in the same manner as a Sickness and benefits will be based on the types of expenses incurred.</p>		

IMPORTANT: CERTAIN HEALTH CARE SERVICES MAY REQUIRE PRE-SERVICE REVIEW TO AVOID BENEFIT REDUCTION. SEE THE **UTILIZATION MANAGEMENT PROGRAM** SECTION.

MEDICAL BENEFIT SUMMARY - CERTIFICATED, continued

ELIGIBLE MEDICAL EXPENSES	Covered Person Pays	Plan Pays
NOTE: ALL BENEFITS PROVIDED BY NON-PPO (ANTHEM BLUE CROSS) MEMBERS ARE PAID AT 50% AFTER DEDUCTIBLES ARE MET		
Ambulance	20%	80%
Benefits for air ambulance service outside of the United States are limited to \$2,500.		
Chiropractic Care	20% *	80% *
Limited to 52 visits per Calendar Year effective January 1, 2011. Subject to the following restrictions: No coverage for massage therapy or inversion therapy. The benefit only covers musculoskeletal manipulation provided by a licensed chiropractor (DC) to correct vertebral disorders such as incomplete dislocation, off-centering, misalignment, misplacement, fixation, abnormal spacing, sprain or strain. * Benefit reduced to 50% for Non-PPO (Anthem Blue Cross) Members.		
Hospital Services		
Inpatient Care	20%	80%
Emergency Room, per use – see NOTE	\$75 Co-Pay + 20% *	80% after Co-Pay *
Other Outpatient Services & Supplies	20%	80%
Coverage for Inpatient Hospital care is limited to 365 days per period of disability. A “period of disability” is a series of Hospital confinements when the dates of discharge and readmission are separated by less than 30 days. However, if, as the result of a new Accidental Injury, readmission to a Hospital is required before the expiration of 30 days, such readmission shall be considered to be the beginning of a new and separate period of disability. Eligible Expenses for Inpatient room and board are limited to the Semi-Private Room Charge (see Definitions) or the Usual, Customary and Reasonable charge for an Intensive Care Unit or other necessary and prescribed isolation accommodation. NOTE: The emergency room Co-Pay is waived if the Covered Person is admitted to the Hospital directly from the emergency room. *There is no penalty for using NON-PPO Member Emergency Facilities, all ER’s are paid as in-network.		
Mental Health Care & Counseling		
Inpatient Care & Medication Management	20%	80%
Outpatient Visits for Counseling Services	50%	50%
Outpatient mental health care is limited to 52 visits per Calendar Year.		
Physician Services		
Inpatient Visits	20%	80%
Office Visits, per visit	\$20 Co-Pay + 20%	80% after Co-Pay
Prescription Drugs, Outpatient		
Generic Drug	\$10 Co-Pay†	Balance
Brand-Name Drug (no generic available)	\$20 Co-Pay†	Balance
Brand-Name Drug (generic available)	\$100 (or actual cost if less) Co-Pay†	Balance
Prescription drug coverage involves a program through an independent vendor. To use the program, a Covered Person takes his drug ID card to a participating pharmacy to fill his prescription order. A prescription can be purchased in up to a 30-day supply or 100 tablets, whichever is greater, for the Co-Pays shown. A mail-order option is included for maintenance (longer-term) drugs. Mail-order drugs are available in up to a 90-day supply for two times the Co-Pays shown, i.e. \$10.00 x 2 for generic drug 90-day supply. When medical documentation is submitted and approved by the Insurance Advisory Committee that negative health effects exist from use of the generic drug, the Co-Pay will revert to the Brand-Name Drug (no generic available). Prescription drugs that are not available through the independent program such as injectibles (other than insulin) and non-covered items approved for specific medical conditions with approval of the Plan Sponsor's insurance committee will be covered as “All Other Eligible Medical Expenses” <i>and will not be subject to penalty for using Non-PPO Members</i> – see below. NOTE: The full terms and conditions of the prescription drug program are not described herein but are as determined between the Plan Sponsor and the organization(s) offering the program(s). Further information should be obtained from the Employer's Health & Welfare Coordinator's office or the office of the Plan Sponsor.		

IMPORTANT: CERTAIN SERVICES MAY REQUIRE PRE-SERVICE REVIEW TO AVOID BENEFIT REDUCTION. SEE THE UTILIZATION MANAGEMENT PROGRAM SECTION.

MEDICAL BENEFIT SUMMARY - CERTIFICATED, continued

ELIGIBLE MEDICAL EXPENSES	Covered Person Pays	Plan Pays
NOTE: ALL BENEFITS PROVIDED BY NON-PPO(ANTHEM BLUE CROSS) MEMBERS ARE PAID AT 50% AFTER DEDUCTIBLES ARE MET		
Preventive Care	-0- †	100% †
Preventive Care includes: routine physical examination every Calendar year including screening for alcohol misuse, aspirin use, blood pressure, cholesterol, depression, type 2 diabetes, obesity, tobacco use, Chlamydia, gonorrhea, HIV, STI, and syphilis; a routine Pap smear and mammogram each Calendar Year, including the related office visits; a fecal occult blood testing or sigmoidoscopy every 5 years for Covered Persons age 50 to 75 years; osteoporosis screening for women over age 60 one time screening for abdominal aortic aneurysm for men over age 18 who have ever smoked well-baby/well-child care/ medical history throughout development, hearing, vision, sickle cell, PKU and congenital hypothyroidism screening, plus gonorrhea preventative medication for the eyes of all newborns, autism screening only for children at 18 & 24 months, dyslipidemia, hematocrit or hemoglobin and development, height, weight and body mass index screening, behavioral assessments, iron, lead and fluoride screening and supplements, tuberculin testing for children at risk and standard childhood immunizations for a Dependent from birth . The following standard immunizations: hepatitis A&B, herpes zoster, human papillomavirus, influenza, measles/mumps/rubella, meningococcal, pneumococcal, tetanus/diphtheria/pertussis, varicella, rotavirus and chicken pox shall be included under preventive care.		
Second (& 3rd) Surgical Opinion	-0-†	100%†
Skilled Nursing Facility / Rehabilitation Center	20%	80%
Eligible Expenses for room and board are limited to the facility's 3-bed ward rate.		
Transplant-Related Expenses	(benefits are based on types of expenses incurred)	
Transplants must be performed at a District-approved facility (i.e. a facility in a District-sponsored network or stop loss related network). See "Transplant-Related Expenses" in Eligible Medical Expenses section for more information.		
All Other Eligible Medical Expenses	20%	80%

† Calendar Year Deductible does not apply.

ABOUT THE SCHEDULE...

The percentages shown in the schedule reflect the amounts the Plan pays of Eligible Expenses after any required Deductible or Co-Pay has been applied. The percentages apply to "Usual, Customary and Reasonable" charges.

A "Co-Pay" is an amount the Covered Person must pay. Co-Pays are usually paid to the provider at the time of service.

THIS IS A SUMMARY ONLY. SEE THE ELIGIBLE MEDICAL EXPENSES AND MEDICAL LIMITATIONS AND EXCLUSIONS SECTIONS FOR MORE INFORMATION.

IMPORTANT: CERTAIN SERVICES MAY REQUIRE PRE-SERVICE REVIEW TO AVOID BENEFIT REDUCTION. SEE THE UTILIZATION MANAGEMENT PROGRAM SECTION.

MEDICAL BENEFIT SUMMARY – CLASSIFIED & CONFIDENTIAL/MANAGEMENT

(This schedule applies to Classified & Confidential/Management Employees & their eligible & enrolled Dependents)

SCHEDULE OF MEDICAL BENEFITS

MAXIMUM LIFETIME BENEFIT	NO LONGER APPLICABLE
CALENDAR YEAR DEDUCTIBLES	
Individual Deductible	\$100
Family Maximum Deductible	\$300
<p><u>Individual Deductible</u> - The Individual Deductible is an amount a Covered Person must contribute each year toward payment of eligible medical expenses. The deductible usually applies before the Plan begins to provide benefits.</p> <p><u>Family Maximum Deductible</u> - If \$300 in eligible medical expenses is incurred collectively by family members during a Calendar Year and is applied toward Individual Deductibles, the Family Maximum Deductible is satisfied. A "family" includes a covered Employee and his covered Dependents.</p> <p><u>Deductible Carry-Over</u> - Eligible Expenses incurred in the last 3 months of a Calendar Year and applied toward that year's Deductible can be carried forward and applied toward the person's Deductible for the next Calendar Year, provided the Deductible amount is satisfied during a period of 12 consecutive months. This carry-over allowance does not apply to the family maximum deductible.</p> <p><u>Common Accident Provision</u> - If 2 or more Covered Persons who are members of the same family are injured in the same accident, only 1 Individual Deductible will be taken from the total eligible medical expenses incurred as the result of such accident during the Calendar Year in which the accident occurred.</p>	
OUT-OF-POCKET MAXIMUMS	
Individual Out-of-Pocket Maximum (Co-Insurance)	\$400
Family Out-of-Pocket Maximum (Co-Insurance)	\$700
<p><u>Individual Out-of-Pocket Maximum</u> - Except as noted, a Covered Person will not be required to pay more than \$400 in any Calendar Year toward his share of Eligible Expenses that are not paid by the Plan. Once he has paid his out-of-pocket maximum, his Eligible Expenses will be paid at 100% for the balance of the Calendar Year.</p> <p><u>Family Out-of-Pocket Maximum</u> - Except as noted, a covered family (Employee and his Dependents) will not be required to pay more than \$700 in any Calendar Year toward their Eligible Expense obligations. Once the family has paid their out-of-pocket maximum, their Eligible Expenses will be paid at 100% for the balance of the Calendar Year.</p> <p>NOTE: The out-of-pocket maximums do not apply to or include:</p> <ul style="list-style-type: none"> Amounts applied or paid to satisfy any Deductible or Co-Pay requirements; Eligible Expenses that are paid at 50%; Eligible Expenses that become the Covered Person's responsibility for failure to comply with the requirements of the Utilization Management Program, and are therefore paid at 60%. 	

IMPORTANT: CERTAIN HEALTH CARE SERVICES MAY REQUIRE PRE-SERVICE REVIEW TO AVOID BENEFIT REDUCTION. SEE THE **UTILIZATION MANAGEMENT PROGRAM** SECTION. ALSO, BENEFITS MAY BE REDUCED OR DENIED FOR PREEXISTING CONDITIONS. SEE **SPECIAL RESTRICTIONS FOR PREEXISTING CONDITIONS** FOR MORE INFORMATION.

MEDICAL BENEFIT SUMMARY - CLASSIFIED, continued

ELIGIBLE MEDICAL EXPENSES	Covered Person Pays	Plan Pays
Accident-Related Expense , up to \$500	-0-†	100%†
The \$500 benefit for accident-related expenses is available only for expenses incurred within 3 months after the date of the accident. Other expenses will be covered in the same manner as a Sickness and benefits will be based on the types of expenses incurred.		
Ambulance	20%	80%
Benefits for air ambulance service outside of the United States are limited to \$2,500.		
Chiropractic Care	20%	80%
Limited to 52 visits per Calendar Year effective March 1, 2009. Subject to the following restrictions: No coverage for massage therapy or inversion therapy. The benefit only covers musculoskeletal manipulation provided by a licensed chiropractor (DC) to correct vertebral disorders such as incomplete dislocation, off-centering, misalignment, misplacement, fixation, abnormal spacing, sprain or strain.		
Hospital Services – Inpatient & Outpatient	20%	80%
Coverage for Inpatient Hospital care is limited to 365 days per period of disability. A “period of disability” is a series of Hospital confinements when the dates of discharge and readmission are separated by less than 30 days. However, if, as the result of a new Accidental Injury, readmission to a Hospital is required before the expiration of 30 days, such readmission shall be considered to be the beginning of a new and separate period of disability. Eligible Expenses for Inpatient room and board are limited to the Semi-Private Room Charge (see Definitions) or the Usual, Customary and Reasonable charge for an Intensive Care Unit or other necessary and prescribed isolation accommodation.		
Mental Health Care & Counseling		
Inpatient Care & Medication Management	20%	80%
Outpatient Visits for Counseling Services	50%	50%
Outpatient mental health care is limited to 52 visits per Calendar Year.		
Physician Services	20%	80%
Prescription Drugs, Outpatient		
Generic Drug	\$5 Co-Pay†	Balance
Brand-Name Drug (no generic available)	\$10 Co-Pay†	Balance
Brand-Name Drug (generic available)	\$25 Co-Pay†	Balance
Prescription drug coverage involves a program through an independent vendor. To use the program, a Covered Person takes his drug ID card to a participating pharmacy to fill his prescription order. A prescription can be purchased in up to a 30-day supply or 100 tablets, whichever is greater, for the Co-Pays shown. A mail-order option is included for maintenance (longer-term) drugs. Mail-order drugs are available in up to a 90-day supply for two times the Co-Pays shown, i.e. \$5.00 x 2 for generic drug 90-day supply. Prescription drugs that are not available through the independent program such as injectibles (other than insulin) and non-covered items approved for specific medical conditions with approval of the Plan Sponsor's insurance committee will be covered as “All Other Eligible Medical Expenses” – see below. NOTE: The full terms and conditions of the prescription drug program are not described herein but are as determined between the Plan Sponsor and the organization(s) offering the program(s). Further information should be obtained from the Employer's Health & Welfare Coordinator's office or the office of the Plan Sponsor.		

IMPORTANT: CERTAIN SERVICES MAY REQUIRE PRE-SERVICE REVIEW TO AVOID BENEFIT REDUCTION. SEE THE UTILIZATION MANAGEMENT PROGRAM SECTION. ALSO, BENEFITS MAY BE REDUCED OR DENIED FOR PREEXISTING CONDITIONS. SEE SPECIAL RESTRICTIONS FOR PREEXISTING CONDITIONS FOR MORE INFORMATION.

MEDICAL BENEFIT SUMMARY - CLASSIFIED, continued

ELIGIBLE MEDICAL EXPENSES	Covered Person Pays	Plan Pays
Preventive Care	-0- †	100% †
Preventive Care includes: routine physical examination every Calendar year including screening for alcohol misuse, aspirin use, blood pressure, cholesterol, depression, type 2 diabetes, obesity, tobacco use, Chlamydia, gonorrhea, HIV, STI, and syphilis; a routine Pap smear and mammogram each Calendar Year, including the related office visits; a fecal occult blood testing or sigmoidoscopy every 5 years for Covered Persons age 50 to 75 years; osteoporosis screening for women over age 60 one time screening for abdominal aortic aneurysm for men over 18 who have ever smoked well-baby/well-child care/ medical history throughout development, hearing, vision, sickle cell, PKU and congenital hypothyroidism screening, plus gonorrhea preventative medication for the eyes of all newborns, autism screening only for children at 18 & 24 months, dyslipidemia, hematocrit or hemoglobin and development, height, weight and body mass index screening, behavioral assessments, iron, lead and fluoride screening and supplements, tuberculin testing for children at risk and standard childhood immunizations for a Dependent from birth . The following standard immunizations: hepatitis A&B, herpes zoster, human papillomavirus, influenza, measles/mumps/rubella, meningococcal, pneumococcal, tetanus/diphtheria/pertussis, varicella, rotavirus and chicken pox shall be included under preventive care.		
Second (& 3rd) Surgical Opinion	-0-†	100%†
Skilled Nursing Facility / Rehabilitation Center	20%	80%
Eligible Expenses for room and board are limited to the facility's 3-bed ward rate.		
Transplant-Related Expenses	(benefits are based on types of expenses incurred)	
Transplants must be performed at a District-approved facility (i.e. a facility in a District-sponsored network or stop loss related network). See "Transplant-Related Expenses" in Eligible Medical Expenses section for more information.		
All Other Eligible Medical Expenses	20%	80%

† Calendar Year Deductible does not apply.

ABOUT THE SCHEDULE...

The percentages shown in the schedule reflect the amounts the Plan pays of Eligible Expenses after any required Deductible or Co-Pay has been applied. The percentages apply to "Usual, Customary and Reasonable" charges.

A "Co-Pay" is an amount the Covered Person must pay. Co-Pays are usually paid to the provider at the time of service.

THIS IS A SUMMARY ONLY. SEE THE ELIGIBLE MEDICAL EXPENSES AND MEDICAL LIMITATIONS AND EXCLUSIONS SECTIONS FOR MORE INFORMATION.

IMPORTANT: CERTAIN SERVICES MAY REQUIRE PRE-SERVICE REVIEW TO AVOID BENEFIT REDUCTION. SEE THE UTILIZATION MANAGEMENT PROGRAM SECTION. ALSO, BENEFITS MAY BE REDUCED OR DENIED FOR PREEXISTING CONDITIONS. SEE SPECIAL RESTRICTIONS FOR PREEXISTING CONDITIONS FOR MORE INFORMATION.

ELIGIBLE MEDICAL EXPENSES

This section is a listing of those medical services, supplies and conditions that are covered by the Plan. This section must be read in conjunction with the **Medical Benefit Summary** to understand how Plan benefits are determined (e.g. application of Deductible requirements and benefit sharing percentages). All medical care must be received from or ordered by a Covered Provider.

Except as otherwise noted below or in the **Medical Benefit Summary**, eligible medical expenses are the **Usual, Customary and Reasonable charges** for the items listed below and that are incurred by a Covered Person - subject to the **Definitions, Limitations and Exclusions** and all other provisions of the Plan. In general, services and supplies must be approved by a Physician or other appropriate Covered Provider and must be Medically Necessary for the care and treatment of a covered Sickness, Accidental Injury, Pregnancy or other covered health care condition.

For benefit purposes, medical expenses will be deemed to be incurred on:

the date a purchase is contracted; or

the actual date a service is rendered.

Acupuncture – Acupuncture treatment for a Sickness or Accidental Injury when provided by a Physician (MD).

Ambulance – Necessary professional ambulance service to transport a Covered Person to the nearest Hospital where care and treatment of the Sickness or Accidental Injury can be given, or to another medical institution for necessary special treatment not locally obtainable and which is considered a Medical Necessity.

Ambulance service to transfer a patient from a Hospital to a Skilled Nursing Facility or Rehabilitation Center when determined to be Medically Necessary by the attending Physician.

Air ambulance service to transport a Covered Person to the nearest appropriate treatment center, as determined by the Covered Person's attending Physician. Benefits for air ambulance service outside of the United States are limited to \$2,500.

Ambulatory Surgical Center - Services and supplies provided by an Ambulatory Surgical Center (see **Definitions**) in connection with a covered Outpatient surgery.

Anesthesia - Anesthetics and services of a Physician or certified registered nurse anesthetist (CRNA) for the administration of anesthesia.

Birthing Center - Services and supplies provided by a Birthing Center (see **Definitions**) in connection with a covered Pregnancy.

Blood - Blood and blood derivatives (if not replaced by or for the patient), including blood processing and administration services.

Chemotherapy - Professional services and supplies related to the administration of chemical agents in the treatment or control of a Sickness.

Chiropractic Care - Musculoskeletal manipulation provided by a chiropractor (DC) to correct vertebral disorders such as incomplete dislocation, off-centering, misalignment, misplacement, fixation, abnormal spacing, sprain or strain. The Plan does not cover massage therapy, inversion therapy, or application of heat or cold therapy

X-ray exams performed by a chiropractor if, in the opinion of the Plan Administrator, the quality and nature of the film is such as to be useful in establishing a diagnosis for the particular Sickness or Accidental Injury. Such X-rays

IMPORTANT: CERTAIN ELIGIBLE MEDICAL EXPENSES ARE SUBJECT TO BENEFIT LIMITS. SEE THE **MEDICAL BENEFIT SUMMARY** FOR THAT INFORMATION.

ELIGIBLE MEDICAL EXPENSES, continued

shall be made available to the Plan Administrator upon request. Limited to a maximum of 52 visits per calendar year, effective March 1, 2009 for Classified & Confidential Management; effective January 1, 2011 for Certificated.

Contraceptives - Contraceptive supplies and related Physician or professional services necessary for their administration. Such contraceptives include, but are not limited to, devices such as IUDs, injectables such as DepoProvera, and implants such as Norplant.

NOTE: Contraceptives that can be obtained without a Physician's written prescription (e.g., condoms, foams, jellies) or contraceptives that do not require the services of a Physician are not covered. Also, any contraceptive that can be obtained through the prescription drug program (see "Prescription Drugs, Outpatient" in the **Medical Benefit Summary**), must be obtained through that program.

Diagnostic Lab & X-ray, Outpatient – Laboratory, X-ray and other non-surgical services performed to diagnose medical disorders, including scanning and imaging work (e.g., CT scans, MRIs), electrocardiograms, basal metabolism tests, and similar diagnostic tests generally used by Physicians throughout the United States.

Dialysis - Dialysis services and supplies, including the training of a person to assist the patient with home dialysis, when provided by a Hospital, freestanding dialysis center or other appropriate Covered Provider.

Durable Medical Equipment - Rental of durable medical equipment (but not to exceed the fair market purchase price) or purchase of such equipment where only purchase is permitted or where purchase is more cost-effective due to a long-term need for the equipment. Such equipment must be prescribed by a Physician and required for therapeutic use in treatment of an active Sickness or Accidental Injury.

"Durable medical equipment" includes items such as crutches, wheelchairs, hospital beds, traction apparatus, head halters, cervical collars, oxygen, iron lung and dialysis equipment that: (1) can withstand repeated use, (2) are primarily and customarily used to serve a medical purpose, (3) generally are not useful to a person in the absence of Sickness or Accidental Injury, and (4) are appropriate for use in the home.

NOTE: Coverage is limited to the least expensive item that is adequate for the patient's needs. Duplicate/Replacement equipment or excess charges for deluxe equipment or devices will not be covered. Taxes, batteries and repairs to such equipment are not covered.

Hearing Aids – Hearing aids when necessitated by Sickness or Accidental Injury which occurred during the time the patient was covered under the plan. This benefit is limited to one hearing aid per ear during the lifetime of the patient. Taxes, batteries and repairs are not covered. Coverage is limited to the least expensive items adequate for the patient's needs. Deluxe, specialized or experimental devices are not covered.

NOTE: Hearing aids for hearing loss resulting from a persons' normal aging process are not covered.

Home Health Care - Services and supplies that are furnished to a Covered Person in accordance with a written home health care plan. The home health care plan must be established by the Covered Person's attending Physician and must be monitored by the Physician during the period of home health care.

Home health care services and/or supplies must be provided through a Home Health Care Agency or by other Covered Providers as specified in the written home health care plan. Covered home health care services and supplies include, but are not limited to, the following:

part-time or intermittent services of a registered nurse (RN) or a licensed practical nurse (LPN);

services of physical, occupational and speech therapists;

part-time or intermittent services of home health aides under the supervision of a registered nurse (RN) or a physical, occupational or speech therapist;

IMPORTANT: CERTAIN ELIGIBLE MEDICAL EXPENSES ARE SUBJECT TO BENEFIT LIMITS. SEE THE **MEDICAL BENEFIT SUMMARY FOR THAT INFORMATION.**

ELIGIBLE MEDICAL EXPENSES, continued

medical supplies, drugs and medicines prescribed by a Physician and laboratory services, but only to the extent that such items would have been covered if the patient had been confined in a Hospital or Skilled Nursing Facility.

NOTE: Covered home health care expenses will not include food, food supplements, home-delivered meals, transportation, housekeeping services or other services that are custodial in nature and could be rendered by non-professionals.

Hospital Services - Hospital services and supplies provided on an Outpatient basis and Inpatient care, including daily room and board and ancillary services and supplies.

Medical Supplies, Disposable – Disposable medical supplies such as surgical dressings, catheters, colostomy bags and related supplies.

Medicines - Medicines that are dispensed and administered to a Covered Person during an Inpatient confinement, during a Physician's office visit, as part of a home health care program.

Mental Health Care - Inpatient and Outpatient treatment of mental health conditions.

For Plan purposes, "mental health conditions" include, but are not limited to: schizophrenic disorders, paranoid disorders, affective disorders (depression, mania, manic-depressive illness), anxiety disorders, somatoform disorders, personality disorders, and disorders of infancy, childhood and adolescence. Medication management of these disorders only shall be considered an office visit. Counseling shall be limited to 52 visits per year and paid at 50% of applicable charges only.

NOTE: A mental health condition or covered mental health care will not include:

learning and behavior disorders including attention deficit disorder, hyperkinetic syndrome, autism or mental retardation;

hypnotherapy;

marriage and family counseling;

sex counseling or sex therapy;

vocational testing or training.

Midwife - Services of a certified or registered nurse midwife when provided in conjunction with a covered Pregnancy - see "Pregnancy Care" below.

Newborn Care - Medically Necessary services and supplies as listed herein for a covered newborn who is sick or injured.

See "Pregnancy Care" for well-newborn expenses.

Nursing Services, Private Duty - Private-duty nursing services by a registered nurse (RN), licensed vocational nurse (LVN) or licensed practical nurse (LPN) when Medically Necessary and prescribed in writing by the attending Physician or surgeon specifically as to duration and type.

Orthotics – Orthopedic (non-dental) braces, casts, splints, trusses and other orthotics that are prescribed by a Physician.

NOTE: Foot orthotics are not covered.

Oxygen - see "Durable Medical Equipment"

IMPORTANT: CERTAIN ELIGIBLE MEDICAL EXPENSES ARE SUBJECT TO BENEFIT LIMITS. SEE THE **MEDICAL BENEFIT SUMMARY** FOR THAT INFORMATION.

ELIGIBLE MEDICAL EXPENSES, continued

Physical Therapy - Professional services of a licensed physical therapist, when rendered under the direction of a Physician.

Physical therapy services provided during a Covered Person's confinement in a Skilled Nursing Facility if prescribed by the attending Physician.

Physician Services - Medical and surgical treatment by a Physician (MD or DO), including office, home or Hospital visits, clinic care and consultations. See "Second (& 3rd) Surgical Opinion" below for requirements applicable to surgery opinion consultations.

Services of a Physician consultant when requested by a Covered Person's attending Physician.

Pregnancy Care – Eligible Pregnancy-related expenses of a Covered Person. Eligible Expenses include the following, are covered at least to the same extent as any other Sickness, and may include other care that is deemed to be Medically Necessary by the patient's attending Physician:

pre-natal visits and routine pre-natal and post-partum care including screening for hepatitis B, anemia, bacteriuria, Rh compatibility and folic acid supplements;

expenses associated with a normal or cesarean delivery as well as expenses associated with any complications of pregnancy;

genetic testing or counseling when deemed Medically Necessary by a Physician;

routine newborn services and supplies, and breast feeding support and promotion provided during the mother's confinement for delivery.

In accordance with the Newborns' and Mothers' Health Protection Act, the Plan will not restrict benefits for a Pregnancy Hospital stay for a mother and her newborn to less than forty-eight (48) hours following a normal vaginal delivery or ninety-six (96) hours following a cesarean section. Also, the **Utilization Management Program** requirements for Inpatient Hospital admissions will not apply for this minimum length of stay and early discharge is only permitted if the decision is made between the attending Physician and the mother.

NOTE: Pregnancy coverage will not include: (1) Lamaze and other charges for education related to pre-natal care and birthing procedures, (2) adoption expenses, or (3) expenses of a surrogate mother who is not a Covered Person.

Prescription Drugs - Medicines that are dispensed and administered to a Covered Person during an Inpatient confinement, during a Physician's office visit, as part of a home health care program.

Outpatient drug coverage (i.e., pharmacy purchases) is provided through an independent vendor. Coverage is also available under the medical benefits of the Plan for items that are not available through the independent program, such as injectables (other than insulin) and non-covered items such as vitamins when necessary for specific medical conditions with approval of the Plan Sponsor's insurance committee.

Preventive Care - Certain preventive services that are provided in the absence of sickness or injury. See the **Medical Benefit Summary** for further information.

Prosthetics - An initial artificial limb, eye or other prosthetic appliance required to replace a natural body part or to aid in the function of an impaired body part. To comply with the Women's Health and Cancer Rights Act, coverage includes post-mastectomy breast prostheses.

Radiation Therapy - Radium and radioactive isotope therapy.

Rehabilitation Center - see "Skilled Nursing Facility or Rehabilitation Center"

Respiratory Therapy - Professional services of a licensed respiratory or inhalation therapist, when specifically

IMPORTANT: CERTAIN ELIGIBLE MEDICAL EXPENSES ARE SUBJECT TO BENEFIT LIMITS. SEE THE **MEDICAL BENEFIT SUMMARY** FOR THAT INFORMATION.

ELIGIBLE MEDICAL EXPENSES, continued

prescribed by a Physician or surgeon as to type and duration, but only to the extent that the therapy is for improvement of respiratory function.

Second (& 3rd) Surgical Opinion - A second surgical opinion consultation following a surgeon's recommendation for surgery. The Physician rendering the second opinion regarding the Medical Necessity of a proposed surgery must be qualified to render such a service, either through experience, specialist training or education, or similar criteria, and must not be affiliated in any way with the Physician who will be performing the actual surgery.

A third opinion consultation if the second opinion does not concur with the first Physician's recommendation. This third Physician must be qualified to render such a service and must not be affiliated in any way with the Physician who will be performing the actual surgery.

Skilled Nursing Facility or Rehabilitation Center - Inpatient care in Skilled Nursing Facility or Rehabilitation Center, but only when the admission to the facility or center is Medically Necessary, is preceded by confinement of at least three (3) days in a Hospital, and is for the same condition necessitating the preceding Hospital confinement.

Speech Therapy – Restoratory or rehabilitary speech therapy by a qualified speech therapist when necessary for speech loss or impairment due to an illness or injury, other than a functional nervous disorder, or due to surgery as a result of such an illness or injury.

Sterilization Procedures - A surgical procedure for the purpose of sterilization (i.e., a vasectomy for a male or a tubal ligation for a female).

NOTE: Reconstruction (reversal) of a prior elective sterilization procedure is not covered.

Transplant-Related Expenses (Human Tissue) - Eligible Expenses incurred by a Covered Person who is the recipient of a human organ or tissue transplant that is not experimental or investigational in nature, subject to the following:

transplants of only the following organs or tissue will be covered:

- bone marrow
- cornea
- heart
- heart/lung
- kidney
- liver
- lung
- pancreas

the transplant must be performed at a designated facility (i.e., a facility in a District-sponsored network or stop loss related transplant network) and with prior approval from the Plan;

the recipient must have been eligible for benefits under the District's Plan for the twelve (12) consecutive months preceding the transplant. This restriction shall not apply if the transplant is necessitated by an Accidental Injury or is a bone marrow, kidney or cornea transplant;

the recipient must obtain prior approval from the District's Utilization Management Organization for certification of Medical Necessity and that the procedure is not considered experimental;

the recipient must not be suffering from a terminal illness and must be reasonably expected to live at least one (1) or more years beyond the transplant date.

NOTE: Eligible transplant-related expenses do not include: (1) expenses of an organ donor, regardless of whether or not the donor is a Covered Person, or (2) any transplant that is required as the result of an Accidental Injury or Sickness that is not covered by the Plan.

Urgent Care Facility - see **Definitions**

IMPORTANT: CERTAIN ELIGIBLE MEDICAL EXPENSES ARE SUBJECT TO BENEFIT LIMITS. SEE THE MEDICAL BENEFIT SUMMARY FOR THAT INFORMATION.

MEDICAL LIMITATIONS AND EXCLUSIONS

Except as specifically stated otherwise, no benefits will be payable for:

Abortion - Elective abortion, unless the mother's life would be endangered if the Pregnancy were allowed to continue to term.

NOTE: Complications arising out of an abortion are covered as any other Sickness.

Air Purification Units, Etc. - Air conditioners, air-purification units, humidifiers and electric heating units.

Alcoholism – Expenses incurred for the treatment of alcoholism addiction or abuse.

Bariatric Surgery – Any surgery or invasive treatment designed to treat obesity, effective January 1, 2008.

Biofeedback - Biofeedback, recreational, or educational therapy, or other forms of self-care or self-help training or any related diagnostic testing.

Chemical Dependency – Expenses incurred for the treatment of substance (e.g., narcotics) addiction or abuse including physician prescribed substances..

Cosmetic & Reconstructive Surgery, Etc. - Any surgery, service, drug or supply designed to improve the appearance of an individual by alteration of a physical characteristic that is within the broad range of normal but that may be considered unpleasing or unsightly, except for:

treatment necessitated by an Accidental Injury, provided the treatment begins within ninety (90) days of the accident;

coverage required by the Women's Health and Cancer Rights Act (i.e., reconstruction of the breast on which a mastectomy has been performed or surgery and reconstruction of the other breast to produce symmetrical appearance, and physical complications of all stages of a mastectomy, including lymphedemas). Coverage will be provided for such care as determined by the attending Physician in consultation with the patient;

treatment necessary to correct a congenital abnormality (birth defect) in a covered Dependent child

Custodial & Maintenance Care - Care or confinement primarily for the purpose of meeting personal needs (e.g., bathing or walking) that could be rendered at home or by persons without professional skills or training.

Services or supplies that cannot reasonably be expected to lessen the patient's disability or to enable him to live outside of an institution.

Any type of maintenance care that is not reasonably expected to improve the patient's condition within a reasonable period of time.

Dental & Oral Care - Care or treatment on or to the teeth, alveolar processes, gingival tissue, or for malocclusion, except for:

removal of oral tumors;

removal of impacted wisdom teeth;

repair sound natural teeth or other body tissues that are damaged in an Accidental Injury but limited to treatment provided within ninety (90) days following the accident.

Diagnostic Hospital Admissions - Confinement in a Hospital that is for diagnostic purposes only, when such diagnostic services could be performed in an Outpatient setting.

MEDICAL LIMITATIONS AND EXCLUSIONS, continued

Dietician Services & Supplies – Dietician services, including dietary supplements.

Ecological or Environmental Medicine - Chelation or chelation therapy, orthomolecular substances, or use of substances of animal, vegetable, chemical or mineral origin that are not specifically approved by the FDA as effective for treatment.

Educational or Vocational Testing or Training - Testing and/or training for educational purposes or to assist an individual in pursuing a trade or occupation.

Training of a Covered Person for the development of skills needed to cope with an Accidental Injury or Sickness, except as may be expressly included.

Exercise Equipment / Health Clubs - Exercising equipment, vibratory equipment, swimming or therapy pools. Enrollment in health, athletic or similar clubs.

Foot Care, Routine - Routine and non-surgical foot care services and supplies including, but not limited to:

trimming or treatment of toenails;

foot massage;

treatment of corns, calluses, metatarsalgia or bunions;

treatment of weak, strained, flat, unstable or unbalanced feet;

orthopedic shoes or other appliances for support of the feet.

NOTE: This exclusion does not apply to Medically Necessary treatment of the feet (e.g., the removal of nail roots, other podiatry surgeries, or foot care services necessary due to a metabolic or peripheral-vascular disease).

Genetic Counseling or Testing - Counseling or testing concerning inherited (genetic) disorders. However, this limitation does not apply when such services are determined by a Physician to be Medically Necessary during the course of a covered Pregnancy.

Hair Restoration - Any surgeries, treatments, drugs, services or supplies relating to baldness or hair loss, including replacement of nonproductive hair follicles with productive follicles from another area of the scalp or body.

NOTE: When prescribed by a Physician, the Plan will cover the purchase of an initial wig for hair loss resulting from chemotherapy. Replacement or maintenance of a wig is not covered.

Hearing-Related Service & Supplies - Hearing exams and related services and supplies are not covered except as required for children under the new well baby care requirements, and for persons who have experienced an illness or injury affecting their hearing. Age related hearing tests are not a covered benefit. See “Hearing Aids” in the list of **Eligible Medical Expenses** for limited coverage information.

Holistic, Homeopathic or Naturopathic Medicine - Services, supplies, drugs or accommodations provided in connection with holistic, homeopathic or naturopathic treatment.

Hospice Care

Hypnotherapy - Treatment by hypnotism.

Impregnation - Artificial insemination, in-vitro fertilization, G.I.F.T. (Gamete Intrafallopian Transfer) or any type of artificial impregnation procedure, whether or not any such procedure is successful.

Infertility Testing or Treatment - Diagnostic tests or studies, or procedures, drugs or supplies to correct infertility or to restore or enhance fertility.

MEDICAL LIMITATIONS AND EXCLUSIONS, continued

Learning & Behavioral Disorders - Testing or treatment for learning or behavioral disorders including attention deficit disorder (ADD), attention deficit hyperactive disorder (ADHD), mental retardation, or autism.

Maintenance Care – see “Custodial & Maintenance Care”

Marriage & Family Counseling - Counseling for marital or family problems when there is no diagnosed mental health condition.

Medical Marijuana – Even when prescribed by a licensed physician for a medical condition.

Narcotism – see “Chemical Dependency” above

Nicotine Addiction - Nicotine withdrawal programs, facilities, drugs or supplies.

Non-Prescription Drugs - Drugs for use outside of a hospital or other Inpatient facility that can be purchased over-the-counter and without a Physician's written prescription - except as may be included in the prescription coverages of the Plan.

Drugs for which there is a non-prescription equivalent available.

Not Medically Necessary / Not Physician Prescribed - Any services or supplies that are: (1) not Medically Necessary, and (2) not incurred on the advice of a Physician - unless expressly included herein.

Inpatient room and board when hospitalization is for services that could have been performed safely on an Outpatient basis including, but not limited to: preliminary diagnostic tests, physical therapy, medical observation, treatment of chronic pain or convalescent or rest cure.

Occupational Therapy, Etc. - Occupational therapy (except during an Inpatient Hospital confinement or as included in Home Health Care services). Vocational, educational, recreational, art, dance, or music therapy.

Orthognathic Surgery - Surgery to correct a receding or protruding jaw.

Personal Comfort or Convenience Items - Services or supplies that are primarily and customarily used for nonmedical purposes or are used for environmental control or enhancement (whether or not prescribed by a Physician) including but not limited to: (1) air conditioners, air purifiers, or vacuum cleaners, (2) motorized transportation equipment, escalators, elevators, ramps, (3) waterbeds or non-hospital adjustable beds, (4) hypoallergenic mattresses, pillows, blankets or mattress covers, (5) cervical pillows, (6) swimming pools, spas, whirlpools, exercise equipment, or gravity lumbar reduction chairs, (7) home blood pressure kits, (8) personal computers and related equipment, televisions, telephones, or other similar items or equipment, (9) food liquidizers, or (10) structural changes to homes or autos.

Preexisting Conditions - see section entitled **Special Restrictions for Preexisting Conditions** for information. Does not apply to children under the age of 19 years who are entering the plan.

Preventive or Routine Care - Routine exams, physicals or anything not ordered by a Physician or not Medically Necessary for treatment of Sickness, Accidental Injury or Pregnancy, except as may be specifically included in the **Medical Benefit Summary**.

Self-Procured Services - Services rendered to a Covered Person who is not under the regular care of a Physician and for services, supplies or treatment, including any periods of hospital confinement, that are not recommended, approved and certified as necessary and reasonable by a Physician, except as may be specifically included in the list of **Eligible Medical Expenses**.

Sex-Related Disorders - Transsexualism, gender dysphoria, sexual reassignment or change or any resulting complications, or other sexual dysfunctions or inadequacies. Excluded services and supplies include, but are not limited to: therapy or counseling, medications, implants, hormone therapy, surgery, and other medical or psychiatric treatment.

MEDICAL LIMITATIONS AND EXCLUSIONS, continued

TMJ / Jaw Joint Treatment - Procedures, restorations or appliances for the treatment or for the prevention of temporomandibular joint dysfunction syndrome.

Vision Care - Eye examinations for the purpose of prescribing corrective lenses.

Vision supplies (e.g., eyeglasses or contact lenses) or their fitting, replacement, repair or adjustment.

Orthoptics, vision therapy, vision perception training, or other special vision procedures, including procedures whose purpose is the correction of refractive error, such as radial keratotomy or laser surgery.

NOTE: This exclusion will not apply to: (1) services necessitated by a Sickness or Accidental Injury, or (2) the initial purchase of glasses or contact lenses following cataract surgery.

Vitamins or Dietary Supplements - Prescription or non-prescription organic substances used for nutritional purposes. Exception: those vitamins ordered by a physician for the treatment of a specific illness or injury.

Vocational Testing or Training - Vocational testing, evaluation, counseling or training.

Weight Control, Etc. – Except as noted, any of the following weight-related services or supplies:

weight loss programs of any kind, whether or not prescribed by a Physician;

services, surgery or supplies directly related to treatment of obesity, including bariatric surgeries of all types, effective January 1, 2008;

surgery for removal of excess fat in any area of the body.

resection or surgery for removal of any excess skin or fat following weight loss or pregnancy.

Wigs or Wig Maintenance - see "Hair Restoration"

- (See also *General Exclusions* section) -

SPECIAL RESTRICTIONS FOR PREEXISTING CONDITIONS

(Applies ONLY to Classified Employees & their Spouses)

Definition of a Preexisting Condition

or Plan purposes, a "preexisting condition" is an illness or injury for which medical advice, diagnosis, care or treatment was recommended or received during the six (6) months before an individual's enrollment date. A Pregnancy will not be considered a preexisting condition, regardless of the date of conception, diagnosis, or first treatment. Genetic information is not a preexisting condition in the absence of a diagnosis of a condition related to the genetic information.

For purposes of the Plan and the above paragraph, the following will apply:

Medical advice, diagnosis, care or treatment must have been received from a health care provider or practitioner duly licensed to provide such care under state law and who is operating within the scope of practice authorized by applicable state law.

An individual's "enrollment date" is his first day of Plan coverage or, if there is a waiting period for coverage, the first day of such waiting period. For a special enrollee (i.e., an individual who becomes covered under the "Special Enrollment Rights" – see the **Eligibility and Effective Dates** section) or a late enrollee, the "enrollment date" is the individual's first day of Plan coverage.

Special Waiting Periods for a Preexisting Condition

A preexisting condition will not be covered until the 12-month anniversary of an individual's enrollment date (i.e., 12 months from his first day of Plan coverage or, if there is a waiting period, 12 months from the first day of the waiting period for such coverage).

The preexisting condition waiting periods may be credited if an individual had other coverage. See the "Allowance for Prior Creditable Coverage" below.

Exceptions to the Preexisting Condition Limitations

The preexisting condition limitation will not apply to an Employee's adopted child, newborn child or other child acquired by the member through any means who is enrolled in a timely manner when the child is first eligible (see **Eligibility and Effective Dates** section) –For these purposes, an "adopted child" is any person under the age of 19 as of the date of adoption or placement for adoption. "Placement for adoption" means the assumption and retention by the Employee of the legal obligation for the total or partial support of a child to be adopted. Placement ends whenever the legal support obligation ends.

NOTE: These preexisting condition limitations are intended to comply with at least the minimum requirements of the Health Insurance Portability and Accountability Act of 1996 (H.R. 3103) and Final Regulations, if they are incomplete or in conflict with the law, the law will prevail.

Allowance for Prior Creditable Coverage

An individual (Employee or Dependent) who enrolls in this Plan has a right to demonstrate "creditable coverage" and reduce or eliminate the pre-existing condition limitations that would otherwise apply – but only if the individual has less than a 63-day break in coverage (i.e., not more than 62 days of non-coverage, not counting any days applied toward waiting period requirements). To demonstrate "creditable coverage" and any applicable waiting periods, an individual has the right to request certificate(s) of creditable coverage from prior/other health plan(s). This Plan will help any such individual in obtaining such certificate(s). An individual also has the right to demonstrate creditable coverage through the presentation of documentation or other means where a certificate of creditable coverage cannot be obtained from the other health plan(s).

Where coverage is determined to be "creditable coverage," the Plan enrollee will be credited with time covered under such prior plan(s) toward the time limits of this Plan's preexisting condition limitations. If, after creditable coverage has been taken into account, there will still be a preexisting condition limitation imposed on an individual, the individual will be notified of that fact.

SPECIAL RESTRICTIONS FOR PRE-EXISTING CONDITIONS, continued

"Creditable coverage" includes coverage under a group health plan (including a governmental or church plan), individual health insurance coverage, Medicaid (other than coverage solely under § 1928 of the Social Security Act – the program for distribution of pediatric vaccines), Medicare, military-sponsored health care, a program of the Indian Health Services or of a tribal organization, a State health benefits risk pool, the Federal Employees Health Benefit Program, The State Children's Health Insurance Program, a public health plan as defined in the portability regulations (i.e., any plan established or maintained by a State, the U.S. government, a foreign country, or any political subdivision of a State, the U.S. government, or a foreign country that provides health coverage to individuals who are enrolled in the plan), and a health benefit plan under the Peace Corps Act. A coverage can be "creditable coverage" even if such coverage remains in effect.

NOTE: See "Creditable Coverage Certificates" in the **General Plan Information** section for information on how to obtain such certificates from this Plan.

DENTAL BENEFIT SUMMARY REGULAR INCENTIVE DENTAL PROGRAM

CALENDAR YEAR MAXIMUM BENEFIT – see NOTE		
Certificated Enrollees	\$1,500	
Classified Enrollees	\$1,250	
Confidential/Management Enrollees	\$1,250	
Except as noted, Plan benefits for each Covered Person will not exceed the maximum shown above.		
NOTE: Additional benefits are available for treatment of an Accidental Injury that requires repair of the natural teeth or existing partial dentures or full dentures. For a Certificated enrollee the additional benefit is \$1,500. For a Classified enrollee the additional benefit is \$1,250. For a Confidential/Management enrollee, the additional benefit is \$1,250. These benefits must be utilized within 90 days following the Accidental Injury.		
ELIGIBLE DENTAL EXPENSES	Covered Person Pays	Plan Pays
Basic Services		
First Year	30%	70%
Second Year	20%	80%
Third Year	10%	90%
Fourth Year and Thereafter	-0-	100%
The benefit levels described above apply beginning with a Covered Person's first year (i.e., first 12 months) of eligibility. If, during any year of eligibility, the Covered Person does not use these dental benefits, the benefit percentage for Basic Services for the succeeding year will not increase. If, for any reason, a Covered Person loses eligibility, the applicable percentage for Basic Services upon reestablishing eligibility shall commence at 70%.		
Limits applicable to certain Basic Services:		
<ul style="list-style-type: none"> - routine oral examinations and cleanings are limited to 1 exam/cleaning per 6-month period; - a routine full-mouth X-ray series or a panoramic X-ray is limited to once per 2-year period; - routine bitewing X-rays are limited to 1 set per 6-month period. 		
Prosthodontic Services	50%	50%
Rebasing or relining of a denture is limited to once per 2-year period.		

THIS IS A SUMMARY ONLY. PLEASE REFER TO THE ELIGIBLE DENTAL EXPENSES AND DENTAL LIMITATIONS AND EXCLUSIONS SECTIONS FOR MORE INFORMATION.

ELIGIBLE DENTAL EXPENSES

Eligible dental expenses are the Usual, Customary and Reasonable charges for the dental services and supplies that are listed below and: (1) incurred while a person is covered under the Plan, and (2) received from a licensed dentist, a qualified technician working under a dentist's supervision or any Physician furnishing dental services for which he is licensed.

For benefit purposes, dental expenses will be deemed incurred as follows:

for an appliance or modification of an appliance, on the date the final impression is taken;

for a crown, inlay, onlay or gold restoration, on the date the tooth is prepared;

for root canal therapy, on the date the pulp chamber is opened; or

for any other service, on the date the service is rendered.

NOTE: Many dental conditions can be effectively treated in more than one way. The Plan is designed to help pay for dental expenses, but not for treatment that is more expensive than necessary for good dental care. If a Covered Person chooses a more expensive course of treatment, the Plan will pay benefits equivalent to the least expensive treatment that would adequately correct the dental condition.

BASIC SERVICES

Anesthesia - General anesthesia when administered in connection with oral surgery or when deemed necessary by the dental provider for other covered dental services.

NOTE: Separate charges for pre-medication, local anesthesia, analgesia or conscious sedation are not covered. Such services should be included in the cost of the procedure itself.

Consultation - Consultation by a dental specialist upon referral by the patient's attending dentist.

Crowns - A gold, porcelain, stainless steel or composite crown restoration when a tooth cannot be satisfactorily restored with a filling restoration. Coverage for a crown includes a post and core when necessary.

See "Cosmetic Dentistry" in the list of **Dental Limitations and Exclusions** for restrictions on veneer or facing (i.e., "tooth-colored") restorations. Crowns placed for periodontal splinting are not covered.

Endodontia - Endodontic services including but not limited to: root canal therapy (except for final restoration), pulpotomy, apicoectomy and retrograde filling.

Exams & Cleanings, Routine - Routine oral examinations and routine cleaning and polishing of the teeth.

Extraction - see "Oral Surgery"

Fillings, Non-Precious - Amalgam, synthetic porcelain and plastic restorations, including pins to retain a filling restoration when necessary.

NOTE: For teeth posterior to (behind) the second bicuspid, an allowance for amalgam fillings will be made. See "Cosmetic Dentistry" in the list of **Dental Limitations and Exclusions**.

Fluoride - Topical application of stannous or sodium fluoride.

IMPORTANT: CERTAIN ELIGIBLE DENTAL EXPENSES ARE SUBJECT TO BENEFIT LIMITS. SEE THE **DENTAL SCHEDULE(S) OF BENEFITS** FOR THAT INFORMATION.

ELIGIBLE DENTAL EXPENSES, continued

Inlays, Onlays & Gold Fillings - An inlay, onlay or gold filling when a tooth cannot be satisfactorily restored with a less costly filling (e.g., amalgam) restoration.

See "Cosmetic Dentistry" in the list of **Dental Limitations and Exclusions** for restrictions on "tooth-colored" restorations.

Oral Surgery - Extraction of teeth, including simple extractions and surgical extraction of bone or tissue-impacted teeth. Other surgical and adjunctive treatment of disease, injury and defects of the oral cavity and associated structures.

Palliatives - Emergency treatment for the relief of dental pain.

Periodontia - Treatment of the gums and tissues of the mouth, including periodontal scaling and root planing.

Prophylaxis - see "Exams & Cleanings, Routine"

Sealants – Sealants applied to permanent, un-restored 1st and 2nd molars without cavities for children up to age 13.

X-rays - Dental X-rays for diagnostic purposes, as well as routine "full mouth" X-rays or a panoramic X-ray, and routine bitewing X-rays.

PROSTHODONTIC SERVICES

Prosthetics - Placement of a full or partial denture or bridge. Any allowance made for a prosthetic includes necessary adjustments within six (6) months of placement.

Replacement of or addition of teeth to an existing full or partial denture or bridge, but only if:

the replacement or addition of teeth is required because of the extraction of one or more natural teeth;

replacement is required because the existing denture or bridgework cannot be made serviceable and is at least five (5) years old.

Space Maintainers - Fixed and removable appliances to retain the space left by a lost tooth and to prevent abnormal movement of the surrounding teeth.

Repairs & Adjustments - Repair or re-cementing of bridgework or dentures.

Relining or rebasing of dentures when provided more than six (6) months from date of initial placement.

Prosthetic adjustments when provided more than six (6) months after placement.

IMPORTANT: CERTAIN ELIGIBLE DENTAL EXPENSES ARE SUBJECT TO BENEFIT LIMITS. SEE THE DENTAL BENEFIT SUMMARY FOR THAT INFORMATION.

DENTAL LIMITATIONS AND EXCLUSIONS

Except as specifically stated, no benefits will be payable under this Plan for:

Appliances - Items intended for sport or home use, such as athletic mouthguards or habit-breaking appliances.

Cosmetic Dentistry - Treatment rendered for cosmetic purposes.

Excess charges for a veneer or facing (i.e., a "tooth-colored" exterior) on a crown or pontic or excess charges for a tooth-colored restoration on a tooth posterior to the second bicuspid. The maximum allowance will be the allowance for the least costly restoration that will provide a functional result.

Customized Prosthetics – Excess charges for precision or semi-precision attachments, overdentures, or customized prosthetics.

Discoloration Treatment - Teeth whitening or any other treatment to remove or lessen discoloration, except in connection with endodontia.

Excess Care - Services that exceed those necessary to achieve an acceptable level of dental care. If it is determined that alternative procedures, services, or courses of treatment could be (could have been) performed to correct a dental condition, Plan benefits will be limited to the least costly procedure(s) that would produce a professionally satisfactory result.

Duplicate prosthetic devices or appliances.

Experimental & Non-Standard Procedures – Services which are considered experimental or which are not approved by the American Dental Association.

Services or supplies that do not meet the standards accepted by the American Dental Association (ADA) or by the Council of Dental Therapeutics of the American Dental Association.

Grafting - Extra oral grafts (grafting of tissue from outside the mouth to oral tissues).

Hospital Expenses

Implants - Implants (materials implanted into or on bone or soft tissue) and all related services or supplies, or the removal of implants.

Lost or Stolen Prosthetics or Appliances - Replacement of a prosthetic or any other type of appliance that has been lost, misplaced, or stolen.

Medical Expenses - Any dental-related services to the extent to which coverage is provided under the terms of the medical benefits of this Plan.

Myofunctional Therapy - Muscle training therapy or training to correct or control harmful habits.

Non-Professional Care - Services rendered by someone other than:

a dentist (DDS or DMD);

a dental hygienist, X-ray technician or other qualified technician who is under the supervision of a dentist; or

a Physician furnishing dental services for which he is licensed.

Occlusal Restoration - Procedures, appliances or restorations that are performed to alter, restore or maintain occlusion (i.e., the way the teeth mesh), including:

increasing the vertical dimension;

replacing or stabilizing tooth structure lost by attrition;

realignment of teeth;

gnathological recording or bite registration or bite analysis;

occlusal equilibration.

Oral Hygiene Instruction & Supplies, Etc. - Dietary or nutritional counseling or related supplies, personal oral hygiene instruction or plaque control. Oral hygiene supplies including but not limited to: toothpaste, toothbrushes, waterpiks, and mouthwashes.

Orthodontia, Etc. - Orthodontia procedures, appliances or restorations used to increase vertical dimension or to restore occlusion.

Orthognathic Surgery - Surgery to correct a receding or protruding jaw.

Personalization or Characterization of Dentures

Prescription Drugs - see "Prescription Drugs, Outpatient" in the **Medical Benefit Summary**

Prior to Effective Date / After Termination Date - Courses of treatment that began prior to the Covered Person's effective date, including crowns, bridges or dentures that were ordered prior to the effective date.

Expenses incurred after termination of coverage, except that benefits will be extended for up to thirty (30) days for a prosthetic device that was fitted and ordered prior to termination.

Sealants – Sealants applied to non-permanent, restored or teeth other than 1st and 2nd molars; or teeth with cavities; or applied to teeth of children age 13 or older.

Splinting - Appliances or restorations for splinting teeth.

Temporary Restorations & Appliances - Excess charges for temporary restorations and appliances. Expenses for the permanent restoration or appliance will be the maximum Eligible Expense.

TMJ Treatment / Jaw Surgery - Procedures, restorations or appliances for the treatment or for the prevention of temporomandibular joint dysfunction syndrome.

- (See also **General Exclusions** section) -

DELTA PREFERRED OPTION DENTAL PLAN

Any employee eligible for Health & Welfare benefits may choose to enroll in the optional Delta Preferred Option Dental Plan. This plan provides the same preventive and restorative services and frequency of services as the regular Delta Dental Plan, but adds an Orthodontia benefit of 50% of the cost of Orthodontia services, up to a lifetime maximum of \$2,000 per eligible family member.

The Delta Preferred Option allows all eligible family members to begin coverage at the 100% level in their first calendar year of coverage for preventive and restorative services, provided the member uses a participating professional. Prosthodontic services will remain at the 50% level.

The annual maximum coverage for each eligible family member is \$2,000.

Use of an out-of-network provider will reduce the level of payment for all services to 50%, and the annual maximum to \$1,000 per eligible family member.

A list of participating Delta Preferred Option Member Dentists shall be made available in the District Business Office, and through the Delta Dental web site, www.deltadentalca.com.

If an employee enrolls in the Delta Preferred Option plan, then decides to change to the regular incentive level plan, all eligible family members will return to the 70% incentive level and move up each calendar year the plan is used, to the maximum of 100%, with a \$1,250 annual maximum for Classified and Confidential/Management Members and a \$1,500 annual maximum for Certificated Members, just as if they were a newly hired employee.

Changes to enrollment in Delta Dental coverage must be made during the open enrollment period of August 15 to September 15 each year. Coverage provisions will become effective on January 1 of the following calendar year.

THIS IS A SUMMARY ONLY. PLEASE REFER TO THE ELIGIBLE DENTAL EXPENSES AND DENTAL LIMITATIONS AND EXCLUSIONS SECTIONS FOR MORE INFORMATION.

VISION BENEFIT SUMMARY

Vision benefits are available to all Employees of the District who are eligible for and enrolled in the health benefit program, along with their eligible dependents, except those enrolled under the provisions of AB528. These benefits are administered through VISION SERVICE PLAN OF CALIFORNIA, Plan B.

ELIGIBLE VISION BENEFITS

Vision Examination: A complete analysis of the eyes and related structures to determine the presence of vision problems, or other abnormalities.

Available to each eligible member or eligible dependent once every twelve (12) months.

Co-pay at time of examination is \$10.00, payable to the Member Doctor.

Lenses: The VSP Member Doctor will prescribe and order the proper lenses (only if needed). The program provides quality lenses fabricated to exacting standards. The doctor also verifies the accuracy of the finished lenses.

Regular lenses may be obtained once in every twelve (12) months at no cost to member for each eligible member or eligible dependent. This does not include any special services such as a) blended lenses; b) contact lenses (except as noted elsewhere herein); c) oversize lenses; d) progressive multi-focal lenses; e) photo-chromic lenses or tinted lenses other than pink #1 or #2; f) coated lenses; g) laminated lenses; h) UV (ultraviolet) protected lenses; i) any other optional cosmetic processes.

Frames: VSP Member Doctors provide a wide selection of frames that are available to the patient, and will assist the patient in the selection of the frames. VSP Member Doctors will also assure that the frames are properly fitted and adjusted, including subsequent adjustments to frames to maintain comfort and efficiency.

Frames may be obtained once in every twenty-four (24) months at no cost to member for each eligible member or eligible dependent. However, if you select a frame that costs more than the plan allows, there will be an additional charge. If you obtain frames prior to the end of the twenty-four (24) months, you will be responsible for the entire cost of the frames.

Contact Lenses: VSP Member Doctors prescribe and provide a variety of contact lenses.

Contact lenses may be chosen in lieu of all eligible benefits for a period during which patient is eligible for a new frame allowance. There will be additional charges due to the additional cost of fitting and cost of contact lenses that exceeds the amount allowed for regular lenses and frames.

When contact lenses are obtained, the covered person shall not be eligible for lenses again for twelve (12) months and frames for twenty-four (24) months.

NOTE: Necessary contact lenses are furnished under the VSP plan without regard to the above restrictions when provided by a VSP Member Doctor who secures prior authorization following a review by VSP's optometric consultant for the following conditions:

- a) Following cataract surgery,
- b) To correct extreme visual acuity problems that cannot be corrected with spectacle lenses,
- c) Certain conditions of anisometropia, or
- d) Keratoconus

NOTE: THE VISION INFORMATION CONTAINED HEREIN IS ONLY A BENEFIT SUMMARY. VISION COVERAGE IS AN INSURED BENEFIT AND IS SUBJECT TO THE TERMS OF GOVERNING CONTRACTS THAT ARE NOT A PART OF THIS DOCUMENT. IF THERE IS ANY CONFLICT BETWEEN THE ABOVE INFORMATION AND THE TERMS OF THE GOVERNING DOCUMENT(S), THE GOVERNING DOCUMENT(S) WILL PREVAIL.

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VISION LIMITATIONS AND EXCLUSIONS

There is no coverage for the following services or materials:

- 1. Orthoptics or vision training and any associated supplemental testing.
- 2. Plano lenses (less than a +/- .38 diopter power).
- 3. Two pairs of glasses in lieu of one pair of bifocals.
- 4. Lenses and frames furnished under this program that are lost or broken will not be replaced except at the stated intervals when services are otherwise available.
- 5. Medical or surgical treatment of the eyes. (see Medical Program)
- 6. Any eye examination, or any corrective eyewear, that is required by an employer as a condition of employment.
- 7. Contact lenses or other materials requested for cosmetic purposes, and not necessary for vision correction.
- 8. Corrective vision treatment that is experimental in nature.
- 9. Costs for services and/or materials above Plan Benefit allowances.
- 10. Services and/or materials not indicated on this schedule as covered plan benefits.

NON-MEMBER PROVIDER BENEFITS

VISION CARE SERVICES	MAXIMUM ALLOWABLE
<u>Eye examination</u>	Up to \$ 45.00 *
<u>Lenses</u> Single Vision	Up to \$ 45.00
Bifocal	Up to \$ 65.00
Trifocal	Up to \$ 85.00
Lenticular	Up to \$125.00
Available every twelve (12) months	
* Less applicable Co-payment of \$10.00	
<u>Frames</u>	Up to \$ 47.00
Available every twenty-four (24) months	

GENERAL EXCLUSIONS

The following exclusions apply to the Plan's self-funded medical and dental benefits.

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

Drugs in Testing Phases - Medicines or drugs that are in the Food and Drug Administration Phases I, II, or III testing, drugs that are not commercially available for purchase or are not approved by the Food and Drug Administration for general use.

Excess Charges - Charges in excess of the Usual, Customary and Reasonable fees for services or supplies provided.

Experimental / Investigational Treatment - Expenses for treatments, procedures, devices, or drugs which the Plan determines, in the exercise of its discretion, are experimental, investigational, or done primarily for research. Treatments, procedures, devices, or drugs shall be excluded under this Plan unless:

approval of the U.S. Food and Drug Administration for marketing the drug or device has been given at the time it is furnished, if such approval is required by law; and

reliable evidence shows that the treatment, procedure, device or drug is not the subject of ongoing phase I, II, or III clinical trials or under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard means of treatment or diagnoses; and

reliable evidence shows that the consensus of opinion among experts regarding the treatment, procedure, device, or drug is that further studies or clinical trials are not necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard means of treatment or diagnoses.

"Reliable evidence" shall include anything determined to be such by the Plan, within the exercise of its discretion, and may include published reports and articles in the medical and scientific literature generally considered to be authoritative by the medical professional community in the United States, including the *CMS Medicare Coverage Issues Manual*.

Forms Completion - Charges made for the completion of claim forms or for providing supplemental information.

Government-Operated Facilities - Services furnished to the Covered Person in any veterans' hospital, military hospital, institution or facility operated by the United States government or by any state government or any agency or instrumentality of such governments.

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

Late-Filed Claims - Claims that are not filed with the Contract Administrator for handling within the required time periods as included in the **Claims Procedures** section. Maximum time for filing is 6 months following the end of the benefit year in which such claims were incurred.

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

Missed Appointments - Expenses incurred for failure to keep a scheduled appointment.

No Charge / No Legal Requirement to Pay - Services for which no charge is made or for which a Covered Person is not required to pay, or is not billed or would not have been billed in the absence of coverage under this Plan. Where Medicare coverage is involved and this Plan is a "secondary" coverage, this exclusion will apply to those

GENERAL EXCLUSIONS, continued

amounts a Covered Person is not legally required to pay due to Medicare's "limiting charge" amounts.

NOTE: This exclusion does not apply to any benefit or coverage that is available through the Medical Assistance Act (Medicaid).

Not Listed Services or Supplies - Any services, care or supplies that are not specifically listed in the Benefit Document as Eligible Expenses.

Other Coverage - Services or supplies for which a Covered Person is entitled (or could have been entitled if proper application had been made) to have reimbursed by or furnished by any plan, authority or law of any government, governmental agency (Federal or State, Dominion or Province or any political subdivision thereof). However, this provision does not apply to Medicare Secondary Payor or Medicaid Priority rules.

Services or supplies received from a health care department maintained by or on behalf of an employer, mutual benefit association, labor union, trustees or similar person(s) or group.

Outside United States - Charges incurred outside of the United States if the Covered Person traveled to such a location for the primary purpose of obtaining such services or supplies.

Postage, Shipping, Handling Charges, Etc. - Any postage, shipping or handling charges that may occur in the transmittal of information to the Contract Administrator. Interest or financing charges resulting from charges incurred are not covered.

Prior Coverages - Services or supplies for which the Covered Person is eligible for benefits under the terms of the document that this Benefit Document replaces.

Prior to Effective Date / After Termination Date - Charges incurred prior to an individual's effective date of coverage under the Plan or after coverage is terminated, except as may be expressly stated.

Relative or Resident Care - Any service rendered to a Covered Person by a relative (i.e., a spouse, or a parent, brother, sister, or child of the Employee or of the Employee's spouse) or anyone who customarily lives in the Covered Person's household.

Sales Tax, Etc. - Sales or other taxes or charges imposed by any government or entity. However, this exclusion will not apply to surcharges required by the New York Health Care Reform Act of 1996 (or as later amended) or similar surcharges imposed by other states.

Self-Inflicted Injury - Any expenses resulting from voluntary self-inflicted injury or voluntary attempted self-destruction, except that, this exclusion will not apply where such self-inflicted injury results from a medical condition (physical or mental), including a medical condition resulting from domestic violence (e.g., depression).

Telecommunications - Advice or consultation given by or through any form of telecommunication.

Travel - Travel or accommodation charges, whether or not recommended by a Physician, except for ambulance charges or as otherwise expressly included.

War or Active Duty - Health conditions resulting from insurrection, war (declared or undeclared) or any act of war and any complications therefrom, or service (past or present) in the armed forces of any country, to the extent not prohibited by law.

Work-Related Conditions - Any condition for which the Covered Person has or had a right to compensation under any Workers' Compensation or occupational disease law or any other legislation of similar purpose, whether or not a claim is made for such benefits. If the Plan provides benefits for any such condition, the Plan Sponsor will be entitled to establish a lien upon such other benefits up to the amount paid.

LIFE INSURANCE BENEFITS

In addition to the benefits provided under the PORTERVILLE UNIFIED SCHOOL DISTRICT HEALTH AND WELFARE PLAN, a Term Life Insurance Plan is provided for all Certificated and Classified employees of the District who are eligible for and properly enrolled in the Health and Welfare Plan, through the self-funded plan.

SCHEDULE OF BENEFITS

	<u>Life Insurance</u>
All Eligible Employees	\$5,000.00

The amount of Term Life Insurance in force is the amount shown above if the individual employee has not attained his or her 70th birthday. Thereafter, the amount of life insurance is reduced in accordance with the following schedule:

70 th Birthday and Over	Fifty percent (50%) of above schedule
75 th Birthday	Insurance in force will terminate

ACCIDENTAL DEATH SUPPLEMENT

	<u>Accidental Death Supplement</u>
All Eligible Employees	\$5,000.00

The amount of Accidental Death Supplement Insurance in force is the amount shown above if the individual employee has not attained his/her 70th birthday. Thereafter, the amount of Accidental Death Supplement Insurance is reduced in accordance with the above schedule.

All eligible employees must name a beneficiary on their Health and Welfare Plan Enrollment Form. An employee may change the named beneficiary of his/her life insurance at any time and for any reason by contacting the District Business Office Health Benefits Representative and verifying the change with his/her signature.

These benefits are processed through the District Health and Welfare Benefits Coordinator's Office.

LIFE INSURANCE BENEFITS

(This section applies to Confidential/Management Employees only)

In addition to the benefits provided under the PORTERVILLE UNIFIED SCHOOL DISTRICT HEALTH AND WELFARE PLAN, a Term Life Insurance and Accidental Death and Dismemberment Plan is provided for all Confidential/Management employees of the District who receive compensation from the District for Active Service. This plan is provided at no cost to the employee.

SCHEDULE OF BENEFITS

Confidential/Management Employees	Life Insurance	\$50,000.00
	Accidental Death & Dismemberment	\$50,000.00

There is a ninety (90) day waiting period following employment before these benefits become effective.

These benefits are provided through UNUM INSURANCE COMPANY OF AMERICA, 2211 Congress Street, Portland, Maine 04122.

All claims payable under this plan are to be processed through the District Health & Welfare Coordinator's Office.

NOTE: These benefits are available only during the period the employee is actively employed by the District. All benefits are terminated on the employee's last workday. Benefits are not portable and are not convertible.

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LONG TERM DISABILITY INSURANCE

(This section applies to Classified Employees only)

The District shall provide a Long Term Disability Income Insurance Plan for all Classified employees working 20 hours or more per week, and are under age 70. The District shall pay .47% of each covered employee's subject salary toward the Long Term Disability Income Insurance Plan, any amounts above that rate shall be paid by the employee through the Payroll Deduction process.

SCHEDULE OF BENEFITS

Monthly Disability Benefit	60% of the Insured's actual Monthly compensation (exclusive of Overtime, bonus and other such compensation) not to exceed: 1) the amount for which premium is being paid; 2) a monthly maximum Monthly Disability Benefit of \$1,200; and 3) a maximum covered Monthly Compensation of \$2,000.00	
Maximum Disability Period	Accident 5 years or to age 70, whichever occurs first	Sickness 5 years or to age 70, whichever occurs first
Maximum Mental Illness Period	2 years or to age 70, whichever occurs first. (including hospital confinement).	2 years or to age 70, whichever occurs first. (including hospital confinement).
Minimum Monthly Disability Benefit	\$50.00	\$50.00
Elimination Period	90 days	90 days
Termination Age	Age 70 years	Age 70 years

ADJUSTMENTS AND LIMITATIONS

The Monthly Disability Benefits paid to the Insured will be reduced by the amount of lump sum or periodic payments the Insured or his dependents are entitled to receive from:

- a) group insurance coverage or like coverage for persons in a group
- b) Federal Social Security Act (this included benefits paid to the Insured or his dependents on account of the Insured's disability);
- c) State or federal government disability or retirement plan;
- d) Pension plan to which the Policyholder or Employer contributes or makes payroll deductions;
- e) Salary or wage continuance plans paid for by the Policyholder or the Employer of the Insured which extend beyond the period stated in the Schedule;
- f) Workers' Compensation or like law; and
- g) Federal Old Age Benefits under the Federal Social Security Act on the Insured's own behalf.

LONG TERM DISABILITY, continued

For the purposes of items (b) and (g), unless the Insured shows proof to the Company that payments under these acts have been applied for but will not be paid, the Company will:

- a) assume each Insured who is covered under the Federal Social Security Act is receiving such payments; and
- b) deduct any lump sum payment received by the Insured from the Monthly Disability Benefits payable.

These benefits are provided through AMERICAN FIDELITY ASSURANCE COMPANY, PO Box 255393, Sacramento, CA 95825.

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LONG TERM DISABILITY INSURANCE
 (This section applies to Confidential/Management Employees only)

The District shall provide a Long Term Disability Income Insurance Plan for all Confidential/Management Employees of the District, at no cost to the employee, beginning December 1, 2002.

SCHEDULE OF BENEFITS

Monthly Disability Benefit	60% of the Insured's actual Monthly compensation (exclusive of Overtime, bonus and other such compensation) not to exceed:	
	1) the amount for which premium is being paid; 2) a monthly maximum Monthly Disability Benefit of \$6,000.00; and 3) a maximum covered Monthly Compensation of \$10,000.00	
Minimum Monthly Disability Benefit	\$100.00	
Elimination Period	90 days	
	<u>Age</u>	<u>Maximum Period</u>
Maximum Benefit Period	Before 60	the day before retirement age
	60 but before 65	the day before retirement age or 36 months of disability, whichever is longer
	65 but before 68	24 months of disability
	68 but before 70	18 months of disability
	70 but before 72	15 months of disability
	72 or more	12 months of disability

NOTE: Retirement age means the Social Security Normal Retirement Age as stated in the 1983 revision of the United States Social Security Act.

There is a ninety (90) day waiting period following employment before these benefits become effective.

These benefits are provided through ASSURANT EMPLOYEE BENEFITS, PO Box 806644-1, Kansas City, MO 64180-6644.

NOTE: THE ABOVE INFORMATION IS ONLY A BENEFIT SUMMARY. LONG TERM DISABILITY INSURANCE IS SUBJECT TO THE TERMS OF GOVERNING CONTRACTS THAT ARE NOT A PART OF THIS DOCUMENT. IF THERE IS ANY CONFLICT BETWEEN THE ABOVE INFORMATION AND THE TERMS OF THE GOVERNING DOCUMENT(S), THE GOVERNING DOCUMENT(S) WILL PREVAIL.

MEDICARE SUPPLEMENT REIMBURSEMENT

(This section applies only to Certificated and Confidential/Management Retirees)

Any Certificated Unit Member or Confidential/Management Member employed by the district before January 1, 2008 and who retires from the District who is sixty-five (65) years of age or older, shall be entitled to receive from the District reimbursement for his/her premium cost of supplemental health insurance. The retiree must enroll in Medicare Parts A & B at his/her own expense and purchase a Medicare supplement plan. Effective for those retiring through June 30, 2010, the District will reimburse the employee, upon receipt of proof of payment for eighty (80) percent of the paid premium to a maximum of eighty (80) percent of the Blue Cross premium for supplemental coverage. Effective for those retiring after July 1, 2010, the percentage shall become seventy-five (75) percent. Any Certificated Unit Member or Confidential/Management Member who retires from the District, prior to his/her sixty-fifth (65th) birthday, shall, upon reaching age sixty-five (65) and being covered under Medicare A & B, be entitled to the same benefit.

NOTE: This benefit applies only to the Retiree and not to the spouse of the Retiree.

In those cases where the premium for a Retiree and spouse are stated as one amount, and there is no documentation provided to determine the exact amount of the Retiree's portion of the premium, the entire premium amount shall be reduced by fifty (50) percent, then the eighty (80) percent or seventy-five (75) percent reimbursement shall be applied.

Because some Retirees may choose not to purchase their supplement through Blue Cross, an annual maximum benefit payable shall be established. The District shall obtain the Blue Cross Supplement Plan published rates in effect as of July 1st of each year, and apply the eighty (80) percent or seventy-five (75) percent reimbursement rate to the most expensive Blue Cross Plan being offered at that time to new enrollees to arrive at the maximum benefits allowable in each age category. Plans no longer being offered to new enrollees in Blue Cross Medicare Supplement Plans will not be considered when establishing this maximum, and will be subject to the same reductions as plans other than Blue Cross.

Claim forms for this reimbursement shall be made available to eligible Retirees through the District Business Office. Retirees may file reimbursement claims as often as monthly, but no less than one time during each fiscal year. Reimbursement claims greater than one year old may be disallowed, unless sufficient cause is present to overlook the passage of time (e.g. medical or mental incapacity of Retiree, or appointment of Conservator or Guardian for Retiree).

Nothing in this section shall be applicable to Medicare part D or any supplement purchased in place of Part D (Prescription Coverage).

Reimbursements under this provision are processed through the District's Health and Welfare Benefit Coordinator's office.

NOTE: THE ABOVE INFORMATION IS ONLY A BENEFIT SUMMARY. MEDICARE SUPPLEMENT REIMBURSEMENT COVERAGE IS SUBJECT TO THE TERMS GOVERNING CONTRACTS THAT ARE NOT A PART OF THIS DOCUMENT. IF THERE IS ANY CONFLICT BETWEEN THE ABOVE INFORMATION AND THE TERMS OF THE GOVERNING DOCUMENT(S), THE GOVERNING DOCUMENT WILL PREVAIL.

COORDINATION OF BENEFITS (COB)

The self-funded health care benefits provided under the Plan are subject to Coordination of Benefits as described below, unless specifically stated otherwise.

DEFINITIONS

As used in this COB section, the following terms will be capitalized and will have the meanings indicated:

Other Plan - Any of the following that provides health care benefits or services:

- group or blanket insurance coverage;
- any group Blue Cross or Blue Shield plan;
- group practice or other group prepayment coverage;
- any employer organization plan or union welfare plan;
- any group coverage under a labor-management trusted plan or any other employee benefit program;
- coverage provided under no-fault worker's compensation law;
- individual auto insurance containing a provision for medical coverage;
- any government program (e.g., Medicare).

NOTES: An "Other Plan" includes benefits that are actually paid or payable or benefits that would have been paid or payable if a claim had been properly made for them.

If an Other Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate plan.

This Plan - The health benefits of this Plan.

Allowable Expense - A health care service or expense, including deductibles and copayments, that is covered at least in part by any of the plans (i.e., This Plan or Other Plan(s)) covering the Claimant. When a plan provides benefits in the form of services (an HMO, for example), the reasonable cash value of each service will be considered an Allowable Expense and a benefit paid.

Any expense or service that is not covered by any of the plans is not an Allowable Expense. The following are examples of expenses or services that are not Allowable Expenses:

If a Claimant is confined in a private hospital room, the difference in cost between a semi-private room in the hospital and a private room will not be an Allowable Expense unless the private room accommodation is medically necessary in terms of generally accepted medical practice or unless one of the plans routinely provides coverage for private rooms.

If a person is covered by two (2) or more plans that compute benefits on the basis of usual and customary allowances, any amount in excess of the highest usual and customary allowance is not an Allowable Expense.

If a person is covered by two (2) or more plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the lowest of the negotiated fee is not an Allowable Expense.

If a person is covered by one plan that calculates its benefits or services on the basis of usual and customary and another plan that provides its benefits or services on the basis of negotiated fees, the lesser of those amounts shall be the Allowable Expense for This Plan.

COORDINATION OF BENEFITS, continued

NOTE: Any expense not payable by a primary plan due to the individual's failure to comply with any utilization review requirements (e.g., precertification of admissions, second surgical opinion requirements) will not be considered an Allowable Expense.

Claim Determination Period - A period that commences each January 1 and ends at 12 o'clock midnight on the next succeeding December 31, or that portion of such period during which the Claimant is covered under This Plan. The Claim Determination Period is the period during which This Plan's normal liability is determined (see "Effect on Benefits Under This Plan").

Custodial Parent - A parent awarded custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than one half of the Calendar Year without regard to any temporary visitation.

EFFECT ON BENEFITS UNDER THIS PLAN

When Other Plan Does Not Contain a COB Provision - If an Other Plan does not contain a coordination of benefits provision that is consistent with the NAIC Model COB Contract Provisions, then such Other Plan will be "primary" and This Plan will pay its benefits AFTER such Other Plan(s). This Plan's liability will be the lesser of: (1) its normal liability, or (2) total Allowable Expenses minus benefits paid or payable by the Other Plan(s).

When Other Plan Contains a COB Provision - When an Other Plan also contains a coordination of benefits provision similar to this one, This Plan will determine its benefits using the "Order of Benefit Determination Rules" below. If, in accordance with those rules, This Plan is to pay benefits BEFORE an Other Plan, This Plan will pay its normal liability without regard to the benefits of the Other Plan. If This Plan, however, is to pay its benefits AFTER an Other Plan(s), it will pay the lesser of: (1) its normal liability, or (2) total Allowable Expenses minus benefits paid or payable by the Other Plan(s).

NOTE: The determination of This Plan's "normal liability" will be made for an entire Claim Determination Period (i.e. Calendar Year). If this Plan is "secondary", the difference between the benefit payments that This Plan would have paid had it been the primary plan and the benefit payments that it actually pays as a secondary plan is recorded as a "benefit reserve" for the Covered Person and will be used to pay Allowable Expenses not otherwise paid during the balance of the Claim Determination Period. At the end of the Claim Determination Period, the benefit reserve returns to zero.

ORDER OF BENEFIT DETERMINATION RULES

Whether This Plan is the "primary" plan or a "secondary" plan is determined in accordance with the following rules.

No COB Provision – If an Other Plan does not contain a coordination of benefit provision, then the Other Plan will be primary and This Plan will be secondary.

Medicare as an "Other Plan" - Medicare will be the primary, secondary or last payer in accordance with federal law. When Medicare is the primary payer, This Plan will determine its benefits based on Medicare Part A and Part B benefits that would have been paid or payable, whether or not the person was enrolled for such benefits.

Non-Dependent vs. Dependent - The benefits of a plan that covers the Claimant other than as a dependent will be determined before the benefits of a plan that covers such Claimant as a dependent. However, if the Claimant is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the plan covering the person as a dependent and primary to the plan covering the person as other than a dependent (e.g., a retired employee), then the order of benefits between the two plans is reversed so that the plan covering the person as an employee, member, subscriber or retiree is secondary and the other plan is primary.

Child Covered Under More Than One Plan - When the Claimant is a dependent child, the primary plan is the plan of the parent whose birthday is earlier in the year if: (1) the child's parents are married, (2) the parents are not separated (whether or not they have ever been married), or (3) a court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage. If both parents have the same birthday, the plan that covered either of the parents longer is primary.

COORDINATION OF BENEFITS, continued

When the Claimant is a dependent child and the specific terms of a court decree state that one of the parents is responsible for the child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. This rule applies to Claim Determination Periods or plan years commencing after the plan is given notice of the court decree.

When the Claimant is a dependent child whose father and mother are not married, are separated (whether or not they have ever been married) or are divorced, the order of benefits is:

- the plan of the Custodial Parent;
- the plan of the spouse of the Custodial Parent;
- the plan of the noncustodial parent; and then
- the plan of the spouse of the noncustodial parent.

Active vs. Inactive Employee - The plan that covers the Claimant as an employee who is neither laid off nor retired, is primary. The plan that covers a person as a dependent of an employee who is neither laid off nor retired, is primary. If the Other Plan does not have this rule and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

Continuation Coverage (COBRA) Enrollee - If a Claimant is a COBRA enrollee under This Plan, an Other Plan covering the person as an employee, member, subscriber, or retiree (or as that person's dependent) is primary and This Plan is secondary. If the Other Plan does not have this rule and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

Longer vs. Shorter Length of Coverage - If none of the above rules establish which plan is primary, the benefits of the plan that has covered the Claimant for the longer period of time will be determined before those of the plan that has covered that person for the shorter period of time.

NOTE: If the preceding rules do not determine the primary plan, the Allowable Expenses shall be shared equally between This Plan and the Other Plan(s). However, This Plan will not pay more than it would have paid had it been primary.

OTHER INFORMATION ABOUT COORDINATION OF BENEFITS

Right to Receive and Release Necessary Information - For the purpose of enforcing or determining the applicability of the terms of this COB section or any similar provision of any Other Plan, the Contract Administrator may, without the consent of any person, release to or obtain from any insurance company, organization or person any information with respect to any person it deems to be necessary for such purposes. Any person claiming benefits under This Plan will furnish to the Contract Administrator such information as may be necessary to enforce this provision.

Facility of Payment - A payment made under an Other Plan may include an amount that should have been paid under This Plan. If it does, the Contract Administrator may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under This Plan. The Plan will not have to pay that amount again.

Right of Recovery - If the amount of the payments made by the Plan is more than it should have paid under this COB section, the Plan may recover the excess from one or more of the persons it has paid or for whom it has paid - or any other person or organization that may be responsible for the benefits or services provided for the Claimant. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

SUBROGATION AND REIMBURSEMENT PROVISIONS

Benefits Subject to This Provision

This provision shall apply to the self-funded health care benefits provided under any section of this Plan document.

Payment Condition

The Plan, in its sole discretion, may elect to conditionally advance payment of medical benefits in those situations where an injury, sickness, disease or disability is caused in whole or in part by, or results from the acts or omissions of Covered Persons or their dependants, beneficiaries, estate, heirs, guardian, personal representative, or assigns (collectively referred to hereinafter in this section as (“Plan Beneficiary”) or a third party, where other insurance is available, including but not limited to no-fault, uninsured motorist, underinsured motorist, and medical payment provisions (collectively “Coverage”).

Plan Beneficiary, his or her attorney, and/or legal guardian of a minor or incapacitated individual agrees that acceptance of the Plan’s payment of medical benefits is constructive notice of these provisions in their entirety and agrees to maintain one hundred percent (100%) of the Plan’s payment of benefits or the full extent of payment from any one or combination of first and third party sources in trust, without disruption except for reimbursement to the Plan or the Plan’s assignee.

By accepting benefits, the Plan Beneficiary agrees the Plan shall have an equitable lien on any funds received by the Plan Beneficiary and/or their attorney from any source and said funds shall be held in trust until such time as the obligations under this provision are fully satisfied. The Plan Beneficiary agrees to include the Plan’s name as a co-payee on any and all settlement drafts.

In the event a Plan Beneficiary settles, recovers, or is reimbursed by any third party or Coverage, the Plan Beneficiary agrees to reimburse the Plan for all benefits paid or that will be paid. If the Plan Beneficiary fails to reimburse the Plan out of any judgment or settlement received, the Plan Beneficiary will be responsible for any and all expenses (fees and costs) associated with the Plan’s attempt to recover such money.

Subrogation

As a condition to participating in and receiving benefits under this Plan, the Plan Beneficiary agrees to subrogate the Plan to any and all claims, causes of action or rights that may arise against any person, corporation and/or entity and to any Coverage to which the Plan Beneficiary is entitled, regardless of how classified or characterized.

If a Plan Beneficiary receives or becomes entitled to receive benefits, an automatic equitable subrogation lien attaches in favor of the Plan to any claim, which any Plan Beneficiary may have against any party causing the sickness or injury to the extent of such payment by the Plan plus reasonable costs of collection.

The Plan may in its own name or in the name of the Plan Beneficiary commence a proceeding or pursue a claim against any third party or Coverage for the recovery of all damages to the full extent of the value of any such benefits or payments advanced by the Plan.

If the Plan Beneficiary fails to file a claim or pursue damages against:

the responsible party, its insurer, or any other source on behalf of that party;

any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage;

any policy of insurance from any insurance company or guarantor of a third party;

worker’s compensation or other liability insurance company; or

any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverages;

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

When a Covered Person Retains an Attorney

The Covered Person agrees not to retain an attorney who does not recognize and consent to the fact that the Plan precludes the operation of the "made-whole" and "common fund" doctrines, and as such, will not assert either doctrine against the Plan's lien. The Plan will neither pay the Covered Person's attorneys' fees and costs associated with the recovery of funds, nor reduce its reimbursement pro rata for the payment of the Covered Person's attorneys' fees and costs. Attorneys' fees will be payable from the Recovery only after the Plan has received full Reimbursement.

When a Covered Person Does Not Comply

When a Covered Person does not comply with the provisions of this section, the Plan Administrator shall have the authority, in its sole discretion, to deny payment of any claims for benefits by the Covered Person and to deny or reduce future benefits payable (including payment of future benefits for other injuries or illnesses) under the Plan by the amount due as Reimbursement to the Plan. The Plan Administrator may also, in its sole discretion, deny or reduce future benefits (including future benefits for other injuries or illnesses) under any other group benefits plan maintained by the Plan Sponsor. The reductions will equal the amount of the required Reimbursement. If the Plan must bring an action against a Covered Person to enforce this provision, then that Covered Person agrees to pay the Plan's attorneys' fees and costs, regardless of the action's outcome.

Defined Terms for Subrogation:

Another Party - Any individual or organization, other than the Plan, who is liable or legally responsible to pay expenses, compensation or damages in connection with a Covered Person's injuries or illness.

Another Party shall include the party or parties who caused the injuries or illness; the insurer, guarantor or other indemnifier of the party or parties who caused the injuries or illness; a Covered Person's own insurer, such as uninsured, underinsured, medical payments, no-fault, homeowner's, renter's or any other liability insurer; a workers' compensation insurer; and any other individual or organization that is liable or legally responsible for payment in connection with the injuries or illness.

Covered Person - Anyone covered under the Plan, including minor Dependents.

Recovery - Any and all monies paid to the Covered Person by way of judgment, settlement or otherwise (no matter how those monies may be characterized, designated or allocated) to compensate for any losses caused by, or in connection with, the injuries or illness. Any Recovery shall be deemed to apply, first, for Reimbursement.

Reimbursement - Repayment to the Plan for medical or other benefits that it has paid toward care and treatment of the injury or illness and for the expenses incurred by the Plan in collecting this benefit amount.

Subrogation - The Plan's right to pursue the Covered Person's claims for medical or other charges paid by the Plan against Another Party.

ELIGIBILITY AND EFFECTIVE DATES

Eligibility Requirements - Employees

To participate as an "Employee" in the self-funded health care benefits that are described herein, an individual must be in active regular employment for the Employer, performing all customary duties of his occupation at his usual place of employment (or at a location to which the business of the Employer requires him to travel) and regularly scheduled to work at least 5 hours per day or twenty-five (25) hours per week, for Classified Employees; or be scheduled to work at least 2 periods per day, or 40% of full-time for Certificated Employees. **Exception:** Classified employees hired prior to December 1, 2002 for at least 4 hours per day or twenty (20) hours per week, will retain their benefits if assigned to less than 5 hours but more than 4 hours per day.

An Employee will be deemed in "active employment" on each day he is actually performing services for the Employer and on each day of a regular paid vacation or on a regular non-working day, provided he was actively at work on the last preceding regular working day. An Employee will also be deemed in "active employment" on any day on which he is absent from work during an approved FMLA leave or solely due to his own health status (see "Non-Discrimination Due to Health Status" in the **General Plan Information** section). An exception applies only to an Employee's first scheduled day of work. If an Employee does not report for employment on his first scheduled workday, he will not be considered as having commenced active employment.

See the **Extensions of Coverage** section for instances when these eligibility requirements may be waived or modified.

Eligibility for Medicaid or the receipt of Medicaid benefits will not be taken into account in determining eligibility.

Effective Date - Employees

An Employee's coverage is effective, subject to timely enrollment, upon completion of a waiting period to the first day of the month next following his completion of thirty (30) days of active employment in an eligible status.

If an Employee fails to enroll within thirty-one (31) days after completion of the waiting period, his coverage can become effective only in accordance with the "Late Enrollment/Re-Enrollment" or "Special Enrollment Rights" provisions below.

Eligibility Requirements - Dependents

Except as noted at the end of this provision, an eligible Dependent of an Employee is:

a legally married spouse. A "spouse" will mean a person of the opposite sex or same sex as the Employee who is legally married to the employee. "Legally Married" means a legal union (as defined by the Employee's state of residence) between one man and one woman as husband and wife or two persons of the same sex;

a registered domestic partner when the partner and Employee have registered their domestic partnership with the Secretary of State of the State of California. The State of California permits state registration of: (1) same-sex domestic partnerships, and (2) opposite-sex partnerships after one partner attains age 62. A domestic partnership registration from outside of California will be recognized on the same basis as a California state-registered domestic partnership only if the out-of-California partnership is a legal union of two persons of the same sex or persons of opposite sex with one person age 62 or over, other than a marriage, and is substantially equivalent to a registered California domestic partnership.

an employee's child from birth to age 26, who has no other form of health insurance available to him/her, regardless of child's dependency status. For those children from their 19th birthday to their 26th birthday, each member must re-enroll the child using the form provided by the District and provide the child's social security number and a copy of the child's birth certificate. For these purposes a "child" will include:

- a natural child;

- a stepchild or foster child who resides with Employee in a parent-child relationship;
- a child who is adopted by the Employee or placed with him for adoption. "Placed for adoption" means the assumption and retention by the Employee 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 begun. Placement ends when the legal support obligation ends;
- notwithstanding any residency or main support and care requirements, a child for whom Plan coverage is required due to a Medical Child Support Order (MCSO) that the Plan Sponsor determines to be a Qualified Medical Child Support Order in accordance with its written procedures (that are incorporated herein by reference and that can be obtained without charge). A QMCSO will also include a judgment, decree or order issued by a court of competent jurisdiction or through an administrative process established under state law and that satisfies the QMCSO requirements. A child whose coverage is subject to a court order need not be a Tax Code dependent of an Employee;

NOTES: An eligible Dependent does not include:

a spouse following legal separation or a final decree of dissolution of marriage or divorce;

a domestic partner following the filing of a Notice of Termination of Domestic Partnership with the Secretary of State of the State of California. The termination of a domestic partnership will be treated as equivalent to a divorce between a husband and wife;

any person who is on active duty in a military service, to the extent permitted by law.

See the **Extensions of Coverage** section for instances when these eligibility requirements may be waived or modified.

Eligibility for Medicaid or the receipt of Medicaid benefits will not be taken into account in determining a Dependent's eligibility.

Mandated Spousal or Registered Domestic Partner Coverage Requirement:

Certificated

The working spouses or domestic partners of PUSD Certificated employees who are offered an employer sponsored health program(s), must enroll in that health insurance program when becoming eligible to do so, to be eligible for coverage through the PUSD health plan as a secondary health insurance program.

Classified

Effective July 1, 2009, the spouse or domestic partner of a Classified or Confidential/Management employee covered by the PUSD health plan who is eligible for medical benefits in the spouse's or domestic partner's group health plan, must enroll in the spouse's or domestic partner's group health plan when becoming eligible. Should such enrollment not take place, the monthly contribution for medical coverage shall increase as follows:

	<u>Family Plan</u>	
8 hour employees	\$50.00/month	formerly \$18.10
6 hours or more, but less than 8	\$64.00/month	formerly \$23.10
** 5 hours or more, but less than 6	\$78.00/month	formerly \$28.10

(** 4 hours for employees hired for four hours or more prior to November 1, 2002. All references to eligibility shall be changed to reflect five (5) hours for all employees hired as of November 1, 2002.)

Effective Date - Dependents

A Dependent who is eligible and enrolled when the Employee enrolls, will have coverage effective on the same date as the Employee. Dependents acquired later may be enrolled within thirty (30) days of their eligibility date. See the "Special Enrollment Rights" provision for additional details as well as instances when the loss of other coverage and other circumstances can allow a Dependent to be enrolled. Otherwise, a Dependent can be enrolled only in accordance with the "Late Enrollment/Re-Enrollment" provision. Or during the period designated as Open Enrollment (usually August 15 – September 15 of each year.)

NOTE: In no instance will a Dependent's coverage become effective prior to the Employee's coverage effective date.

Newborn Children - Limited Automatic 30-Day Benefit Period

An Employee's newborn child will be eligible for benefits for Eligible Expenses that are incurred within the first thirty (30) days after the child's birth. Benefits for such child will be available for the 30-day period only. The child will be covered after the 30-day benefit period only if the child is enrolled within thirty (30) days of birth – see "Entitlement Due to Acquiring New Dependent(s)" in the **Special Enrollment Rights**.

NOTE: During the limited 30-day benefit period, a newborn child is not a Covered Person. Any extended coverage periods or coverage continuation options that are available to Covered Persons WILL NOT APPLY to a newborn child who is provided with these thirty (30) days of limited benefits and who is not enrolled within such 30-day period.

Clerical Error – Failure on the part of the District to report a covered person who has qualified for benefits or for a change in the amount of his/her contribution for such benefits in compliance with the provisions of this Plan shall not deprive such individual of such benefits or change in contribution, nor shall failure on the part of the District to report any discontinuance of benefits or change in contribution of any covered employee beyond the date on which it should have occurred in accordance with the provisions of this Plan. In the event of such an error, a contribution adjustment shall be made as follows:

1. Such adjustment shall be retroactive to the date on which the covered person's benefits should have become effective, should have been discontinued, or should have been changed in amount, except that in no event shall the period for which any refund is made extend beyond the last prior benefit year.
2. Such adjustment shall be applied to contributions for the benefit year in which the adjustment is made.

Changes in dependent eligibility not reported by the covered employee that would result in a change in the contribution amount shall be made as of the date the employee reports such change to the District.

Special Enrollment Rights

Entitlement Due to Loss of Other Coverage - An individual who did not enroll in the Plan when previously eligible, will be allowed to apply for coverage under the Plan at a later date if:

he was covered under another group health plan or other health insurance coverage (including Medicaid) at the time coverage was initially offered or previously available to him. "Health insurance coverage" means benefits consisting of medical care under any hospital or medical service policy or certificate, hospital or medical service plan contract or health maintenance organization contract offered by a health insurance issuer;

the Employee stated in writing at the time a prior enrollment was offered or available that other coverage was the reason for declining enrollment in the Plan. The Plan Sponsor will require such written statement to be done on a form provided by the Plan Sponsor for this purpose. This signed statement will be attached to the employee's medical plan enrollment forms;

the individual lost the other coverage as a result of a certain event such as, but not limited to, the following:

- loss of eligibility as a result of legal separation, divorce, cessation of dependent status, death of an employee, termination of employment, reduction in the number of hours of employment;
- 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);
- 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;
- loss of eligibility when an individual incurs a claim that would meet or exceed a lifetime limit on all benefits. An individual has a special enrollment right when a claim that would exceed a lifetime limit on all benefits is incurred, and the right continues at least until thirty (30) days after the earliest date that a claim is denied due to the operation of the lifetime limit;
- loss of eligibility when a plan no longer offers any benefits to a class of similarly situated individuals. For example, if a plan terminates health coverage for all part-time workers, the part-time workers incur a loss of eligibility, even if the plan continues to provide coverage to other employees;
- loss of eligibility when employer contributions toward the employee's or dependent's coverage terminates. This is the case even if an individual continues the other coverage by paying the amount previously paid by the employer;
- loss of eligibility when COBRA continuation coverage is exhausted; and
the Employee requested Plan enrollment within thirty (30) days of termination of the other coverage.

If the above conditions are met, Plan coverage will be effective on the first day of the first calendar month that begins after the date on which the Plan received the completed application.

NOTES: For a Dependent to enroll under the terms of this provision, the Employee must be enrolled or must enroll concurrently.

Loss of other coverage for failure to pay premiums on a timely basis or for cause (e.g., making a fraudulent claim or making an intentional misrepresentation of a material fact with respect to the other coverage) will not be a valid loss of coverage for these purposes.

Entitlement Due to Acquiring New Dependent(s) - If an Employee acquires one (1) or more new eligible Dependents through marriage, domestic partnership, birth, adoption, or placement for adoption (as defined by Federal law), application for their coverage may be made within thirty (30) days of the date the new Dependent or Dependents are acquired (the "triggering event") and Plan coverage will be effective as follows - see NOTE:

where Employee's marriage is the "triggering event" - the spouse's coverage (and the coverage of any eligible Dependent children the Employee acquires in the marriage) **will be effective on the later of the date of marriage or the date on which the Plan receives the completed application;**

where acquisition of a child is the "triggering event" - the child's coverage will be effective on the date of the event (i.e., concurrent with the child's date of birth, date of placement or date of adoption). The "triggering event" date for a newborn adoptive child is the child's date of birth if the child is placed with the Employee within 30 days of birth.

NOTES: For a newly-acquired Dependent to be enrolled under the terms of this provision, the Employee must be enrolled or must be eligible to enroll (i.e., must have satisfied any waiting period requirement) and must enroll concurrently. If the newly-acquired Dependent is a child, the spouse is also eligible to enroll. However, other

Dependent children who were not enrolled when first eligible are not considered to be newly acquired and can only be enrolled in accordance with the late enrollment provisions of the Plan.

Court or Agency Ordered Coverage – In accordance with state and federal law, if the Plan receives a Medical Child Support Order (MCSO) from a state court or agency and such order is determined by the Plan to be a qualified order (QMCSO), the child shall be enrolled as of the earliest possible date following such determination.

If the Employee is not enrolled when the Plan is presented with an MCSO that is determined to be qualified, and the Employee's enrollment is required in order to enroll the child, both must be enrolled. The Employer is entitled to withhold any applicable payroll contributions for coverage from the Employee's pay.

Late Enrollment / Re-Enrollment

If an individual does not enroll when he is first eligible or if he allows coverage to lapse but later re-enrolls, then Plan coverage will be effective as of the first day of the month following one (1) month after the date application is made.

NOTE: See "Special Enrollment Rights" for exceptions to this provision.

Reinstatement / Rehire

If coverage terminates while an Employee is totally disabled, temporarily laid off, or granted a leave of absence, coverage (for the Employee and any Dependents covered at the time of termination) shall be reinstated:

if Employee resumes work within six (6) months after such termination, or

if termination was due to disability, Employee resumes active work within one (1) month after ceasing to be disabled.

If an Employee returns to active employment and eligible status immediately following an approved leave of absence taken in accordance with the Employer's guidelines and the Family and Medical Leave Act (FMLA) and during the leave Employee discontinues paying his share of the cost of coverage, then the Employee may have coverage reinstated as if there had been no lapse (for himself and any Dependents who were covered at the point contributions ceased). However, Employee must request that coverage be restored before his family or medical leave expires and the Plan Sponsor will have the right to require that unpaid coverage contribution costs be repaid.

In accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), certain Employees who return to active employment following active duty service as a member of the United States armed forces, will be reinstated to coverage under the Plan immediately upon returning from military service. See "Extension of Coverage During U.S. Military Service" in the **Extensions of Coverage** section for more information.

NOTES: Except in the above instances, any terminated Employee who is rehired will be treated as a new hire and will be required to satisfy all eligibility and enrollment requirements.

Benefits for any Employee or Dependent who is covered under the Plan, whose employment or coverage is terminated, and who is subsequently rehired or reinstated at any time, shall be limited to the maximum benefits that would have been payable had there been no interruption of employment or coverage.

Transfer of Coverage

If a husband and wife are both Employees and are covered as Employees under this Plan and one of them terminates, the terminating spouse and any of his eligible and enrolled Dependents will be permitted to immediately enroll under the remaining Employee's coverage. Such new coverage will be deemed a continuation of prior coverage and will not operate to reduce or increase any coverage to which the person was entitled while enrolled as the Employee or the Dependent of the terminated Employee.

If a Covered Person changes status from Employee to Dependent or vice versa, and the person remains eligible and covered without interruption, then Plan benefits will not be affected by the person's change in status.

TERMINATION OF COVERAGE

Employee Coverage Termination

Except as noted, an Employee's coverage under the self-funded health care benefits will terminate upon the earliest of the following:

termination of the Plan or Plan benefits as described herein;

termination of participation in the Plan by the Employee;

the date the Employee becomes an active member of the armed forces of any country;

at the end of the period for which Employee last made the required contribution, if the coverage is provided on a contributory basis (i.e. Employee shares in the cost);

at midnight of the day the covered Employee leaves or is dismissed from the employment of the Employer or ceases to be eligible or engaged in active employment for the required number of hours as specified in **Eligibility and Effective Dates** section - except when coverage is extended under the **Extensions of Coverage** section;

the date the Employee dies.

Should a covered employee's employment terminate on or following the last day of the school year and before the commencement of the ensuing school year, such employee shall be entitled to continued coverage under the Plan until October 1 of the ensuing school year.

NOTE: Unused vacation days or severance pay following cessation of active work will not count as extending the period of time coverage will remain in effect.

An Employee otherwise eligible and validly enrolled under the Plan shall not be terminated from the Plan solely due to his health status or need for health services.

Dependent Coverage Termination

Except as noted, a Dependent's coverage will terminate upon the earliest of the following:

termination of the Plan or these Plan benefits or discontinuance of Dependent coverage under the Plan;

termination of the coverage of the Employee;

at midnight of the last day the Dependent meets the eligibility requirements of the Plan, except when coverage is extended under the **Extensions of Coverage** section. An Employee's adoptive child ceases to be eligible on the date on which the petition for adoption is dismissed or denied or the date on which the placement is disrupted prior to legal adoption and the child is removed from placement with the Employee;

on the date the Employee requests that Dependent coverage be terminated or at the end of the period for which the Employee last made the required contribution for such coverage, if Dependent's coverage is provided on a contributory basis (i.e., Employee shares in the cost). However, in the case of a child covered due to a Qualified Medical Child Support Order (QMCSO), the Employee must provide proof that the child support order is no longer in effect or that the Dependent has replacement coverage that will take effect immediately upon termination.

NOTE: A Dependent otherwise eligible and validly enrolled under the Plan shall not be terminated from the Plan solely due to his health status or need for health services.

- (See *COBRA Continuation Coverage*) -

EXTENSIONS OF COVERAGE

Self-funded health care coverage may be continued beyond the **Termination of Coverage** date in the circumstances identified below. Unless expressly stated otherwise, however, coverage will not extend: (1) beyond the date the Plan is terminated, and (2) for a Dependent, beyond the date the Employee's coverage ceases.

Extension of Coverage for Developmentally Disabled or Handicapped Dependent Children

If a covered Dependent child attains the age that would otherwise terminate his status as a "Dependent," and:

- if on the day immediately prior to the attainment of such age the child was a covered Dependent under the Plan;
- at the time of attainment of such age the child is incapable of self-sustaining employment by reason of developmental disability or physical handicap;
- and the child is chiefly dependent upon the Employee for support and maintenance;

then coverage with respect to such Dependent shall be continued upon the following conditions:

the covered Employee shall submit to the Plan Administrator a Physician's written certificate of such mental retardation or physical handicap within thirty (30) days of the Dependent's attainment of such age; and

certification from a Physician shall thereafter be submitted to the Plan Administrator on the following schedule:

- within thirty (30) days following six (6) months from the month that the Dependent's coverage would otherwise have been terminated; and
- annually thereafter within the same month that certificate was made in accordance with the above.

Extensions of Coverage During Absence From Work

If an Employee fails to continue in eligible active status but is not terminated from employment (e.g., he is absent due to an **approved** disability leave), he will be permitted to continue health care coverages for himself and his dependents by paying the monthly premiums applicable for persons in his classification during such absence. The district will also continue to make payments for these benefits during the **approved** disability period. Any such extended coverage allowances will be provided on a non-discriminatory basis, and will terminate on the last day of the **approved** disability leave. Persons on **non-approved** disability leaves will be considered terminated as of the date all accumulated paid leave is exhausted, whether or not that person is placed on a re-hire list.

Except as noted, any coverage that is extended under the terms of this provision will automatically and immediately cease on the earliest of the following dates:

on the date coverage terminates as specified in the Employer's personnel policies or other Employer communications, if any. Such documents are incorporated into the Plan by reference;

the end of the period for which the last contribution was paid, if such contribution is required;

the date of termination of this Plan.

NOTE: To the extent that the Employer is subject to the Family and Medical Leave Act of 1993 (FMLA), it intends to comply with the Act. The Employer is subject to FMLA if it is engaged in commerce or in any industry or activity affecting commerce and employs fifty (50) or more employees for each working day during each of twenty (20) or more calendar workweeks in the current or preceding Calendar Year.

In accordance with the FMLA, an Employee is entitled to continued coverage if he: (1) has worked for the Employer for at least twelve months, (2) has worked at least 1,250 hours in the year preceding the start of the leave, and (3) is employed at a worksite where the Employer employs at least fifty employees within a 75-mile radius.

EXTENSIONS OF COVERAGE, continued

Continued coverage under the FMLA is allowed during up to 12 workweeks of unpaid leave in any 12-month period. Such leave must be for one or more of the following reasons:

the birth of an Employee's child and in order to care for the child;

the placement of a child with the Employee for adoption or foster care;

to care for a spouse, child or parent of the Employee where such relative has a serious health condition; or

Employee's own serious health condition that makes him unable to perform the functions of his or her job.

Plan benefits may be maintained during an FMLA leave at the levels and under the conditions that would have been present if employment was continuous. The above is a summary of FMLA requirements. An Employee can obtain a more complete description of his FMLA rights from the Plan Sponsor's Human Resources or Personnel department. Any Plan provisions that are found to conflict with the FMLA are modified to comply with at least the minimum requirements of the Act.

Extension of Coverage During U.S. Military Service

Regardless of an Employer's established termination or leave of absence policies, the Plan will at all times comply with the regulations of the Uniformed Services Employment and Reemployment Rights Act (USERRA) for an Employee entering military service.

An Employee who is ordered to active military service is (and the Employee's eligible Dependent(s) are) considered to have experienced a COBRA qualifying event. The affected persons have the right to elect continuation of coverage under either USERRA or COBRA. Under either option, the Employee retains the right to re-enroll in the Plan in accordance with the stipulations set forth herein.

Notice Requirements - To be protected by USERRA and to continue health coverage, an Employee must generally provide the Employer with advance notice of his military service. Notice may be written or oral, or may be given by an appropriate officer of the military branch in which the Employee will be serving. Notice will not be required to the extent that military necessity prevents the giving of notice or if the giving of notice is otherwise impossible or unreasonable under the relevant circumstances. If the Employee's ability to give advance notice was impossible, unreasonable or precluded by military necessity, then the Employee may elect to continue coverage at the first available moment and the Employee will be retroactively reinstated in the Plan to the last day of active employment before leaving for active military service. The Employee will be responsible for payment of all back premiums from date of termination of Plan coverage. No administrative or reinstatement charges will be imposed.

If the Employee provides the Employer with advance notice of his military service but fails to elect continuation of coverage under USERRA, the Plan Administrator will continue coverage for the first thirty (30) days after Employee's departure from employment due to active military service. The Plan Administrator will terminate coverage if Employee's notice to elect coverage is not received by the end of the 30-day period. If the Employee subsequently elects to continue coverage while on active military service and within the time set forth in the subsection entitled "Maximum Period of Coverage" below, then the Employee will be retroactively reinstated in the Plan as of the last day of active employment before leaving for active military service. The Employee will be responsible for payment of all back premium charges from the date Plan coverage terminated.

Cost of USERRA Continuation Coverage - The Employee must pay the cost of coverage (herein "premium"). The premium may not exceed 102% of the actual cost of coverage, and may not exceed the active Employee cost share if the military leave is less than 31 days. If the Employee fails to make timely payment within the same time period applicable to those enrollees of the plan continuing coverage under COBRA, the Plan Administrator will terminate the Employee's coverage at the end of the month for which the last premium payment was made. If the Employee applies for reinstatement to the Plan while still on active military service and otherwise meets the requirements of the Plan and of USERRA, the Plan Administrator will reinstate the Employee to Plan coverage retroactive to the last day premium was paid. The Employee will be responsible for payment of all back premium charges owed.

EXTENSIONS OF COVERAGE, continued

Maximum Period of Coverage – The maximum period of USERRA continuation coverage is the lesser of:

18 months (or 24 months for elections made on or after December 10, 2004); or

the duration of Employee's active military service.

Reinstatement of Coverage Following Active Duty - Regardless of whether an Employee elects continuation coverage under USERRA, coverage will be reinstated on the first day the Employee returns to active employment if the Employee was released under honorable conditions.

The Employee must return to employment:

on the first full business day following completion of military service for military leave of 30 days or less; or

within 14 days of completion of military service for military leave of 31-180 days; or

within 90 days of completion of military service for military leave of more than 180 days.

When coverage under the Plan is reinstated, all provisions and limitations of the Plan will apply to the extent that they would have applied if the Employee had not taken military leave and coverage had been continuous. No waiting period or preexisting condition exclusion can be imposed on a returning Employee or Dependents if these exclusions would have been satisfied had the coverage not been terminated due to the order to active military service.

Extension of Coverage for Retirees

An eligible Employee who retires between the ages of 55 and 65, who is under the age of 65 and who has completed at least fifteen (15) years of service for the Employer, is eligible to continue coverage for himself and any eligible Dependents, without lapse, and, aside from active employment requirements, will be treated in the same manner as an eligible and active Employee. All retiree insurance coverage shall end on September 30th following their 65th birthday, except, if a retiree's 65th birthday falls on or after July 1st, which is the beginning date of the District's new fiscal year, the retiree shall remain on the insurance plan until the following September 30th.

Extension of Coverage for Survivors

Upon the death of a covered Employee, a Dependent's coverage can be continued through the end of the District's current school year, provided the Dependent continues to pay the current Employee contribution rate.

NOTE: Only those individuals who were covered under the Plan on the day immediately prior to the Employee's death will be eligible for continued Plan coverage under the terms of this provision.

- (See *COBRA Continuation Coverage*) -

EXTENSION OF BENEFITS DURING TOTAL DISABILITY

If an Employee or Dependent is Totally Disabled on the date his coverage terminates, benefits will be extended but only for the condition causing such Total Disability and only during the uninterrupted continuance of that disability. Extended benefits under the terms of this provision will terminate on the earlier of the following:

upon exhaustion of the Maximum Lifetime Benefit;

upon termination of the Total Disability;

twelve (12) months following the date coverage terminated;

upon the individual's eligibility for coverage in any other group plan, self-insured plan, prepayment plan, HMO or government plan that entitles him to any benefits for the disabling condition;

upon termination of the Plan.

"Total Disability" or "Totally Disabled" means that a Covered Person is prevented, solely because of a non-occupational injury or non-occupational disease, from engaging in his regular or customary occupation and is performing no work of any kind for compensation or profit, or is prevented, solely because of a non-occupational injury or non-occupational disease, from engaging in all of the normal activities of a person of like occupational status, age and sex in good health.

A Physician (MD or DO) must certify an Employee or Dependent as Totally Disabled. Also, the individual must be under the care of a Physician (MD or DO) in order to be Totally Disabled for Plan purposes.

- (See *COBRA Continuation Coverage*) -

CLAIMS PROCEDURES

SUBMITTING A CLAIM

A claim is a request for a benefit determination that is made, in accordance with the Plan's procedures, by a Claimant or his authorized representative. A claim must be received by the person or organizational unit customarily responsible for handling benefit matters on behalf of the Plan so that the claim review and benefit determination process can begin. A claim must name the Plan, a specific Claimant, a specific health condition or symptom or diagnostic code, and a specific treatment, service or supply (or procedure/revenue codes) for which a benefit or benefit determination is requested, the date of service, the amount of charges, the address (location) where services are received, and provider name, address, phone number and tax identification number.

The Plan Administrator has contracted with other entities to handle claims communications and benefit determinations for the Plan. Contact information for such entities ("claims offices") is provided below.

There are two types of health claims: (1) Pre-Service Claims, and (2) Post-Service Claims:

- 1) **A Pre-Service Claim** is where the terms of the Plan condition benefits, in whole or in part, on prior approval of the proposed care. See the **Utilization Management Program** section for that information.

Important: A Pre-Service Claim is only for the purposes of assessing the Medical Necessity and appropriateness of care and delivery setting. A determination on a Pre-Service Claim is not a guarantee of benefits from the Plan. Plan benefit payments are subject to review upon submission of a claim to the Plan after medical services have been received, and are subject to all related Plan provisions, including exclusions and limitations.

- 2) **A Post-Service Claim** is a written request for benefit determination after a service has been rendered and expense has been incurred. A Post-Service Claim must be submitted to the claims office within six (6) months after the end of the Calendar Year in which the expense was incurred. However, a late claim filing will be permitted where it is established to the satisfaction of the District and the Contract Administrator that failure to file a timely claim was due to mistake, inadvertence, surprise or excusable neglect.

A Post-Service Claim should be submitted to:

**Advantek Benefit Administrators
P. O. Box 45007
Fresno, CA 93718**

NOTE: In accordance with federal law, the Centers for Medicare and Medicaid Services (CMS) have three (3) years to submit claims when CMS has paid as the primary plan and the Plan should have been primary.

ASSIGNMENTS TO PROVIDERS

All Eligible Expenses reimbursable under the Plan will be paid to the covered Employee except that: (1) assignments of benefits to Hospitals, Physicians or other providers of service will be honored, (2) the Plan may pay benefits directly to providers of service unless the Covered Person requests otherwise, in writing, within the time limits for filing proof of loss, and (3) the Plan may make benefit payments for a child covered by a Qualified Medical Child Support Order (a QMCSO) directly to the custodial parent or legal guardian of such child.

No covered Employee or Dependent may, at any time, either while covered under the Plan or following termination of coverage, assign his right to sue to recover benefits under the Plan, or enforce rights due under the Plan or any other causes of action he may have against the Plan or its fiduciaries.

CLAIMS PROCEDURES, continued

NOTE: Benefit payments on behalf of a Covered Person who is also covered by a state's Medicaid program will be subject to the state's right to reimbursement for benefits it has paid on behalf of the Covered Person, as created by an assignment of rights made by the Covered Person or his beneficiary as may be required by the state Medicaid plan. Furthermore, the Plan will honor any subrogation rights that a state may have gained from a Medicaid-eligible beneficiary due to the state's having paid Medicaid benefits that were payable under the Plan.

CLAIMS TIME LIMITS AND ALLOWANCES

The chart below sets forth the time limits and allowances that apply to the Plan and a Claimant with respect to claims filings, administration and benefit determinations (e.g., how quickly the Plan will respond to claims notices, filings and claims appeals and how much time will be allowed for Claimants to respond).

Important: These claims procedures address the periods within which claims determinations must be decided, not paid. Benefit payments must be made within reasonable periods of time following Plan approval.

"PRE-SERVICE" CLAIM ACTIVITY	TIME LIMIT OR ALLOWANCE
<p>Urgent Claim - defined below</p> <p>Claimant Makes Initial <u>Incomplete</u> Claim Request</p> <p>Plan Receives <u>Completing</u> Information</p> <p>Claimant Makes Initial <u>Complete</u> Claim Request</p> <p>Claimant Appeals</p> <p>Plan Responds to Appeal</p> <p>An "urgent claim" is an oral or written request for benefit determination where the decision would result in either of the following if decided within the time frames for non-urgent claims: (1) serious jeopardy to the Claimant's life or health, or the ability to regain maximum function, or (2) in the judgment of a Physician knowledgeable about the Claimant's condition, severe pain that could not be adequately managed without the care or treatment being claimed.</p> <p>Where the "Time Limit or Allowance" stated above reflects "or sooner if possible", this phrase means that an earlier response may be required, considering the urgency of the medical situation.</p>	<p>Within not more than 24 hours (and as soon as possible considering the urgency of the medical situation), Plan notifies Claimant of information needed to complete the claim request. Notification may be oral unless Claimant requests a written notice.</p> <p>Plan notifies Claimant, in writing or electronically, of its benefit determination as soon as possible and not later than 48 hours after the earlier of: (1) receipt of the completing information, or (2) the period of time Claimant was allowed to provide the completing information. .</p> <p>Within not more than 72 hours (and as soon as possible considering the urgency of the medical situation), Plan responds with written or electronic benefit determination.</p> <p>See "Appeal Procedures" subsection. An appeal for an urgent claim may be made orally or in writing.</p> <p>Within not more than 72 hours (and as soon as possible considering the urgency of the medical situation), after receipt of Claimant's appeal.</p>
"PRE-SERVICE" CLAIM ACTIVITY	TIME LIMIT OR ALLOWANCE
<p>Concurrent Care Claim - defined below</p> <p>Plan Wants to Reduce or Terminate Already Approved Care</p>	<p>Plan notifies Claimant of intent to reduce or deny benefits <u>before</u> any reduction or termination of benefits is made and provides enough time to allow the Claimant to appeal and obtain a response to the appeal before the benefit is reduced or terminated. Any decision with the potential of causing disruption to ongoing care that is Medically Necessary, is subject to the urgent claim rules.</p>

CLAIMS PROCEDURES, continued

<p>Claimant Requests Extension for Urgent Care</p>	<p>Plan notifies Claimant of its benefit determination within 24 hours after receipt of the request (and as soon as possible considering the urgency of the medical situation), provided the Claimant requests to extend the course of treatment at least 24 hours prior to the expiration of the previously-approved period of time or treatment. Otherwise, the Plan's notification must be made in accordance with the time allowances for appeal of an urgent, pre-service or post-service claim, as appropriate.</p>
<p>A "concurrent care claim" is a Claimant's request to extend a previously-approved and ongoing course of treatment beyond the approved period of time or number of treatments. A decision to reduce or terminate benefits already approved does not include a benefit reduction or denial due to Plan amendment or termination.</p>	
<p>Non-Urgent Claim</p>	
<p>Claimant Makes Initial <u>Incomplete</u> Claim Request</p>	<p>Within 5 days of receipt of the incomplete claim request, Plan notifies Claimant, orally or in writing, of information needed to complete the claim request. Claimant may request a written notification. .</p>
<p>Plan Receives <u>Completing</u> Information</p>	<p>Within 15 days, Plan responds with written or electronic benefit determination. 15 additional days may be allowed with full notice to Claimant - see definition of "full notice" below.</p>
<p>Claimant Makes Initial <u>Complete</u> Claim Request</p>	<p>Within 15 days, Plan responds with written or electronic benefit determination. 15 additional days may be allowed with full notice to Claimant - see definition of "full notice" below.</p>
<p>Claimant Appeals</p>	<p>See "Appeal Procedures" subsection.</p>
<p>Plan Responds to Appeal</p>	<p>Within 30 days after receipt of appeal (or where Plan requires 2 mandatory levels of appeal, within 15 days for each appeal).</p>
<p>"Full notice" means that notice is provided to the Claimant describing the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. Such extension must be necessary due to matters beyond the control of the Plan and notification to Claimant must occur prior to the expiration of the initial 15-day period.</p>	
"POST-SERVICE" CLAIM ACTIVITY	TIME LIMIT OR ALLOWANCE
<p>Claimant Makes Initial <u>Incomplete</u> Claim Request</p>	<p>Within 30 days (and sooner if reasonably possible), Plan advises Claimant of information needed to complete the claim request.</p>
<p>Plan Receives <u>Completing</u> Information</p>	<p>Within 30 days, Plan approves or denies claim. 15 additional days may be allowed with full notice to Claimant - see definition of "full notice" below.</p>
<p>Claimant Makes Initial <u>Complete</u> Claim Request</p>	<p>Within 30 days of receiving the claim, Plan approves or denies claim. 15 additional days may be allowed with full notice to Claimant - see definition of "full notice" below.</p>
<p>Claimant Appeals</p>	<p>See "Appeals Procedures" subsection.</p>
<p>Plan Responds to Appeal</p>	<p>Within 60 days after receipt of appeal (or within 30 days for each appeal if Plan provides for two appeal levels).</p>
<p>"Full notice" means that notice is provided to the Claimant describing the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. Such extension must be necessary due to matters beyond the control of the Plan and notification to Claimant must occur prior to the expiration of the initial 30-day or 60-day period.</p>	

Authorized Representative May Act for Claimant

Any of the above actions that can be done by the Claimant can also be done by an authorized representative acting on the Claimant's behalf. The Claimant may be required to provide reasonable proof of such authorization. For an urgent claim, a health care professional, with knowledge of a Claimant's medical condition, will be permitted to act as the authorized representative of the Claimant. "Health care professional" means a physician or other health care professional licensed, accredited, or certified to perform specified health services consistent with state law.

Written or Electronic Notices

The Plan shall provide a Claimant with written or electronic notification of any benefit reduction or denial. Written or electronic notice of an approved benefit must be provided only for Pre-Service benefit determinations.

CLAIMS DENIALS

If a claim is wholly or partially denied, the Claimant will be given written or electronic notification of such denial. The notice will include the following and will be provided in a manner intended to be understood by the Claimant:

the specific reason(s) for the decision to reduce or deny benefits:

specific reference to the Plan provision(s) on which the denial is based as well as identification of and access to any guidelines, rules, and protocols that were relied upon in making the decision;

a statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records or other information relevant to the Claimant's claim for benefits;

a description of any additional information needed to change the decision and an explanation of why it is needed;

a description of the Plan's procedures and time limits for appealed claims.

APPEAL PROCEDURES

Filing an Appeal

Within 180 days of receiving notice of a claim reduction or denial, a Claimant may appeal his claim, in writing, to a new decision-maker and he may submit new information (e.g., comments, documents and records) in support of his appeal. A Claimant may not take legal action on a denied claim until he has exhausted the Plan's mandatory (i.e., non-voluntary) appeal procedures - see NOTE.

In response to his appeal, the Claimant is entitled to a full and fair review of the claim and a new decision. A "full and fair review" takes into account all comments, documents, records and other information submitted by the Claimant relating to the claim, without regard to whether the information was submitted or considered in the initial benefit determination.

At such time as the Claimant appeals a denied claim, he will be provided, upon request and free of charge, with access to and copies of all documents, records and other information relevant to his claim for benefits.

NOTE: The Plan will not require more than two (2) levels of mandatory appeal. If more than one (1) level of mandatory appeal is required, both will be completed within the time frame applicable to one (1) level.

Decision on Appeal

A decision with regard to the claim appeal will be made within the allowed time frame - see "Claims Time Limits and Allowances."

The decision on appeal will be in writing or by electronic notification. If the decision is to continue to reduce or deny benefits, the notification will be provided in a manner calculated to be understood by the Claimant and will include:

the specific reason(s) for the decision;

reference to the pertinent Plan provisions on which the decision is based;

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;

identification of and access to any guidelines, rules, protocols that were relied upon in making the decision;

a statement describing any voluntary appeal procedures offered by the Plan and the Claimant's right to obtain the information about such procedures.

INSURANCE ADVISORY COMMITTEE

The Insurance Advisory Committee shall include representatives from the Porterville Educators Association (P.E.A.), the California School Employees Association, Chapter 38 (C.S.E.A.), and the District. Each organization shall have one vote and two votes shall constitute a majority in a decision.

Review Procedure

Claimants, or their duly authorized representatives, shall have the right of review of claim denials. A request for review shall be made by written application. The claimant (or representative) may review pertinent documents and shall submit issues and comments in writing. The following rules shall apply to such review of claim denials:

Written application for review of denial of a claim shall be received in the office of the Plan Administrator not later than sixty (60) days following receipt by the Claimant of such denial or no appeal shall be allowed.

The Administrator, together with the District, shall decide upon the application within sixty (60) days after its receipt, unless special circumstances (such as the need to hold a hearing) requires an extension of time for processing, in which case a decision shall be rendered as soon as possible but, in no event, more than one hundred twenty (120) days after receipt.

The decision on an application for review of denial shall be in writing and shall specify the reason(s) for the decision and shall make specific reference(s) to the pertinent Plan provisions upon which the decision was based. All decisions shall, to the extent possible, be written in a manner to be understood by a lay Claimant.

Settlement of Non-Therapeutic Disputes

After completion of the review procedure described above, if there remains a dispute, the Claimant may file a written appeal with the District within thirty (30) days of the written decision of the Administrator. Appeals shall be resolved as follows:

Any dispute concerning medical claims shall be forwarded to the Insurance Advisory Committee for review. The Insurance Advisory Committee shall study all the evidence presented and shall issue a written report of its findings within sixty (60) days of receipt, unless special circumstances require an extension of time, in which case a report shall be rendered as soon as possible but, in no event, more than one hundred twenty (120) days after receipt.

The District shall review the written report of the Insurance Advisory Committee referenced above and shall accept the recommendation of the Committee and implement its decision.

The foregoing administrative remedies shall be exhausted before a grievance procedure or any suit is brought pertaining to any dispute. Any such action shall be brought within ninety (90) days from the decision of the Insurance Advisory Committee.

Frequency of Meetings

The Insurance Advisory Committee shall meet with the insurance administrators at least quarterly and at other times as necessary for review of expenditures, cost containment measures, concerns, and exploration of possible resolutions. The District and its agents shall provide whatever statistics, documentation, or other information as necessary to accomplish these tasks.

Settlement of Therapeutic Disputes

A dispute concerning the therapeutic justification for any services rendered to a Covered Person shall be submitted to the appropriate review committee of that medical society which is a component of the California Medical Association for the geographical area in which such services were provided or, in the event that such services were provided outside of the State of California, then by such component society in the area where the Covered Person resides or last resided in the State of California. The review committee shall be requested to render a written report containing recommendations for resolution of the dispute.

The District shall review the written report of the medical review committee referenced above and shall accept the recommendation of the committee and implement its decision.

Appeal Procedure

Any party involved in a claim dispute may appeal the decision of the Insurance Advisory Committee to arbitration.

DEFINITIONS

When capitalized herein, the following items will have the meanings shown below.

Accidental Injury - Any accidental bodily injury that is caused by external forces under unexpected circumstances and that is not excluded due to being employment-related (see **General Exclusions** section). Sprains and strains resulting from over-exertion, excessive use or over-stretching will not be considered Accidental Injury for purposes of benefit determination.

Ambulatory Surgical Center - Any public or private establishment that:

complies with all licensing and other legal requirements and is operating lawfully in the jurisdiction where it is located;

has an organized medical staff of Physicians, with permanent facilities that are equipped and operated primarily for the purpose of performing surgical procedures;

provides continuous Physician services and registered professional nursing services whenever a patient is in the facility; and

does not provide services or other accommodations for patients to stay overnight.

Benefit Document – A document that describes one (1) or more benefits of the Plan.

Birth Center - A special room in a Hospital that exists to provide delivery and pre-natal and post-natal care with minimum medical intervention or a free-standing Outpatient facility that:

is in compliance with licensing and other legal requirements in the jurisdiction where it is located;

is engaged mainly in providing a comprehensive birth service program to persons who are considered normal low-risk patients;

has organized facilities for birth services on its premises;

provides birth services by or under the direction of a Physician specializing in obstetrics and gynecology;

has 24-hour-a-day registered nursing services;

maintains daily clinical records.

Calendar Year - The period of time commencing at 12:01 A.M. on January 1 of each year and ending at 12:01 A.M. on the next succeeding January 1. Each succeeding like period will be considered a new Calendar Year.

Claimant - Any Covered Person on whose behalf a claim is submitted for Plan benefits.

Contract Administrator - A company that performs all functions reasonably related to the administration of one or more benefits of the Plan (e.g., processing of claims for payment) in accordance with the terms and conditions of the Benefit Document and an administration agreement between the Contract Administrator and the Plan Sponsor.

The Contract Administrator is not a fiduciary of the Plan and does not exercise any discretionary authority with regard to the Plan. The Contract Administrator is not an insurer of Plan benefits, is not responsible for Plan financing and does not guarantee the availability of benefits under the Plan.

Convalescent Hospital - see "Skilled Nursing Facility"

DEFINITIONS, continued

Covered Person - An individual who meets the eligibility requirements as contained herein (e.g., a covered Employee, a covered Dependent, or a Qualified Beneficiary (COBRA)). See **Eligibility and Effective Dates, Extensions of Coverage** and the **COBRA Continuation Coverage** sections for further information.

NOTE: In enrolling an individual as a Covered Person or in determining or making benefit payments to or on behalf of a Covered Person, the eligibility of the individual for state Medicaid benefits will not be taken into account.

Covered Provider - An individual who is:

licensed to perform certain health care services that are covered under the Plan and who is acting within the scope of his license; or
in the absence of licensing requirements, is certified by the appropriate regulatory agency or professional association;

and who is a/an:

Audiologist
Certified or Registered Nurse Midwife
Certified Registered Nurse Anesthetist (CRNA)
Chiropractor (DC)
Dentist (DDS or DMD)
Licensed Clinical Psychologist (PhD or EdD)
Licensed Clinical Social Worker (LCSW)
Licensed Practical Nurse (LPN)
Licensed Professional Counselor (LPC)
Licensed Vocational Nurse (LVN)
Marriage Family and Child Counselor (MFCC)
Nurse Practitioner (NP)
Occupational Therapist (OTR)
Optometrist (OD)
Physical Therapist (PT or RPT)
Physician - see definition of "Physician"
Physician Assistant (PA)
Podiatrist or Chiropodist (DPM, DSP, or DSC)
Psychiatrist (MD)
Registered Nurse (RN)
Registered Nurse First Assistant (RNFA)
Respiratory Therapist
Speech Pathologist

A "Covered Provider" will also include the following when appropriately licensed and providing services that are covered by the Plan:

facilities as are defined herein including, but not limited to, Hospitals, Ambulatory Surgical Facilities, Birthing Centers;

licensed Outpatient mental health facilities;

freestanding public health facilities;

hemodialysis and Outpatient clinics under the direction of a Physician (MD);

enuresis control centers;

home infusion therapy providers;

durable medical equipment providers;

prosthetists and prosthetist-orthotists;

portable X-ray companies;

independent laboratories and lab technicians;

diagnostic imaging facilities;

blood banks;

speech and hearing centers;

ambulance companies.

NOTE: A Covered Provider does not include: (1) a Covered Person treating himself or any relative or person who resides in the Covered Person's household - see "Relative or Resident Care" in the list of **General Exclusions**, or (2) any Physician, nurse or other provider who is an employee of a Hospital or other Covered Provider facility and who is paid by the facility for his services.

Dependent - see **Eligibility and Effective Dates** section

Eligible Expense(s) - Expense that is: (1) covered by a specific benefit provision of the Benefit Document and (2) incurred while the person is covered by the Plan.

Emergency - see "Medical Emergency"

Employee - see **Eligibility and Effective Dates** section

Employer(s) - The Employer or Employers participating in the Plan as stated in the **General Plan Information** section.

Fiduciary - Any entity having binding power to make decisions regarding Plan policies, interpretations, practices or procedures.

Home Health Care Agency - An agency or organization that:
is primarily engaged in and duly licensed, if such licensing is required by the appropriate licensing authority, to provide skilled nursing services and other therapeutic services;

has policies established by a professional group associated with the agency or organization that includes at least one registered nurse (RN) to govern the services provided;

provides for full-time supervision of its services by a Physician or by a registered nurse;

maintains a complete medical record on each patient;

has a full-time administrator.

In rural areas where there are no agencies that meet the above requirements or areas in which the available agencies do not meet the needs of the community, the services of visiting nurses may be substituted for the services of an agency.

Hospital - An institution constituted and operated pursuant to law, engaged in providing on an Inpatient basis at the patient's expense, diagnostic and therapeutic facilities for the surgical and medical diagnosis, treatment and care of injured and sick individuals by or under the supervision of a licensed Physician or surgeon, and which continuously provides 24-hour-per-day services by registered nurses.

NOTE: The term "Hospital" shall not include an institution, or part thereof, which is primarily for medical observation or diagnostic examination or other than incidentally a place for rest, a place for the aged, a place for drug addicts, a place for alcoholics, or a skilled nursing facility or convalescent hospital. However, an institution specializing in the care and treatment of mentally ill patients that would qualify as a Hospital under this definition, except solely for the fact that it lacks organized facilities on its premises for major surgery, shall nevertheless be deemed a Hospital hereunder.

Inpatient - A person physically occupying a room and being charged for room and board in a facility (e.g., Hospital, or Skilled Nursing Facility) that is covered by the Plan and to which the person has been assigned on a 24-hour-a-day basis without being issued passes to leave the premises. After twenty-three (23) observation hours, a confinement will be considered an Inpatient confinement.

Intensive Care Unit (ICU), Coronary Care Unit (CCU), Burn Unit, or Intermediate Care Unit - A Hospital area or accommodation exclusively reserved for critically and seriously ill patients requiring constant observation as prescribed by the attending Physician, that provides room and board, specialized registered professional nursing and other nursing care and special equipment and supplies on a stand-by basis and that is separated from the rest of the Hospital's facilities.

Lifetime - All periods an individual is covered under the Plan, including any prior statements of the Plan. It does not mean a Covered Person's entire lifetime.

Medical Emergency - An Accidental Injury or the sudden onset of a medical condition, either of which is of sufficient severity that the absence of immediate medical attention could reasonably be expected to result in: (1) placing the patient's health or, with respect to a pregnancy, the health of the woman or her unborn child, in serious jeopardy, (2) serious impairment of bodily functions, or (3) serious dysfunction of any bodily organ or part.

Medically Necessary - Any health care treatment, service or supply determined by the Plan Administrator to meet each of the following requirements:

it is ordered by a Physician for the diagnosis or treatment of a Sickness or Accidental Injury;

the prevailing opinion within the appropriate specialty of the United States medical profession is that it is safe and effective for its intended use and that omission would adversely affect the person's medical condition;

it is furnished by a provider with appropriate training and experience, acting within the scope of his or her license; and

it is provided at the most appropriate level of care needed to treat the particular condition.

With respect to Inpatient services and supplies, "Medically Necessary" further means that the health condition requires a degree and frequency of services and treatment that can be provided ONLY on an Inpatient basis.

The Plan Administrator will determine whether the above requirements have been met based on: (1) published reports in authoritative medical and scientific literature, (2) regulations, reports, publications or evaluations issued by government agencies such as the National Institute of Health, the Food and Drug Administration (FDA), and the Centers for Medicare and Medicaid Services (CMS), (3) listings in the following compendia: *The American Hospital Formulary Service Drug Information* and *The United States Pharmacopoeia Dispensing Information*; and (4) other authoritative medical resources to the extent the Plan Administrator determines them to be necessary.

Medicare - Health Insurance for the Aged and Disabled as established by Title I of Public Law 89-98 including parts A, B & D and Title XVIII of the Social Security Act, and as amended from time to time.

Outpatient - Services rendered on other than an Inpatient basis at a Hospital or at a covered non-Hospital facility.

Physician - A Doctor of Medicine (MD) or Doctor of Osteopathy (DO) who is licensed to practice medicine or osteopathy where the care is provided.

NOTE: The term "Physician" will not include the Covered Person himself, his relatives (see **General Exclusions**) or interns, residents, fellows or others enrolled in a graduate medical education program.

Plan - The plan of employee welfare benefits provided by the Plan Sponsor. The name of the Plan is shown in the **General Plan Information** section.

Plan Administrator - see "Plan Sponsor"

Plan Document - A formal written document that describes the Plan and the rights and responsibilities of the Plan Sponsor with regard to the Plan, including any amendments.

Plan Sponsor - The entity sponsoring the Plan. The Plan Sponsor may also be referred to as the Plan Administrator. See **General Plan Information** section for further information.

Pregnancy - Pre-natal and post-natal care during pregnancy, childbirth, miscarriage or complications arising therefrom. See "Pregnancy Care" in the list of **Eligible Medical Expenses** for further information.

Rehabilitation Center - A facility that is designed to provide therapeutic and restorative services to sick or injured persons and that:

carries out its stated purpose under all relevant state and local laws; or

is accredited for its stated purpose by either the JCAHO or the Commission on Accreditation for Rehabilitation Facilities; or

is approved for its stated purpose by Medicare.

Semi-Private Room Charge - The standard charge by a facility for semi-private room and board accommodations, or the average of such charges where the facility has more than one established level of such charges, or 90% of the lowest charge by the facility for single bed room and board accommodations where the facility does not provide any semi-private accommodations.

Sickness - Sickness will mean bodily illness or disease (other than mental health conditions or chemical dependencies), congenital abnormalities, birth defects and premature birth. Also, a condition must be diagnosed by a Physician in order to be considered a Sickness by this Plan.

Skilled Nursing Facility - An institution that:

is duly licensed as a convalescent hospital, extended care facility, skilled nursing facility, or intermediate care facility and is operated in accordance with the governing laws and regulations;

is primarily engaged in providing accommodations and skilled nursing care 24-hours-a-day for convalescing persons;

is under the full-time supervision of a Physician or a registered nurse;

admits patients only upon the recommendation of a Physician, maintains complete medical records, and has available at all times the services of a Physician;

has established methods and procedures for the dispensing and administering of drugs;

has an effective utilization review plan;

is approved and licensed by Medicare;

has a written transfer agreement in effect with one or more Hospitals; and

is not, other than incidentally, a nursing home, a hotel, a school or a similar institution, a place of rest, for custodial care, for the aged, for drug addicts, for alcoholics, for the care of mentally ill or persons with nervous disorders, or for the care of senile persons.

Urgent Care Facility - A facility that is engaged primarily in providing minor emergency and episodic medical care and that has:

a board-certified Physician, a registered nurse (RN) and a registered X-ray technician in attendance at all times;

X-ray and laboratory equipment and a life support system.

An Urgent Care Facility may include a clinic located at, operated in conjunction with, or that is part of a regular Hospital.⁵

Usual, Customary and Reasonable (UCR) - A charge made by a provider that does not exceed the general level of charges made by other providers in the area or community who have similar experience and training for the treatment of health conditions comparable in severity and nature to the health condition being treated. The term "area" as it would apply to any particular service, medicine, or supply means a county or such greater area as is necessary to obtain a representative cross section of the level of charges.

The **USUAL** charge shall mean the fee usually charged to patients for a given service by a physician or provider of service.

A charge is **CUSTOMARY** when it is within the range of usual charges for a given service billed by most physicians or providers of service with similar training and experience for the same service within the same geographic area as determined by the Plan Administrator.

A charge is **REASONABLE** when it meets the usual and customary criteria as determined by the Plan Administrator; or it may be reasonable is, upon review by a Medical Review Committee appointed by the District, it is justifiable, considering the nature and extent of special circumstances of treatment of the particular case.

NOTE: Any agreement as to fees or charges made between a Covered Person and his Physician shall not bind the Plan in determining its liability with respect to expenses incurred.

GENERAL PLAN INFORMATION

Name of Plan:	The Porterville Unified School District's Health and Welfare Benefit Plan
Plan Sponsor / Plan Administrator: Address:	Porterville Unified School District 600 West Grand Avenue Porterville, CA 93257
Participating Employer:	Porterville Unified School District
Original Plan Effective Date:	October 1, 1978
Plan Year:	July 1 through June 30
Benefit Year:	January 1 through December 31
Named Fiduciary: Address:	Porterville Unified School District 600 West Grand Avenue Porterville, CA 93257
(See also definition of "Fiduciary")	
Plan Benefits Fully Described Herein:	Self-Funded Medical, Prescription, Dental, Vision and Life Benefits
Type of Administration: <u>Self-Funded Medical Benefits – Contract Administration</u> Mailing Address:	Advantek Benefit Administrators P. O. Box 45007 Fresno, CA 93718 (866) 556-7655
Phone:	
<u>Self-Funded Dental Benefits - Contract Administration</u> Mailing Address:	Delta Dental Plan of California P.O. Box 7736 San Francisco, CA 94120 (415) 972-8300
Phone:	
<u>Self-Funded Prescription Benefits – Contract Administration</u> Mailing Address:	Express Scripts P.O. Box 66773 St. Louis, MO 96166 (800) 955-4879
Phone:	
<u>Vision Benefits – Provider Administration</u> Mailing Address:	Vision Service Plan P.O. Box 5210 San Francisco, CA 94145-5210 (800) 877-7195
Phone:	

FUNDING - SOURCES AND USES

The Plan's self-funded benefits are paid from the general assets of the Plan Sponsor. Any amounts to be paid by active Employees will be deducted from Employees' regular wages.

See the **COBRA Continuation Coverage** section for more information.

ADMINISTRATIVE PROVISIONS FOR THE SELF-FUNDED PLAN BENEFITS

Administration (type of)

The self-funded Plan benefits described herein are administered by one (1) or more Contract Administrators under the terms and conditions of administration agreement(s) between the Plan Sponsor and Contract Administrator(s). A Contract Administrator is not an insurance company.

Alternative Care

In addition to the benefits specified herein, the Plan may elect to offer benefits for services furnished by any provider pursuant to an approved alternative treatment plan for a Covered Person.

The Plan will provide such alternative benefits at the Plan Sponsor's sole discretion and only when and for so long as it determines that alternative services are Medically Necessary and cost-effective, and that the total benefits paid for such services do not exceed the total benefits to which the Claimant would otherwise be entitled under this Plan in the absence of alternative benefits.

If the Plan Sponsor elects to provide alternative benefits for a Covered Person in one instance, it will not be obligated to provide the same or similar benefits for that person or other Covered Persons in any other instance, nor will such election be construed as a waiver of the Plan Sponsor's right to provide benefits thereafter in strict accordance with the provisions of the Benefit Document.

Amendment or Termination of the Plan

Since future conditions affecting the Plan Sponsor or Employer(s) cannot be anticipated or foreseen, the Plan Sponsor must necessarily and does hereby reserve the right to, without the consent of any participant or beneficiary:

- reduce, modify or terminate retiree health care benefits under the Plan, if any;

- alter or postpone the method of payment of any benefit;

- amend any provision of these administrative provisions;

- make any modifications or amendments to the Plan as are necessary or appropriate to qualify or maintain the Plan as a plan meeting the requirements of the applicable sections of the Internal Revenue Code; and

- terminate, suspend, withdraw, amend or modify the Plan in whole or in part at any time and on a retroactive basis, if necessary, provided, however, that no modification or amendment shall divest an Employee of a right to those benefits to which he has become entitled under the Plan.

NOTE: Any modification, amendment or termination action will be done in writing, and by resolution of a majority of the Plan Sponsor's board of directors, or by written amendment that is signed by at least one Fiduciary of the Plan. Employees will be provided with notice of the change within the time allowed by federal law.

Anticipation, Alienation, Sale or Transfer

Except for assignments to providers of service (see **Claims Procedures** section), no benefit payable under the provisions of the Plan will be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance or charge, and any attempt so to anticipate, alienate, sell, transfer, assign, pledge, encumber, or charge will be void; nor will such benefit be in any manner liable for or subject to the debts, contracts, liabilities, engagements, or torts of, or claims against, any Employee, covered Dependent or beneficiary, including claims of creditors, claims for alimony or support, and any like or unlike claims.

Clerical Error

Clerical error by the Employer or Plan Sponsor will not invalidate coverage otherwise validly in force nor continue coverage otherwise validly terminated.

Creditable Coverage Certificates - Under the Health Insurance Portability and Accountability Act of 1996 (commonly known as HIPAA), an individual has the right to receive a certificate of prior health coverage, called a certificate of creditable coverage” or “certificate of group health plan coverage,” from the Plan Sponsor or its delegate. If Plan coverage or COBRA continuation coverage terminates (including termination due to exhaustion of all lifetime benefits under the Plan), the Plan Sponsor will automatically provide a certificate of creditable coverage. The certificate is provided at no charge and will be mailed to the person at the most current address on file. A certificate of creditable coverage will also be provided, on request, in accordance with the law (i.e., a request can be made at any time while coverage is in effect and within twenty-four (24) months after termination of coverage). Written procedures for requesting and receiving certificates of creditable coverage are available from the Plan Sponsor.

Discrepancies

In the event that there may be a discrepancy between any separate booklet(s) provided to Employees ("Summary Plan Descriptions") and the Benefit Document, the Benefit Document will prevail.

Facility of Payment

Every person receiving or claiming benefits under the Plan will be presumed to be mentally and physically competent and of age. However, in the event the Plan determines that the Employee is incompetent or incapable of executing a valid receipt and no guardian has been appointed, or in the event the Employee has not provided the Plan with an address at which he can be located for payment, the Plan may, during the lifetime of the Employee, pay any amount otherwise payable to the Employee, to the husband or wife or relative by blood of the Employee, or to any other person or institution determined by the Plan to be equitably entitled thereto; or in the case of the death of the Employee before all amounts payable have been paid, the Plan may pay any such amount to one or more of the following surviving relatives of the Employee: lawful spouse, child or children, mother, father, brothers, or sisters, or the Employee's estate, as the Plan Sponsor in its sole discretion may designate. Any payment in accordance with this provision will discharge the obligation of the Plan.

If a guardian, conservator or other person legally vested with the care of the estate of any person receiving or claiming benefits under the Plan is appointed by a court of competent jurisdiction, payments will be made to such guardian or conservator or other person, provided that proper proof of appointment is furnished in a form and manner suitable to the Fiduciaries. To the extent permitted by law, any such payment so made will be a complete discharge of any liability therefore under the Plan.

Fiduciary Responsibility, Authority and Discretion

Fiduciaries will serve at the discretion of the Plan Sponsor and will serve without compensation for such services, but they will be entitled to reimbursement of their expenses properly and actually incurred in an official capacity. Fiduciaries will discharge their duties under the Plan solely in the interest of the Employees and their beneficiaries and for the exclusive purpose of providing benefits to Employees and their beneficiaries and defraying the reasonable expenses of administering the Plan.

The Fiduciaries will administer the Plan and will have the authority to exercise the powers and discretion conferred on them by the Plan and will have such other powers and authorities necessary or proper for the administration of the Plan as may be determined from time to time by the Plan Sponsor.

In carrying out their responsibilities under the Plan, Fiduciaries will have discretionary authority to interpret the terms of the Plan and Plan Document, even if the terms are found to be ambiguous, and to determine eligibility for and entitlement to Plan benefits in accordance with the terms of the Plan. Any interpretation or determination made pursuant to such discretionary authority will be given full force and effect, unless it can be shown that the interpretation or determination was arbitrary and capricious.

Fiduciaries may employ such agents, attorneys, accountants, investment advisors or other persons (who also may be employed by the Employer) or third parties (such as, but not limited to provider networks or utilization management organizations) as in their opinion may be desirable for the administration of the Plan, and may pay any such person or third party reasonable compensation. The Fiduciaries may delegate to any agent, attorney, accountant or other

person or third party selected by them, any power or duty vested in, imposed upon, or granted to them by the Plan. However, Fiduciaries will not be liable for acts or omissions of any agent, attorney, accountant or other person or third party except to the extent that the appointing Fiduciaries violated their own general fiduciary duties in: (1) establishing or implementing the Plan procedures for allocation or delegation, (2) allocating or delegating the responsibility, or (3) continuing the allocation or delegation.

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.

Gender and Number

Except when otherwise indicated by the context, any masculine terminology will include the feminine (and vice-versa) and any term in the singular will include the plural (and vice-versa).

Illegality of Particular Provision

The illegality of any particular provision of the Benefit Document will not affect the other provisions and the Benefit Document will be construed in all respects as if such invalid provision were omitted.

Indemnification

To the extent permitted by law, Employees of the Employer, the Fiduciaries, and all agents and representatives of the Fiduciaries will be indemnified by the Plan Sponsor and saved harmless against any claims and conduct relating to the administration of the Plan except claims arising from gross negligence, willful neglect, or willful misconduct. The Plan Sponsor reserves the right to select and approve counsel and also the right to take the lead in any action in which it may be liable as an indemnitor.

Legal Actions

No Employee, Dependent or other beneficiary will have any right or claim to benefits from the Plan, except as specified herein. Any dispute regarding benefits under this Plan will be resolved by the Plan Sponsor through the application of the provisions of the Benefit Document and Plan Document.

No legal action may be brought to recover on the Plan: (1) more than three years from the time written proof of loss is required to be given, or (2) until the Plan's mandatory claim appeal(s) are exhausted. See the **Claims Procedures** section for more information.

Loss of Benefits

To the extent permitted by law, the following circumstances may result in disqualification, ineligibility or denial, loss, forfeiture, suspension, offset, reduction or recovery of any benefit that a Plan participant or beneficiary might otherwise reasonably expect the Plan to provide based on the description of benefits:

- an employee's cessation of active service for the employer;
- a Plan participant's failure to pay his share of the cost of coverage, if any, in a timely manner;
- a dependent ceases to meet the Plan's eligibility requirements (e.g., a child reaches a maximum age limit or a spouse divorces);
- a Plan participant is injured and expenses for treatment may be paid by or recovered from a third party;
- a claim for benefits is not filed within the time limits of the Plan.

Material Modification

In the case of any modification or change to the Plan that is a "material reduction in covered services or benefits," Plan participants and beneficiaries are to be furnished a summary of the change not later than sixty (60) days after the adoption of the change. This does not apply if the Plan Sponsor provides summaries of modifications or changes at regular intervals of not more than ninety (90) days.

"Material modifications" are those which would be construed by the average Plan participant as being "important" reductions in coverage and generally would include any Plan modification or change that: (1) eliminates or reduces benefits payable under the Plan, including a reduction that occurs as a result of a change in formulas, methodologies or schedules that serve as the basis for making benefit determinations, (2) increases premiums, deductibles, coinsurance, copays, or other amounts to be paid by a Plan participant or beneficiary, or (3) establishes new conditions or requirements (i.e., preauthorization requirements) to obtaining services or benefits under the Plan.

Misstatement / Misrepresentation

If the marital status, Dependent status or age of a Covered Person has been misstated or misrepresented in an enrollment form and if the amount of the contribution required with respect to such Covered Person is based on such criteria, an adjustment of the required contribution will be made based on the Covered Person's true status.

If marital status, Dependent status or age is a factor in determining eligibility or the amount of a benefit and there has been a misstatement of such status with regard to an individual in an enrollment form or claims filing, his eligibility, benefits or both, will be adjusted to reflect his true status.

A misstatement of marital status, Dependent status or age will void coverage not validly in force and will neither continue coverage otherwise validly terminated nor terminate coverage otherwise validly in force. The Plan will make any necessary adjustments in contributions, benefits or eligibility as soon as possible after discovery of the misstatement or misrepresentation. The Plan will also be entitled to recover any excess benefits paid or receive any shortage in contributions required due to such misstatement or misrepresentation.

Misuse of Identification Card

If an Employee or covered Dependent permits any person who is not a covered member of the family unit to use any identification card issued, the Plan Sponsor may give Employee written notice that his (and his family's) coverage will be terminated at the end of thirty-one (31) days from the date written notice is given.

Non-Discrimination Due to Health Status

An individual will not be prevented from becoming covered under the Plan due to a health status-related factor. A "health status-related factor" means any of the following:

- a medical condition (whether physical or mental and including conditions arising out of acts of domestic violence)
- claims experience
- receipt of health care
- medical history
- evidence of insurability
- disability
- genetic information

Physical Examination

The Plan Sponsor, at Plan expense, will have the right and opportunity to have a Physician of its choice examine the Covered Person when and as often as it may reasonably require during the pendency of any claim.

Plan Administrator Discretion & Authority

The Plan Administrator has the exclusive authority, in its sole and absolute discretion, to take any and all actions necessary to or appropriate to interpret the terms of the Plan in order to make all determinations thereunder. The Plan Sponsor shall make determinations regarding coverage and eligibility. The Plan Administrator (or the delegated Contract Administrator acting within the scope of its delegated authority on behalf of the Plan) shall make determinations regarding Plan benefits.

Privacy Rules & Security Standards & Intent to Comply

To the extent required by law, the Plan Sponsor certifies that the Plan will: (1) comply with the Standards for Privacy of Individually Identifiable Health Information (i.e., the "Privacy Rules") of the Health Insurance Portability and Accountability Act (HIPAA) and (2) comply with HIPAA Security Standards with respect to electronic Protected Health Information.

The Plan and the Plan Sponsor will not intimidate or retaliate against employees who file complaints with regard to their privacy, and employees will not be required to give up their privacy rights in order to enroll or have benefits.

Purpose of the Plan

The purpose of the Plan is to provide certain health care benefits for eligible Employees of the Participating Employer(s) and their eligible Dependents.

Reimbursements

Plan's Right to Reimburse Another Party - Whenever any benefit payments that should have been made under the Plan have been made by another party, the Plan Sponsor and the Contract Administrator will be authorized to pay such benefits to the other party; provided, however, that the amounts so paid will be deemed to be benefit payments under the Plan, and the Plan will be fully discharged from liability for such payments to the full extent thereof.

Plan's Right to be Reimbursed for Payment in Error - When, as a result of error, clerical or otherwise, benefit payments have been made by the Plan in excess of the benefits to which a Claimant is entitled, the Plan will have the right to recover all such excess amounts from the Employee, or any other persons, insurance companies or other payees, and the Employee or Claimant will make a good faith attempt to assist in such repayment. If the Plan is not reimbursed in a timely manner after notice and proof of such overpayment has been provided to the Employee, then the Contract Administrator, upon authorization from the Plan Sponsor, may deduct the amount of the overpayment from any future claims payable to the Employee or any of his Dependents.

Plan's Right to Recover for Claims Paid Prior to Final Determination of Liability - The Plan Sponsor may, in its sole discretion, pay benefits for care or services pending a determination of whether or not such care or services are covered hereunder. Such payment will not affect or waive any exclusion, and to the extent benefits for such care or services have been provided, the Plan will be entitled to recoup and recover the amount paid therefore from the Covered Person or the provider of service in the event it is determined that such care or services are not covered. The Covered Person (parent, if a minor) will execute and deliver to the Plan Sponsor or the Contract Administrator all assignments and other documents necessary or useful for the purpose of enforcing the Plan's rights under this provision. If the Plan is not reimbursed in a timely manner after notice and proof of such overpayment has been provided to the Employee, then the Contract Administrator, upon authorization from Plan Sponsor, may deduct the amount of the overpayment from any future claims payable to the Employee or any of his Dependents.

Rights Against the Plan Sponsor or Employer

Neither the establishment of the Plan, nor any modification thereof, nor any distributions hereunder, will be construed as giving to any Employee or any person any legal or equitable rights against the Plan Sponsor, its shareholders, directors, or officers, or as giving any person the right to be retained in the employ of the Employer.

Titles or Headings

Where titles or headings precede explanatory text throughout the Benefit Document, such titles or headings are intended for reference only. They are not intended and will not be construed to be a substantive part of the Benefit Document and will not affect the validity, construction or effect of the Benefit Document provisions.

Termination for Fraud

An individual's Plan coverage or eligibility for coverage may be terminated if:

the individual submits any claim that contains false or fraudulent elements under state or federal law;

a civil or criminal court finds that the individual has submitted claims that contain false or fraudulent elements under state or federal law;

an individual has submitted a claim that, in good faith judgment and investigation, he knew or should have known, contained false or fraudulent elements under state or federal law.

Type of Plan

This Plan is a nonfederal governmental group health plan that, for the most part, is exempt from the requirements of the Employee Retirement Income Security Act (ERISA). 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 Act (MHPA), 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, the Plan intends to fully comply with the above-stated federal laws.

Workers' Compensation

The benefits provided by the Plan are not in lieu of and do not affect any requirement for coverage by Workers' Compensation Insurance laws or similar legislation.

COBRA CONTINUATION COVERAGE

In order to comply with the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), the Plan includes a continuation of coverage option, that is available to certain Covered Persons whose health care coverage(s) under the Plan would otherwise terminate. This provision is intended to comply with that law but it is only a summary of the major features of the law. In any individual situation, the law and its clarifications and intent will prevail over this summary.

If a retired Employee is covered under the Plan and one of his Dependents has a Qualifying Event (e.g., divorce or loss of Dependent child eligibility), such Dependent may be eligible for COBRA Continuation Coverage. Also, certain other COBRA rights apply to such retirees and their covered Dependents with regard to an Employer's bankruptcy. Anywhere "retirees" are referenced herein, it means only those retired Employees who were covered under the Plan.

Definitions - When capitalized in this COBRA section, the following items will have the meanings shown below:

Qualified Beneficiary - An individual who, on the day before a Qualifying Event, is covered under the Plan by virtue of being either a covered Employee, or the covered Dependent spouse or child of a covered Employee.

Any child who is born to or placed for adoption with, a covered Employee during a period of COBRA continuation coverage. Such child has the right to immediately elect, under the COBRA continuation coverages the covered Employee has at the time of the child's birth or placement for adoption, the same coverage that a Dependent child of an active Employee would receive. The Employee's Qualifying Event date and resultant continuation coverage period also apply to the child.

An individual who is not covered under the Plan on the day before a Qualifying Event because he was denied Plan coverage or was not offered Plan coverage and such denial or failure to offer constitutes a violation of applicable law. The individual will be considered to have had the Plan coverage and will be a "Qualified Beneficiary" if that individual experiences a Qualifying Event.

Exception: An individual is not a Qualified Beneficiary if the individual's status as a covered Employee is attributable to a period in which he was a nonresident alien who received no earned income from the Employer that constituted income from sources within the United States. If such an Employee is not a Qualified Beneficiary, then a spouse or Dependent child of the Employee is not a Qualified Beneficiary by virtue of the relationship to the Employee.

Qualifying Event - Any of the following events that would result in the loss of health coverage under the Plan in the absence of COBRA continuation coverage:

voluntary or involuntary termination of Employee's employment for any reason other than Employee's gross misconduct;

reduction in an Employee's hours of employment to non-eligible status. In this regard, a Qualifying Event occurs whether or not Employee actually works and may include absence from work due to a disability, temporary layoff or leave of absence where Plan coverage terminates but termination of employment does not occur. If a covered Employee is on FMLA unpaid leave, a Qualifying Event occurs at the time the Employee fails to return to work at the expiration of the leave, even if the Employee fails to pay his portion of the cost of Plan coverage during the FMLA leave;

for an Employee's spouse or child, Employee's entitlement to Medicare. For COBRA purposes, "entitlement" means that the Medicare enrollment process has been completed with the Social Security Administration and the Employee has been notified that his or her Medicare coverage is in effect;

for an Employee's spouse or child, the divorce or legal separation of the Employee and spouse;

for an Employee's spouse or child, the death of the covered Employee;

COBRA CONTINUATION COVERAGE, continued

for retirees and their Dependent spouses and children, loss of Plan coverage due to the Employer's filing of a bankruptcy proceeding under Title 11 of the U.S. Bankruptcy Code. In order for a Qualifying Event to occur, the Employee must have retired on or before the date of substantial elimination of the Plan's benefits and must be covered under the Plan on the day before the bankruptcy proceedings begin. "Substantial elimination" of the Plan's benefits must occur within 12 months before or after the bankruptcy proceedings begin.

NonCOBRA Beneficiary - An individual who is covered under the Plan on an "active" basis (i.e., an individual to whom a Qualifying Event has not occurred).

Notification Responsibilities – If the Employer is the Plan Administrator and if the Qualifying Event is Employee's termination/reduction in hours, death, or Medicare entitlement, then the Plan Administrator must provide Qualified Beneficiaries with notification of their COBRA continuation coverage rights, or the unavailability of COBRA rights, within 44 days of the event. If the Employer is not the Plan Administrator, then the Employer's notification to the Plan Administrator must occur within 30 days of the Qualifying Event and the Plan Administrator must provide Qualified Beneficiaries with their COBRA rights notice within 14 days thereafter. Notice to Qualified Beneficiaries must be provided in person or by first-class mail.

If COBRA continuation coverage terminates early (e.g., the Employer ceases to provide any group health coverage, a Qualified Beneficiary fails to pay a required premium in a timely manner, or a Qualified Beneficiary becomes entitled to Medicare after the date of the COBRA election), the Plan Administrator must provide the Qualified Beneficiary(ies) with notification of such early termination. Notice must include the reason for early termination, the date of termination and any right to alternative or conversion coverage. The early termination notice(s) must be sent as soon as practicable after the decision that coverage should be terminated.

Each Qualified Beneficiary, including a child who is born to or placed for adoption with an Employee during a period of COBRA continuation coverage, has a separate right to receive a written election notice when a Qualifying Event has occurred that permits him to exercise coverage continuation rights under COBRA. However, where more than one Qualified Beneficiary resides at the same address, the notification requirement will be met with regard to all such Qualified Beneficiaries if one election notice is sent to that address, by first-class mail, with clear identification of those beneficiaries who have separate and independent rights to COBRA continuation coverage.

An Employee or Qualified Beneficiary is responsible for notifying the Plan of a Qualifying Event that is a Dependent child's ceasing to be eligible under the requirements of the Plan, or the divorce or legal separation of the Employee from his/her spouse. A Qualified Beneficiary is also responsible for other notifications. See the **COBRA Notification Procedures** as included in the Plan's Summary Plan Description (and the Employer's "COBRA General Notice" or "Initial Notice") for further details and time limits imposed on such notifications. Upon receipt of a notice, the Plan Administrator must notify the Qualified Beneficiary(ies) of their continuation rights within 14 days.

Election and Election Period - COBRA continuation coverage may be elected during the period beginning on the date Plan coverage would otherwise terminate due to a Qualifying Event and ending on the later of the following: (1) 60 days after coverage ends due to a Qualifying Event, or (2) 60 days after the notice of the COBRA continuation coverage rights is provided to the Qualified Beneficiary. See NOTE.

If the COBRA election of a covered Employee or spouse does not specify "self-only" coverage, the election is deemed to include an election on behalf of all other Qualified Beneficiaries with respect to the Qualifying Event. However, each Qualified Beneficiary who would otherwise lose coverage is entitled to choose COBRA continuation coverage, even if others in the same family have declined. A parent or legal guardian may elect or decline for minor Dependent children.

An election of an incapacitated or deceased Qualified Beneficiary can be made by the legal representative of the Qualifying Beneficiary or the Qualified Beneficiary's estate, as determined under applicable state law, or by the spouse of the Qualified Beneficiary.

COBRA CONTINUATION COVERAGE, continued

If, during the election period, a Qualified Beneficiary waives COBRA continuation coverage rights, the waiver can be revoked at any time before the end of the election period. Revocation of the waiver will be an election of COBRA continuation coverage. However, if a waiver is revoked, coverage need not be provided retroactively (that is, from the date of the loss of coverage until the waiver is revoked). Waivers and revocations of waivers are considered to have been made on the date they are sent to the Employer or Plan Administrator.

Open enrollment rights that allow NonCOBRA Beneficiaries to choose among any available coverage options are also applicable to each Qualified Beneficiary. Similarly, the "special enrollment rights" of the Health Insurance Portability and Accountability Act (HIPAA) extend to Qualified Beneficiaries. However, if a former Qualified Beneficiary did not elect COBRA, he does not have special enrollment rights, even though active Employees not participating in the Plan have such rights under HIPAA.

The Plan is required to make a complete response to any inquiry from a healthcare provider regarding a Qualified Beneficiary's right to coverage during the election period.

NOTE: See the "Effect of the Trade Act" provision for information regarding a second 60-day election period allowance.

Effective Date of Coverage - COBRA continuation coverage, if elected within the period allowed for such election, is effective retroactively to the date coverage would otherwise have terminated due to the Qualifying Event, and the Qualified Beneficiary will be charged for coverage in this retroactive period.

See "Election and Election Period" for an exception to the above when a Qualified Beneficiary initially waives COBRA continuation coverage and then revokes his waiver. In that instance, COBRA continuation coverage is effective on the date the waiver is revoked.

Level of Benefits - COBRA continuation coverage will be equivalent to coverage provided to similarly situated NonCOBRA Beneficiaries to whom a Qualifying Event has not occurred. If coverage is modified for similarly situated NonCOBRA Beneficiaries, the same modification will apply to Qualified Beneficiaries.

If the Plan includes a deductible requirement, a Qualified Beneficiary's deductible amount at the beginning of the COBRA continuation period must be equal to his deductible amount immediately before that date. If the deductible is computed on a family basis, only the expenses of those family members electing COBRA continuation coverage are carried forward to the COBRA continuation coverage. If more than one family unit results from a Qualifying Event, the family deductibles are computed separately based on the members in each unit. Other Plan limits are treated in the same manner as deductibles.

If a Qualified Beneficiary is participating in a region-specific health plan that will not be available if the Qualified Beneficiary relocates, any other coverage that the Plan Sponsor makes available to active Employees and that provides service in the relocation area must be offered to the Qualified Beneficiary.

Cost of Continuation Coverage - The cost of COBRA continuation coverage will not exceed 102% of the Plan's full cost of coverage during the same period for similarly situated NonCOBRA Beneficiaries to whom a Qualifying Event has not occurred. The "full cost" includes any part of the cost that is paid by the Employer for NonCOBRA Beneficiaries. Qualified Beneficiaries can be charged up to 150% of the full cost for the 11-month disability extension period if the disabled person is among those extending coverage.

The initial "premium" (cost of coverage) payment must be made within 45 days after the date of the COBRA election by the Qualified Beneficiary. Payment must cover the period of coverage from the date of the COBRA election retroactive to the date of loss of coverage due to the Qualifying Event (or the date a COBRA waiver was revoked, if applicable). Contributions for successive periods of coverage are due on the first of each month thereafter, with a 30-day grace period allowed for payment. Where an employee organization or any other entity that provides Plan benefits on behalf of the Plan Sponsor permits a billing grace period later than the 30 days stated above, such period shall apply in lieu of the 30 days. Premium payment is considered to have been made on the date it was sent to the Plan or Plan Sponsor.

COBRA CONTINUATION COVERAGE, continued

The Plan must allow the payment for COBRA continuation coverage to be made in monthly installments but the Plan is also permitted to allow for payment at other intervals. The Plan is not obligated to send monthly premium notices.

The cost of COBRA continuation coverage can only increase if:

the cost previously charged was less than the maximum permitted by law;

the increase is due to a rate increase at Plan renewal;

the increase occurs due to a disability extension (i.e., the 11-month disability extension) and does not exceed the maximum permitted by law that is 150% of the Plan's full cost of coverage if the disabled person is among those extending coverage; or

the Qualified Beneficiary changes his coverage option(s) that results in a different coverage cost.

Timely payments that are less than the required amount but are not significantly less (an "insignificant shortfall") will be deemed to satisfy the Plan's payment requirement. The Plan may notify the Qualified Beneficiary of the deficiency but must grant a reasonable period of time (at least 30 days) to make full payment. A payment will be considered an "insignificant shortfall" if it is not greater than \$50 or 10% of the required amount, whichever is less.

If premiums are not paid by the first day of the period of coverage, the Plan has the option to cancel coverage until payment is received and then reinstate the coverage retroactively to the beginning of the period of coverage.

NOTES: For Qualified Beneficiaries who reside in a state with a health insurance premium payment program, the State may pay the cost of COBRA coverage for a Qualified Beneficiary who is eligible for health care benefits from the State through a program for the medically indigent or due to a certain disability. The Employer's personnel offices should be contacted for additional information.

See the "Effect of the Trade Act" provision for additional cost of coverage information.

Maximum Coverage Periods - The maximum coverage periods for COBRA continuation coverage are based on the type of Qualifying Event and the status of the Qualified Beneficiary and are as follows:

if the Qualifying Event is a termination of employment or reduction of hours of employment, the maximum coverage period is 18 months after the Qualifying Event. With a disability extension (see "Disability Extension" information below), the 18 months is extended to 29 months;

if the Qualifying Event occurs to a Dependent due to Employee's enrollment in the Medicare program before the Employee himself experiences a Qualifying Event, the maximum coverage period for the Dependent is 36 months from the date the Employee is enrolled in Medicare;

in the case of a bankruptcy Qualifying Event with regard to a retiree, the maximum coverage period is to the date of the retired Employee's death. The maximum coverage period for a Qualified Beneficiary who is the spouse, surviving spouse or Dependent child of the retired Employee ends on the earlier of: (1) 36 months after the death of the retired Employee, or (2) the date of the Qualified Beneficiary's death;

for any other Qualifying Event, the maximum coverage period ends 36 months after the Qualifying Event.

If a Qualifying Event occurs that provides an 18-month or 29-month maximum coverage period and is followed by a second Qualifying Event that allows a 36-month maximum coverage period, the original period will be expanded to 36 months, but only for individuals who are Qualified Beneficiaries at the time of both Qualifying Events. Thus, a termination of employment following a Qualifying Event that is a reduction of hours of employment or a bankruptcy of the Plan Sponsor following any Qualifying Event will not expand the maximum COBRA continuation period. In no circumstance can the COBRA maximum coverage period be more than 36 months after the date of the first

COBRA CONTINUATION COVERAGE, continued

Qualifying Event, except in the case of a bankruptcy Qualifying Event with regard to a retiree where the maximum coverage period is to the date of the retired Employee's death.

COBRA entitlement runs concurrently with continuation of coverage under The Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) - USERRA does not extend the maximum period of COBRA coverage. If coverage is continued under USERRA, the equivalent number of months of COBRA entitlement will be exhausted.

Disability Extension - An 11-month disability extension (an extension from a maximum 18 months of COBRA continuation coverage to a maximum 29 months) will be granted if a Qualified Beneficiary is determined under Title II or XVI of the Social Security Act to have been disabled at the time of the Qualifying Event or at any time during the first 60 days of COBRA continuation coverage. To qualify for the disability extension, the Plan Administrator must be provided with notice of the Social Security Administration's disability determination date that falls within the allowable periods described. The notice must be provided within 60 days of the disability determination and prior to expiration of the initial 18-month COBRA continuation coverage period. The disabled Qualified Beneficiary or any Qualified Beneficiaries in his or her family may notify the Plan Administrator of the determination. The Plan must also be notified if the Qualified Beneficiary is later determined by Social Security to be no longer disabled.

If an individual who is eligible for the 11-month disability extension also has family members who are entitled to COBRA continuation coverage, those family members are also entitled to the 29-month COBRA continuation coverage period. This applies even if the disabled person does not elect the extension himself.

Termination of Continuation Coverage - Except for an initial interruption of Plan coverage in connection with a waiver (see "Election and Election Period" above), COBRA continuation coverage that has been elected by or for a Qualified Beneficiary will extend for the period beginning on the date of the Qualifying Event and ending on the earliest of the following dates:

the last day of the applicable maximum coverage period - see "Maximum Coverage Periods" above;

the date on which the Employer ceases to provide any group health plan to any Employee;

the date, after the date of the COBRA election, that the Qualified Beneficiary first becomes covered under any other plan that does not contain any exclusion or limitation with respect to any preexisting condition that would reduce or exclude benefits for such condition in the Qualified Beneficiary;

the date, after the date of the COBRA election, that the Qualified Beneficiary becomes entitled to Medicare benefits. For COBRA purposes, "entitled" means that the Medicare enrollment process has been completed with the Social Security Administration and the individual has been notified that his or her Medicare coverage is in effect;

in the case of a Qualified Beneficiary entitled to a disability extension, the later of:

29 months after the date of the Qualifying Event, or the first day of the month that is more than 30 days after the date of a final determination under Title II or XVI of the Social Security Act that the disabled Qualified Beneficiary whose disability resulted in the Qualified Beneficiary's entitlement to the disability extension is no longer disabled, whichever is earlier; or

the end of the maximum coverage period that applies to the Qualified Beneficiary without regard to the disability extension;

the end of the last period for which the cost of continuation coverage is paid, if payment is not received in a timely manner (i.e., coverage may be terminated if the Qualified Beneficiary is more than 30 days delinquent in paying the applicable premium). The Plan is required to make a complete response to any inquiry from a healthcare provider regarding a Qualified Beneficiary's right to coverage during any period the Plan has not received payment.

COBRA CONTINUATION COVERAGE, continued

The Plan Sponsor can terminate, for cause, the coverage of any Qualified Beneficiary on the same basis that the Plan may terminate the coverage of similarly situated Non-COBRA Beneficiaries for cause (e.g., for the submission of a fraudulent claim).

If an individual is receiving COBRA continuation coverage solely because of the person's relationship to a Qualified Beneficiary (i.e., a newborn or adopted child acquired during an Employee's COBRA coverage period), the Plan's obligation to make COBRA continuation coverage available will cease when the Plan is no longer obligated to make COBRA continuation coverage available to the Qualified Beneficiary.

Effect of the Trade Act - In response to Public Law 107-210, referred to as the Trade Act of 2002 ("TAA"), the Plan is deemed to be "Qualified Health Insurance" pursuant to TAA, the Plan provides COBRA continuation of coverage in the manner required of the Plan by TAA for individuals who suffer loss of their medical benefits under the Plan due to foreign trade competition or shifts of production to other countries, as determined by the U.S. International Trade Commission and the Department of Labor pursuant to the Trade Act of 1974, as amended.

Eligible Individuals - The Plan Administrator shall recognize those individuals who are deemed eligible for federal income tax credit of their health insurance cost or who receive a benefit from the Pension Benefit Guaranty Corporation ("PBGC"), pursuant to TAA as of or after November 4, 2002. The Plan Administrator shall require documentation evidencing eligibility of TAA benefits, including but not limited to, a government certificate of TAA eligibility, a PBGC benefit statement or federal income tax filings. The Plan need not require every available document to establish evidence of TAA eligibility. The burden for evidencing TAA eligibility is that of the individual applying for coverage under the Plan. The Plan shall not be required to assist such individual in gathering such evidence.

Temporary Extension of COBRA Election Period

Definitions:

Nonelecting TAA-Eligible Individual – A TAA-Eligible Individual who has a TAA related loss of coverage and did not elect COBRA continuation coverage during the TAA-Related Election Period.

TAA-Eligible Individual – An eligible TAA recipient and an eligible alternative TAA recipient.

TAA-Related Election Period – with respect to a TAA-related loss of coverage, the 60-day period that begins on the first day of the month in which the individual becomes a TAA-Eligible Individual.

TAA-Related Loss of Coverage – means, with respect to an individual whose separation from employment gives rise to being a TAA-Eligible Individual, the loss of health benefits coverage associated with such separation.

In the case of an otherwise COBRA Qualified Beneficiary who is a Nonelecting TAA-Eligible Individual, such individual may elect COBRA continuation of coverage during the TAA-Related Election Period, but only if such election is made not later than six (6) months after the date of the TAA-Related Loss of Coverage.

Any continuation of coverage elected by a TAA-Eligible Individual shall commence at the beginning of the TAA-Related Election Period, and shall not include any period prior to the such individual's TAA-Related Election Period.

HIPAA Creditable Coverage Credit

With respect to any TAA-Eligible Individual who elects COBRA continuation of coverage as a Nonelecting TAA Individual, the period beginning on the date the TAA-Related Loss of Coverage, and ending on the first day of the TAA-Related Election Period shall be disregarded for purposes of determining the 63-day break-in-coverage period pursuant to HIPAA rules regarding determination of prior creditable coverage for application to the Plan's preexisting condition exclusion provision.

COBRA CONTINUATION COVERAGE, continued

Applicable Cost of Coverage Payments

Payments of any portion of the applicable COBRA cost of coverage by the federal government on behalf of a TAA-Eligible Individual pursuant to TAA shall be treated as a payment to the Plan. Where the balance of any contribution owed the Plan by such individual is determined to be significantly less than the required applicable cost of coverage, as explained in IRS regulations 54.4980B-8, A-5(d), the Plan will notify such individual of the deficient payment and allow thirty (30) days to make full payment. Otherwise the Plan shall return such deficient payment to the individual and coverage will terminate as of the original cost of coverage due date.

COBRA NOTIFICATION PROCEDURES

It is a Plan participant's responsibility to provide the following Notices as they relate to COBRA Continuation Coverage:

Notice of Divorce or Legal Separation - Notice of the occurrence of a Qualifying Event that is a divorce or legal separation of a covered Employee from his or her spouse.

Notice of a Second Qualifying Event - Notice of the occurrence of a second Qualifying Event after a Qualified Beneficiary has become entitled to COBRA Continuation Coverage with a maximum duration of 18 (or 29) months.

Notice Regarding Disability - Notice that: (a) a Qualified Beneficiary entitled to receive COBRA Continuation Coverage with a maximum duration of 18 months has been determined by the Social Security Administration to be disabled at any time during the first 60 days of continuation coverage, or (b) a Qualified Beneficiary as described in "(a)" has subsequently been determined by the Social Security Administration to no longer be disabled.

Notice Regarding Address Changes – It is important that the Plan Administrator be kept informed of the current addresses of all Plan participants or beneficiaries who are or may become Qualified Beneficiaries.

Notification must be made in accordance with the following procedures. Any individual who is either the covered Employee, a Qualified Beneficiary with respect to the Qualifying Event, or any representative acting on behalf of the covered Employee or Qualified Beneficiary may provide the Notice. Notice by one individual shall satisfy any responsibility to provide Notice on behalf of all related Qualified Beneficiaries with respect to the Qualifying Event.

Form, Content & Delivery- Notification of the Qualifying Event must be provided in writing to the COBRA Administrator. The COBRA Administrator is PORTERVILLE UNIFIED SCHOOL DISTRICT, 600 West Grand Avenue, Porterville, CA 93257, Attn: Health and Welfare Benefits Coordinator. For questions, the phone number is: (559) 793-2427.

Notification must include evidence that a Qualifying Event or other event extending coverage has occurred (e.g., copy of divorce decree, copy of child's birth certificate, copy of the Social Security Administration's disability determination letter).

Time Requirements for Notification - In the case of a divorce, legal separation or a child losing dependent status, Notice must be delivered within 60 days from the later of: (1) the date of the Qualifying Event, (2) the date health plan coverage is lost due to the event, or (3) the date the Qualified Beneficiary is notified of the obligation to provide Notice through the Summary Plan Description or the Plan Sponsor's General COBRA Notice. If Notice is not received within the 60-day period, **COBRA Continuation Coverage** will not be available, except in the case of a loss of coverage due to foreign competition where a second COBRA election period may be available – see "Effect of the Trade Act" in the **COBRA Continuation Coverage** section of the Plan's Summary Plan Description or Benefit Document.

If an Employee or Qualified Beneficiary is determined to be disabled under the Social Security Act, Notice must be delivered within 60 days from the later of: (1) the date of the determination, (2) the date of the Qualifying event, (3) the date coverage is lost as a result of the Qualifying Event, or (4) the date the covered Employee or Qualified Beneficiary is advised of the Notice obligation through the SPD or the Plan Sponsor's General COBRA Notice. Notice must be provided within the 18-month COBRA coverage period. Any such Qualified Beneficiary must also provide Notice within 30 days of the date he is subsequently determined by the Social Security Administration to no longer be disabled.

ADOPTION OF THE DOCUMENT

Adoption

The Plan Sponsor hereby adopts this document on the date shown below.

This document replaces any and all prior statements of the Plan benefits that are described herein and in that respect this document is adopted as the Benefit Document.

Purpose of the Plan

The purpose of the Plan is to provide certain benefits for eligible Employees of the Participating Employer(s) and their eligible Dependents. The benefits provided by the Plan are as listed in the **General Plan Information** section.

Conformity with Law

If any provision of this Plan is contrary to any law to which it is subject, such provision is hereby amended to conform to such law.

Participating Employers

Employers participating in this Plan are as stated in the section entitled **General Plan Information**.

The Plan Sponsor may act for and on behalf of any and all of the Participating Employers in all matters pertaining to the Plan, and every act, agreement, or notice by the Plan Sponsor will be binding on all such Employers.

Restatement / Replacement of Benefits

This document replaces prior benefits offered by the Plan Sponsor but this is not a new Plan. Except to the extent benefits are expressly added, removed or modified, any benefits provided with respect to covered persons under the prior benefits will be deemed to be benefits provided hereunder for a person who is eligible as an active enrollee or a COBRA enrollee under the document on its effective date. Any contiguous periods a person was covered under the benefits replaced by this document will be deemed to be time covered hereunder.

Acceptance of the Document

IN WITNESS WHEREOF, the Plan Sponsor has caused this instrument to be executed, effective as of July 1, 2006.

Porterville Unified School District

By: _____

Title: _____

WITNESS:

By: _____

Title: _____