

**ORANGE COUNTY  
ELECTRICAL INDUSTRY**



**HEALTH AND  
WELFARE PROGRAM**

Revised 2004

Your insurance has been designed to provide financial help for you when a covered loss occurs. This plan has chosen benefits provided by a Group Policy issued by Us, Principal Life Insurance Company. To the extent that benefits are provided by that Group Policy, the administration and payment of claims will be done by Us as an insurer.

Members rights and benefits are determined by the provisions of the Group Policy. This booklet briefly describes those rights and benefits. It outlines what you must do to be insured. It explains how to file claims. It is your certificate while you are insured.

If you or one of your Dependents is undergoing a course of treatment from a Preferred Provider that terminates from the PPO network, continuity of care may apply. Please call the toll-free number shown on your ID Card for additional information.

THIS BOOKLET REPLACES ANY PRIOR BOOKLET THAT YOU MAY HAVE RECEIVED. If you have any questions about this new booklet, please contact your employer. In the event of future plan changes, you will be provided with a new booklet-certificate or a booklet-certificate rider.

If you have an electronic booklet, paper copies of this booklet-certificate are also available. Please contact your employer if you would like to request a paper copy.

PLEASE READ YOUR BOOKLET CAREFULLY. We suggest that you start with a review of the terms listed in the DEFINITIONS Section (at the back of the booklet). The meanings of these terms will help you understand the insurance.

The group insurance policy and your coverage under the Group Policy may be discontinued or altered by the Policyholder or Us at any time without your consent.

We reserve complete discretion to construe or interpret the provisions of this group insurance, to determine eligibility for benefits, and to determine the type and extent of benefits, if any, to be provided. Our decisions in such matters will be controlling, binding, and final as between Us and persons covered by the Group Policy, subject to the Claim Procedures shown on page GH 146 A of this booklet.

YOUR MEDICAL BENEFITS MAY BE REDUCED IF THE UTILIZATION MANAGEMENT REQUIREMENTS DESCRIBED IN THIS BOOKLET ARE NOT FOLLOWED. IF YOU HAVE ANY QUESTIONS, PLEASE CALL THE TOLL-FREE NUMBER SHOWN ON YOUR ID CARD ON ANY BUSINESS DAY OR SEE YOUR EMPLOYER FOR THE TOLL-FREE NUMBER.

The insurance provided in this booklet is subject to the laws of the state of California.

PRINCIPAL LIFE INSURANCE COMPANY  
Des Moines, IA 50392-0001

## **YOUR ROLE IN CONTROLLING HEALTH CARE COSTS**

Making choices about your health can sometimes be difficult. When you seek health care, take the same approach you use for buying anything else. Ask questions. Make sure you get the most appropriate care for your condition. Use the following guidelines to help you be a wise health care consumer:

**Practice Good Health Habits.** Staying healthy is the best way to control your medical costs. Eat a balanced diet, exercise regularly, and get enough sleep. Learn how to handle stress. Stop smoking and avoid excessive use of alcohol.

**See your Doctor Early.** Don't let a minor problem become a major one. This makes treatment more difficult and expensive.

**Make Sure You Need Surgery.** If a second opinion program is included in your coverage, get one if you're unsure about the surgery you face. If you need surgery, ask about same day surgery. Many procedures can be performed safely without a Hospital stay. You have these surgeries as an outpatient or at a place other than a Hospital and go home the same day.

**Use Outpatient Services for X-ray or Laboratory Tests.** Outpatient preadmission and diagnostic tests can save costly room and board charges.

**Compare Prescription Drug Prices.** Discuss the use of generic drugs with your doctor or pharmacist. Generic drugs are often cheaper than brand name drugs for the same quality.

**Consider Hospital Stay Alternatives.** Home Health Care, Skilled Nursing Facilities, and Hospice Care services offer quality care in comfortable surroundings for less cost than staying in the Hospital.

**Review Medical Bills Carefully.** Make sure you understand all charges and receive bills only for services you receive. Keep your medical records up-to-date.

**Talk to Your Doctor.** Discuss the need for treatment with your doctor. It is your body. To make wise health care decisions, you must understand the treatment and any risks or complications involved. Ask about treatment costs too. With today's health care costs, your doctor will understand your concern about your medical expenses.

**Be a wise health care consumer.** Review your benefits carefully so you can make informed health care decisions. You can help control health care costs while getting the most your health care insurance has to offer.

### **BENEFIT ADVICE**

**WE WANT TO HELP YOU BE A WISE HEALTH CARE CONSUMER. PLEASE GIVE US A CALL IF YOU HAVE ANY QUESTIONS ABOUT YOUR MEDICAL INSURANCE.**

**1-800-247-4695**

**YOU MAY REFER TO THE CLAIM PROCEDURES SECTION OF THIS BOOKLET FOR MORE DETAILED INFORMATION.**

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## SUMMARY OF BENEFITS

### COMPREHENSIVE MEDICAL EXPENSE INSURANCE

This section highlights the benefits provided under this insurance. The purpose is to give you quick access to the information you will most often want to review. **Please read the other sections of this booklet for a more detailed explanation of benefits and any limitations or restrictions that might apply.**

If you or one of your Dependents are sick or injured, Scheduled Benefits then in force will be payable for Medically Necessary Care. Scheduled Benefits are based on your class:

| Class  | Scheduled Benefit  |
|--|--|
| All Residential Sound Members<br>and their Dependents..... | Comprehensive Medical and Mail Order<br>Maintenance Prescription Drugs |

### PREFERRED PROVIDER ORGANIZATION (PPO)

Your employer participates in a Preferred Provider Organization (PPO) network established and administered by the PPO identified on your ID card.

As you may know, Preferred Provider Organization networks are arrangements whereby Hospitals, Physicians, and other providers are contracted to furnish, at negotiated costs, medical care for the employees and their Dependents of participating employers.

It is expected that your employer's participation in the PPO will result in significant savings of funds needed to maintain your insurance. These savings are to be passed on to you in the form of higher benefits payable for services received by you or a Dependent from Preferred Providers.

Please note that your employer's participation in the PPO network does not mean that your choice of provider will be restricted. You may still seek needed medical care from any Hospital, Physician, or other provider you wish. However, in order to avoid higher charges and reduced benefit payments, you are urged to obtain such care from Preferred Providers whenever possible.

We have the right to terminate the PPO portion of this insurance if We or the PPO terminate the arrangement.

We also have the right to identify different Preferred Provider Organizations from time to time, and to terminate the designation of any Preferred Provider at any time.

A current listing of the participating Hospital, Physicians, and other providers is available through an on-line Preferred Provider directory. By accessing the Principal Life Insurance Company website [www.principal.com](http://www.principal.com), you can review Preferred Provider directories for your PPO Network. Click on "Provider Directory," then "Search for a Medical Provider," then you can continue to follow prompts to file your PPO Network. The name of your PPO network will then be listed and you can continue to follow the prompts. If you do not have internet access, you can request a paper copy of the provider directory for your PPO network from (800) 554-

3392 for medical providers. Whether using the internet or a paper directory, we recommend that you (1) verify your provider's participation in the network before seeking treatment and (2) confirm PPO participation with your provider when making your appointment.

**See page GH 407 B for a full description of Covered Charges.**

## **BENEFITS PAYABLE**

Benefits will be payable during a calendar year as shown below, and will vary depending upon whether or not needed care is received from a Hospital, Physician, or other provider who has contracted with the Preferred Provider Organization:

- 60% of each person's first \$15,000 of Covered Charges in excess of the Deductible amount until the Stop Loss Expense Limit is met; and
- 100% of each person's Covered Charges in excess of the Stop Loss Expense Limit.

Covered Charges used to satisfy the Stop Loss Expense Limit that applies when care is received from Other than Preferred Providers will be counted toward satisfaction of the Stop Loss Expense Limit that applies when care is received from Preferred Providers.

Stop Loss Expense Limit means the first \$15,000 of each person's Covered Charges in excess of the Deductible or Copay amount per calendar year.

**The following exceptions apply to the Benefits Payable provisions described above:**

- For medical care received from Non-PPO Providers: Hospital Inpatient Confinement Charges and Surgery Related Charges, benefits payable will be reduced by 25% (but not more than \$2,000 per individual each calendar year) unless the Utilization Management Requirements are satisfied. **See page GH 407 CC for a complete description of the Utilization Management Program.**
- For a second or third opinion obtained with respect to the surgical procedures listed under Presurgery Review, benefits payable will be 100% of Second Opinion Consultation Charges, subject to Prevailing Charges.
- For Physician Visit Charges incurred if Preferred Provider is used, benefits payable will be 100% in excess of the Copay amount.
- For Hospitalization Charges incurred in a PPO facility, benefits payable will be 70% in excess of the Deductible amount.
- For Hospitalization Charges incurred in a Non-PPO facility, benefits payable will be 60% in excess of the Deductible amount, up to a maximum benefit of \$200 per day for confinement in other than an Intensive Care Unit of a Hospital and up to a maximum benefit of \$500 per day for confinement in an Intensive Care Unit of a Hospital.
- For Mental Health, Behavioral, Alcohol, or Drug Abuse Treatment Services, see the Benefits Payable provisions described below. **See page GH 401 B for a complete description of the benefits payable for these services.**
- For payment conditions applicable to Transplant Services, see page GH 401 B.

- For payment conditions applicable to outpatient Laboratory Services, see Special Payment Conditions described below.
- For payment conditions applicable to Medical Emergency, see Special Payment Conditions described below.

If you or one of your Dependents are referred to another provider, you or your Dependent should verify with the Physician that the referral is for a PPO Provider. Examples of this would be an anesthesiologist, x-ray facilities, surgeons, radiologists, etc. If that provider is not a PPO Provider, the level of benefits for Non-PPO Providers will apply.

## **COPAY AMOUNTS**

The Copay amount for a Member or Dependent for each Preferred Provider Physician Visit will be \$10.

The Preferred Provider Physician Visit Charges Copay amount shown above:

- (1) will not be counted toward satisfaction of the Stop Loss Expense Limit; and
- (2) will not be counted toward the satisfaction of the \$250 calendar year Deductible; and
- (3) will continue to apply after the Stop Loss Expense Limit has been satisfied.

In addition, the Copay provision does not apply to charges incurred for MRIs, CATs, PETs, and other similar imaging tests. These charges are subject to the calendar year Deductible.

## **DEDUCTIBLE AMOUNTS**

### **- Individual Deductible**

The individual Deductible amounts for a Member or Dependent will be:

- none with respect to Second Opinion Consultation Charges for a second or third opinion obtained with respect to the surgical procedures listed under the heading Presurgery Review on page GH 407 CC; and
- \$250 each calendar year for all other Covered Charges.

### **- Family Maximum Deductible**

The family maximum combined Deductible amount with respect to the calendar year Deductible described above for all persons in the same family (you and your Dependents) each calendar year will be \$500, but not counting more than \$250 of such Covered Charges for each person in the family.

When the family maximum Deductible is satisfied, benefits will be payable as if the individual calendar year Deductible for each person in the family has been satisfied.

Covered Charges used to satisfy the Physician Visit Charges per visit Copay, as described above, cannot be used to satisfy this family Deductible limit.

Covered Charges used to satisfy the individual and family maximum calendar year Deductible that applies when care is received from either a Preferred Provider or from a Non-

Preferred Provider will be used to satisfy the individual and family maximum calendar year Deductibles.

**SPECIAL PAYMENT CONDITIONS**

**Mental Health or Behavioral Treatment Services (other than Severe Mental Illness) and Alcohol or Drug Abuse Treatment Services (Applicable to medical care received from PPO Providers or from Non-PPO Providers)**

| Service   | PPO<br>Providers   | Non-PPO<br>Providers          |
|---|--|-------------------------------|
| - <b>Inpatient Hospital Services</b>                            |  |                               |
| - Coinsurance.....  | 70%  | 60% up to the per day maximum |
| - Deductible or Copay Amount .....                              | Same as for any other Hospital Inpatient Confinement   |                               |
| - Maximum Benefit Payable                                       |  |                               |
| - Calendar Year Maximum.....                                    | 30 days per calendar year (combined with Partial Hospitalization or Day Treatment Services days) |                               |
| - <b>Partial Hospitalization or Day Treatment Services.....</b> | Paid same as Inpatient Hospital Services   |                               |
| - Maximum Benefit Payable                                       |  |                               |
| - Calendar Year Maximum.....                                    | 30 days per calendar year (combined with Inpatient Hospital Services days)                       |                               |
| - <b>Outpatient Services.....</b>                               | Not Covered  |                               |

Covered Charges for Mental Health or Behavioral Treatment Service (other than Severe Mental Illness) and Alcohol or Drug Abuse Treatment Services will not apply toward the Stop Loss Expense limits and will never be paid at 100%.

**Severe Mental Illness (Inpatient Hospital Services, Partial Hospitalization, or Outpatient Services)**

|                                    |  |
|------------------------------------|--|
| - Coinsurance Rate .....           | Same as for any other covered Treatment or Service |
| - Deductible or Copay Amount ..... | Same as for any other covered Treatment or Service |

The Maximum Benefit Payable for all services applies to combined PPO Provider and Non-PPO Provider charges.

See page GH 401 B for a complete description of the benefits payable for these services.

### **Outpatient Laboratory Services**

LabOne is a laboratory provider that conducts outpatient testing. We have entered into an agreement with LabOne to provide these services at a negotiated rate.

"Laboratory Services" means Covered Charges for testing of materials, fluids or tissues obtained from patients for the purpose of screening or diagnosing a condition and for determining appropriate treatment.

When you or your Dependents require outpatient Laboratory Services, you or your Physician may choose any laboratory you wish. However, if you use the services of a LabOne facility, the benefits will be more favorable.

When utilizing a LabOne facility, there are two ways in which laboratory work is completed:

- Specimens are drawn at the Physician's office and are sent to LabOne for testing; or
- The insured visits a LabOne patient service center with a Physician's directive and has the specimen drawn. The specimen is then sent to the centralized laboratory for testing.

If you or a Dependent go to a PPO or non-PPO Physician's office or clinic and the Physician sends the laboratory work to a LabOne facility for processing, We will pay 100% of Covered Charges for the Laboratory Services. No Copay or Deductible will be applied to these services.

If you or a Dependent go to a PPO or non-PPO Physician's office or clinic and the Physician sends the laboratory work to a non-LabOne facility, the level of benefits for Non-Preferred Providers will apply.

If you or a Dependent go to a LabOne facility with a Physician's directive, We will pay 100% of Covered Charges for the Laboratory Services. No Copay or Deductible will be applied to these services. If the laboratory facility is not a LabOne facility, the level of benefits for Non-Preferred Providers will apply.

If you or a Dependent go to a PPO or Non-PPO Physician's office or clinic and the Physician does not send the laboratory work to LabOne facility but instead sends the laboratory work to a PPO facility for processing, the PPO level of benefits will be paid. If you or your Dependent are not seen by that facility, the Physician Visit Charges Copay, if any, will not apply, but the PPO level of benefits will be paid.

If you or a Dependent go to a PPO or Non-PPO Physician's office or clinic and the Physician does not send the laboratory work to LabOne facility but instead sends the laboratory work to non-PPO facility, the level of benefits for Non-Preferred Providers will apply.

If you or a Dependent go to a LabOne facility, We will pay 100% of Covered Charges for the Laboratory Services. If the laboratory facility is not a LabOne facility but is a PPO facility, the Physician Visit Charges Copay, if any, will apply and the PPO level of benefits will be paid. If the facility is not a Preferred Provider, the level of benefits for Non-Preferred Providers will apply.

## Medical Emergency

If you or one of your Dependents require treatment for a Medical Emergency, either within the PPO Service Area or outside the PPO Service Area, and cannot reasonably reach a Preferred Provider, benefits for such treatment received will be paid as if the treatment had been provided by a Preferred Provider.

## BENEFIT MAXIMUMS

Overall Lifetime Maximum Payment Limit ..... Unlimited

As described below, there are Maximum Payment Limits applicable to certain medical Treatment or Service.

The Hospital room and board maximum for confinement in other than an Intensive Care Unit of the Hospital is ..... \$200 per day (no dollar limit if a PPO facility is used).

The Hospital room and board maximum for confinement in an Intensive Care Unit of the Hospital is ..... \$500 per day (no dollar limit if a PPO facility is used).

Mental Health Behavioral, Alcohol or Drug Abuse Treatment or Service ..... See benefits under Special Payment Conditions.

Ambulance Services..... \$5,000 per person/per calendar year

Hospice ..... \$60 per day and \$4,000 for any one Episode of Hospice Care

Skilled Nursing Facility Confinement ..... \$100 per day and 120 days for all confinements resulting from the same sickness or injury

Acupuncture treatment..... \$500 per calendar year

Special footwear..... \$500 during an insured person's lifetime

## Your Responsibilities

- **If you use providers outside the PPO network**, your medical ID card includes a toll-free telephone number to call for Hospital Admission Review and Presurgery Review approvals. You must follow all of the requirements described on page GH 407 CC -- Utilization Management Program or your benefits will be reduced.
- **If you use providers within the PPO network**, your PPO Physician automatically handles the Hospital Admission Review and the Presurgery Review approvals.

See page GH 146 for important claim procedures information on filing your medical claims.

Refer to the Description of Benefits section for specific details on the preapproval requirements for these services.

### MAIL ORDER MAINTENANCE PRESCRIPTION DRUGS

#### Benefits Payable

For each prescription and each refill..... 100% of Covered Charges in excess of the Copay Amount

#### Copay Amount

For each prescription and each refill, a Copay of:

- For Generic Prescription Drugs ..... \$15
- For Preferred Brand Name Prescription Drugs..... \$30
- For non-Preferred Brand Name Prescription Drugs  
and all other drugs ..... \$45

Charges incurred under the Comprehensive Medical benefits cannot be used to satisfy the Prescription Drugs Copay amount and vice versa.

In addition, charges incurred under this section for Prescription Drugs cannot be used to satisfy the Comprehensive Medical Stop Loss Expense limits.

**You will receive a list from Us showing those drugs that are included on the Preferred Brand Name Drugs list. When you receive a prescription from your Physician, you should encourage the Physician to prescribe one of the drugs from the list. Explain that your drug cost is significantly lower when you use a Preferred Brand Name Drug. Your employer also has a copy of this list.**

See page GH 433 for a complete description of Mail Order Maintenance Prescription Drugs Expense Insurance.

## **HOW TO BE INSURED - MEMBERS**

### **MEDICAL EXPENSE INSURANCE**

#### **Eligibility**

To be eligible for insurance you must be a Member.

**Member** means any person who is:

- regularly scheduled to work for a Subscribing Employer; and
- a Member of the Union.

Member will also include any such person retired on or after September 1, 1981, under the Southern California I.B.E.W. – N.E.C.A. Pension Plan provided that they meet the eligibility and contribution requirements established for the trust.

#### **Effective Date**

If you are in an eligible class, you will become eligible for insurance on the first day of the second calendar month next following any period of three consecutive calendar months during which you complete a total of at least 400 employment hours.

#### **Continuing Eligibility**

You will continue to be eligible for insurance each calendar month, provided:

- you continue to be a Member as defined; and
- your Hour Bank Account will be debited with 135 employment hours each calendar month to provide insurance coverage for that month.

#### **Deletion of Hour Bank**

The Hour Bank Account will be deleted in its entirety at the end of the fifth consecutive month in which no hours have been reported except that this provision will not apply to a Frozen Hour Bank or to a Member who is self-paying premiums. See the following pages for Frozen Hour Bank and Self-Pay provisions.

**NOTE:** Because hours can accumulate in an Hour Bank Account over a period of years, the Administrator must be contacted immediately regarding discrepancies in the Hour Bank Account.

#### **Maximum Bank**

At no time will the number of hours in the Hour Bank Account, after deductions have been made for the current month, exceed 675.

You may elect to cover your spouse as a Dependent even though such spouse is also insured under the Group Policy as a Member, provided the spouse otherwise qualifies as a Dependent and the Member remains insured under the Group Policy. With respect to such spouse, benefits payable shall be subject to the terms and conditions described in the Coordination with Other Benefits section of this book, and in no event shall exceed 100% of the charge for the covered Treatment or Service.

You will not be eligible for Comprehensive Medical Expense Insurance under the Group Policy while you are covered under an HMO. You may, however, be eligible for all other benefits provided under this plan which apply to your class.

### **Eligibility Provisions (Retired Members)**

You are eligible for Comprehensive Medical Insurance on the date you retire from active employment, provided:

- you are under the Southern California I.B.E.W.-N.E.C.A. Pension Plan; and
- you meet the eligibility and contributions requirements established by the Trust.

### **Effective Date of Insurance for retired Members**

Your medical insurance will become effective on the date you become eligible for insurance as determined by the Eligibility Provisions listed above.

### **Individual Incontestability and Eligibility**

All statements made by any person insured (you or one of your Dependents) will be representations and not warranties. In the absence of fraud, these statements may not be used to contest the insured person's insurance unless:

- the insurance has been in force for less than two years during the insured person's lifetime; and
- the statement is in Written form Signed by the insured person; and
- a copy of the form which contains the statement is given to the insured person or the insured person's beneficiary at the time insurance is contested.

However, the above will not preclude the assertion at any time of defenses based upon the person's not being eligible for insurance under the Group Policy or upon other provisions of the Group Policy.

In addition, if a person's age is misstated, We may, at any time, adjust premiums and benefits to reflect the correct age.

We may at any time terminate a Member's or Dependent's eligibility under the Group Policy:

- In Writing and with 31-day notice, if the individual submits any claim that contains false or fraudulent elements under state or federal law;

- In Writing and with 31-day notice, upon finding in a civil or criminal case that a Member or Dependent has submitted claims that contain false or fraudulent elements under state or federal law;
- In Writing and with 31-day notice, when a Member or Dependent has submitted a claim which, in good faith judgment and investigation, a Member or Dependent knew or should have known, contains false or fraudulent elements under state or federal law.

### **Statement of Health Requirements**

A statement of health, in a form provided by The Principal, may be required from you when you first request insurance under this plan. The statement of health will be used for rating the group, case management or reinsurance purposes. In no event will a person be declined for insurance, or charged an additional premium, due to his or her health status.

### **Effective Date for Benefit Changes**

A change in your Scheduled Benefit amount because of a change in your status (insurance class) will be effective on the date of change in status.

A change in the Scheduled Benefits because of a change in the schedule of insurance elected by the Policyholder will be effective on the date of change.

### **Effective Date On Transfer From An HMO**

If the Policyholder offers coverage under an HMO as alternative coverage and if you would otherwise be eligible for coverage under the Group Policy, as provided above, you may transfer from an HMO to this coverage:

- During the annual open enrollment period designated by the Policyholder or such transfer.
- On any date you are transferred or otherwise change residence out of the HMO service area; or on any date the HMO ceases to operate.

If you transfer to this plan from the HMO, you must provide proof of enrollment in the HMO. Enrollment must have terminated on the day before the date of transfer to this plan. If no proof of enrollment is provided, you will be subject to the Late Enrollment provisions described above.

### **Termination**

Unless continued as provided below or on Continuation of Coverage, COBRA Continuation, FMLA, and USERRA, your insurance under the Group Policy will cease on the earliest of:

- the date the Group Policy terminates; or
- the end of the calendar month in which you cease to belong to a class for which insurance is provided; or
- the end of the calendar month in which you cease to be a Member; or

- the end of the calendar month in which you cease to be actively employed; or
- the last day of the calendar month in which your Hour Bank Account balance is less than 135 Employment Hours, after being debited by 135 Employment Hours, to continue the coverage for that calendar month; or
- the date you transfer to an HMO offered by the Policyholder as an alternative to coverage under the Group Policy.

**Termination (Retired Members)**

Your insurance will terminate at the earliest time indicated below:

- the last day of the calendar month for which the last premium payment is made for your insurance.
- on the date you attain age 65.

**Reinstatement of Eligibility:**

- If your insurance terminates at any time because there are less than 135 employment hours in your hour bank account, and if, within a period of five consecutive calendar months immediately following such termination, your hour bank account shows a balance of at least 135 employment hours, you will again become eligible for insurance on the first day of the second calendar month next following the calendar month in which your hour bank account shows a balance of at least 135 employment hours. However, if you worked under the Collective Bargaining Agreement of the Union at least 1,000 hours in each of the last five consecutive years immediately preceding such termination, you will again become eligible for insurance if, within five years after your insurance terminated, your bank is credited with at least 135 employment hours in a single calendar month, provided you furnish the Administrator's Office with necessary proof as to your eligibility for reinstatement. In the event your insurance is not reinstated within such period, you will not again become eligible for insurance until you have completed the eligibility requirements as specified under Eligibility Provisions, Initial Eligibility.
- If your insurance terminates because of your entry into full-time military, naval, or air service and if you return to active work in an eligible class with a Subscribing Employer within 90 days from the date of discharge from such service, you will again become eligible for insurance on the date you return to active employment in an eligible class, provided your reserve account on entry into such service contained at least 135 employment hours.

**Continuation**

If you cease to be actively employed because of retirement, your Medical Expense Insurance may be continued until the date it would otherwise terminate as described above.

If you cease to be actively employed, insurance may be continued on a limited basis.

In addition, by paying the required contribution, if any, your insurance may be continued under the continuation provisions described on Continuation of Coverage, COBRA Continuation, FMLA, and USERRA.

If you are interested in continuing your insurance beyond the date it would normally terminate, you should consult with the Policyholder before your insurance terminates.

## **HOW TO BE INSURED - DEPENDENTS**

### **MEDICAL EXPENSE INSURANCE**

#### **Eligibility**

You will be eligible for insurance for your Dependents on the latest of:

- the date you are eligible for Member insurance; or
- the date you enter a class for which Dependent insurance is provided; or
- the date you first acquire a Dependent.

#### **Effective Date**

Dependent insurance is available only with respect to Dependents of Members currently insured for Member insurance. If a Member is eligible for Dependent insurance, such insurance will become effective under the same terms as described earlier for Member insurance, except any required statement of health will be with respect to the health of your Dependents.

If Dependent insurance is then in effect for any other Dependent, a new Dependent will be insured on the date acquired. Request for insurance is not required provided We are notified of the new Dependent within 31 days after the date the Dependent is acquired. With respect to medical benefits for a newborn or newly adopted Dependent Child, effective-date provisions are modified as described below.

#### **Insurance for a Newborn or Newly Adopted Child**

A newly born or newly adopted Dependent Child will be insured for medical benefits from the moment of birth or calendar month on the date of adoption or Placement for Adoption (whichever is earlier), provided the child meets the definition of a Dependent Child. Any applicable prior-application or first of the calendar month provisions will be waived with respect to such child. With respect to a newborn child, no premium will be charged for the child's coverage during the 31-day period following the date of birth.

However, if you are required to contribute toward the cost of Dependent insurance, you must notify Us within 31 days after the date of birth, adoption or Placement in order to continue the child's insurance beyond the 31-day period. If such notice is not given to Us within the 31-day period, the child will be subject to the Late Enrollment provisions.

If the child's insurance terminates because you fail to request insurance (or pay the required premium) within the 31-day period, following the child's date of birth, adoption or Placement, benefits will be payable only for covered expenses incurred by the child during the 31-day period in which insurance was in force. The Individual Purchase Rights and the Extended Benefits (after termination of insurance) will not apply to the child.

## **Individual Incontestability and Eligibility**

Your Dependents will be subject to the Individual Incontestability and Eligibility as described earlier for Member insurance.

## **Termination**

Unless continued as provided on Continuation of Coverage, COBRA Continuation, FMLA and USERRA:

- Insurance for all of your calendar month Dependents will terminate on the earliest of:
  - the end of the in which you cease to belong to a class for which Dependent insurance is provided; or
  - the date Dependent coverage is removed from the Group Policy; or
  - the date your Member insurance ceases.
- Insurance for any one Dependent will terminate on the last day of the calendar month in which he or she ceases to be your Dependent.

However, insurance will be continued beyond the maximum age for a Dependent Child who is incapable of self-support because of a Developmental Disability or Physical Handicap and is dependent on you for primary support. You must apply for this continuation within 31 days after the child reaches the maximum age.

If you should die while insured under the Group Policy with respect to a qualified Dependent, your Hour Bank Account will remain open and will be debited with 135 Employment Hours each month to provide Dependents Insurance with respect to such Dependent during such month. Your Dependent Medical Expense Insurance with respect to such Dependent will terminate on the last day of the calendar month in which the number of Employment Hours in your bank account does not equal at least 135 hours.

## **Continuation**

In addition, under certain conditions, your Dependent's Medical Expense Insurance may be continued after the date it would normally terminate. See the continuation provisions described on page Continuation of Coverage, COBRA Continuation, FMLA, and USERRA.

## CONTINUATION OF COVERAGE

### Self-Pay

Your insurance will terminate at the earliest date indicated below:

- On the last day of the calendar month in which your hour bank account, after being debited with the 135 employment hours necessary to provide insurance during such month, has a balance of less than 135 employment hours.

### Self-Pay Opportunities

- You may continue to pay monthly contributions directly to the Trustees for your medical insurance in an amount as established from time-to-time by the Trustees, provided you were eligible by reason of hours worked in the month immediately preceding the month for which self-pay commences.
- Effective on and after February 1, 1993, if your hour bank account is below 135 hours and you elect to self-pay, you may "zero-out" the account hours in your bank at your current contribution rate. In other words, you may use the hours now in your bank and "buy" the additional hours necessary to total 135. For example, if your bank is at 100 hours and you elect to self-pay, you may use these 100 hours and "buy" 35 at your current contribution rate.

The election to "zero-out" your hours must be made with your election to self-pay. If you elect to self-pay, but not to zero-out your hours, you will **not** be given another opportunity to "zero-out" your bank--unless or until you re-establish eligibility and then begin a new self-pay period.

- On the date you enter into full-time military, naval or air service.
- On the date you cease to be a member of a class of persons eligible for insurance.
- On the date of discontinuance of the policies with respect to class of persons of which you are a member.
- Upon payment of monthly disability benefits for the maximum period for which monthly benefits are payable under the Group Disability Insurance Policy for any one period of total disability.

### Frozen Hour Bank

An insured person may have their hour bank frozen at its current level if:

- He or she has at least 135 hours in his Hour Bank Account.
- He or she is Totally Disabled by bodily injury or illness, which prevents him/her from performing any gainful employment.

- He or she submits a letter from his/her doctor certifying Total Disability from injury or illness.

The **Initial Period** of freezing an hour bank shall be up to 3 months. An extension of two separate additional periods of up to 3 months may be applied for and approved by the Trustees as they consider appropriate. The overall maximum period for which frozen hour banks will be granted is 9 months.

The **Effective Date** of the freezing of an hour bank shall be the first day of the month closest to receipt of notification of disability by the **Administrator's Office**. Receipt of notification is clarified to mean a phone call, letter or personal visit by the disabled employee, attending Physician or any other person reasonably deemed to be knowledgeable about the employee's disability. A Written statement from the disabled employee's Physician is mandatory before the freeze can be approved; however, the date of freeze will be calculated based upon the first notification which, as described above, may be communicated by phone or in person.

The first day of the month closest to receipt of notification of disability is calculated as follows:

- In every month EXCEPT FEBRUARY, if notification is received from the first of the month through and including the 16th of the month, the freeze begins on the first of that month. In every month EXCEPT FEBRUARY, if notification is received from the 17th of the month through and including the last day of the month, the freeze begins on the first of the following month.
- In FEBRUARY (with either 28 or 29 days), if notification is received from the first of the month through and including the 15th of the month, the freeze begins on February 1. If notification is received from the 16th of the month through and including the last day of the month, the freeze begins March 1.

### **Recurrent Disabilities**

If a period of total disability, which has resulted in a frozen hour bank, was occasioned by or is contributed to by the same cause or causes as a previous period of Total Disability which resulted in a frozen hour bank, and if the two periods are separated by less than six consecutive months of active availability for work, the two periods of disability shall be deemed to be one continuous period of disability. Further, the maximum period for which a frozen hour bank will be granted shall apply to the combined period of disability.

### **Dependents who Lose Eligibility Due to Your Death**

If you should die while insured, your Dependent's Medical Expense Insurance will be continued without contributions until the earlier of:

- the date the Group Policy terminates; or
- the date insurance has been continued for three months.

If you should die while insured and are a retired Member who is 65 years of age or older, insurance may be continued for your Dependent spouse and Dependent children, subject to the proper payment of premium, until your Dependent spouse reaches age 65.

This continuation period will be concurrent with the COBRA or state continuation period.

**State Required Continuation – California: Member**

**Member is 60 Years or Older, Employed at least Five Years, and has Completed COBRA Continuation**

You qualify for state-required continuation beyond the COBRA continuation period if:

- the COBRA Qualifying Event was your termination of employment; and
- on the date your employment terminated, you had worked for the Policyholder for at least five years and were 60 years of age or older; and
- you were entitled to COBRA and elected to continue benefits under COBRA; and
- the maximum continuation period under COBRA has been exhausted.

Your insured spouse has a separate right to elect continuation, provided you qualify as stated above and your spouse was insured as a Dependent under your COBRA coverage.

If elected, continuation will begin on the date following the end of the maximum COBRA continuation period and will end on the earliest of:

- the date you reach age 65; or
- for your spouse, the date five years after the date COBRA was scheduled to end; or
- the end of the period for which premium is paid, if payment of a required premium is not made within the Grace Period; or
- the date you or your spouse are covered under any other health plan, regardless of whether that coverage is less valuable; or
- the date you or your spouse are entitled to Medicare; or
- the date the Group Policy terminates.

**Member Whose COBRA Qualifying Event Occurred on or after January 1, 2003 and has Completed COBRA Continuation**

- **Definitions**

**Qualified Person** means a Member or any covered Dependent who, on the day before a Qualifying Event described below, is covered under the Group Policy by means of electing COBRA continuation due to termination of employment or reduction in work hours for reasons other than gross misconduct. Qualified Person will also include any child born to or placed for adoption with the Member who is on continuation.

**Qualifying Event** means, except for the election to continue coverage, insurance would otherwise cease due to the Member's completion of the COBRA maximum continuation period of 18 months (or 29 months if determined disabled under COBRA provisions).

- **Qualification for Continuation**

Qualified Persons who would lose insurance under the Group Policy because of a Qualifying Event may elect to continue insurance on the date insurance would otherwise cease if:

- the Group Policy is in force; and
- the Qualified Person timely elects to continue insurance and agrees to pay the required premium; and
- the Qualified Person is not entitled to Medicare; and
- the Qualified Person is not covered under any other health plan in which the pre-existing exclusion provisions have been satisfied; and
- the Qualified Person is not covered or eligible for COBRA continuation as a dependent.

- **Period of Continuation**

Insurance for the Qualified Person may be continued until the earliest of:

- the date the Group Policy is terminated; or
- the date insurance would otherwise cease as provided in the Group Policy; or
- the end of the period for which premium is paid, if payment of the required premium is not made within the Grace Period; or
- the date the Qualified Person becomes entitled to Medicare; or
- the date the Qualified Person becomes covered by any other health plan and has satisfied the preexisting exclusion provision (if any); or
- the date the Qualified Person becomes covered or eligible for COBRA continuation as a dependent; or
- the date insurance has been continued for 36 months dating back to the original COBRA Qualifying Event.

For a Member's child who is born to or placed for adoption with the Member while on continuation, the maximum continuation period for that child will be the Member's maximum continuation period.

- **Notice, Election, and Premium Requirements**

The Administrator's office will notify a Qualified Person of the availability to continue insurance prior to the date COBRA continuation will terminate. The notification will include premium information and an election form and will be mailed to the Qualified Person's last known address.

Qualified Persons must notify the Administrator's office within 30 days of the date a child is born to or placed for adoption with the Member.

If the Group Policy terminates, Qualified Persons may elect to complete the remaining continuation period under the employer's replacing plan, if any. Qualified Persons must elect continuation and pay the required payment within 30 days after receiving the replacing carrier's notice.

Premium charged for the continuation will be 110% of the applicable group rate.

The first premium payment must be delivered to the Administrator's office by first class or certified mail (or other reliable means) within 45 days after the date of election. The first premium payment must be sufficient to pay all required payments. Failure to make the first payment as required will disqualify the Qualified Person from continuation. All subsequent payments are due monthly on or before the due date. Failure to make the required premium payment with the Grace Period will disqualify the Qualified Person from continuation.

**During a Labor Dispute.** Arrangements may be made to continue your insurance if your active employment ceases because of a labor dispute. You may continue your insurance up to six months, but only if certain conditions of the Group Policy are met (including payment of the required contribution by at least 75% of the eligible Members). See your employer to make arrangements for continuing your insurance. Your insurance will be terminated unless you make arrangements within 31 days after you cease active employment because of the labor dispute.

**State Required Continuation – California Dependents**

**After Termination of the COBRA Continuation Period**

Your former spouse, whether you are an employee or former employee, who was a covered Dependent under the Group Policy, qualifies for state-required continuation beyond the COBRA continuation period if:

- the COBRA Qualifying Event was divorce from you, or your death; and
- your former spouse was entitled to COBRA and elected to continue benefits under COBRA; and
- the maximum continuation under COBRA has been exhausted.

If elected, continuation will begin on the date following the end of the maximum COBRA continuation period, and will end on the earliest of:

- the date your former spouse reaches age 65; or

- the date five years after the date COBRA was scheduled to end; or
- the end of the period for which premium is paid, if payment of a required premium is not made within the Grace Period; or
- the date your former spouse is insured under any other group health plan, regardless of whether that insurance is less valuable; or
- the date the former spouse becomes entitled to Medicare; or
- the date the Group Policy terminates.

## COBRA CONTINUATION

### Federal Required Continuation - Consolidated Omnibus Budget Reconciliation Act (COBRA)

COBRA applies to any employer (excepting the federal government and religious organizations) who: (a) maintains group health coverage; and (b) normally employed 20 or more employees on a typical business day during the preceding calendar year. For this purpose, "employee" means full-time employees and full-time equivalent for part-time employees.

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) requires that your group insurance allow qualified persons (described below) to continue group health coverage after it would normally end. The term "group health coverage" includes any medical, dental, vision care, and prescription drug coverages that are included.

#### A. Qualified Persons/Qualifying Events

Continuation of group health coverage must be offered to:

- (1) a Member (and any covered Dependents) following:
  - (a) termination of employment for a reason other than gross misconduct; or
  - (b) a reduction in work hours.

(Note: Taking a family or medical leave under the Federal Family & Medical Leave Act (FMLA) is not a qualifying event under COBRA. A Member qualifies for COBRA when the Member (i) does not return to work after completion of FMLA leave; or (ii) notifies the employer of the intent not to return to work during a FMLA leave); and
- (2) a Member's former spouse (and any Dependent Children) following a divorce or legal separation from the Member; and
- (3) a Member's surviving spouse (and any Dependent Children) following the Member's death; and
- (4) a Member's Dependent Child following loss of status as a Dependent under the terms of the Group Policy (e.g., attaining the maximum age, marriage, joining the armed forces, etc.); and
- (5) a Member's spouse (and any Dependent Children) following the Member's entitlement to Medicare and decision to terminate employment, reduce work hours, or drop group coverage; and
- (6) a Member's Dependent Child who is born to or placed for adoption with the Member who is on COBRA continuation due to termination of employment or reduction in work hours; and
- (7) if the Group Policy covers retired Members, a retired Member and his/her Dependents (or surviving Dependents) when retired health benefits are "substantially eliminated" or terminated within one year before or after an employer's Chapter 11 (United States Code) bankruptcy proceedings.

Note: Persons who, after the date of COBRA continuation election, become entitled to Medicare or become covered under another group health plan and have satisfied the preexisting exclusion provision, are not eligible for continued coverage. However, if the Group Policy covers retired Members, continued coverage for retired persons and their Dependents (or surviving Dependents) due to qualifying event A (7) above may not be terminated due to Medicare coverage.

## **B. Qualifying Events/Continuation Period**

Following a qualifying event, health coverage can continue up to the maximum continuation period. The maximum continuation period for a Member (and any Dependents) following a termination of employment or reduction in work hours is 18 months. For a Member's Dependent Child that is born to or placed for adoption with the Member while on COBRA continuation, the maximum continuation period for that child will be the Member's maximum continuation period.

Following a termination of employment or reduction in work hours, a qualified person may request an 11-month extension of COBRA continuation. The maximum COBRA continuation will be 29 months (see Disabled Extension, Section D).

When a Member becomes entitled to Medicare before employment terminates, work hours are reduced, or a decision to drop coverage, the maximum continuation period for the Dependents will be the longer of:

- (1) 36 months dating back to the Member's entitlement to Medicare; or
- (2) 18 months from the date of the qualifying event (termination of employment, reduction in work hours, or decision to drop group coverage).

The maximum continuation period for qualified Dependents following a qualifying event described in A (2) through A (4) is 36 months.

If the Group Policy covers retired Members: For a retired Member on continued coverage under A (7) above (Chapter 11 bankruptcy) the continuation period ends on the date of his/her death. For a retired Member's surviving Dependents, continued coverage ends on the date 36 months after the retired Member dies.

## **C. Second Qualifying Events/Continuation Period**

If during an 18-month continuation period (or, 29 months for qualified persons on the disabled extension), a second qualifying event described in A(2) through A(5) occurs, the maximum continuation period can be extended for the qualified Dependents up to 36 months. That is, following a second qualifying event, qualified Dependents may continue for up to a maximum of 36 months dating from the Member's termination of employment or reduction in work hours. A Member's Dependent Child who is born to or placed for adoption with the Member who is on COBRA continuation may also be eligible for a second qualifying event that occurred prior to birth or placement for adoption.

**Note: Qualified Dependents must request extended continued coverage within 60 days after a second Qualifying Event occurs.**

#### **D. Disabled Extension**

Following a termination of employment or reduction in work hours, a qualified person (Member or Dependent) who has been determined disabled by the Social Security Administration either before or within 60 days after a qualifying event may request an extension of the continued coverage from 18 months to 29 months. A Member's Dependent Child who is born to or placed for adoption with the Member who is on COBRA continuation must be determined disabled by the Social Security Administration within 60 days after the date of birth or placement for adoption. The disabled extension applies to each qualified person (the disabled person and any family members) who is not disabled, who are entitled to COBRA continuation as a result termination of employment or reduction in work hours.

The qualified person must submit a written request for the extension to the employer (plan administrator) within 60 days after receiving the Social Security determination. If a request for the extension is not made (a) within 60 days after the Social Security disability determination is received; and (b) before the 18-month continuation ends, the right to the 11-month extension expires. The 11-month extension for all qualified persons will end the earlier of (a) 30 days following the date the disabled person is no longer determined by Social Security to be disabled, or (b) the date continuation would normally end as outlined in Section E below.

#### **E. Termination of Continued Coverage**

Continued coverage ends the earliest of the following:

- (1) the date the maximum continuation period ends; or
- (2) the date the qualified person enrolls in Medicare; or
- (3) the end of the last coverage period for which payment was made if payment is not made prior to the expiration of the grace period. (See Grace Period, Section I.); or
- (4) the date the employer's group health insurance is terminated (and not replaced by another group health plan); or
- (5) the date the qualified person becomes covered by and has satisfied the preexisting exclusion provision of another group health plan.

#### **F. Employer Notification Requirement**

Qualified persons must be notified of the right to elect continuation of group health coverage within 14 days after a qualifying event. Qualified persons must make written election within 60 days after the later of (1) the date coverage would normally end, or (2) the date of the election notice. The election notice must be returned to the employer within this 60-day period; otherwise the right to elect continuation ends. Persons electing continued coverage have 45 days after the election date to remit the first payment. All remaining payments must be received no later than: (a) 30 days after the first day of each month; or (b) within the 31-day Grace Period (see Grace Period, Section I).

#### **G. Qualified Person Notification Requirement**

Qualified persons must notify the employer within 60 days after (a) a divorce or legal separation from the Member, and (b) the date a child ceases to be a Dependent Child under the

terms of the insurance. Within 14 days following notice by the qualified person of these qualifying events, the employer must provide the qualified person with an election notice. Qualified persons must elect to continue coverage within this 60-day period after receipt of the election notice, otherwise the right to elect ends. Payment must be made within the time limits explained above.

#### **H. Monthly Cost**

Persons electing continued coverage can be required to pay 102% of the cost for the applicable coverage (COBRA permits the inclusion of a 2% billing fee). Persons who qualify for the disabled extension and are not part of the family unit that includes the disabled person can be required to continue to pay 102% of the cost for the applicable coverage. Persons who qualify for the disabled extension and are part of the family unit that includes the disabled person can be required to pay 148% of the cost for the applicable coverage (plus a 2% billing fee) for the 19th through the 29th month of coverage (or through the 36th month if a second qualifying event occurs during the disabled extension).

#### **I. Grace Period**

"Grace Period" means the first 31-day period following a premium due date. Except for the first premium (see Section F), a Grace Period of 31 days will be allowed for payment of premium. Continued coverage will remain in effect during the Grace Period provided payment is made prior to the expiration of the Grace Period. If payment is not made prior to the expiration of the Grace Period, continued coverage will terminate at the end of the last coverage period for which payment was made.

#### **J. Policy Changes**

Continued coverage will be subject to the same benefits and rate changes as the group coverage.

#### **K. Newly Acquired Dependents**

A qualified person may elect coverage for a Dependent acquired during COBRA continuation. All enrollment requirements that apply to Dependents of active Members apply to Dependents acquired by qualified persons during COBRA continuation.

Coverage for a newly acquired Dependent will end on the same dates as described for qualified persons in Section B above. Exception: Coverage for newly acquired Dependents, other than the Member's Dependent Child who is born to or placed for adoption with the Member, will not be extended as a result of a second qualifying event.

#### **L. Individual Purchase Rights**

When a qualified person is no longer eligible for continued coverage, he/she may apply for Individual Purchase. Persons who are eligible for similar benefits, which would result in over-insurance, may not purchase conversion coverage. An application for Individual Purchase will be provided 180 days prior to the end of the maximum continuation period. Application for Individual Purchase, and payment of the required premium, must be made within 31 days after the continued coverage ends. Dental, Vision Care, and Prescription Drug coverages are not included with the Individual Purchase Option (however, benefits for prescription drugs are included in the Individual Purchase coverage).

**NOTE:** Under some circumstances insurance under this Group Policy may be extended beyond the maximum COBRA continuation period. See “State Required Continuation – California” on the “Continuation of Coverage” page in this booklet.

## FEDERAL FAMILY AND MEDICAL LEAVE ACT (FMLA)

### Continuation

Federal law requires that Eligible Employees be provided a continuation period in accordance with the provisions of the Federal Family and Medical Leave Act (FMLA).

This is a general summary of the FMLA and how it affects the Group Policy. See your employer for details on this continuation provision.

### FMLA and Other Continuation Provisions

If your employer is an Eligible Employer and if the continuation portion of the FMLA applies to your coverage, these FMLA continuation provisions:

- are in addition to any other continuation provisions of the Group Policy, if any; and
- will run concurrently with any other continuation provisions of the Group Policy for sickness, injury, layoff, or approved leave of absence, if any.

If continuation qualifies for both state and FMLA continuation, the continuation period will be counted concurrently toward satisfaction of the continuation period under both the state and FMLA continuation periods.

### Eligible Employer

Eligible Employer means any employer who is engaged in commerce or in any industry or activity affecting commerce who employs 50 or more employees for each working day during each of 20 or more calendar workweeks in the current or preceding calendar year.

### Eligible Employee

Eligible Employee means an employee who has worked for the Eligible Employer:

- for at least 12 months; and
- for at least 1,250 hours (approximately 24 hours per week) during the year preceding the start of the leave; and
- at a work-site where the Eligible Employer employs at least 50 employees within a 75-mile radius.

For this purpose, "employs" has the meaning provided by the Federal Family and Medical Leave Act (FMLA).

## **Mandated Unpaid Leave**

Eligible Employers are required to allow 12 workweeks of unpaid leave during any 12-month period to Eligible Employees for one or more of the following reasons:

- The birth of a child of an Eligible Employee and in order to care for the child.
- The placement of a child with the Eligible Employee for adoption or foster care.
- To care (physical or psychological care) for the spouse, child, or parent of the Eligible Employee, if they have a "serious health condition".
- A "serious health condition" that makes the Eligible Employee unable to perform the functions of his or her job.

## **Reinstatement**

An Eligible Employee's terminated insurance may be reinstated in accordance with the provisions of the Federal Family and Medical Leave Act (FMLA).

See your employer for details on this reinstatement provision.

## **UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT OF 1994 (USERRA)**

Federal law requires that if your insurance would otherwise end because you enter into active military duty, you may elect to continue insurance (including Dependents insurance) in accordance with the provisions of Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA).

### **Continuation**

If active employment ends because you enter active military duty, insurance may be continued until the earliest of:

- for you and your Dependents:
  - the date the Group Policy is terminated; or
  - the end of the premium period for which premium is paid if you fail to make timely payment of a required premium; or
  - the date 18 months after the date you enter active military duty; or
  - the date after the day in which you fail to return to active employment or apply for reemployment with the Policyholder.
  
- for your Dependents:
  - the date Dependent Medical Expense Insurance would otherwise cease as provided on GH 125 A; or
  - any date desired, if requested by you before that date.

The continuation provision will be in addition to any other continuation provisions described in the Group Policy for sickness, injury, layoff, or approved leave of absence, if any. If you qualify for both state and USERRA continuation, the election of one means the rejection of the other.

### **Reinstatement**

For Medical Expense Insurance, the reinstatement time period may be extended for an approved leave of absence taken in accordance with the provisions of the federal law regarding USERRA.

This is a general summary of the USERRA and how it affects your Group Policy. See your employer for details on this continuation provision.

## DESCRIPTION OF BENEFITS

### MEDICAL EXPENSE INSURANCE (PAYMENT PROVISIONS)

#### Benefit Qualification

To qualify for payment of the benefits provided by your plan, for an insured class, you and your Dependents must:

- be insured in that class on the date medical Treatment or Service is received; and
- satisfy the requirements listed in the CLAIM PROCEDURES Section.

#### Benefits Payable

Benefits payable will be as described in this section, subject to:

- all listed limitations; and
- the terms and conditions of Utilization Management Program, Coordination With Other Benefits, and Subrogation and Reimbursement.

#### Benefits Payable – Required by Federal Law

Subject to the benefits payable provisions as described above, benefits will be payable for:

- **Pediatric Vaccines**

Covered Charges will include the cost of Pediatric Vaccines administered to a Dependent Child from birth through 18 years of age.

"Pediatric Vaccines" mean those vaccines shown on the list established and periodically reviewed by the Advisory Committee on Immunization Practices as referenced by Section 1928 of Title 19 of the Social Security Act or such other list of vaccines as mandated by other Federal or State laws that are applicable to this coverage.

Benefits for Pediatric Vaccines will be paid at 100% of Prevailing Charges and no Deductible or Copay will be applied.

- **Newborns' and Mothers' Health Protection Act of 1996**

Under Federal Law, Group Health Plans generally may not restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's Physician, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, a Group Health Plan may not, under Federal law, require that a provider obtain authori-

zation from the Group Health Plan for prescribing a length of stay not in excess of 48 hours (or 96 hours).

See "Maternity Coverage" under Benefits Payable - State-Required – California below for description of how benefits will be payable under the Group Policy.

- **Women's Health and Cancer Rights Act of 1998**

Under Federal law, group health plans and health insurance issuers providing benefits for mastectomy must also provide, in connection with the mastectomy for which the participant or beneficiary is receiving benefits, coverage for:

- reconstruction of the breast on which the mastectomy has been performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- prostheses and physical complications of mastectomy, including lymphedemas;

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

Also see "Breast Cancer Treatment" under Benefits Payable – State Required – California below.

**Benefits Payable - Transplant Services**

"Transplant Services" means Covered Charges incurred in connection with the Covered Transplants listed below that are for Medically Necessary Care and not considered to be an Experimental or Investigational Measure. The following benefits will be payable for Treatment or Service for Transplant Services. These benefits will be payable instead of any other benefits described in this booklet, except as otherwise provided in this section.

- **Covered Transplants**

A transplant recipient who is covered under the Group Policy will be eligible to receive the following human-to-human organ or bone marrow transplant procedures, subject to all limitations and maximums described in this section:

- Heart;
- Heart/lung (simultaneous);
- Lung;
- Liver;
- Kidney;
- Kidney/pancreas;
- Cornea;
- Skin;
- Bone marrow transplant or peripheral stem cell infusion when a positive response to standard medical treatment or chemotherapy has been documented. Unless otherwise indicated, coverage is for one transplant or infusion only within a 12 month period.

Benefits for these Transplant Services will be payable on the same basis as for any other sickness.

- **Covered Charges**

For the purpose of Benefits Payable - Transplant Services, Covered Charges will include all services listed in the general Comprehensive Medical Covered Charges section, as described in GH 407 B, including, but not limited to, Hospice, Skilled Nursing Facility, and services for Durable Medical Equipment as described in GH 407 B.

Benefits for these Transplant Services will be payable the same as any other sickness.

Covered Charges will also include charges incurred by the organ donor for a Covered Transplant if the charges are not covered by any other medical expense coverage.

- **Limitations**

The general Comprehensive Medical limitations as described in GH 407 B will apply to Transplant Services. In addition, limitations specific to Durable Medical Equipment, Hospice, and Skilled Nursing Facility provisions will apply to Transplant Services if those benefits are used in connection with a Covered Transplant. Additionally, benefits will not be payable for:

- cryopreservation and storage;
- if the transplant is not a Covered Transplant under this Plan, all charges related to the transplant will be excluded from payment under this Plan, including, but not limited to, dose-intensive chemotherapy; or
- animal-to-human organ transplants; or
- implantation within the human body of artificial or mechanical devices designed to replace human organ(s).

**Benefits Payable - Mental Health, Behavioral, Alcohol or Drug Abuse Treatment Services**

The following benefits will be payable for Mental Health, Behavioral, Alcohol or Drug Abuse Treatment Services. These benefits will be payable instead of any other benefits described in this booklet, except as otherwise indicated in this section. In the event you or one of your Dependents receive Treatment or Services for more than one condition during the same period of time, benefits will be payable based on the primary focus of the Treatment or Service, as determined by Us.

- **Mental Health or Behavioral Treatment Services (other than Severe Mental Illness) and Alcohol or Drug Abuse Treatment Services**

- **Inpatient Hospital Services**

If you or one of your Dependents is Hospital Inpatient Confined in a Psychiatric Hospital, an Inpatient Alcohol or Drug Abuse Treatment Facility or a psychiatric or alcohol/drug unit of a general Hospital, benefits will be payable for charges for room, board, and other usual services provided during such confinement, and for Physician Visits provided during such confinement.

Benefits will be payable as described below for not more than 30 days of inpatient services each calendar year for each insured person. Each day of Partial Hospitaliza-

tion or Day Treatment Services, as described below, will reduce this 30-day benefit by one day.

- **Partial Hospitalization or Day Treatment Services**

If you or one of your Dependents receive Partial Hospitalization or Day Treatment Services, benefits will be payable for such services as described in Benefits Payable below.

Partial Hospitalization or Day Treatment Services are subject to the Inpatient Hospital Services 30-day calendar year limit. Each day of Partial Hospitalization or Day Treatment Services will reduce the 30-day calendar year benefit by one day.

"Partial Hospitalization Facility or Day Treatment Facility" mean a Hospital or free-standing facility that is licensed by the proper authority of the state in which it is located to provide Partial Hospitalization or Day Treatment Services.

"Partial Hospitalization or Day Treatment Services" mean a structured program under the supervision of a Physician, which provides diagnostic and therapeutic Mental Health, Behavioral, Alcohol or Drug Abuse Treatment Services in a Partial Hospitalization Facility or Day Treatment Facility for not less than four and not more than 12 consecutive hours in a 24-hour period.

- **Outpatient Services**

Benefits are not payable for Outpatient Services for Mental Health, Behavioral, or Alcohol or Drug Abuse Treatment Services.

"Outpatient Services" mean Mental Health, Behavioral, including Physician Visits, which are provided other than while Hospital Inpatient Confined or receiving Partial Hospitalization or Day Treatment Services.

- **Physician Visits**

If you or one of your Dependents receive any Mental Health, Behavior by a Physician or Health Care Extender, benefits will be payable as follows:

- **While Hospital Inpatient Confined:** Benefits will be payable for Physician Visits when provided while the person is Hospital Inpatient Confined, only if they occur during the period for which inpatient Hospital benefits are payable. Benefits will be payable as described under Benefits Payable below.
- **While Receiving Partial Hospitalization or Day Treatment Services:** Benefits will be payable for Physician Visits when provided while the person is receiving Partial Hospitalization or Day Treatment Services, only if they occur during the period for which Partial Hospitalization or Day Treatment Services benefits are payable. Benefits will be payable as described under Benefits Payable below.

- **All Other Physician Visits:** Benefits for Physician Visits provided other than while Hospital Inpatient Confined or while receiving Partial Hospitalization or Day Treatment Services will be not be payable.
- **Benefits Payable**
  - **Inpatient Hospital Services:** Benefits will be payable as follows:
    - 70% of Covered Charges if medical care is received from Preferred Providers; and
    - 60% of Covered Charges if medical care is received from Non-Preferred Providers up to the Hospital per day maximum benefit amount.

Benefits payable will be subject to the same Deductible or Copay that applies to any other Hospital Inpatient Confinement, as well as the calendar year and lifetime maximum benefits described in Inpatient Hospital Services as shown above.

- **Partial Hospitalization or Day Treatment Services:** Benefits will be payable on the same basis as described above for Inpatient Hospital Services and will be subject to the calendar year Deductible, as well as the calendar year maximum benefits described in Partial Hospitalization or Day Treatment Services as shown above.
- **Outpatient Services:** Not payable
- **Physician Visits:** Benefits will be payable at 60% of Covered Charges.

Benefits payable will be subject to any applicable per-visit Copay or calendar year Deductible, as well as the applicable limit described above for Physician Visits.

Covered Charges incurred for outpatient laboratory services and for outpatient drugs and medicines requiring a Physician's prescription are payable the same as for any other covered Treatment or Service and are not subject to the limits described in this section.

Charges for Mental Health, Behavioral Treatment Services will not apply toward the Stop Loss Expense limits and will never be paid at 100%.

- **Severe Mental Illness**
  - **Inpatient Hospital**

If you or one of your Dependents receive Treatment or Service for a Severe Mental Illness or for the Serious Emotional Disturbances of a Child or Adolescent while Hospital Inpatient Confined in a Psychiatric Hospital or a psychiatric unit of a general Hospital, benefits will be payable for charges for room, board, and other usual services provided during such confinement, and for Physician Visits provided during such confinement.

Benefits will be payable the same as for any other covered Treatment or Service.

- **Partial Hospitalization or Day Treatment Services**

If you or one of your Dependents receive Partial Hospitalization or Day Treatment Services, benefits will be payable for such services the same as for any other covered Treatment or Service.

"Partial Hospitalization Facility or Day Treatment Facility" means a Hospital or free-standing facility that is licensed by the proper authority of the state in which it is located to provide Partial Hospitalization or Day Treatment Services.

"Partial Hospitalization or Day Treatment Services" mean a structured program under the supervision of a Physician, which provides diagnostic and therapeutic Mental Health or Behavioral Treatment Services in a Partial Hospitalization Facility or Day Treatment Facility for not less than four and not more than 12 consecutive hours in a 24-hour period.

- **Outpatient Services**

If you or one of your Dependents receive any Outpatient Services for a Severe Mental Illness or for the Serious Emotional Disturbances of a Child or Adolescent by a Physician or Health Care Extender, Hospital, or Community Mental Health Center, benefits will be payable the same as any other covered Treatment or Service.

"Outpatient Services" mean Mental Health or Behavioral Treatment Services, including Physician Visits, which are provided other than while Hospital Inpatient Confined or receiving Partial Hospitalization or Day Treatment Services.

- **Definitions**

For the purposes of this section:

"Severe Mental Illness" means any of the following mental illnesses: (a) Schizophrenia, (b) Schizoaffective Disorder, (c) Bipolar Disorder (manic-depressive illness), (d) Major Depressive Disorder, (e) Panic Disorder, (f) Obsessive-Compulsive Disorder, (g) Pervasive developmental disorder or autism, (h) Anorexia nervosa, and (i) Bulimia nervosa.

"Serious Emotional Disturbances of a Child or Adolescent" means a minor under the age of 18 who:

- has one or more mental disorders as identified in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, other than a primary substance use disorder or developmental disorder, that result in behavior inappropriate to the child's age according to expected developmental norms; and
- meets one or more of the following criteria used in the California Welfare and Institutions Code:
  - as a result of the mental disorder the child has substantial impairment in at least two of the following areas: self-care, school functioning, family rela-

tionships, or ability to function in the community; and either of the following occur:

- the child is at risk of removal from home or has already been removed from the home; or
- the mental disorder and impairments have been present for more than six months or are likely to continue for more than one year without treatment;
- the child displays one of the following: psychotic features, risk of suicide, or risk of violence due to a mental disorder;
- the child meets special education eligibility requirements under the California Government Code.

- **Limitations for Mental Health, Behavioral, Alcohol, or Drug Abuse Treatment Services**

No benefits will be payable for any charges incurred in excess of the limits and maximums described in this section. The general Comprehensive Medical limitations, as described in GH 407 B, will apply to Mental Health, Behavioral, Alcohol or Drug Abuse Treatment Services and Severe Mental Illness. In addition, Mental Health, Behavioral, Alcohol or Drug Abuse Treatment Services and Severe Mental Illness will not include and no benefits will be paid for:

- recreational therapy, art therapy, music therapy, dance therapy, or wilderness therapy; or
- psychoanalysis and aversion therapy; or
- Social Detoxification; or
- residential or inpatient Hospital alcohol or drug abuse rehabilitation or counseling Treatment or Service; or
- residential mental health or behavioral Treatment or Service; or
- after-care treatment programs for alcohol or drug abuse.

Benefits payable for medical care received from either a Preferred Provider or a Non-Preferred Provider will be combined and applied toward the limits and maximums described.

**Benefits Payable - State Required - California**

Subject to the provisions as described above, benefits will be payable for:

- **Children's Preventive Pediatric Care Services**

Benefits payable for a Dependent Child will include Covered Charges incurred for Children's Preventive Pediatric Care Services from the moment of birth through age 18 as described below.

- **Covered Services**

Benefits for Children's Preventive Pediatric Care Services will be consistent with the guidelines adopted by the American Academy of Pediatrics and will include:

- periodic physical examinations; and
- immunizations; and
- laboratory services in connection with the periodic physical examinations.

- **Rate of Payment**

Benefits will be payable on the same basis as for any other covered Treatment or Service.

Note: This benefit will be coordinated with the Pediatric Vaccine benefit as described above.

- **Screening for Blood Lead Levels**

Benefits payable for a Dependent Child will include Covered Charges incurred for screening for blood lead levels. Benefits will be payable on the same basis as for any other covered Treatment or Service.

- **Diabetes**

- **Diabetic Outpatient Self-Management Education Programs**

Covered Charges will include charges for Diabetic Outpatient Self-Management Education as described below:

- **Definition**

Diabetic Self-Management Education Program means an instructional course designed to enable diabetic patients and their families to understand the diabetic disease process and the daily management of diabetic therapy. The program must be state-certified and must be provided by healthcare professionals, including but not limited to Physicians, licensed registered nurses (R.N.s) and licensed pharmacists who are knowledgeable about the treatment of diabetic patients. Programs whose sole or primary purpose is weight reduction are not covered.

- **Benefits Payable**

Covered Charges will include professional fees, laboratory services, and prescription drugs. Benefits will be payable the same as for any other covered Treatment or Service; however, Physician Visits are limited to one per day. Benefits are payable only if the person enrolled in the program is a Member or Dependent who has been diagnosed as a diabetic. Benefits are not payable for nutritional components or books, or for any charges incurred by the Member's or Dependent's family members.

- **Diabetic Equipment, Supplies, and Prescriptions**

- **Benefits Payable**

Covered Charges will include charges incurred for diabetic equipment, and supplies for the management and treatment of insulin-using diabetes, non-insulin-using diabetes, and gestational diabetes as medically necessary even if the items are available without a prescription.

Covered Charges will also include diabetes outpatient self-management training, education, and medical nutrition therapy necessary to enable the Member or Dependent to properly use the equipment, supplies, and medications.

Benefits will be payable the same as for any other covered Treatment or Service.

- **Covered Charges**

- **Equipment and Supplies**

Coverage for medically necessary equipment and supplies will be the following:

- Blood glucose monitors and blood glucose testing strips;
- Blood glucose monitors designed to assist the visually impaired;
- Insulin pumps and all related necessary supplies;
- Ketone urine testing strips;
- Lancets and lancet puncture devices;
- Pen delivery systems for the administration of insulin;
- Podiatric devices to prevent or treat diabetes-related complications;
- Insulin syringes;
- Visual aids, excluding eyewear, to assist the visually impaired with proper dosing of insulin.

- **Prescriptions**

In addition, Covered Charges will include the following prescription items if the items are determined to be medically necessary:

- Insulin;
- Prescriptive medications for the treatment of diabetes;
- Glucagon.

**NOTE:** For the purpose of these state-required benefits, the following diabetic supplies will be payable under Mail Order Maintenance Prescription Drug Expense Covered Charges: insulin; disposable insulin needles/syringes; disposable blood/urine glucose acetone testing agents (e.g. Chemstrips, Acetest tablets, and Clinitest tablets);

lancets; glucometers (limited to no more than one each calendar year); glucagon; pre-prescriptive medications for the treatment of diabetes; and alcohol swabs.

All other diabetic supplies will be payable the same as any other covered Treatment or Service under Benefits Payable – State Required – California.

- **Screening Procedures for Cancer**

- **Mammography Services and Cervical Cancer Screening Tests**

Covered Charges will include charges incurred for mammography services. Covered Charges will include charges incurred for an annual cervical cancer screening test upon referral by a Physician, nurse practitioner or certified nurse midwife and any cervical cancer screening test approved by the federal Food and Drug Administration, upon the referral of the patient's health care provider. Covered Charges will also include charges incurred for a pap smear.

Benefits will be payable the same as for any other covered Treatment or Service.

- **Prostate Cancer Screenings**

Covered Charges will include charges incurred for the screening and diagnosis of prostate cancer. Benefits will include prostate-specific antigen testing and digital rectal examinations when medically necessary.

Benefits will be payable the same as for any other covered Treatment or Service.

- **Maternity Coverage**

Covered Charges will include Hospital Inpatient Confinement charges incurred by a mother and newborn Dependent Child. Benefits will be payable for a minimum of 48 hours following a vaginal delivery and a minimum of 96 hours following a cesarean section. Benefits will be payable the same as for any other covered Treatment or Service; however, the 48-hour and 96-hour minimum will not be subject to the Hospital Admission Review or Medically Necessary Care requirements of the Group Policy. Any benefits payable in excess of the 48-hour or 96-hour minimum will be subject to all terms and conditions of the Group Policy that apply to any other covered Treatment or Service.

- **Expanded Alpha Feto Protein (AFP) Program**

Covered Charges will include charges incurred while participating in the Expanded Alpha Feto Protein (AFP) Program which is a statewide prenatal testing program administered by the State Department of Health Services.

Benefits will be payable the same as for any other covered Treatment or Service.

- **Breast Cancer Treatment**

Covered Charges will include charges incurred for the screening and diagnosis of breast cancer and charges incurred for mastectomies and lymph node dissections, including but not limited to:

- prosthetic devices or reconstructive surgery, including devices or surgery on a nondiseased breast to restore and achieve symmetry with a diseased breast when reconstructive surgery on the diseased breast is performed; and
- complications from a mastectomy, including lymphedema.

Benefits will be payable the same as for any other covered Treatment or Service, however, these benefits will not be subject to the Hospital Admission Review or Medically Necessary Care requirements of the Group Policy.

- **Reconstructive Surgery**

Covered Charges will include coverage for reconstructive surgery.

“Reconstructive surgery” means surgery performed to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease, if the surgery is to do either of the following:

- to improve function; or
- to create a normal appearance, to the extent possible.

Benefits will be payable the same as for any other covered Treatment or Service.

- **Contraceptive Drugs and Devices**

Covered Charges will include charges for outpatient prescription contraceptive drugs or devices that are approved by the United States Food and Drug Administration for use as contraceptive method as designated by Us.

Benefits will be payable the same as for any other covered Treatment or Service.

- **Dental Anesthesia and Hospital Charges**

Covered Charges will include charges incurred for general anesthesia and associated facility charges for dental procedures performed in a Hospital or surgical center.

Benefits are payable when incurred by:

- your Dependent who is under the age of seven; or
- you or your Dependent who are severely disabled; or
- you or your Dependent, regardless of age, whose health is compromised and for whom general anesthesia is Medically Necessary.

Benefits will be payable the same as for any other covered Treatment or Service.

- **Phenylketonuria (PKU)**

- **Benefits Payable**

Covered Charges will include charges for treatment of Phenylketonuria (PKU) for those Formulas and Special Food Products that are a part of a diet prescribed by a licensed Physician and managed by a health care professional in consultation with a Physician who specializes in the treatment of metabolic disease and who participates in or is authorized by the insurer, provided that the diet is deemed Medically Necessary to avert the development of serious physical or mental disabilities or to promote normal development or function as a consequence of PKU.

Benefits will be payable the same as for any other covered Treatment or Service.

- **Definitions**

“Formula” means an enteral product or enteral products for use at home that are prescribed by a Physician or nurse practitioner, or ordered by a registered dietician upon referral by a health care provider authorized to prescribe dietary treatments, as Medically Necessary for the treatment of PKU.

“Special Food Product” means a food product that is both of the following:

- Prescribed by a Physician or nurse practitioner for the treatment of PKU and is consistent with the recommendations and best practices of qualified health professionals with expertise germane to, and experience in the treatment and care of PKU. It does not include a food that is naturally low in protein, but may include a food product that is specially formulated to have less than one gram of protein per serving; and
- Used in place of normal food products, such as grocery store foods, used by the general population.

- **Osteoporosis**

Covered Charges still include services related to the diagnosis, treatment, and appropriate management of osteoporosis. Such services will include, but are not limited to, all Food and Drug Administration approved technologies such as bone mass measurement when Medically Necessary.

Benefits will be paid the same as any other covered Treatment or Service.

- **AIDS Vaccine**

Covered Charges will include the cost of a vaccine administered for acquired immune deficiency syndrome (AIDS). The vaccine must be approved for marketing by the Federal Food and Drug Administration and recommended by the United Public Health Services.

Benefits will be payable the same as for any other covered Treatment or Service.

- **Laryngectomy – Prosthetic Devices**

**Benefits Payable**

Covered Charges will include charges for prosthetic devices to restore a method of speaking.

Benefits will be payable the same as for any other covered Treatment or Service.

**Definitions**

"Laryngectomy" means the removal of the larynx for medically necessary reasons, as determined by a licensed physician and surgeon.

"Prosthetic devices" mean and include the provision of initial and subsequent prosthetic devices, including installation accessories, pursuant to an order of the patient's physician and surgeon. "Prosthetic devices" do not include electronic voice producing machines.

- **Orthotic and Prosthetic Devices**

Covered Charges will include original and replacement orthotic devices as prescribed by a physician or as ordered by a licensed health care provider acting within the scope of his or her limited license. Covered Charges will also include original and replacement prosthetic devices as prescribed by a physician.

Benefits will be payable the same as for any other covered Treatment of Service.

- **Telemedicine**

Covered Charges will include charges for Telemedicine.

Telemedicine means the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, or data communications. Telemedicine does not include charges incurred for consultation provided by a health care provider by telephone or facsimile.

Benefits will be payable the same as for any other covered Treatment or Service.

## **DESCRIPTION OF BENEFITS**

### **COMPREHENSIVE MEDICAL**

#### **Payment Conditions**

If you or one of your Dependents receive Treatment or Service for a sickness or injury, We will pay Comprehensive Medical benefits for Covered Charges:

- in excess of the Deductible or Copay amount; and
- at the payment percentages indicated; and
- to the applicable Maximum Payment Limit;

as described in the Summary of Benefits section.

#### **Covered Charges**

Covered Charges will be the actual cost charged to you or one of your Dependents for Medically Necessary Care but only to the extent that the actual cost charged does not exceed Prevailing Charges.

Payment of Covered Charges not listed shall be determined by Us based on the amount payable for a Covered Charge of a comparable nature.

- drugs and medicines requiring a Physician's prescription and approved by the Food and Drug Administration for general marketing (excluding those charges paid under Mail Order Maintenance Prescription Drugs Expense Insurance; and
- charges by a Hospital for room and board (maximum Covered Charge for a room is the semiprivate room rate being charge by the Hospital (the most frequent semiprivate room rate if confined to a private room) up to a maximum benefit of \$200 per day (no limit if a PPO facility is used) for confinement in other than an Intensive Care Unit of a Hospital; maximum benefit is \$500 (no limit if a PPO facility is used) for confinement in an Intensive Care Unit of a Hospital) and other services required for purposes of treatment; and
- the services of a Physician or legally licensed chiropractor, including Physician Visits; and
- for services of a legally licensed physiotherapist, licensed practical nurse or graduate registered nurse, provided the services are not rendered by a person in the Member's Immediate Family; and
- for surgical dressings, casts, splints, braces, crutches, artificial limbs, and artificial eyes; and
- anesthesia, blood, blood plasma, and oxygen and rental of equipment for its administration of oxygen; and

- for x-ray and laboratory examinations, radium, and radioactive isotope therapy; and
- transportation by ambulance (including Emergency Medical Transportation Services), provided by a Hospital or a licensed service to and from a local Hospital (or to and from the nearest Hospital equipped to furnish needed treatment not available in a local Hospital) not to exceed a maximum Covered Charge of \$5,000 each calendar year for each Member or Dependent; and
- removal of impacted teeth and treatment or service by a dentist for non-odontogenic surgery (nondental cysts and tumors), excluding such charges payable under Dental Insurance; and
- Dental Services to repair damage to the jaw and sound natural teeth, if the damage is the direct result of an accident (but did not result from chewing) and if the Dental Services are completed within six months after the accident; and
- The services of a certified respiratory care practitioner when performing pulmonary rehabilitation and respiratory home care services, if such services are furnished according to a method or treatment prescribed by a Physician; and
- The services of a licensed speech pathologist or audiologist for treatment of speech or hearing impairments; and
- routine physical examinations; and
- Hospice Care as described below in this section; and
- convalescent care in a Skilled Nursing Facility as described below in this section; and
- special footwear for foot disfigurement when medically necessary and prescribed by a Physician, up to a lifetime maximum benefit of \$500 for each insured Member or Dependent. Foot disfigurement includes, but is not limited to, disfigurement from cerebral palsy, arthritis, polio, spina bifida, diabetes, and foot disfigurement caused by accident or Developmental Disability; and
- the services of a Physician or licensed acupuncturist for acupuncture treatment, up to a maximum benefit of \$500 each calendar year for each insured person.

### **Covered Charges for Multiple Surgical Procedures**

If you or one of your Dependents undergo two or more procedures during the same anesthesia period, Covered Charges for the services of the Physician, facility or other covered provider for each procedure that is clearly identified and defined as a separate procedure will be based on:

- 100% of Prevailing Charges for the first or primary procedure; and
- 50% of Prevailing Charges for the second procedure; and
- 25% of Prevailing Charges for each of the other procedures.

## **Covered Charges for an Assistant during Surgical Procedures**

Benefits will be payable for the services of an assistant to a surgeon if such services are determined by Us to be Medically Necessary Care. The services provided by an assistant to a surgeon is considered to be Medically Necessary Care if the skill level of an M.D. or D.O. would be required to assist the primary surgeon. Covered Charges for such services will be paid at up to 20% of Prevailing Charges of the covered surgical procedure if the procedure is performed by a Physician or a Health Care Extender.

In addition, the multiple surgical procedures percentiles, as described above will be applied.

## **Durable Medical Equipment**

### **- Covered Charges**

Covered Charges will include charges for rental or purchase of Durable Medical Equipment. Durable Medical Equipment means equipment that:

- can withstand repeated use; and
- is primarily and customarily used to serve a medical purpose; and
- is generally not useful to a person who is not sick or injured, or used by other family members; and
- is appropriate for home use; and
- improves bodily function caused by sickness or injury, or further prevents deterioration of the medical condition.

Covered Charges will include repair, adjustment, or replacement of purchased Durable Medical Equipment, unless damage results from negligence or abuse of such equipment by you or one of your Dependents.

### **- Benefits Payable**

Benefits will be payable the same as for any other covered Treatment or Service. However, the Covered Charge for rental of Durable Medical Equipment will be limited to the purchase price. When We determine whether to purchase or rent the equipment, We will consider the type of equipment requested, and the condition and length of time for which it will be used.

Claims submitted for Durable Medical Equipment must be accompanied by the Physician's Written prescription of necessity. However, this prescription does not by itself entitle you or your Dependent to benefits.

### **- Limitations**

The general Comprehensive Medical limitations listed in this section will apply to Durable Medical Equipment charges. In addition, Durable Medical Equipment Covered Charges will not include Durable Medical Equipment charges which:

- are in excess of the purchase price of the equipment; or
- are provided during rental for repair, adjustment, or replacement of components and accessories necessary for the functioning and maintenance of covered equipment, as this is the responsibility of the Durable Medical Equipment supplier.

## **Hospice Care**

### **- Covered Charges**

Covered Charges will include charges for Hospice Care Services provided by a Hospice, Hospice Care Team, Hospital, or Skilled Nursing Facility for:

- any terminally ill individual (you or any one of your Dependents) who chooses to participate in a Hospice Care Program rather than receive medical treatment, to promote cure and who, in the opinion of the attending Physician, is not expected to live longer than 6 months; and
- the family of such individual (you or any one of your Dependents);

but only to the extent that such Hospice Care Services are provided under the terms of a Hospice Care Program and are billed through the Hospice that manages the program.

Hospice Care Services consist of:

- inpatient and outpatient hospice care, home care, nursing care, homemaking services, dietary services, social counseling, and other supportive services and supplies provided to meet the physical, psychological, spiritual, and social needs of the dying individual; and
- medical equipment, drugs and medicines (requiring a Physician's prescription) prescribed for the dying individual by any Physician who is a part of the Hospice Care Team; and
- instructions for care of the patient, social counseling, and other supportive services for the family of the dying individual.

### **- Benefits Payable**

Benefits will be payable the same as for any other covered Treatment or Service. Covered Charges will not include charges that:

- (1) exceed \$60 for any one day of Hospice Care; or
- (2) exceed \$4,000 for any one Episode of Hospice Care.

### **- Limitations**

The general Comprehensive Medical limitations listed in this section will apply to Hospice Care. In addition, Hospice Care Covered Charges will not include Hospice Care charges that:

- are in excess of the limits and maximums described in this subsection; or
- are for Hospice Care Services not approved by the attending Physician and Us; or
- are for transportation services; or
- are for Hospice Care Services provided at a time other than while provided in a Hospice Care Program.

### **Skilled Nursing Facility Confinement**

#### **- Covered Charges**

If you or a Dependent are confined in a Skilled Nursing Facility, Covered Charges will include any charges incurred for room, board, and other services required for treatment, provided:

- you or a Dependent requires daily skilled nursing or skilled rehabilitation care on an inpatient basis as determined by Us; and
- the Skilled Nursing Facility confinement follows three or more consecutive days of Hospital Inpatient Confinement for which benefits were payable under the Group Policy; and
- the Skilled Nursing Facility confinement results from the sickness or injury that was the cause of the Hospital Inpatient Confinement; and
- the Skilled Nursing Facility confinement begins not later than 14 days after the end of Hospital Inpatient Confinement or begins not later than 14 days after the end of a prior Skilled Nursing Facility confinement for which benefits were payable under the Group Policy.
- inpatient Skilled Nursing Facility confinement is certified by a Physician as necessary to treat a sickness or injury.

Covered Charges for each day will not be more than 50% of the actual room charge (if the Hospital confinement was in a semiprivate room) to a maximum benefit of \$100 (no dollar limit if a Preferred Provider is used) charged by the Hospital in which you or your Dependent was confined before the Skilled Nursing Facility confinement. Also, Covered Charges will not include charges for more than 120 days for all Skilled Nursing Facility confinements that result from the same or a related sickness or injury.

The following services will not be subject to the Skilled Nursing Facility confinement maximums as stated above: drugs and medicines (requiring a Physician's prescription) that are not billed by the Skilled Nursing Facility, visits by a Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.), Durable Medical Equipment, and x-ray or laboratory services.

- **Limitations**

The general Comprehensive Medical limitations listed in this section will apply to Skilled Nursing Facility confinements. In addition, Skilled Nursing Facility Covered Charges will not include Skilled Nursing Facility confinement charges billed by the Skilled Nursing Facility that:

- are in excess of the limits and maximums described in this subsection; or
- are incurred on or after the date the attending Physician ceases to prescribe Skilled Nursing Care.

**Limitations**

Covered Charges will not include and no benefits will be paid for:

- Treatment or Service that is not for Medically Necessary Care; or
- Treatment or Service that is an Experimental or Investigational Measure. (The denial of any claim on the basis of the exclusion of coverage for experimental or investigational Treatment or Service may be appealed through the procedure prescribed in the notice of that claim decision); or
- any part of a charge for Treatment or Service that exceeds Prevailing Charges; or
- Treatment or Service due to any form of temporomandibular joint disorder (malfunction, degeneration, or disease related to the joint that connects the jaw to the skull), except that benefits are payable for medically necessary surgical procedures directly affecting the upper or lower jawbone or associated joints; or
- the services of any person who is in your Immediate Family or any person in your Dependent's Immediate Family; or
- Dental Services or materials, except as described under Covered Charges; or
- eye examinations for the correction of vision or the fitting of glasses; vision materials (frames or lenses); or
- hearing aids; or
- acupuncture treatment; acupressure treatment, except as described under Covered Charges; or
- drugs or medicines that do not require a Physician's prescription or have not been approved by the Food and Drug Administration for general marketing; or
- vitamins, minerals (except prescription potassium supplements) whether or not they require a Physician's prescription; or

- nutritional supplements (even if the only source of nutrition), or special diets (whether or not they require a Physician's prescription), except as provided for under Phenylketonuria (PKU) or Diabetes; or
- wigs or hair prostheses; or
- Treatment or Service for Cosmetic Treatment and Surgery (except as provided for under Reconstructive Surgery), or complications arising therefrom, unless the Treatment or Service results from a sickness or an accidental injury which occurs while the individual claiming benefits is insured under the Group Policy, and unless the Treatment or Service is completed within 12 months after the date of that sickness or injury; or
- personal hygiene, comfort, or convenience items, whether or not recommended by a Physician, including, but not limited to, air conditioners, humidifiers, diapers, underpads, bed tables, tub bench, Hoyer lift, gait belts, bedpans, physical fitness equipment, stair glides, elevators or lift; or
- "barrier free" home modifications, whether or not recommended by a Physician, including, but not limited to, ramps, grab bars, or railings; or
- non-implantable communication-assist devices, including, but not limited to, communication boards, and computers; or
- Treatment or Service for work-hardening programs or vocational rehabilitation services; or
- Treatment or Service leading to, in connection with, or resulting from sexual transformation or intersex surgery; or
- cryopreservation or storage; or
- Treatment or Service for education or training (except as provided under Diabetic Outpatient Self- Management Programs), developmental delay, or learning disorders; or
- social counseling (except as provided under Hospice Care), marital counseling, or sexual disorder therapy; or
- Treatment or Service for which you or your Dependent have no financial liability or that would be provided at no charge or at a different charge in the absence of insurance; or
- Treatment or Service that is paid for or furnished by the United States Government or one of its agencies (except as required under Medicaid provisions or Federal law); or
- Treatment or Service that results from war or act of war; or
- Treatment or Service that results from participation in criminal activities; or

- Treatment or Service for smoking cessation or nicotine addiction, gambling addiction, or stress management; or
- Treatment or Service for insertion, removal, or revision of breast implants, unless provided post-mastectomy; or
- Treatment or Service for any sickness or condition for which the insertion of breast implants, or the fact of having breast implants within the body, was a contributing factor, unless the sickness or condition occurs post-mastectomy.
- Treatment or Service for Kerato-Refractive Eye Surgery or myopia (nearsightedness), hyperopia (farsightedness) or astigmatism by changing the shape of the cornea, including but not limited to radial keratotomy and keratomileusis surgery, unless corrected vision in the operated eye is worse than 20/70 prior to surgery and can be corrected to 20/70 or better only by such surgery; or
- charges for telephone calls or telephone consultations or missed appointments; or
- Treatment or Service covered by medical expense insurance issued under the Individual Purchase Rights described in this booklet; or
- Treatment or Service that results from a sickness that is covered by a Workers' Compensation Act or other similar law; or
- any nursing services (except as described under Covered Charges and as required by state law); or
- Treatment or Service for foot care with respect to: corns, calluses, flat feet, fallen arches, chronic foot strain, or symptomatic complaints of the feet, casting for orthotics, or any appliance (including orthotics), except that benefits will be payable for special footwear for foot disfigurement, as described under Covered Charges; or
- dietetic counseling, unless provided while you or one of your Dependents are Hospital Inpatient Confined, or as provided under Hospice Care or Diabetic Outpatient Self-Management Education Programs; or
- Treatment or Service by any type of health care practitioner not otherwise provided for in the Group Policy, unless recognition is state mandated; or
- Treatment or Service that is subject to the Preexisting Condition Exclusion described in this booklet; or
- Treatment or Service that results from the abortion of a pregnancy, except benefits will be payable for an abortion if continuation of the pregnancy would endanger the life of the mother. However, if the medical treatment is required because of complications resulting from an abortion, benefits will be payable for such medical treatment; or

- for Dependent daughters, Treatment or Service that results from pregnancy, except that benefits will be payable for Complications of Pregnancy. Complications of Pregnancy is any condition that greatly affects the usual medical treatment of a normal pregnancy; this includes nonelective abortion and cesarean section; or
- Treatment or Services for Custodial Care.

**COMPREHENSIVE MEDICAL EXPENSE INSURANCE  
UTILIZATION MANAGEMENT PROGRAM**

**Definitions Applicable to the Utilization Management Program**

**Concurrent Review**

Utilization Review conducted during a patient's Hospital stay or course of treatment.

**Continued Stay Review**

A review by Us of a Physician's report of the need for continued Hospital Inpatient Confinement to determine if the continued stay is for Medically Necessary Care.

**Health Professional**

An individual who:

- has undergone formal training in a health care field;
- holds an associate or higher degree in a health care field, or holds a state license or state certificate in a health care field; and
- has professional experience in providing direct patient care.

**Hospital Admission Review**

A review by Us of a Physician's report of the need for Hospital Inpatient Confinement (scheduled or emergency) to determine if the confinement is for Medically Necessary Care.

**Initial Clinical Review(er)**

Clinical review conducted by appropriate licensed or certified Health Professionals. Initial Clinical Review staff may approve requests for admissions, procedures, and services that meet clinical review criteria, but must refer requests that do not meet clinical review criteria to a Peer Clinical Reviewer for certification or Noncertification.

**Noncertification**

A determination by Us that an admission, continued stay, or other health care service has been reviewed and, based upon the information provided, does not meet Our requirements for Medically Necessary Care, appropriateness, health care setting level of care or effectiveness, and the request is therefore denied, reduced, or terminated.

**Ordering Provider**

The Physician or other provider who specifically prescribes the health care service being reviewed.

### **Peer Clinical Review(er)**

Clinical review conducted by a Physician or other Health Professional when a request for an admission, procedure, or service was not approved during the Initial Clinical Review.

In the case of an appeal review, the Peer Clinical Reviewer is a Physician or other Health Professional who holds an unrestricted license and is in the same or similar specialty as typically manages the medical condition, procedures, or treatment under review. Generally, as a peer in a similar specialty, the individual must be in the same profession, i.e., the same licensure category as the Ordering Provider.

### **Presurgery Review**

A review by Us of a Physician's report of the need for a listed surgery to determine if a Second Opinion will be required for the surgery.

### **Prospective Review**

Utilization Review conducted prior to a patient's stay in a Hospital or other health care facility or course of treatment, including any required preauthorization or precertification.

### **Retrospective Review**

Utilization Review conducted after the patient is discharged from a Hospital or other health care facility or has completed a course of treatment.

### **Second Opinion**

An opportunity or requirement to obtain a clinical evaluation by a provider other than the provider originally making a recommendation for a proposed Treatment or Service to assess the clinical necessity and appropriateness of the proposed service.

### **Second Opinion Consultation Charges**

Covered Charges for:

- consultation with a Second Opinion Physician to obtain a second or third opinion prior to a surgery for which a Second Opinion is recommended; and
- necessary diagnostic, x-ray, or laboratory examinations performed in connection with such consultation.

### **Second Opinion Physician**

A Physician who is:

- an appropriate specialist for the particular surgery recommended; and
- not a partner or associate of the Physician who recommended or will perform the surgery.

## **Surgery Related Charges**

Covered Charges by a:

- Physician for performing a surgical operation (including charges for a surgical suite, if any); and
- Physician for pathology, radiology, or the administration of anesthesia required for the purpose of surgery; and
- Hospital or other licensed health care facility for room and board and other usual services.

## **Utilization Review**

A set of formal techniques designed to monitor the use of or evaluate the clinical necessity, appropriateness, efficacy or efficiency of health care services, procedures, providers, or facilities.

### **Utilization Management Requirements (Applicable to medical care received from a Non-PPO Provider)**

Benefits payable for Hospital Inpatient Confinement Charges and Surgery Related Charges will be reduced by 25% unless:

- For Hospital Inpatient Confinement Charges, a Hospital Admission Review is requested from Us by you, a Dependent, or a designated patient representative as soon as a Hospital Inpatient Confinement is scheduled, but no later than the day of a Hospital Inpatient Confinement, for other than a Medical Emergency; and for a Medical Emergency within two business days of a Hospital Inpatient Confinement.

If a Hospital Admission Review is not requested in a timely manner as specified above, the 25% reduction in benefits payable will be applied to all Hospital Inpatient Confinement Charges.

Benefits will be payable only for that part of the Hospital Inpatient Confinement Charges We determine to be Medically Necessary Care.

(Certain exceptions apply to Hospital Inpatient Confinement for childbirth as described below.)

- For Surgery Related Charges, a Presurgery Review is requested from Us by you, your Dependent, or a designated patient representative for the surgeries listed below under Presurgery Review, and an opinion (whether confirming or not) as to the need for surgery is obtained from a Second Opinion Physician (if We require a Second Opinion as part of the Presurgery Review process), as soon as the surgery is scheduled but no later than the day of surgery, unless it is demonstrated that a Medical Emergency existed.

The 25% reduction in Benefits Payable is a penalty for failure to comply with any of the Utilization Management Requirements listed. The reduction:

- will not count toward satisfaction of the Stop Loss Expense limits described in the Summary of Benefits section; and
- will not exceed \$2,000 per individual each calendar year.

**Hospital Admission Review (Applicable to medical care received from Non-Preferred Providers)**

A Hospital Admission Review by Us is required for all Hospital Inpatient Confinements (scheduled or emergency).

The following exceptions apply to Hospital Inpatient Confinement:

- For mastectomy or lymph node dissection, Medically Necessary Care requirements are waived and a Hospital Admission Review is not required;
- For childbirth, Medically Necessary Care requirements are waived and a Hospital Admission Review is not required for mother and baby for:
  - A 48-hour Hospital Inpatient Confinement following vaginal delivery; or
  - A 96-hour Hospital Inpatient Confinement following cesarean section.

A request for review by Us of the need for continued Hospital Inpatient Confinement for mother or baby beyond the automatically approved time period stated above must be made by you, a Dependent, or a designated patient representative before the end of that time period.

If you, a Dependent, or a designated patient representative fail to request a Hospital Admission Review as specified in this section, benefits will be reduced as described above.

However, in no event are benefits payable for normal pregnancy for a Dependent daughter. Benefits are payable only for Complications of Pregnancy for a Dependent daughter as defined in this booklet.

Exception: For all Hospital Inpatient Confinement Charges incurred beyond the 48-hour or 96-hour automatically approved Hospital Inpatient Confinement for childbirth, the penalty will be applied beginning the date the automatically time period ends. **Except as waived above, no benefits will be payable for any Treatment or Service that is not for Medically Necessary Care.**

For the purpose of these requirements, "Hospital Admission Review" means review by Us of a Physician's report of the need for a Hospital Inpatient Confinement, scheduled or emergency, (unless it is for an automatically approved Hospital Inpatient Confinement for childbirth).

The report (verbal or Written) must include the:

- reason(s) for the Hospital Inpatient Confinement; and
- significant symptoms, physical findings, and treatment plan; and

- procedures performed or to be performed during the Hospital Inpatient Confinement; and
- estimated length of the Hospital Inpatient Confinement.

If a Hospital Inpatient Confinement will exceed the approved number of days, We will initiate a Continued Stay Review. For the purpose of these requirements, "Continued Stay Review" means a review by Us of a Physician's report of the need for continued Hospital Inpatient Confinement.

The report (verbal or Written) must include the:

- reason(s) for requesting continued Hospital Inpatient Confinement; and
- significant symptoms, physical findings, and treatment plan; and
- procedures performed or to be performed during the Hospital Inpatient Confinement; and
- estimated length of the continued Hospital Inpatient Confinement.

**Presurgery Review (Applicable to medical care received from a Non-PPO Provider)**

A Presurgery Review by Us is required for the surgeries listed below.

If you, your Dependent, or a designated patient representative fail to request a Presurgery Review as soon as the surgery is scheduled, but no later than the day of surgery or fails to comply with Our recommendation regarding the need for a Second Opinion, benefits will be reduced as described in this section, unless it can be demonstrated that a Medical Emergency existed.

- Adenoidectomy
- Blepharoplasty (eyelid surgery)
- Bunionectomy and/or hammertoe (multiple)
- Cholecystectomy
- Coronary artery bypass (heart surgery)
- Extracorporeal shock wave lithotripsy (kidney stone removal)
- Gastric surgery for obesity
- Hernia surgery
- Hysterectomy
- Jaw surgery
- Joint replacement surgery

- Laminectomy
- Lipectomy (removal of fat tissue)
- Mammoplasty (breast surgery)
- Marshall-Marchetti-Krantz
- Nephrolithotomy (kidney surgery)
- Percutaneous transluminal coronary angioplasty ("balloon" procedure of the coronary arteries)
- Prostate Surgery
- Radial keratotomy (eye surgery)
- Rhinoplasty (nose bone surgery)
- Septoplasty (nose cartilage surgery)
- Thyroid surgery
- Thyroidectomy
- Tonsillectomy
- Transplants (except bone marrow, cornea, and skin)
- Varicose Vein Surgery

For the purpose of these requirements, "Presurgery Review" means a review by Us of a Physician's report to determine if a second opinion will be required for a proposed surgery on the Presurgery Review list, unless the surgery is a Medical Emergency.

The report must include the:

- reason(s) for the proposed surgery; and
- significant symptoms, physical findings, and treatment history.

#### **Utilization Review Program**

- **Prospective Review**

For an initial Prospective Review, a decision will be made within two (2) business days of the date We receive all the necessary information needed to complete the review. If We certify a health care service, notification will be provided promptly by telephone, facsimile, or in Writing to the attending Physician or other Ordering Provider, the facility rendering service, and you or the patient. Written notification will be sent within two (2) business days of the determination. For Noncertifications, notification will be made to the attending Physician or other Ordering Provider or facility

rendering service by telephone within one (1) business day and Written notification will be sent within one (1) business day, with notice also sent to you or the patient.

- **Concurrent Review**

For a Concurrent Review, a review decision will be made within one (1) business day of the date We receive all necessary information needed to complete the review or prior to the end of the current certified period. If We certify a health care service, notification will be provided promptly either by telephone, facsimile, or in Writing to the attending Physician or other Ordering Provider within 24 hours of making the decision to, the facility rendering service, and to you or the patient within one (1) business day of receipt of all information necessary to complete the review. For Noncertifications, notification will be made to the attending Physician or other Ordering Provider or facility rendering service by telephone within one (1) business day and Written notification sent within one (1) business day, with notice also sent to you or the patient.

- **Retrospective Review**

For a Retrospective Review, a determination will be made within thirty (30) business days after the date We receive all necessary information about the admission, procedure, or health care service. Written notification will be sent to the attending Physician or other Ordering Provider, the facility rendering service, and you or the patient within two (2) business days of the determination (but not later than 30 days from the time of receiving the information to complete the Retrospective Review).

- **Noncertification**

A Written notice of Noncertification will include the principal reasons for the determination not to certify, a statement that the clinical rationale and clinical review criteria used in making the Noncertification decision will be provided in Writing upon request, with proper authorization, and instructions for initiating an appeal review.

- **Request for Reconsideration**

When an initial determination is made not to certify an admission or other service and no peer-to-peer conversation has occurred, the Peer Clinical Reviewer that made the initial decision must be made available within one (1) business day to discuss the Noncertification decision with the attending Physician or other Ordering Provider upon their request. If the original Peer Clinical Reviewer is not available, another Peer Clinical Reviewer must be made available to discuss the review.

At the time of the conversation, if the reconsideration process is unable to resolve the difference of opinion regarding a decision not to certify, the attending Physician or other Ordering Provider will be informed of their right to initiate an expedited or standard appeal and the procedure to do so.

- **Appeal of Noncertifications**

You, your Dependent, or a designated patient representative, Physician or other health care provider has the right to request an appeal review of any utilization management determination, by telephone, fax, or in Writing.

- **Expedited Appeal Review**

An Expedited Appeal is a request, usually by telephone, for an additional review of a determination not to certify imminent or ongoing services. To resolve the expedited appeal, maximum information will be shared by telephone, fax, or in Writing. A Peer Clinical Reviewer who did not make the original determination and who is in the same or similar specialty as the attending Physician or other Ordering Provider will conduct the review.

A determination on the expedited appeal will be made within one (1) business day of receiving the necessary information needed to complete the appeal review. Notification of the appeal review outcome will be made by telephone to the attending Physician or other Ordering Provider with Written notification sent to the you or the patient, the attending Physician or other Ordering Provider within two (2) business days of an expedited appeal of an initial review and within one (1) business day of an expedited appeal of a Concurrent Review or declination.

The Written notification for a determination not to certify will include:

- The title and qualifying credentials of the reviewer;
- A statement of the reviewers' understanding of the appeal request;
- The principal reason(s) for the determination not to certify;
- A statement that the clinical rationale and review criteria used to make the determination will be available in Writing, upon request and with proper authorization; and
- A statement of the method for the standard appeal process.

Note: The expedited appeal process does not apply to Retrospective Reviews.

- **Standard Appeal Review**

A standard appeal may be requested either in Writing or verbally. A statement from the attending Physician or other Ordering Provider and all or part of the medical records is needed to complete the standard appeal process. A Peer Clinical Reviewer who was not involved in the prior review and who is in the same or similar specialty as the attending Physician or other Ordering Provider will conduct the review of the documentation provided. A determination will be made within thirty (30) days of receiving the necessary information to complete the standard appeal.

Notification will be made in Writing to you or the patient, the attending Physician or other Ordering Provider within two (2) business days (but not later than 30 days from the time of receiving the information to complete the standard appeal).

Written notification of a determination not to certify will include:

- The title and qualifying credentials of the reviewer;
- A statement of the reviewers' understanding of the appeal request;
- The principal reason(s) for the determination not to certify;
- A statement that the clinical rationale and review criteria used in making the determination will be available in Writing, upon request and with proper authorization.

**External Appeal Review – Utilization Review, Medically Necessary Care, Experimental, or Investigational Measures**

**- Utilization Review – Medical Necessary Care**

You or your Dependent has the right to apply to the California Insurance Department for an independent medical review of a decision to deny, modify, or delay health care services, based in whole or in part on the finding that the disputed health care services was not considered Medically Necessary Care.

Application must be made within six months of the following qualifying events:

- The patient's provider has recommended a health care service is Medically Necessary Care; or
- The patient has received urgent care or emergency services that a provider determined was Medically Necessary Care; or
- The patient, in the absence of the qualifying events shown above, has been seen by an in-network provider for the diagnosis or treatment of the medical condition for which the patient seeks independent review; or
- You or your Dependent has filed an appeal of a non-certification and the disputed decision is upheld or the appeal remains unresolved after 30 days. In the case of an appeal that requires expedited review, you or your Dependent shall not be required to participate in the appeal process for more than three days.

Disputed Health Care Service means any health care service eligible for coverage and payment under the Group Policy that has been denied, modified, or delayed by a decision, in whole or in part due to a finding that the service is not considered Medically Necessary Care.

**- Experimental or Investigational Measures**

You or your Dependent has the right to apply to the California Insurance Department for an independent medical review for coverage decisions regarding therapies that are an Experimental or Investigational Measure. The following criteria must be met:

- The patient has a life-threatening or seriously debilitating condition.
- The patient's Physician certifies that the condition is life-threatening or seriously debilitating and for which:
  - standard therapies have not been effective in improving the condition;
  - standard therapies would not be medically appropriate for the patient; and
  - there is no more beneficial standard therapy covered by the Group Policy than the therapy proposed.
- Either (a) the patient's contracting Physician has recommended a drug, device, procedure or other therapy that the Physician certifies in Writing is likely to be

more beneficial to the patient than any available standard therapies or (b) the patient, or the patient's Physician who is a licensed, board-certified or board-eligible Physician qualified to practice in the area of practice appropriate to treat the patient's condition, has requested a therapy that, based on two documents from the medical and scientific evidence, is likely to be more beneficial for the patient than an available standard therapy.

- The patient has been denied coverage under the Group Policy for a drug, device, procedure, or other therapy recommended or requested, unless coverage for the specific therapy has been excluded under the Group Policy.
- The specific drug, device, procedure, or other therapy recommended would be covered Treatment or Service except for the Group Policy's determination that the therapy is an Experimental or Investigational Measure.

"Life-threatening" means either or both of the following:

- Diseases or conditions where the likelihood of death is high unless the course of the disease is interrupted.
- Diseases or conditions with potentially fatal outcomes, where the end point of clinical intervention is survival.

"Seriously debilitating" means diseases or conditions that cause major irreversible morbidity.

**SEE THE CLAIMS PROCEDURES SECTION OF THIS BOOKLET FOR IMPORTANT CLAIM PROCEDURES INFORMATION ON FILING YOUR MEDICAL CLAIMS.**

## **DESCRIPTION OF BENEFITS**

### **MAIL ORDER MAINTENANCE PRESCRIPTION DRUGS EXPENSE INSURANCE**

Subject to the terms and limitations of the Group Policy summarized in this booklet, if Maintenance Drugs and Medicines are prescribed to treat you or one of your Dependents, We will pay 100% of charges in excess of the Copay amount as described in the Summary of Benefits Section.

Benefit payment will be limited to:

- prescribed maintenance medications which are necessary to treat a chronic or long-term sickness or injury and that can be legally dispensed only upon the Written prescription of a Physician; and
- a 90-day supply for each prescription and each refill; and
- prescriptions which are filled through the pharmacy designated by Us to administer the mail order prescription drugs program.

#### **Definitions**

"Average Wholesale Price" means the published cost of a drug product that is paid by the pharmacist to the wholesaler.

"Brand Name Prescription Drug/Brand Name Drug" means a drug that is customarily recognized throughout the pharmaceutical profession as the original or trademarked preparation of a drug entity and for which the Food and Drug Administration (FDA) has given general marketing approval.

"Formulary" means a comprehensive listing of drugs by therapeutic class or diagnosis that provides drug therapy guidelines and cost comparisons for prescribers. Use of a formulary may generate formulary credits.

"Generic Prescription Drugs" mean pharmaceutical products manufactured and sold under their chemical, common, or official name.

"Payment Schedule" means the maximum reimbursement amount allowed under the program as established by The Principal.

"Preferred Brand Name Prescription Drugs" mean a list of drugs established by Us that are considered to be clinically appropriate and cost effective. The Preferred Brand Name Drugs list is a subset (i.e., a shorter list) of the Formulary list.

"Prescription Drug Copay" means a specified dollar amount that must be paid by you or one of your Dependents for each prescription and each refill. The Prescription Drug Copay amount will not be applied to the Comprehensive Medical Deductible Amount or Stop Loss Expense Limits.

"Prescription Legend Drugs" mean any medicinal substance, the label of which under the Federal Food, Drug and Cosmetic Act is required to bear the legend, "Caution, Federal Law prohibits dispensing without a prescription."

## **Prescription Drugs Utilization Review**

A prescription will not be refilled if there is a previously dispensed quantity for the same prescription (for the same insured person) and the dispensing date for the current prescription is earlier than the date on which approximately 75% of the previously dispensed quantity would be expected to last if the previously dispensed quantity was consumed based on the dosage instructions provided by the Physician.

## **Mail Order Pharmacy**

We have contracted with AdvancePCS, a mail service pharmacy to administer this program.

## **Brand Name versus Generic Name**

Most maintenance drugs come in two forms, brand name and generic. Both brand name and generic drugs are covered under the program.

The Pharmacy will automatically fill your prescription with a generic drug (if available) if the prescribing Physician has indicated that a generic substitution is acceptable. If the prescribing Physician indicates that generic substitution is not acceptable (even though available), the Pharmacy will use the brand name drug.

## **90-Day Supplies**

Typically, prescriptions submitted to the Pharmacy will be filled in 90-day supplies. Please have your physician contact the Pharmacy at the toll-free number shown below if there are any questions.

## **How to Order From the Pharmacy**

Your initial order consists of three parts: the written prescription from your Physician; a Patient/Profile Order form with preaddressed envelope; and a Copayment. These are described below. You should allow 14 days for your order to be completed and shipped to you. All orders are mailed either by Federal Express or First Class U.S. Mail.

## **The Written Prescription**

When obtaining your prescription, be sure to ask your Physician to specify the following information:

- patient name;
- 90-day supply of medication (the Physician should indicate the total number of pills required for that period of time. For example, 270 tablets would be needed for medication that must be taken three times a day.);
- refills (many maintenance drugs can be prescribed for up to one year; therefore, a prescription for a 90-day supply may specify up to three refills.);
- Physician's signature.

Also it is very important to include your name, address, and social security number on the prescription form, so that eligibility for the program can be verified when the Pharmacy receives the order.

### **Patient Profile/Order Form**

Included in the installation package you receive, as well as with each order shipped, is the Patient Profile/Order Form. This form is to be completed and sent to the Pharmacy with each order. The Patient Profile/Order Form provides information concerning eligibility in addition to health and allergy conditions pertaining to each insured person.

### **Copay**

A check or money order for the correct Copay must accompany each order. The Copay amount is described in the Summary of Benefits Section. You may also be able to charge your Copay as explained on the Patient Profile/Order Form.

### **Refills or Follow-up Orders**

Each filled order you receive includes Refill Ordering Instructions, a Patient/Profile Order Form, and a preaddressed envelope. Orders for refills should be placed approximately two weeks before the current supply or medication is expected to run out.

### **Special Situations**

If a maintenance medication is prescribed for immediate use, you should obtain two prescriptions--one for a 14-day supply, to be filled immediately at a local pharmacy, and a second for a 90-day supply with refills, to be filled by AdvancePCS.

If a maintenance medication is prescribed on a trial basis, you should obtain two prescriptions: one for a limited supply, to be filled immediately at a local pharmacy, and a second for a 90-day supply with refills, to be filled by AdvancePCS if and when the medication proves satisfactory.

### **Questions**

If you have a question concerning medication or a particular order, you can call the pharmacy's customer service number. The toll-free number is shown on your order form.

Also included with each order filled by AdvancePCS is a Patient Counseling information sheet which has specific information about the medication included with the order.

### **Limitations**

Prescription Drugs Covered Charges will not include and no benefits will be paid for:

- drugs or medicines that are not for Medically Necessary Care; or
- drugs or medicines that are Experimental or Investigational. (The denial of any claim on the basis of the exclusion of coverage for Experimental or Investigational drugs or medicines may be appealed through the procedure prescribed in the notice of that claim decision); or

- drugs or medicines (other than insulin) that can be purchased without a Physician's prescription; or
- drugs or medicines dispensed by a Hospital, Skilled Nursing Facility, rest home, or other institution in which you or a Dependent is confined; or
- drugs or medicines delivered or administered by the prescriber; or
- drugs or medicines prescribed or dispensed by any person in your Immediate Family or any person in your Dependent's Immediate Family; or
- vitamins, singly or in combination. Exception: legend prenatal vitamins are covered; or
- dietary supplements; or
- contraceptives, oral or other, whether medication or device; or
- therapeutic devices or appliances, including hypodermic needles, syringes, support garments and other non-medicinal substances, regardless of intended use; or
- infertility drugs, immunization agents, biological sera, blood, blood plasma, injectables (other than insulin) or any prescription directing parenteral administration or use; or
- administration of any drug or medicine; or
- any prescription or refill in excess of the number directed by the Physician or any refill dispensed more than one year after the prescription date; or
- drugs or medicines for which you or a Dependent has no financial liability or that would be provided at no charge in the absence of insurance; or
- drugs or medicines paid for or furnished by the United States Government or one of its agencies (except as required under Medicaid provisions or Federal law); or
- drugs or medicines provided as the result of a sickness or injury that is due to war or act of war; or
- drugs or medicines provided as the result of a sickness or injury that is due to participation in criminal activities; or
- drugs or medicines covered by medical expense insurance issued under the Individual Purchase Rights described in this booklet; or
- drugs or medicines provided as the result of a sickness that is covered by a Workers' Compensation Act or other similar law; or
- drugs or medicines provided as the result of an injury arising out of or in the course of any employment for wage or profit; or
- growth hormones; or

- cosmetic, and health and beauty aids; or
- Levonorgestrel (Norplant); or
- drugs labeled "Caution--limited by Federal law to investigational use," or experimental, even through a charge is made to the individual; or
- topical dental fluorides; or
- dermatologicals used as hair growth stimulants; or any other drug or medicines used for cosmetic purposes; or
- DESI drugs (drugs determined by the Food and Drug Administration as lacking in substantial evidence of effectiveness); or
- drugs or medicines that are lost, stolen or spilled; or
- smoking deterrent medications containing nicotine or any other smoking cessation aids, all dosage forms; or
- anorectics (any drug used for the purpose of weight control); or
- minerals. Exception: Potassium supplements are covered; or
- drugs or medicines that are paid for by a Medicare Supplement Insurance Plan.

### **Group Medical Drug Insurance**

Insurance for prescribed drugs and medications will continue to be available under the Comprehensive Medical Expense Insurance. Under the Comprehensive Medical Expense Insurance, a calendar year Deductible must first be satisfied and then benefits will be payable as described in the Summary of Benefits section.

## MEDICAL EXPENSE INSURANCE

### PREEXISTING CONDITION EXCLUSION

The Preexisting Condition Exclusion provisions described in this section will apply only to individuals who are Late Enrollees as defined in GH 115 A (MED) or unless the provisions under Credit for Previous Creditable Coverage applies.

#### Definition

A Preexisting Condition is a condition (whether physical or mental), regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended or received within the six-month period ending on the effective date of an individual's coverage under the Group Policy.

However, pregnancy will not be considered a Preexisting Condition.

Genetic information will not be considered a Preexisting Condition in the absence of a diagnosis of the condition related to such information

#### Exclusion Period

Benefits for Treatment or Service of an individual's Preexisting Condition will be excluded for a period of six consecutive months after the effective date of the individual's coverage under the Group Policy; and then benefits will be payable only with respect to Treatment or Service received after the exclusion period.

Exemption for Certain Dependent Children. The Preexisting Condition Exclusion described above will not apply to any Dependent Child:

- who is the Member's newborn child, or a child newly adopted by the Member (or Placed for Adoption with the Member) prior to the child's attainment of age 18; and
- whose coverage becomes effective under the Group Policy within the 31-day period immediately following the date of birth, adoption, or Placement for Adoption.

If a Dependent Child becomes covered under the Group Policy other than as described above, that child will also be exempt from the Preexisting Condition Exclusion if:

- the child was covered under another Creditable Coverage as of the last day of the 31-day period beginning with the child's date of birth, adoption or Placement for Adoption (provided the adoption or Placement occurred prior to the child's attainment of age 18); and
- the child has subsequently maintained continuous Creditable Coverage, with no gap in coverage exceeding 63 days (180 days if loss of other coverage was due to termination of employment or employer contributions).

If any such child's coverage under the Group Policy terminates and the child later becomes covered again under the Group Policy, the exemption will continue to apply to the child unless there has

been a period of at least 63 (180 days if loss of other coverage was due to termination of employment or employer contributions) days during all of which the child was not covered under any Creditable Coverage.

For the purpose of these provisions, an HMO Affiliation Period will not be considered a break in Creditable Coverage.

### **Credit for Previous Creditable Coverage**

The Preexisting Condition exclusion period will be reduced by days of continuous Creditable Coverage, if any, applicable to the individual as of the effective date of his or her coverage under the Group Policy.

In determining days of continuous Creditable Coverage, any period of Creditable Coverage which occurs before a significant break in coverage will not be counted. For this purpose, "significant break in coverage" means a period of 63 days (180 days if loss of other coverage was due to termination of employment or employer contributions) during all of which a person is not covered under any Creditable Coverage. However, an HMO Affiliation Period will not be considered a break in coverage.

With respect to an individual becoming covered under the Group Policy, a period of Creditable Coverage will not be considered continuous if, after such period and before the effective date of the individual's coverage, there was a 63-day (180 days if loss of other coverage was due to termination of employment or employer contributions) period during all of which the individual was not covered under any Creditable Coverage.

## **MEDICAL EXPENSE INSURANCE**

### **EXTENDED BENEFITS**

**(after termination of insurance)**

If Medical Expense Insurance under the Group Policy ceases and if you or your Dependents qualify, We will pay Comprehensive Medical benefits for Treatment or Service received after termination of insurance to the extent that these benefits would have been paid had insurance remained in force.

You or your Dependent will qualify if you or one of your Dependent are Hospital Inpatient Confined from the date insurance ceases to the date of Treatment or Service. Benefits will be payable until the date Hospital Inpatient Confinement ends, but in no event beyond three months.

These extended benefits will be payable only for Treatment or Service received for the condition that caused the Hospital Inpatient Confinement and which was diagnosed by a Physician before the date coverage terminated.

No benefits will be paid for Treatment or Service received on or after the date you or your Dependent become eligible for other group medical expense coverage.

Extended benefits are payable without application of the Hospital Inpatient Confinement requirements described above, if insurance ceases due to termination of the Group Policy, either in its entirety or for your employer. Extended benefits will be payable for up to 12 months, provided:

- you or your Dependent have been Totally Disabled from the date insurance ceased until the date of the Treatment or Service; and
- you or your Dependent would have qualified for payment of Comprehensive Medical benefits if insurance had remained in force; and
- the sickness or injury for which you or your Dependent receive Treatment or Service is the disabling condition and was diagnosed by a Physician before the date insurance terminated.

These extended benefits are payable whether or not the Group Policy is replaced. However, if the Group Policy is replaced within 60 days, the extended benefits will cease on the earlier of:

- the date 12 months after the date insurance terminates; or
- the date the succeeding carrier provides replacement coverage to the you or your Dependents without limitation as to the disabling condition.

These extended benefits will not apply to insurance which terminates because you or your Dependents transfer to an HMO.

## MEDICAL EXPENSE INSURANCE

### INDIVIDUAL PURCHASE RIGHTS

If your Medical Expense Insurance terminates and you have been continuously insured under the Group Policy (or for similar benefits under any group policy which it replaces) for at least the three-month period immediately prior to the date insurance terminates, you may buy other medical expense insurance from Us. Except that, you may not buy other medical expense insurance if your Medical Expense Insurance terminates because:

- you fail to pay any required premium; or
- the Group Policy terminates and continuous coverage is provided under a replacement group medical expense coverage.

A statement of health will not be required. The other coverage will be on one of the forms We then issue to persons who apply for individual purchase.

NOTE: The benefits provided under the conversion policy are not the same as the benefits provided under the Group Policy. Specific details regarding the terms of the conversion policy may be obtained from Us or from your employer.

The persons to be covered under the other medical expense insurance will be you and all of your Dependents who are covered under the Group Policy on the date insurance ceases, except that any Developmentally Disabled or Physically Handicapped child beyond the maximum age for Dependent Children will be covered as provided in the last paragraph.

We will not issue other medical expense insurance if you are covered by similar coverage which, together with this coverage, may result in overinsurance based on standards for overinsurance.

You must apply for individual purchase and pay the first premium to Us within 31 days after your insurance under the Group Policy is terminated. The premium you pay will be at Our normal rate for your age and for the risk class to which you belong. See the Policyholder for the proper forms. The other medical expense insurance will then be in force on the day after that termination date.

Your spouse may buy other medical expense insurance in the same manner as described above for you, if insurance under the Group Policy ceases for your spouse because:

- of your death; or
- of divorce or legal separation.

A Dependent Child may also buy other medical expense insurance in the same manner as described above for you, if insurance under the Group Policy ceases for the Dependent Child because the child is no longer eligible as a Dependent.

NOTE: Individual Purchase is also available at the end of any continuation period, provided the person is not then covered for similar coverage which, together with this coverage, would result in overinsurance based on Our standards for overinsurance.

If the Policyholder offers coverage under an HMO as an alternative to this coverage, these Individual Purchase Rights will not apply to any person who is covered by an HMO on the date insurance terminates or to any person who becomes covered by an HMO within 31 days after this insurance terminates.

## MEDICAL EXPENSE INSURANCE

### COORDINATION WITH OTHER BENEFITS

#### Applicability

These Coordination of Other Benefits (COB) provisions apply to This Plan when you or one of your Dependents have health care insurance under more than one Plan. "Plan" and "This Plan" are defined below.

If the COB provision applies, the order of benefit determination rules should be looked at first. Those rules determine whether the benefits of This Plan are determined before or after those of another plan. The benefits of This Plan:

- Will not be reduced when, under the order of benefit determination rules, This Plan determines its benefits before another plan; but
- May be reduced when, under the order of benefits determination rules, another plan determines its benefits first.

#### Definitions

"Plan" is any of these which provides benefits or services for, or because of, medical care or treatment.

- \* - any insured or noninsured group, service, prepayment, or other program arranged through an employer, trustee, union, or association; and
- any program required or established by state or Federal law (including Medicare Parts A and B); and
- any program sponsored by or arranged through a school or other educational agency.

The term Plan will not include benefits provided under:

- a student accident policy; or
- a state medical assistance program where eligibility is based on financial need; or
- individual or family policies; or
- individual or family subscriber contracts; or
- entitlements to Medi-Cal benefits; or
- benefits provided under the California Crippled Children Services program; or
- the medical payment benefits customarily included in the traditional automobile contracts; or
- any other coverage provided for or required by law when its benefits are excess to any private insurance or other non-governmental program.

\*In the event a husband and wife are both employed by the Policyholder, each Plan will be considered a separate Plan with respect to these coordination of benefits provisions. The amount payable will not be more than 100% of the actual cost charged for treatment or service.

**Primary Plan/Secondary Plan:** The order of benefit determination rules determine whether This Plan is a "Primary Plan" or a "Secondary Plan" when compared to another Plan covering the person.

When this Plan is Primary, its benefits are determined before those of any other Plan and without considering any other Plan's benefits. When this Plan is Secondary, its benefits are determined after those of another Plan and may be reduced because of the Primary Plan's benefits.

**Allowable Expense:** A health care service or expense, including Deductibles, coinsurance, and Copayments, if any, that is covered at least in part by any of the Plans covering the person for whom benefits are claimed. When a Plan provides benefits in the form of services (for example an HMO), the reasonable cash value of each service will be considered an allowable expense and a benefit paid. An 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 person is covered by two or more Plans that compute their benefits payments on the basis of usual and customary fees, any amount in excess of the highest of the usual and customary fees for a specific benefit is not an Allowable Expense.
- If a person is covered by two or more Plans that provide benefits or services on the basis of a negotiated fee, an amount in excess of the highest of the negotiated fees 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 fees and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary Plan's payment arrangements will be the Allowable Expense for all Plans.
- The amount a benefit is reduced by the Primary Plan because a covered person does not comply with the Plan provisions. Examples of these provisions are second surgical opinions, precertification of admissions and preferred provider arrangements

"Claim Determination Period" means the part of a calendar year during which you or a Dependent would receive benefit payments under This Plan if this section were not in force.

### **Effect on Benefits**

Benefits otherwise payable under This Plan for Allowable Expenses during a Claim Determination Period may be reduced if:

- benefits are payable under any other Plan for the same Allowable Expenses; and
- the rules listed below provide that benefits payable under the other Plan are to be determined before the benefits payable under This Plan.

The reduction will be the amount needed to provide that the sum of payments under This Plan plus benefits payable under the other Plan(s) is not more than the total of Allowable Expenses.

For this purpose:

- benefits payable under other Plans will include the benefits that would have been paid had claim been made for them;
- for any person covered by Medicare Part A, benefits payable will include benefits provided by Medicare Part B whether or not the person is covered under that Part B.

### **Order of Benefit Determination**

**General.** Except as described below under Medicare Exception, the benefits payable of a Plan that does not have a coordination of benefits provision similar to the provision described in this section will be determined before the benefits payable of a Plan that does have such a provision. In all other instances, the order of determination will be:

**Rules.** This Plan determines its order of benefits using the first of the following rules which applies:

- **Non-Dependent/Dependent.** The plan which covers the person as an employee, member, or subscriber (that is, other than as a Dependent) are determined before those of the plan which covers the person as a Dependent. Exception: If the person is also a Medicare beneficiary, and as a result of the rule established by Title XVIII of the Social Security Act and implementing regulations, 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 benefits of the Plan covering the person as a dependent are determined before those of the Plan covering that person as other than a Dependent.
- **Dependent Child--Parents Not Separated or Divorced.** If a child is covered by both parents' Plans, the Plan of the parent whose birthday falls earlier in the calendar year will be determined before those of the Plan of the parent whose birthday falls later in that year. But, if both parents have the same birthday or if the other Plan does not have a birthday rule, and as a result the Plans do not agree on the order of benefits, the benefits of the Plan which covered a parent longer are determined before those of the Plan which covered the other parent for a shorter period of time.

However, if the other Plan does not have the rule described above, but instead has a rule based upon the gender of the parent, and if, as a result, the Plans do not agree on the order of benefits, the rule in the other Plan will determine the order of benefits.

- **Dependent Child--Separated or Divorced Parents.** If a child of legally separated or divorced parents is covered under two or more Plans, benefits for the child are determined in this order:
  - First, the Plan of the parent with custody of the child;
  - Then, the Plan of the spouse of the parent with custody of the child; and
  - finally, the Plan of the parent not having custody of the child.

However, if the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the entity obligated to pay or provide the benefits of the Plan of that parent has actual knowledge of those terms, the benefits of that Plan are determined first. This paragraph does not apply for any Claim Determination Period or Plan year during which any benefits are actually paid or provided before the entity has that actual knowledge.

- **Joint Custody.** If the specific terms of a court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the Plans covering the child shall follow the order of benefit determination rules for Dependent children of parents who are not separated or divorced.
  - **Active/Inactive Employee.** The benefits of a Plan which covers a person as an employee who is neither laid-off nor retired are determined before those of a Plan which covers that person as a laid-off or retired employee. The same would hold true if a person is a dependent of a person covered as a retiree and an employee. 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 will not apply.
  - **Continuation of Coverage.** If a person for whom coverage is provided under a right of continuation according to Federal or state law is also covered under another Plan, the following will be the order of benefit determination:
    - first, the benefits of a Plan covering the person as an employee, Member, or subscriber (or as that person's Dependent);
    - second, the benefits under the continuation coverage.
- If the other Plan does not have the rule described above, and if, as a result, the Plans do not agree on the order of benefits, this rule will not apply.
- **Longer/Shorter Length of Coverage.** If none of the above rules determine the order of benefits, the benefits of the Plan which covered an employee, Member, or subscriber longer are determined before those of the Plan which covered that person for the shorter time.

### **Medicare Exception**

Unless otherwise required by Federal law, benefits payable under Medicare will be determined before the benefits payable under the Group Policy.

Federal law will usually apply in such instances if:

- the benefits are applicable to an active (rather than a retired) Member or to that Member's spouse; and
- the Member's employer has 20 or more employees.

## How COB Works

**Example 1:** The natural father is insured as a Member under This Plan. Company A covers the natural mother. Company B covers the stepfather. The natural mother has custody of the child and the divorce decree does not establish financial responsibility for medical, dental, or other health care expenses.

The following order of benefits would apply to the child:

1. Company A would be Primary (mother's carrier).
2. Company B would be Secondary (stepfather's carrier).
3. We would then determine the benefits payable, if any, under This Plan.

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**Example 2A:** Mrs. Smith has filed a claim for \$2,400 with both Company A and Company B. Company A insures Mrs. Smith as an employee under a plan which pays 80% of Covered Charges after a \$200 calendar year deductible is satisfied. Company B insures her as a dependent spouse under a plan.

Both plans have a COB provision, therefore, Company A would pay first since it insures Mrs. Smith as an employee. Since Company A pays first, it calculates benefits in full as though duplicate coverage did not exist.

### Company A

|  |                            |
|--|----------------------------|
| Billed Charges                                       | \$ 2,400.00                |
| Not Covered By Primary Carrier                       | \$ 200.00 (Personal Items) |
| Total Covered Charges                                | \$ 2,200.00                |
| Other Carriers Deductible                            | \$ 200.00                  |
| Benefits Payable ( $\$2,000 \times 80\% = \$1,600$ ) | \$ 1,600.00                |

Once Company A has determined and paid its benefits, Mrs. Smith's claim is then considered by Company B. In calculating its benefit, Company B must include any expenses that would be allowable expenses under the Company A plan.

### Company B

|                         |             |
|-------------------------|-------------|
| Allowable Expenses      | \$ 2,200.00 |
| Less Company A Benefits | \$ 1,600.00 |
| Benefits Payable        | \$ 600.00   |

The Patient is responsible for \$200 which is not considered a covered expense under either policy.

**Example 2B:** The same rules apply in this example as they did in Example 2A. Mrs. Smith has filed an additional claim for \$5,000 with both Company A and Company B. Company A insures Mrs. Smith as an employee under a plan which pays 80% of Covered Charges after a \$200 calendar year deductible is satisfied. Company B insures her as a dependent spouse under a plan.

Both plans have a COB provision, therefore, Company A would pay first since it insures Mrs. Smith as an employee. Since Company A pays first, it calculates benefits according to their plans Covered Charges as though duplicate coverage did not exist.

Company A

|  |                         |
|--|-------------------------|
| Billed Charges                             | \$ 5,000.00             |
| Not Covered By Primary Carrier             | \$ 500.00(Private Room) |
| Total Covered Charges                      | \$ 4,500.00             |
| Other Carriers Deductible                  | \$ 200.00               |
| Benefits Payable (\$4,300 X 80% = \$3,440) | \$ 3,440.00             |

Once Company A has determined and paid its benefits, Mrs. Smith's claim is then considered by Company B. In calculating its benefit, Company B must include any expenses that would be allowable expenses under the Company A plan.

Company B

|                               |             |
|-------------------------------|-------------|
| Allowable Expenses            | \$ 4,500.00 |
| Less Company A Benefits       | \$ 3,440.00 |
| Benefits Payable By Company B | \$ 1,060.00 |

The Patient is responsible for \$500 which is not considered a covered expense under either policy.

## **MEDICAL EXPENSE INSURANCE**

### **SUBROGATION AND REIMBURSEMENT**

#### **Applicability**

Subject to applicable law, this section will apply to Members and Dependents who:

- receive benefit payment under the Group Policy as a result of a sickness or injury; and
- have a lawful claim against another party, parties, or insurer (including uninsured, underinsured, and no-fault automobile insurers) for compensation, damages, or other payment because of that same sickness or injury.

We will have the right of first reimbursement from any recovery a Member or Dependent receives even if the Member or Dependent has not been made whole.

#### **Transfer of Rights**

In those instances where this section applies, the rights of the Member and/or Dependents to claim or receive compensation, damages, or other payment from the other party or parties will be transferred to Us, but only to the extent of benefit payments made under the Group Policy.

#### **Member and Dependent Obligations**

To secure Our rights under this section, a Member and/or Dependents must:

- Complete any applications or other instruments and provide any documents We might require, and cooperate with Us and Our agents in order to protect Our subrogation rights.
- If payment from the other party or parties has been received, reimburse Us for benefit payment made under the Group Policy (but not more than the amount paid by the other party or parties.)
- The Member and/or Dependent will not take any action that prejudices Our rights. If the Member or Dependent enters into litigation or settlement negotiations regarding the obligations of other parties, the Member and/or Dependent must not prejudice, in any way, Our subrogation rights under this Section.

The costs of legal representation retained by Us in matters related to subrogation will be borne solely by Us. The costs of legal representation retained by the Member and/or Dependent will be borne solely by the Member or Dependent.

## **CLAIM PROCEDURES**

### **Notice of Claim**

Except in the case of medical care received from Preferred Providers, We will acknowledge verbal or Written notice of claim within 15 days of receipt, unless payment is made within that time period. This verbal or Written acknowledgement will be received from the PPO when care is received from a Preferred Provider.

### **Claim Forms**

When We receive notice of claim for medical care received from a Non-Preferred Provider, We will provide claim forms, instructions, and reasonable assistance within 15 days of receipt of such notice.

### **Proof of Loss**

Completed claim forms and other information needed to prove loss should be filed promptly. Written proof of loss should be sent to Us within 90 days after the date of loss. Proof required includes the date, nature, and extent of the loss. We may request additional information to substantiate your loss or require a Signed unaltered authorization to obtain that information from the provider. Your failure to comply with such request could result in declination of the claim.

### **Payment, Denial, and Review**

Federal law permits up to 90 days for processing claims and up to 60 days for reviewing denied claims. State law permits up to 40 calendar days (30 working days for emergency medical services) after receipt of proof of claim to determine if the claim will be paid or denied. If a determination cannot be made within the appropriate time period described above, We can request a 30-day extension in Writing prior to the end of the original time period, and every 30 days thereafter. (Exception: If there is a reasonable basis for Us to believe a claim is false or fraudulent, the original time period (30 days for emergency medical services and 40 days for non-emergency medical services) is extended to 80 calendar days.)

If it is determined that the claim will be paid, payment must be made within 30 days of (a) determination of coverage, or (b) execution of a settlement agreement.

If the claim is denied, in whole or in part, We will notify the claimant in Writing of the basis for the denial. This denial notice will include an explanation of the policy provision, condition, or exclusion relevant to the facts of the claim. The notice will also provide the address and telephone number of the unit of the California Department of Insurance the claimant should contact for review if he or she believes the claim has been wrongfully denied.

### **Medical Examinations**

We may have the person whose loss is the basis for claim examined by a Physician. We will pay for these examinations and will choose the Physician to perform them.

## **Legal Action**

Legal action with respect to a claim may not be started earlier than 90 days after proof of loss is filed. Further, no legal action may be started later than three years after proof is required to be filed.

## **Time Limits**

All time limits listed in this section will be adjusted as required by law.

## **For Medical Insurance**

### **Preferred Providers**

When you become insured, you will be issued an identification card. This card should be presented to each Preferred Provider at the time you or a Dependent receives needed medical care. We will assist you with the Hospital Admission Review and Presurgery Review requirements.

### **Benefit Advice**

Benefit Advice is Our toll-free service that can answer questions about your benefit program or specific coverages. The staff provides information on topics such as outpatient surgery, generic drugs, health care alternatives, health care providers, and treatment costs in your area.

The staff does not prescribe medical treatment. That is up to your Physician. But they can help you understand your benefits and how to use them in the most cost-effective manner.

Call Our toll-free Health Info Line number (see your ID card or your employer for the Health Info Line number) if you wish to discuss medical benefits with Our Benefit Advice staff. The number is also listed on page GH 103 in this booklet.

### **Hospital Admission Review - Applies only to Medical Care received from Non-PPO Providers**

If a Hospital Inpatient Confinement is necessary, you will need to follow the procedures below in order to qualify for payment of Hospital Inpatient Confinement Charges at the standard rate for your plan. The procedures differ depending on the type of Hospital Inpatient Confinement:

- **For Other than a Medical Emergency**

You, your Dependent, or a designated patient representative must call Us at the toll-free number as soon as Hospital Inpatient Confinement is scheduled, but no later than the day of a Hospital Inpatient Confinement.

- **For a Medical Emergency**

You, your Dependent, or a designated patient representative must call Us at the toll free number within two business days of a Hospital Inpatient Confinement.

- **For a Continued Stay Review**

If the Hospital Inpatient Confinement will exceed the approved number of days, We will initiate a Continued Stay Review.

- **For Childbirth**

A Hospital Admission Review is not required for the first two days of Hospital Inpatient Confinement for childbirth, for mother and baby.

You, your Dependent, or a designated patient representative must call Us at the toll-free number to request a review of the need for continued Hospital Inpatient Confinement for mother or baby before the end of the second day of confinement if the mother or baby will remain Hospital Inpatient Confined beyond that time period.

Notification of the number of approval days will be sent to you, your Physician, and the Hospital.

**Presurgery Review** - Applies only to Medical Care received from Non-PPO Providers

You may elect to obtain a second opinion for any proposed surgery. However, if the surgery is not on the Presurgery Review list, Second Opinion Consultation Charges will be payable at the standard rate of your plan.

If you are required by Us to obtain a second opinion, we will send you a Second Surgical Opinion claim form. You must:

- complete the statement of employee section, and
- have your Physician (or the Physician who will be performing the surgery) complete the attending Physician information section; and
- take the claim form and any medical information your Physician provides to the Second Opinion Physician. The Second Opinion Physician should perform an examination and complete the consulting Physician information section of the claim form.

You and your Physician should determine the next step. If you want a third opinion, you should repeat the steps above. The completed form should then be filed with Us.

**Facility of Payment For Medical Insurance**

We will normally pay all benefits to you. However, if the claimed benefits result from a Dependent's sickness or injury, We may make payment to the Dependent. Also, in the special instances listed below, payment will be as indicated. All payments so made will discharge Us to the full extent of those payments.

- If payment amounts remain due upon your death, those amounts may, at Our option, be paid to your estate, spouse, child, or parent, or a provider of medical services.

- If We believe a person is not legally able to give a valid receipt for a benefit payment, and no guardian has been appointed, We may pay whoever has assumed the care and support of the person.
- Reimbursement for covered medical transportation shall be made directly to the provider of such service.
- Reimbursement for perinatal services shall be made directly to certified nurse midwives or nurse practitioners when providing such service.
- Benefits payable to a PPO Provider will be paid directly to the PPO Provider on behalf of you or a Dependent.
- Benefits payable to LabOne facility will be paid directly to the facility.

## STATEMENT OF RIGHTS

Federal law requires that this section be included in your booklet:

As a participant in this plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA).

ERISA provides that all plan participants shall be entitled to:

- Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites and union halls, all documents, including insurance contracts, collective bargaining agreements, and copies of all documents filed by the plan with the U.S. Department of Labor, such as detailed annual reports and plan descriptions.
- Obtain copies of all plan documents and other plan information upon written request to the plan administrator. The administrator may make a reasonable charge for the copies.
- Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA. If your claim for a welfare benefit is denied in whole or in part you must receive a written explanation of the reason for the denial. You have the right to have the plan review and reconsider your claim.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. If it should happen that fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, if, for example, it finds your claim is frivolous.

If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210.

## SUPPLEMENT TO YOUR BOOKLET-CERTIFICATE

The Employee Retirement Income Security Act (ERISA) requires that certain information be furnished to each participant in an employee benefit plan. Your booklet-certificate and this Supplement are the Summary Plan Description for purposes of ERISA.

1. **Employer Plan Identification Number:**

EIN: 95-6041108  
PN: 501-148967

2. **Type of Administration:**

Medical Insurance Contract.

3. **Plan Administrator:**

Beneficial Administration Company, Inc.  
2505 McCabe Way  
Irvine, CA 92614-6243

4. **Plan Sponsor:**

Beneficial Administration Company, Inc.  
2505 McCabe Way  
Irvine, CA 92614-6243

5. **Agent for Legal Services:**

Beneficial Administration Company, Inc.  
2505 McCabe Way  
Irvine, CA 92614-6243

Legal process may also be served upon the plan administrator.

6. **Type of Participants Insured Under the Plan:**

The Plan's requirements as outlined in this booklet. See definition of Member in the definitions section of this booklet (page GH 136 A (MED)).

7. **Sources and Methods of Premium Payments to the Plan:**

The contributions necessary to finance the Plan are made by participating employers through negotiations for 100% of the employee and dependent cost. The contributions are calculated actuarially.

8. **Ending Date of Plan's Fiscal Year:**

April 30

9. The plan is maintained pursuant to collective bargaining agreement(s) and copies may be obtained upon written request to the plan administrator or are available for examination at the business office of the plan administrator.

10. **Trustees of the Plan**

A current listing of Trustees is available at the Plan Administrators Office.

Creditable Coverage does not include coverage consisting solely of coverage of Excepted Benefits. For this purpose, "Excepted Benefits" means benefits or coverage under one or more (or any combination) of the following:

- Coverage only for accident (including accidental death and dismemberment);
- Disability income insurance;
- Liability insurance, including general liability insurance and automobile liability insurance;
- Coverage issued as a supplement to liability insurance;
- Workers' Compensation or similar insurance;
- Automobile medical payment insurance;
- Credit-only insurance (for example, mortgage insurance);
- Coverage for on-site medical clinics;
- Other similar insurance coverage, under which benefits for medical care are secondary or incidental to other insurance benefits;
- The following benefits if offered separately from medical expense benefits (provided under a separate policy, certificate or contract of insurance, or otherwise not an integral part of the plan):
  - limited scope dental or vision benefits;
  - benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof;
  - other similar limited benefits;
- The following benefits if offered as independent, noncoordinated benefits:
  - coverage only for a specified disease or illness;
  - hospital indemnity or other fixed indemnity insurance;
- The following benefits if offered as a separate insurance policy:
  - Medicare Supplement insurance;
  - coverage supplemental to CHAMPUS;
  - similar supplemental coverage provided to coverage under a Group Health Plan.

**Custodial Care** means assistance with meeting personal needs or the Activities of Daily Living.

For this purpose, "Activities of Daily Living" means activities that do not require the services of a Physician, registered nurse (R.N.), licensed practical nurse (L.P.N.), chiropractor, physical therapist, occupational therapist, speech therapist or other health care professional including, but not limited to, bathing, dressing, getting in and out of bed, feeding, walking, elimination and taking medications.

**Deductible; Deductible Amount**

A specified dollar amount of Covered Charges that must be incurred by the insured person before benefits will be payable under the Group Policy for all or part of the remaining Covered Charges during the calendar year.

**Dental Services** mean any Treatment or Service provided to diagnose, prevent, or correct:

- periodontal disease (disease of the surrounding and supplemental tissues of the teeth, including deformities of the bone surrounding the teeth); or
- malocclusion (abnormal positioning or relationship of the teeth); or
- ailments or defects of the teeth and supporting tissue and bone (excluding impacted teeth and appliances used to close an acquired or congenital opening. However, the term **Dental Services** will include treatment performed to replace or restore any natural teeth in conjunction with the use of any such appliance).

**Dependent** means:

- Your spouse, if your spouse is not in the Armed Forces of any country.
- Your Dependent Child (or Children) as defined below.

**Dependent Child; Dependent Children** means:

- Your natural or legally adopted child, if that child:
  - is not married; and
  - is not in the Armed Forces of any country; and
  - is not insured under the Group Policy as a Member; and
  - is less than 19 years of age.

A newly adopted child will be considered a Dependent Child from the date of Placement with you for the purpose of adoption or the date of adoption, whichever is earlier. The child will continue to be a Dependent Child unless the Placement is disrupted prior to legal adoption and the child is removed from Placement.

- Your stepchild, if this child:
  - meets the requirements above; and
  - receives principal support from you.
- Your foster child, if this child:
  - meets the requirements above; and
  - lives with you; and
  - receives principal support from you; and
  - is approved in Writing by Us as a Dependent Child.

## DEFINITIONS

Several words and phrases used to describe your coverage are capitalized whenever they are used in this booklet. These words and phrases have special meanings as explained in this section.

**Ambulatory Surgery Center** means a facility designed to provide surgical care which does not require Hospital Inpatient Confinement but is at a level above what is available in a Physician's office or clinic. An Ambulatory Surgery Center:

- is licensed by the proper authority in the state in which it is located, has an organized Physician staff, and has permanent facilities that are equipped and operated primarily for the purpose of performing surgical procedures; and
- provides Physician services and full-time skilled nursing services directed by a licensed registered nurse (R.N.) whenever a patient is in the facility; and
- does not provide the services or other accommodations for Hospital Inpatient Confinement; and
- is not a facility used as an office or clinic for the private practice of a Physician or other professional providers.

**Average Wholesale Price** means the published cost of a drug product to the wholesaler.

**Birthing Center** means a freestanding facility that is licensed by the proper authority of the state in which it is located and that:

- provides prenatal care, delivery, and immediate postpartum care; and
- operates under the direction of a Physician who is a specialist in obstetrics and gynecology; and
- has a Physician or certified nurse midwife present at all births and during the immediate postpartum period; and
- provides, during labor, delivery and the immediate postpartum period, full-time skilled nursing services directed by a licensed registered nurse (R.N.) or certified nurse midwife; and
- has a Written agreement with a Hospital in the area for emergency transfer of a patient or a newborn child, with Written procedures for such transfer being displayed and staff members being aware of such procedures.

**Community Mental Health Center** means a community or county mental health facility that is licensed by the proper authority of the state in which it is located, and is primarily engaged in providing outpatient Mental Health, Behavioral, Alcohol, or Drug Abuse Treatment Services.

**Copayment; Copay** means a specified dollar amount that must be paid by you or a Dependent each time certain or specified services are rendered. In no event will the Copay amount exceed:

- for services provided by PPO Providers, the negotiated fee; and
- for services provided by Non-PPO Providers, the actual cost charged to you or your Dependent.

**Cosmetic Treatment and Services** mean Treatment or Services to change:

- the texture or appearance of the skin; or
- the relative size or position of any part of the body;

when such Treatment or Service is performed primarily for psychological purposes or is not needed to correct or improve a bodily function. Cosmetic Treatment and Services include, but are not limited to surgery, pharmacological regimens, and all related charges.

**Covered Charges** mean charges for the types of Treatment or Service listed under Covered Charges in the Comprehensive Medical section of this booklet, to the extent that the charges do not exceed Prevailing Charges. The Treatment or Service must be required for the treatment of a sickness, injury, or certain routine care and must be considered by Us to be Medically Necessary Care.

**Creditable Coverage** means with respect to an individual, coverage of the individual under any of the following:

- A Group Health Plan, as defined in this section;
- Health Insurance Coverage, as defined in this section;
- Medicare (Part A or Part B of Title XVIII of the Social Security Act);
- Medicaid (Title XIX of the Social Security Act, other than coverage consisting solely of benefits under Section 1928);
- CHAMPUS (Chapter 55 of Title 10, United States Code);
- A medical care program of the Indian Health Service or of a tribal organization;
- A state health benefits risk pool;
- A health benefit plan for government employees (Chapter 89 of Title 5, United States Code);
- A public health plan;
- A health benefit plan provided under the Peace Corp Act;
- Any other similar coverage permitted under state or federal law or regulations;
- Any other publicly sponsored program, provided in California or elsewhere, of medical, hospital and surgical care.

- Your child 19 years but less than 23 years of age who otherwise qualifies above, if that child receives principal support from you and is a Full-Time Student, as defined.

Dependent Child will include any child covered under a Qualified Medical Child Support Order (QMCSO) as defined by applicable federal law and state insurance laws that are applicable to the Group Policy, provided the child meets the definition of a Dependent Child.

**Developmental Disability** means a Dependent Child's substantial handicap which:

- results from mental retardation, cerebral palsy, epilepsy, or other neurological disorder; and
- is diagnosed by a Physician as a permanent or long-term continuing condition.

**Emergency Medical Transportation Services** means Ambulance Services provided through the "911" emergency response system.

**Employment Hours** mean the actual work hours credited to a Member while employed by one or more employers who are Subscribing Employers on or after March 1, 1967, and for which contributions have been made into the Fund.

**Episode of Hospice Care** means the period of time:

- beginning on the date a Hospice Care Program is established for a dying individual; and
- ending on the earlier of the date six months after the date the Hospice Care Program is established, the date the attending Physician withdraws approval of the Hospice Care Program, the date the individual recovers or the date the individual dies.

Two or more Episodes of Hospice Care for the same individual will be considered one Episode of Hospice Care, unless separated by a period of at least three months during which no Hospice Care Program is in effect for the individual.

**Experimental or Investigational Measures** means any Treatment or Service, regardless of any claimed therapeutic value, not Generally Accepted by specialists in that particular field of medicine.

**Full-Time Student** means your Dependent Child attending a school that has a regular teaching staff, curriculum and student body and who:

- attends school on a full-time basis, as determined by the school's criteria; and
- is dependent on you for principal support.

**Fund** means the funds managed by the Trustees of the Orange County Electrical Industries Health and Welfare Trust for the purpose of providing benefits under this plan.

**Generally Accepted** means that the Treatment or Service:

- has been accepted as the standard of practice according to the prevailing opinion among experts as shown by (or in) articles published in authoritative, peer-reviewed medical and scientific literature; and
- is in general use in the medical community; and

- is not under continued scientific testing or research as a therapy for the particular injury or sickness which is the subject of claim.

**Group Health Plan** means an employee welfare benefit plan, as defined in ERISA, to the extent that the plan provides medical care to employees or their dependents (as defined under the terms of the plan) directly or through insurance reimbursement, or otherwise.

**Group Policy** means the policy of group insurance issued to the Policyholder by Us which describes benefits and provisions for Members and Dependents.

**Health Care Extender** means a health care provider who assists in the delivery of covered medical services under the direction and supervision of a Physician.

"Direction and supervision" means the Physician co-signs any progress notes Written by the Health Care Extender; or there is a legal agreement that places overall responsibility for the Health Care Extender's services on the Physician.

**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 (HMO) contract, offered by an insurance company, insurance service, or insurance organization (including an HMO) licensed to engage in the business of insurance and subject to state law which regulates insurance.

**Health Maintenance Organization (HMO)** means an entity that is:

- A federally qualified Health Maintenance Organization as defined by federal law; or
- An organization recognized under state law as a Health Maintenance Organization; or
- A similar organization regulated under state law for solvency in the same manner and to the same extent as such a Health Maintenance Organization.

**HMO Affiliation Period** means a period of time which, under the terms of the Health Insurance Coverage offered by a Health Maintenance Organization (HMO), must expire before an individual's coverage becomes effective.

**Hospice** means a facility, agency, or service that:

- is licensed by the proper authority in the state in which it is located to establish and manage Hospice Care Programs; and
- arranges, coordinates, and provides Hospice Care Services for dying individuals and their families; and
- maintains records of Hospice Care Services provided and bills for such services on a consolidated basis.

**Hospice Care Program** means a program that furnishes palliative or supportive care focused on comfort and not cure and that is:

- managed by a Hospice; and
- established jointly by a Hospice, a Hospice Care Team, and an attending Physician;

to meet the special physical, psychological, and spiritual needs of dying individuals and their families.

**Hospice Care Team** means a group that provides coordinated Hospice Care Services and normally includes:

- a Physician;
- a patient care coordinator (Physician or nurse who serves as an intermediary between the program and the attending Physician);
- a nurse;
- a mental health specialist;
- a social worker;
- a chaplain; and
- lay volunteers.

**Hospital** means an institution that is licensed as a Hospital by the proper authority of the state in which it is located, but not including any institution, or part thereof, that is used primarily as a clinic, Skilled Nursing Facility, convalescent home, rest home, home for the aged, nursing home, custodial care facility, or training center.

For the purpose of Mental Health, Behavioral, Alcohol or Drug Abuse Treatment Services, the definition of "Hospital" will include each of the following facilities provided it is licensed by the proper authority of the state in which it is located:

- a Psychiatric Hospital; and
- an Inpatient Alcohol or Drug Abuse Treatment Facility; and
- any other facility required by state law to be recognized as a treatment facility under the Group Policy.

**Hospital Inpatient Confined; Hospital Inpatient Confinement** means any period of Treatment or Service in a Hospital in excess of 23 consecutive hours for any cause. A Hospital Admission Review is required for all Hospital Inpatient Confinements.

**Hospital Inpatient Confinement Charges** mean Covered Charges by a Hospital for room, board, and other usual services and by a Physician for pathology, radiology, or the administration of anesthesia provided while a person is Hospital Inpatient Confined.

**Hospitalization Charges** mean Covered Charges by a Hospital for room, board, and other usual services provided while a person is Hospital Inpatient Confined.

**Hospital Room Maximum** means Covered Charges by a Hospital for room and board while confined in a private room up to:

- the Hospital's most frequent semiprivate room rate if the Hospital has semiprivate rooms; or
- the Hospital's most frequent private room rate, if the Hospital has no semiprivate rooms.

**Hour Bank Account** means the account established by the Trustees in the name of a Member to which there shall be credited all of the Member's Employment Hours earned on or after March 1, 1973, except that at no time will the number of Employment Hours in the Member's hour bank account exceed 675.

**Immediate Family** means an insured person's spouse, natural or adoptive parent, natural or adoptive child, sibling, stepparent, stepchild, stepbrother or stepsister, father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, sister-in-law, grandparent, grandchild or spouse of grandparent or grandchild.

**Inpatient Alcohol or Drug Abuse Treatment Facility** means an institution that is licensed by the proper authority of the state in which it is located and is primarily engaged in providing alcohol or drug detoxification or rehabilitation treatment services and;

- is supervised on a full-time basis by a Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.); and
- provides 24-hour a day on-site nursing care by licensed registered nurses (R.N.s).

**Intensive Care Unit** means a section, ward, or wing within the Hospital which is separated from other Hospital facilities.

**Medical Detoxification** means treatment in a Hospital when a patient's life or vital bodily functions are threatened by complications associated with withdrawal from alcohol or drug use, requiring 24-hour nursing care and medical therapy supervised by a Physician in order to stabilize the patient's physical condition.

**Medical Emergency** means any Treatment or Service that We determine to be due to the sudden onset of severe medical symptoms that:

- could not have been reasonably anticipated; and
- requires immediate medical care.

**Medically Necessary Care** means as determined by Us, any Treatment or Service that is prescribed by a Physician and considered to be necessary and appropriate and not in conflict with Generally Accepted medical standards.

**Member** means any person who is:

- an employee of a Participating Unit; and
- a member of a union.

Member, for Comprehensive Medical Expense Insurance, will also include any such person retired on or after September 1, 1981, under the Southern California I.B.E.W. – N.E.C.A. Pension Plan provide that they meet the eligibility and contribution requirements established for the trust.

**Mental Health, Behavioral, Alcohol or Drug Abuse Treatment Services** means Treatment or Service provided to alter a person's behavior regardless of the cause of that behavior, including but not limited to: individual, family or group psychotherapy; psychological testing; electroconvulsive therapy; psychiatric diagnostic interviews or examinations; behavior modification; psychiatric, alcohol or drug abuse medication management; alcohol or drug abuse rehabilitation or counseling services; hypnotherapy; narcosynthesis; biofeedback, milieu or other therapies (physical, occupational or speech therapy), used to diagnose or treat mental health, behavioral, alcohol or drug abuse problems.

**Non-Preferred Provider/Non-PPO Provider** means a Hospital, Physician, or other provider not contracted with the preferred provider organization (PPO) network established by the PPO identified on your ID card.

**Outpatient Alcohol or Drug Abuse Treatment Facility** means a facility that is licensed by the proper authority of the state in which it is located, and is primarily engaged in providing outpatient alcohol or drug abuse treatment services.

**Participating Unit** means any employer, sole proprietorship, partnership, corporation, or firm who adopts and subscribes to the Agreement and Declaration of Trust between Orange County Chapter of the National Electrical Contractors Association and Orange County Electrical Workers Local No. 441, establishing the Fund, and who is bound by the terms of a collective bargaining agreement with the Union to make contributions to the Fund for the benefit of employees.

**Physical Handicap** means a Dependent Child's substantial physical or mental impairment which:

- results from injury, accident, congenital defect or sickness; and
- is diagnosed by a Physician as a permanent or long-term dysfunction or malformation of the body.

**Physician** means:

- a licensed Doctor of Medicine (M.D.) or Osteopathy (D.O.); or
- any other licensed health care practitioner that state law requires be recognized as a Physician under the Group Policy.

Whether or not required by state law, the following licensed or certified health care practitioners will be recognized, on the same basis as a Physician, for Covered Charges of services performed within the scope of their license: audiologist, chiropractor, dentist, occupational therapist, optometrist, physician's assistant, physical therapist, podiatrist, psychologist, social worker, and speech pathologist.

**Physician Visit** means a face-to-face meeting between a Physician or the Physician's staff and a patient for the purpose of medical Treatment or Service except when health care is performed via Telemedicine.

**Physician Visit Charges** mean Covered Charges for Treatment or Services furnished at a Physician's clinic or office or by a Physician at your home or your Dependent's home. Such services include charges for: dressings; supplies; equipment; injections; anesthesia; take-home drugs; blood; blood plasma; x-ray and laboratory examinations; x-ray, radium, and radioactive isotope therapy; and routine physical examinations; but do not include magnetic resonance imaging (MRIs); computerized axial tomography (CATs); and positron emission tomography (PETs) or other similar imaging tests.

**Placement for Adoption; Placement** means the assumption and retention by a person of a legal obligation for total or partial support of a child in anticipation of adopting the child. The child's placement with the person terminates upon the termination of such legal obligation.

**Policyholder** means Trustees of the Orange County Electrical Industry Health and Welfare Fund and shall include any affiliate or subsidiary of the Policyholder participating under the Group Policy.

**Preferred Provider/PPO Provider** means a Hospital, Physician, or other provider contracted with the preferred provider organization (PPO) network established by the PPO identified on your ID card.

The Policyholder's participation in a PPO network does not mean that an insured person's choice of provider will be restricted. The insured person may seek needed medical care from any Hospital, Physician, or other provider of his or her choice. However, in order to avoid higher charges and reduced benefit payment, the insured persons are urged to obtain such care from Preferred Providers whenever possible.

We have the right to terminate the PPO portion of the Group Policy if We or the PPO terminates the arrangement.

We also have the right to identify different preferred provider organizations from time to time and, to terminate the designation of any Preferred Provider at any time.

**Preferred Provider Organization (PPO)** means the PPO identified on your ID card.

**Preferred Provider Organization (PPO) Service Area** means the geographic area within which Preferred Provider services are available to persons covered under the Group Policy.

**Prevailing Charges** means:

- For medical care received from Preferred Providers, the amount based on the negotiated fee between the Provider and the PPO; and
- For medical care received from Non-Preferred Providers, the amount, as determined by Us, that most health care providers charge within a geographic cost area for a Treatment or Service.

For purposes of coverage provided under the Group Policy, an actual charge for a Treatment or Service will be in excess of Prevailing Charges if, as determined by Us, 90% or more of all other charges reported to Us for the same (or a similar) Treatment or Service provided within the same (or a comparable) cost area are lower in amount than the actual charge.

- For drugs and medicines requiring a Physician's prescription and considered a covered Treatment or Service, Prevailing Charges will not exceed the Average Wholesale Price.

**Psychiatric Hospital** means an institution that is licensed as a Hospital by the proper authority of the state in which it is located, and is primarily engaged in providing diagnostic and therapeutic Mental Health, Behavioral, Alcohol, or Drug Abuse Treatment Services.

For the purpose of this definition, a Psychiatric Hospital will also include any inpatient bed in a licensed general Hospital used to provide diagnostic and therapeutic Mental Health, Behavioral, Alcohol or Drug Abuse Treatment Services in the absence of a specialized or designated psychiatric or drug treatment unit.

**Signed or Signature** means any symbol or method executed or adopted by a person with the present intention to authenticate a record, and which is on or transmitted by paper or electronic media, and which is consistent with applicable law and is agreed to by The Principal.

**Skilled Nursing Facility** means an institution (including one providing sub-acute care), or a distinct part thereof, that is licensed by the proper authority of the state in which it is located to provide skilled nursing care and that:

- is supervised on a full-time basis by a Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.) or a licensed registered nurse (R.N.); and
- has transfer arrangements with one or more Hospitals, a utilization review plan, and operating policies developed and monitored by a professional group that includes at least one M.D. or D.O.; and
- has an existing contract for the services of an M.D. or D.O., maintains daily records on each patient, and is equipped to dispense and administer drugs; and
- provides 24-hour nursing care and other medical treatment.

Not included are rest homes, homes for the aged, nursing homes, or places which furnish Mental Health, Behavioral, Alcohol, or Drug Abuse Treatment Services.

**Social Detoxification** means Treatment or Service designed to achieve detoxification without the use of drugs or other medical interventions.

**Stop Loss Expense Limit** means the first \$15,000 of each person's Covered Charges in excess of the Deductible amount per calendar year.

**Subscribing Employer** means an employer who adopts and is signatory to the Agreement and Declaration of Trust between Orange County Chapter of the National Electrical Contractors Association and Orange County Electrical Workers Local No. 441, establishing the Fund, and who is bound by the terms of a collective bargaining agreement to make contribution to the Fund for the benefit of his or her employees.

**Telemedicine** means the practice of health care delivery of diagnosis, consultation, treatment, transfer of medical data and education using interactive audio, video or data communication and does not include services performed using telephone or facsimile machine.

**Total Disability; Totally Disabled** means:

- For a Member (other than a retired Member), a Member's inability, as determined by Us, due to sickness or injury, to work at any job that reasonably fits his or her background or training; and
- For a Dependent or a retired Member, a substantial impairment, due to sickness or injury, that prevents the individual from performing the normal function of his or her regular duties or activities.

**Treatment or Service**, when used in this booklet, will be considered to mean: "confinement, treatment, service, substance, material or device."

**Trustees** mean the Trustees of the Orange County Electrical Industries Health and Welfare Trust.

**Union** means Local 441 or the International Brotherhood of Electrical Workers AFL-CIO.

**We, Us, and Our** mean Principal Life Insurance Company, Des Moines, Iowa.

**Written or Writing** means a record which is on or transmitted by paper or electronic media, and which is consistent with applicable law.

## **BOOKLET-CERTIFICATE NOTICE**

*California insurance law requires that a group policy include the telephone number of the insurance company issuing the policy in order for the persons to present inquiries, to obtain information about coverage, and to provide assistance in resolving complaints. Persons may call or write to:*

**Principal Life Insurance Company  
711 High Street  
Des Moines, Iowa 50392-0001**

**For Medical claim-related inquiries:  
Attn: Group Claim - Health Info Line Services  
Phone: 1-800-247-4695**

**For administration-related inquiries:  
Attn: Group Call Center  
Phone: 1-800-247-6699**

*Consumers should contact the Principal Life Insurance Company, their agent or other representative regarding complaints. If the policy or certificate was issued or delivered by an agent or broker, the insured must contact his or her agent or broker for assistance.*

*The California Department of Insurance should be contacted only after discussions with the insurer, or its agent or other representative, or both have failed to produce a satisfactory resolution to the problem.*

*Persons may call or write to:*

**California Insurance Department  
Claims Services Bureau  
11<sup>th</sup> Floor  
300 South Spring Street  
Los Angeles, CA 90013  
Phone: 1800-927-HELP (In State)  
1-213-897-8921 (Out of State)**

**This Notice is for your information only and does not become a part or condition of this booklet-certificate.**

## CALIFORNIA NOTICE

*Your state requires Principal Life Insurance Company (The Principal) to provide specific information regarding the use of prescription drug formularies and a telephone number to enable persons to obtain information about their prescription drug coverage.*

*Prescription drug expense coverage includes a Formulary feature.*

**For information regarding prescription drug benefits call the telephone number shown on the Member ID card.**

**This Notice is for your information only and does not become a part or condition of this booklet-certificate.**

Please attach your copy of the enrollment card to this page. The effective date of your coverage is as shown on the card.

Any Change of Beneficiary or Change of Name forms should also be attached to this page after having been properly recorded and returned to you.

You should also attach any riders to this page.

## Notes

Arranged by

**INNOVATIVE COST MANAGEMENT SERVICES**

1871 The Alameda Suite 335

San Jose, CA 95126-1746

Telephone

(408) 244-8535

Claims Office

**PRINCIPAL LIFE INSURANCE COMPANY**

P.O. Box 39710

Colorado Springs, CO 80949-3910

Administered by

**BENEFICIAL ADMINISTRATION COMPANY**

Administrative Office  
United Administrative Service  
P.O. Box 5057  
San Jose, Ca 95150-5057

