

City of Stockton

Modified Employee

Medical Plan Document/Summary Plan Description

Restated September 1, 2011

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INTRODUCTION

This Plan Document/Summary Plan Description provides a description of benefits, limitations, exclusions and other plan provisions that apply to the City of Stockton's Modified Employee Medical Plan as of September 1, 2011. This document replaces and supersedes all other Plan Documents/Summary Plan Descriptions and amendments thereto issued prior to that date.

You should review this document and share it with those members of your family who are or will be covered by the Plan. It will give all of you an understanding of the coverage provided; the procedures to follow in submitting claims; and your responsibilities to provide necessary information to the Plan.

While recognizing the many benefits associated with this Plan, it is also important to note that not every expense you incur for health care is covered by this Plan.

IMPORTANT NOTICE

You or another family member must promptly furnish to the City information regarding change of name, address, marriage, divorce or legal separation, death of any covered Family Member, change in Domestic Partnership status, change in status of a Family Member, Medicare enrollment or disenrollment or the existence of other coverage.

Notify the City's Human Resources Department – Benefits Section in writing no later than 31 days after any of the above noted events. Failure to do so may cause you or a Family Member to lose certain rights under the Plan or may result in your liability to the Plan if any benefits are paid to an ineligible person.

FOR HELP OR INFORMATION

When you need information, please check this document first. If you need further help, call the people listed in the following Quick Reference Chart.

QUICK REFERENCE CHART

Information Needed	Whom to Contact
<p>Plan Administrator</p> <ul style="list-style-type: none"> • Claim Forms (Medical) • Modified Medical Plan Claims and Appeals • Eligibility for Coverage • Modified Medical Plan Benefit Information • HIPAA Certificate of Creditable Coverage • Medicare Part D Notice of Creditable Coverage • COBRA Information and Enrollment Forms 	<p>Delta Health Systems P.O. Box 80 Stockton, CA 95201-3080 (800) 291-0726 www.deltahealthsystems.com</p>
<p>City's Human Resources Department – Benefits Section</p> <ul style="list-style-type: none"> • Enroll or cancel dependent(s) • Problems with eligibility • Submit Change of Address • Obtain copy of Summary Plan Description • Information on premium contributions 	<p>City of Stockton Human Resources Department – Benefits Section 22 East Weber Avenue, Suite 150 Stockton, CA 95202-2317 (209) 937-8233 or 937-8622 http://www.stocktongov.com</p>
<p>PPO Network</p> <ul style="list-style-type: none"> • Medical Network Provider Directory • Additions/Deletions of Network Providers • (Always check with the Network before you visit a provider to be sure they are still contracted and will give you the discounted price) 	<p>Anthem Blue Cross P.O. Box 60007 Los Angeles, CA 90060-0007 (800) 274-7767 www.anthem.com/ca</p> <p>CAUTION: Use of a Non-Participating Provider could result in you having to pay a substantial balance on the provider's billing. Your lowest out of pocket costs will occur when you use Participating Providers.</p>
<p>Utilization Management (UM) Program</p> <ul style="list-style-type: none"> • Precertification of Admissions and Medical Services • Second and Third Opinions • Case Management • Appeals of UM decisions 	<p>Delta Health Systems P.O. Box 80 Stockton, CA 95201-3080 (800) 291-0726 www.deltahealthsystems.com</p>
<p>Prescription Drug Plan</p> <ul style="list-style-type: none"> • ID Cards • Retail Network Pharmacies • Mail Order (Home Delivery) Pharmacy • Prescription Drug Information • Formulary of Preferred Drugs • Precertification of Certain Drugs 	<p>Medco P.O. Box 14711 Lexington, KY 40512 (800) 711-0917 www.medco.com</p>
<p>Employee Assistance Program (EAP) Professional, confidential information, support and referral to help individuals cope with personal problems that impact their home and work life. EAP counselors can help you with stress, marriage/family/work-related problems, substance abuse, financial and legal problems.</p>	<p>Integrated Behavioral Health 3070 Bristol Street, Suite 350, Costa Mesa, CA 92626 (800) 395-1616 www.ihbcorp.com</p>

**OVERVIEW OF THE CITY OF STOCKTON'S MODIFIED MEDICAL PLAN AS OF
SEPTEMBER 1, 2011**

The following is an overview of the City's Modified Medical Plan provided to eligible active and retired Employees and their eligible Family Members. Since this is only a summary of the benefits, you should refer to the Articles of this document for a more complete description of Plan benefits, limitations and exclusions.

Note: Capitalized terms used in this document have a very precise meaning (for example, "Medically Necessary", "Emergency" and "Allowable Charges"). To be sure you understand the meaning of capitalized terms, please refer to the Definitions contained in Article 1.

Plan Feature	Coverage Amount	
	When Provided by a Participating Provider	When Provided by a Non-Participating Provider
Calendar year deductible (<i>only Allowable Charges for Covered Services in Article 3 of this document can be applied toward the deductible</i>)	\$500 per person; \$1,500 maximum per family (<i>for example: the family deductible is met if 5 Family Members each have \$300 applied toward their individual deductibles</i>)	\$1,500 per person; \$3,000 maximum per family (<i>for example: the family deductible is met if 5 Family Members each have \$600 applied toward their individual deductibles</i>)
Calendar year out-of-pocket maximum on Allowable Charges (<i>only Allowable Charges for Covered Services in Article 3 of this document can be applied toward the out-of-pocket maximum</i>)	\$5,000 per person; \$10,000 maximum per family	None
Overall lifetime maximum benefit	None	None
Hospital		
Inpatient confinement	80% of Allowable Charges after a copayment of \$75 per admission	50% of Allowable Charges after a copayment of \$200 per admission
Outpatient department	80% of Allowable Charges	50% of Allowable Charges
Emergency room	80% of Allowable Charges; 50% of Allowable Charges if it is determined that an Emergency did not exist (<i>refer to Article 1 for the Plan's definition of Emergency</i>)	80% of Allowable Charges; 50% of Allowable Charges if it is determined that an Emergency did not exist (<i>refer to Article 1 for the Plan's definition of Emergency</i>)
Skilled Nursing Facility	80% of Allowable Charges after a copayment of \$75 per admission	50% of Allowable Charges after a copayment of \$200 per admission

Plan Feature	Coverage Amount	
	When Provided by a Participating Provider	When Provided by a Non-Participating Provider
Outpatient therapy (<i>physical, respiratory, cardiac & speech</i>)	80% of Allowable Charges	50% of Allowable Charges
Home health care	80% of Allowable Charges	Not covered
Hospice care	80% of Allowable Charges	Not covered
Mental or nervous disorder		
Inpatient confinement	80% of Allowable Charges after a copayment of \$75 per admission	50% of Allowable Charges after a copayment of \$200 per admission
Outpatient services	80% of Allowable Charges	50% of Allowable Charges
Substance abuse treatment (<i>Retired Employees and their Family Members are NOT covered for these benefits</i>)		
Inpatient confinement	80% of Allowable Charges after a copayment of \$75 per admission	50% of Allowable Charges after a copayment of \$200 per admission
Outpatient services	80% of Allowable Charges	50% of Allowable Charges
Outpatient diagnostic radiology & laboratory	80% of Allowable Charges	50% of Allowable Charges
Radiation therapy, chemotherapy & dialysis treatment	80% of Allowable Charges	50% of Allowable Charges
Physician services		
Office & hospital visits	80% of Allowable Charges	50% of Allowable Charges
Emergency room care	80% of Allowable Charges; 50% of Allowable Charges if it is determined that an Emergency did not exist (<i>refer to Article 1 for the Plan's definition of Emergency</i>)	80% of Allowable Charges; 50% of Allowable Charges if it is determined that an Emergency did not exist (<i>refer to Article 1 for the Plan's definition of Emergency</i>)
Surgery	80% of Allowable Charges	50% of Allowable Charges
Anesthesia and its administration	80% of Allowable Charges	50% of Allowable Charges
Preventive Care (<i>physical exam, screenings, tests & immunizations as recommended by certain government agencies – refer to the definition of Preventive Care Services in Article 1</i>)	Not subject to the calendar year deductible; 100% of Allowable Charges	Calendar year deductible applies; 50% of Allowable Charges
Dental treatment	Not covered except 80% of	Not covered except for 50%

Plan Feature	Coverage Amount	
	When Provided by a Participating Provider	When Provided by a Non-Participating Provider
	Allowable Charges for treatment of Accidental Injury to natural teeth	of Allowable Charges for treatment of Accidental Injury to natural teeth
Chiropractic services	80% of Allowable Charges	50% of Allowable Charges
Pregnancy & childbirth <i>(dependent children are not covered by this benefit)</i>	Covered on the same basis as an illness	Covered on the same basis as an illness
Infertility	80% of Allowable Charges	50% of Allowable Charges
Organ & tissue transplants	Payable on the same basis as any other illness	Payable on the same basis as any other illness
Ambulance service	80% of Allowable Charges	50% of Allowable Charges
Prosthetics & orthotics	80% of Allowable Charges	50% of Allowable Charges
Durable medical equipment	80% of Allowable Charges	50% of Allowable Charges
Acupuncture	80% of Allowable Charges	50% of Allowable Charges
Hearing aids	No Coverage	No Coverage
Prescription Drug Program <i>(no calendar year deductible applies)</i>	When Dispensed at a Participating Pharmacy	When Dispensed at a Non-Participating Pharmacy
Retail pharmacy <i>(30 day supply limit)</i>	\$10 copayment for a generic drug; \$35 copayment for a non-generic formulary drug; \$35 copayment plus the cost difference between non-formulary and formulary for non-generic non-formulary drugs	Not covered
Mail service pharmacy <i>(90 day supply limit)</i> Mandatory Mail Order for Maintenance Medications	\$20 copayment for a generic drug; \$70 copayment for a non-generic formulary drug; \$70 copayment plus the cost difference between non-formulary and formulary for non-generic non-formulary drugs	Not covered

Refer to Articles 3 and 4 on how to file a claim, and Article 7 on how to appeal a claim if it has been denied in whole or in part.

ARTICLE 1. DEFINITIONS

The following definitions apply to the terms used in this document.

Section 1.01 The term “**Accidental Injury**” means physical harm or disability which is the result of a specific unexpected incident. The physical harm or disability must have occurred at an identifiable time and place.

Section 1.02 The term “**Active Employee**” means any person who meets the eligibility rules in Section 2.01 A.1.

Section 1.03 The term “**Administrator**” means the organization contracting with the City to perform certain administrative duties with regard to the Plan.

Section 1.04 The term “**Allowed Charge(s)**” means:

A. For charges made by Participating Providers – Allowable Charge is the lesser of the billed charge or the contracted fee agreed upon by the Plan’s Preferred Provider Organization and the Participating Provider for the Covered Service.

B. For charges made by Non-Participating Providers – Allowable Charge is the lesser of the billed charge or applicable amount in the schedule that lists the dollar amounts the Plan has determined it will allow for eligible Medically Necessary services or supplies performed by Non-Participating Providers. The Plan’s allowed charge amount list is not based on or intended to be reflective of fees that are or may be described as usual and customary (U&C), reasonable and customary (R&C), usual, customary and reasonable charge (UCR), prevailing or any similar term. The Plan reserves the right to have the billed amount of a claim reviewed by an independent medical review firm/provider to assist in determining the amount the Plan will allow for the submitted claim.

With respect to Hospital emergency room services in a Non-Participating Hospital, the Allowable Charge is the greater of:

1. the negotiated median amount for Participating Provider Hospitals, or
2. 100% of the Plan’s usual payment (Allowed Charge) formula (reduced for cost-sharing), or
3. When such database is available, the amount that Medicare Parts A or B would pay (reduced for cost-sharing).

All charges in excess of Allowable Charges are not covered by the Plan.

Section 1.05 The term “**Ambulatory Surgical Facility/Center**” means a specialized facility that is established, equipped, operated and staffed primarily for the purpose of performing surgical procedures and which fully meets one of the following two tests:

A. It is licensed as an Ambulatory Surgical Facility/Center by the regulatory authority responsible for the licensing under the laws of the jurisdiction in which it is located; or

- B. Where licensing is not required, it meets all of the following requirements:
1. It is operated under the supervision of a licensed Physician (M.D. or D.O.) who is devoting full time to supervision and permits a surgical procedure to be performed only by a duly qualified Physician who, at the time the procedure is performed, is privileged to perform the procedure in at least one Hospital in the area.
 2. It requires in all cases, except those requiring only local infiltration anesthetics, that a licensed anesthesiologist administer the anesthetic or supervise an anesthetist who is administering the anesthetic, and that the anesthesiologist or anesthetist remain present throughout the surgical procedure.
 3. It provides at least one operating room and at least one post-anesthesia recovery room.
 4. It is equipped to perform diagnostic x-ray and laboratory examinations or has an arrangement to obtain these services.
 5. It has trained personnel and necessary equipment to handle emergency situations.
 6. It has immediate access to a blood bank or blood supplies.
 7. It provides the full-time services of one or more registered nurses (RNs) for patient care in the operating rooms and in the post-anesthesia recovery room.
 8. It maintains an adequate medical record for each patient, which contains an admitting diagnosis (including, for all patients except those undergoing a procedure under local anesthesia, a preoperative examination report, medical history and laboratory tests and/or x-rays), an operative report and a discharge summary.

An Ambulatory Surgical Facility/Center that is part of a Hospital, as defined in this Article, will be considered an Ambulatory Surgical Facility/Center for the purposes of this Plan.

Section 1.06 The term “Birthing Center” means a specialized facility that is primarily a place for delivery of children following a normal uncomplicated pregnancy and which fully meets one of the two following tests:

- A. It is licensed by the regulatory authority having responsibility for the licensing under the laws of the jurisdiction in which it is located; or
- B. Where licensing is not required, it meets all of the following requirements:
1. It is operated and equipped in accordance with any applicable state law for the purpose of providing prenatal care, delivery, immediate post partum care, and care of a child born at the center.
 2. It is equipped to perform routine diagnostic and laboratory examinations, including but not limited to hematocrit and urinalysis for glucose, protein, bacteria and specific gravity, and diagnostic x-rays, or has an arrangement to obtain those services.
 3. It has available to handle foreseeable emergencies, trained personnel and necessary equipment, including but not limited to oxygen, positive pressure mask, suction, intravenous equipment, equipment for maintaining infant temperature and ventilation, and blood expanders.
 4. It provides at least two beds or two birthing rooms.
 5. It is operated under the full-time supervision of a licensed Physician (M.D. or D.O.) or Registered Nurse (R.N.).
 6. It has a written agreement with at least one Hospital in the area for immediate acceptance of patients who develop complications.
 7. It has trained personnel and necessary equipment to handle emergency situations.
 8. It has immediate access to a blood bank or blood supplies.

9. It has the capacity to administer local anesthetic and to perform minor Surgery.
10. It maintains an adequate medical record for each patient that contains prenatal history, prenatal examination, any laboratory or diagnostic tests and a post partum summary.
11. It is expected to discharge or transfer patients within 48 hours following delivery; and
12. Is accredited by the American Association of Birth Centers (AABC).

Section 1.07 The term “**Calendar Year**” means January 1 to December 31 of any given year.

Section 1.08 The term “**Case Management Program**” means a program which coordinates a variety of medical care services needed by a Member with a catastrophic illness or injury or a long-term chronic, high dollar condition.

Section 1.09 The term “**Child**” means a natural child, a legally adopted child or child placed for adoption of either the Employee or the Spouse/Registered Partner. To be eligible for coverage, the Child must be under the age of 26 with the following exception. A covered unmarried dependent Child who is incapable of self-sustaining employment by reason of mental or physical disability and who is chiefly dependent upon the Employee for support, can remain covered beyond age 26 provided that written proof by a Physician of such incapacity and dependency is provided to the City’s Human Resources Department within 31 days of the date the Child reached age 26. Proof of continuing dependency and disability may be required at periodic intervals as requested by the Administrator.

Section 1.10 The term “**City**” means the City of Stockton.

Section 1.11 The term “**Consolidated Omnibus Budget Reconciliation Act**” (**COBRA**) refers to the federal law that requires group health plans to offer a temporary extension of health coverage at group rates in certain instances when coverage would otherwise end.

Section 1.12 The term “**Cosmetic Treatment**” means surgery or medical treatment to improve or preserve physical appearance, but not physical function. Cosmetic Treatment includes, but is not limited to, removal of tattoos, breast augmentation, or other medical/surgical treatment, prescription drugs and dental treatment intended to restore or improve physical appearance, as determined by the Plan Administrator or its designee.

Section 1.13 The term “**Covered Service(s)**” means the services and supplies as specified in Article 3, Section 3.06, which are certified by the attending Physician and determined by the Plan to be Medically Necessary.

Section 1.14 The term “**Custodial Care**” means care and services given mainly for personal hygiene or to perform the activities of daily living. Some examples of Custodial Care are helping patients get in and out of bed, bathe, dress, eat, use the toilet, prepare food, walk (ambulate), or take drugs or medicines that can be self-administered. These services are Custodial Care regardless of where the care is given or who recommends, provides, or directs the care. Custodial Care can be given safely and adequately (in terms of generally accepted medical standards) by people who are not trained or licensed medical or nursing personnel. Custodial Care may be payable by this Plan under certain circumstances such as when Custodial Care is provided during a covered period of hospice care.

Section 1.15 The term “**Day Care Center**” means an outpatient psychiatric facility which is part of or affiliated with a Hospital. It must be licensed according to state and local laws to provide outpatient care and treatment of Mental and Nervous Disorders under the supervision of a psychiatrist.

Section 1.16 The term “**Emergency**” means a sudden unexpected onset of a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or in the case of a pregnant woman, the health of her unborn child) in serious jeopardy, serious impairment to bodily functions or serious dysfunction/impairment of any bodily organ or part. For psychiatric conditions, the lack of the treatment could reasonably be expected to result in the patient harming himself or herself and/or other persons.

Section 1.17 The term “**Employee**” means each eligible Active Employee or each Retired Employee.

Section 1.18 The term “**Employee Assistance Program**” (**EAP**) means a program provided through an organization which has entered into an agreement with the City to provide mental health services for assessment, counseling, or referral to Active Employees and their eligible Family Members.

Section 1.19 The term “**Experimental**” and/or “**Investigational**” means if, in the opinion of the Plan Administrator or its designee, based on the information and resources available at the time the service was performed or the supply was provided, any of the following conditions were present with respect to one or more essential provisions of the service or supply:

A. The service or supply is described as an alternative to more conventional therapies in the protocols (the plan for the course of medical treatment that is under investigation) or consent document (the consent form signed by or on behalf of the patient) of the health care provider that performs the service or prescribes the supply.

B. The prescribed service or supply may be given only with the approval of an Institutional Review Board as defined by federal law.

C. In the opinion of the Plan Administrator or its designee, there is either an absence of authoritative medical, dental or scientific literature on the subject, or a preponderance of such literature published in the United States; and written by experts in the field; that shows that recognized medical, dental or scientific experts: classify the service or supply as experimental and/or investigational; or indicate that more research is required before the service or supply could be classified as equally or more effective than conventional therapies.

D. With respect to services or supplies regulated by the US Food and Drug Administration (FDA), FDA approval is required in order for the service and supply to be lawfully marketed; and it has not been granted at the time the service or supply is prescribed or provided; or a

current investigational new drug or new device application has been submitted and filed with the FDA.

E. In determining if a service or supply is or should be classified as Experimental and/or Investigational, the Plan Administrator or its designee will rely only on the following specific information and resources that are available at the time the service or supply was performed, provided or considered:

1. Medical or dental records of the covered person;
2. The consent document signed, or required to be signed, in order to receive the prescribed service or supply;
3. Protocols of the Physician that renders the prescribed service or prescribes or dispenses the supply;
4. Authoritative peer reviewed medical or scientific writings that are published in the United States regarding the prescribed service or supply for the treatment of the covered person's diagnosis, including, but not limited to "United States Pharmacopeia Dispensing Information"; and "American Hospital Formulary Service";
5. The published opinions of: the American Medical Association (AMA) or specialty organizations recognized by the AMA; or the National Institutes of Health (NIH); or the Center for Disease Control (CDC); or the Office of Technology Assessment; or the published screening criteria of national insurance companies such as Aetna and CIGNA, or Milliman Care Guidelines or, the American Dental Association (ADA), with respect to dental services or supplies;
6. Federal laws or final regulations that are issued by or applied to the FDA or Department of Health and Human Services regarding the prescribed service or supply;
7. The latest edition of "The Medicare National Coverage Determinations Manual."

Section 1.20 The term "**Family**" means all enrolled Members of the same family unit.

Section 1.21 The term "**Family Member**" means each enrolled Child or other person eligible and enrolled by virtue of a relationship with the Employee (e.g. a child for whom the Employee is legal guardian) .

Section 1.22 The term "**Home Health Agencies**" and "**Visiting Nurse Associations**" are home health care providers which are licensed according to state and local laws to provide skilled nursing, hospice care and other services on a visiting basis in the Member's home. They must be recognized as home health care providers under Medicare.

Section 1.23 The term "**Hospital**" means a medical care facility which provides diagnosis, treatment, and care of persons who need acute inpatient Hospital care under the supervision of Physicians, and to which a Member is admitted pursuant to arrangements made by a Physician. It must be licensed as a general acute care hospital according to state and local laws and meet the accreditation standards of the Joint Commission on Accreditation of Hospitals.

Section 1.24 The term "**Incurred**" means the date a service or supply given rise to a charge is rendered or obtained. A Hospital or Skilled Nursing Facility confinement will be considered Incurred on the date of admission.

Section 1.25 The term “**Medically Necessary**” means a medical or dental service or supply if it meets the following requirements as determined by the Plan Administrator or its designee:

A. is provided by or under the direction of a Physician who is authorized to provide or prescribe it; and

B. is determined by the Plan Administrator or its designee to be necessary in terms of generally accepted American medical and dental standards; and

C. is determined by the Plan Administrator or its designee to meet all of the following requirements:

1. It is consistent with the symptoms or diagnosis and treatment of an illness or injury; and
2. It is not provided solely for the convenience of the patient, Physician, Hospital or other person or entity; and
3. It is an “Appropriate” service or supply given the patient’s circumstances and condition; and
4. It is a “Cost-Efficient” supply or level of service that can be safely provided to the patient; and
5. It is safe and effective for the illness or injury for which it is used.

D. A medical or dental service or supply will be considered to be “Appropriate” if:

1. It is a diagnostic procedure that is called for by the health status of the patient, and is as likely to result in information that could affect the course of treatment as, and no more likely to produce a negative outcome than, any alternative service or supply, both with respect to the illness or injury involved and the patient’s overall health condition.
2. It is care or treatment that is as likely to produce a significant positive outcome as and no more likely to produce a negative outcome than any alternative service or supply, both with respect to the illness or injury involved and the patient’s overall health condition.

E. A medical or dental service or supply will be considered to be “Cost-Efficient” if it is no more costly than any alternative appropriate service or supply when considered in relation to all health care expenses incurred in connection with the service or supply.

F. The fact that your Physician may provide, order, recommend or approve a service or supply does not mean that the service or supply will be considered to be Medically Necessary for the medical or dental coverage provided by the Plan.

G. A Hospitalization or confinement to a facility will not be considered to be Medically Necessary if the patient’s illness or injury could safely and appropriately be diagnosed or treated while not confined.

H. A medical or dental service or supply that can safely and appropriately be furnished in a Physician's office or other less costly facility will not be considered to be Medically Necessary if it is furnished in a Hospital or other more costly facility.

I. The non-availability of a bed in another facility, or the non-availability of a health care practitioner to provide medical services will not result in a determination that continued confinement in a Hospital or other facility is Medically Necessary.

J. A medical or dental service or supply will not be considered to be Medically Necessary if it does not require the technical skills of a Physician or if it is furnished mainly for the personal comfort or convenience of the patient, the patient's family, any person who cares for the patient, any health care practitioner, Hospital or other facility.

Section 1.26 The term "**Member**" means each Employee, Spouse or Domestic Partner and each enrolled Child or other person eligible and enrolled by virtue of a relationship with the Employee (e.g. a child for whom the Employee is legal guardian) .

Section 1.27 The term "**Mental, Nervous, and Substance Abuse Disorders**" are those conditions, including drug or alcohol dependence, which are listed in the International Classification of Diseases as diagnostic codes 290 to and including 319. One or more of these conditions may be specifically excluded in the Plan.

Section 1.28 The term "**Non-Participating Provider**" (Out-of-Network) means a Hospital, Physician, pharmacy, laboratory, or other provider which does not have an agreement in effect with the City under the Preferred Provider Organization at the time its services are rendered.

Section 1.29 The term "**Participating Provider**" (In-Network) means a Hospital, Physician, pharmacy, laboratory, or other provider which has an agreement in effect with the City under the Preferred Provider Organization and which is applicable to this Plan at the time that the provider provides services covered under this Plan.

Section 1.30 The term "**Physician**" means:

A. A doctor of Medicine (M.D.) or a doctor of Osteopathy (D.O.) who is licensed to practice medicine in the state in which care is provided, or

B. One of the following providers, but only when the provider is licensed to practice where the care is provided, is rendering a service within the scope of that license and is providing a service for which benefits are specified in this Plan; and when benefits would be payable if the services were provided by a Physician as defined in A. above:

1. Dentist (D.D.S.)
2. Podiatrist or Chiropodist (D.P.M., D.S.P., or D.S.C.)
3. Chiropractor (D.C.)
4. Psychologist
5. Clinical Social Worker (C.S.W. or L.C.S.W.)
6. Marriage, Family and Child Counselor (M.F.C.C.)
7. Mental Health Nurse
8. Physical Therapist (P.T. or R.P.T.)

9. Speech Pathologist
10. Occupational Therapist (O.T.R.)*
11. Optometrist
12. Dispensing Optician
13. Respiratory Therapist*
14. Acupuncturist

Note: The providers indicated by one asterisk (*) are covered only by referral of a Physician as defined in A. above.

Section 1.31 The term “**Plan**” means the medical plan provided through the City of Stockton, also known as the “Modified Employee Medical Plan.”

Section 1.32 The term “**Preferred Provider Organization**” means a program whereby Hospitals, Physicians, pharmacies, laboratories, and other providers contract with an organization which has a contract with the City to provide necessary hospitalization and medical services to Family Members payable on the basis of a negotiated rate, approved by the City and amended from time to time.

Section 1.33 The term “**Preventive Care Services**” mean services with an “A” or “B” rating from the U.S. Preventive Services Task Force (USPSTF), immunizations recommended by the Centers for Disease Control and Prevention’s Advisory Committee on Immunization Practices (ACIP), and with respect to infants, children, and adolescents, and women, additional preventive care and screenings provided for in guidelines supported by the Health Resources and Services Administration (HRSA). An office visit to a Physician shall be considered a Preventive Care Service if the primary purpose for the visit is the delivery of a Preventive Care Service and no separate charge is made for the Preventive Care Service provided during the visit.

Section 1.34 The term “**Psychiatric Health Facility**” means a health facility which provides 24-hour inpatient care for mentally disordered, incompetent, or other persons as described in Division 5 (commencing with Section 5000) or Division 6 (commencing with section 6000) of the Welfare and Institutions Code or Department of Health Services.

Section 1.35 The term “**Registered Domestic Partner**” refers to the Employee’s partner of the same sex. This term can also refer to the Employee’s partner of the opposite sex if one or both are over the age of 62, and have filed a Declaration of Domestic Partnership (in accordance with Family Code Section 298), with the California Secretary of State.

Section 1.36 The term “**Retired Employee**” means any person who meets the eligibility rules in Section 2.01 A.2.

Section 1.37 The term “**Skilled Nursing Facility**” means a public or private facility, licensed and operated according to law, that primarily provides skilled nursing and related services to people who require medical or nursing care and that rehabilitates injured, disabled or sick people, and that meets all of the following requirements:

- A. It is accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) as a Skilled Nursing Facility or is recognized by Medicare as a Skilled Nursing Facility; and

B. It is regularly engaged in providing room and board and continuously provides 24 hour-a-day Skilled Nursing Care of sick and injured persons at the patient's expense during the convalescent stage of an Injury or Illness, maintains on its premises all facilities necessary for medical care and treatment, and is authorized to administer medication to patients on the order of a licensed Physician (M.D. or D.O.); and

C. It provides services under the supervision of Physicians (M.D. or D.O.); and

D. It provides nursing services by or under the supervision of a licensed Registered Nurse (RN), with one licensed Registered Nurse on duty at all times; and

E. It maintains a daily medical record of each patient who is under the care of a licensed Physician (M.D. or D.O.); and

F. It is not (other than incidentally) a home for maternity care, rest, domiciliary (non-skilled/custodial) care, or care of people who are aged, alcoholic, blind, deaf, drug addicts, mentally deficient, mentally ill; and

G. It is not a hotel or motel.

A Skilled Nursing Facility that is part of a Hospital, as defined in this document, will be considered a Skilled Nursing Facility for the purposes of this Plan.

Section 1.38 The term “**Special Care Units**” means special areas of a Hospital which have highly skilled personnel and special equipment for acute conditions that require special treatment and observation.

Section 1.39 The term “**Spouse**” means the Employee’s spouse under a legally valid marriage between the Employee and a person of the opposite sex.

Section 1.40 The term “**Substance Abuse Treatment Center**” means a facility licensed by the state in which it practices as a Chemical Dependency Recovery Hospital. The term shall also include a center for the treatment of alcoholism, drug addiction or drug abuse which is licensed by the proper governmental authority to provide detoxification, counseling and rehabilitative services.

Section 1.41 The term “**Totally Disabled Active Employee**” means an Active Employee who, because of illness or injury, is unable to work for income in any job for which he or she is qualified or for which he or she can reasonably become qualified by training or experience, and who is in fact unemployed.

Section 1.42 The term “**Totally Disabled Family Member**” means a Family Member other than an Active Employee who is unable to perform all the activities usual for a person of that age.

Section 1.43 The term “**Utilization Review Organization**” (**URO**) means an organization, under contract with the City, which is responsible for administering the Plan’s utilization review program as described in Article III of this document.

ARTICLE 2. ELIGIBILITY FOR BENEFITS

Section 2.01 Eligibility Rules for Employees and their Family Members

A. Eligible Employees

The following persons are eligible for enrollment as Employees in the Plan:

1. Active Employees

Full-time employees and eligible regular part-time employees of the City, some elected officials, or individuals who occupy a position which, according to the Memorandum of Understanding, management compensation plan, or other employment/contract, is entitled to benefits.

2. Retired Employees

Retired employees of the City who are entitled to benefits for a period of time, according to the provisions of the Memorandum of Understanding in effect at the time of their retirement. Retired employees eligible for Medicare are required to enroll in Medicare Parts A and B.

B. Eligible Family Members

The following persons may be enrolled as eligible Family Members of the Employee:

1. The Employee's Spouse, or
2. The Employee's Registered Domestic Partner.
3. Child of the Employee or the Spouse or Registered Domestic Partner of the Employee.

A child is "Placed for Adoption" with you on the date you first become legally obligated to provide full or partial support of the child whom you plan to adopt.

Disabled Child(ren). A covered unmarried dependent Child who is incapable of self-sustaining employment by reason of mental or physical disability and who is chiefly dependent upon the Employee for support, can remain covered beyond age 26 provided that written proof by a Physician of such incapacity and dependency is provided to the City of Stockton Human Resources Department within 31 days of the date the Child reached age 26. Proof of continuing dependency and disability may be required periodically as requested by the Administrator.

4. Legal Guardianship. The Plan will cover a minor child as a dependent on the Plan, who does not meet the definition of Child, until he/she reaches age 18, provided the following conditions are met:

- a. A Legal Guardian Statement form is completed and submitted certifying the minor child is under the legal guardianship of the Employee.
- b. A copy of the Letter of Guardianship is provided to the Plan.
- c. The minor child must reside with the Employee full-time.

- d. The minor child must be claimed as a dependent on the Employee's Income Taxes. (A copy of the first page of the tax return reflecting the minor child as a dependent shall be required annually.)
- e. The minor child must be enrolled in the Medi-Cal program. A copy of the minor child's Medi-Cal identification card must be provided to the Plan.

5. Qualified Medical Child Support Orders (QMCSOs).

This Plan will provide benefits to a child named as an "alternate recipient" under a Qualified Medical Child Support Order (QMCSO). In this document the term QMCSO is used and includes compliance with a National Medical Support Notice. According to federal law, a Qualified Medical Child Support Order is a judgment, decree or order (issued by a court or resulting from a state's administrative proceeding) that creates or recognizes the rights of a child, also called the "alternate recipient," to receive benefits under a group health plan, typically the non-custodial parent's plan. The QMCSO typically requires that the plan recognize the child as a dependent even though the child may not meet the plan's definition of dependent. A QMCSO usually results from a divorce or legal separation and typically:

- a. Designates one parent to pay for a child's health plan coverage;
- b. Indicates the name and last known address of the parent required to pay for the coverage and the name and mailing address of each child covered by the QMCSO;
- c. Contains a reasonable description of the type of coverage to be provided under the designated parent's health care Plan or the manner in which such type of coverage is to be determined;
- d. States the period for which the QMCSO applies; and
- e. Identifies each health care plan to which the QMCSO applies.

An order is not a QMCSO if it requires the Plan to provide any type or form of benefit or any option that the Plan does not otherwise provide, or if it requires an employee who is not covered by the Plan to provide coverage for a dependent child, except as required by a state's Medicaid-related child support laws. For a state administrative agency order to be a QMCSO, state statutory law must provide that such an order will have the force and effect of law, and the order must be issued through an administrative process established by state law.

If a court or state administrative agency has issued an order with respect to health care coverage for any dependent child of the Employee, the Plan Administrator or its designee will determine if that order is a QMCSO as defined by federal law. That determination will be binding on the Employee, the other parent, the child, and any other party acting on behalf of the child. The Plan Administrator or its designee will notify the parents and each child if an order is determined to be a QMCSO and, if the Employee is covered by the Plan, advise them of the procedures to be followed to provide coverage of the dependent child(ren).

If the Employee is a Plan participant, the QMCSO may require the Plan to provide coverage for the Employee's dependent child(ren) and to accept contributions for that coverage from a parent who is not a Plan participant. The Plan will accept special enrollment of the dependent child(ren) specified by the QMCSO from either the Employee or the custodial parent. Coverage of the dependent child(ren) will become effective as of the date the enrollment is received by the Plan and will be subject to all terms and provisions of the Plan.

No coverage will be provided for any dependent child under a QMCSO unless the applicable Employee contributions for that dependent child's coverage, if any, are paid and all of the Plan's requirements for coverage of that dependent child have been satisfied.

Coverage of a dependent child under a QMCSO will terminate when coverage of the Employee-parent terminates for any reason, including failure to pay any required

contributions, subject to the dependent child's right to elect COBRA continuation coverage, if that right applies.

Note regarding Imputed Income

Please note that if you add a child for coverage, and the child does not qualify as a tax dependent under IRC § 152 or where a state law definition of a dependent does not match with the federal law definition of a dependent, the City must include in your gross income the fair market value of the coverage provided to the adult child. This is known as "imputed income." This will likely increase both the employee's taxable income and tax liability.

C. Application for Enrollment

Employees must file a written application with the City Human Resources Department – Benefits Section, within 31 days of becoming eligible for coverage hereunder and as to Family Members, within 31 days of marriage or the acquiring or birth of a Child.

Refer to Article 9 for Special Enrollment rights that may apply if you do not enroll within 31 days of becoming eligible.

D. Effective Date of Coverage

After the Employee has met the provisions of sub-section 2.01 C. of this Article 2, and if payment of any required premiums to the City have been made, coverage shall commence as follows:

1. For a Member enrolled on the Effective Date of this Plan, coverage shall commence as of the Effective Date of this Plan.
2. For an Active Employee enrolled subsequent to the Effective Date, coverage shall commence on the first day of the month following 30 days active employment. The 30 day waiting period is waived for Active Employees who reinstate within 6 months from the date of termination.
3. For a Retired Employee, the first day of the month following the date of retirement.
4. For a Family Member, other than a newborn Child, who becomes eligible after the Employee has been enrolled, coverage shall commence on the first day of the following month, provided written application for the addition of such Family Member is filed with the City's Human Resources Department – Benefits Section, and any required premiums are paid within 31 days of marriage or the acquiring of the Child.
5. For a Child born while the Employee is covered hereunder, coverage shall commence from the date of birth, provided written application for the addition of such Child is filed with the City's Human Resources Department – Benefits Section, and any required premiums are paid within 31 days of the date of birth.

E. Termination of Eligibility

A Member's eligibility will terminate on the first day of the month following any of the following events:

1. Failure of the Employee or Family Member to meet the Plan's eligibility requirements.
2. Failure of the Employee to pay any required premiums on or before the due date for such payment.
3. Date of separation from employment, unless the Employee is eligible for retiree medical benefits per the Memorandum of Understanding in effect at the time of their retirement.

If an Employee fails to notify the Plan that a Family Member is no longer eligible for coverage, and the Plan pays claims for that ineligible Family Member, the Plan shall seek reimbursement for any expenses paid.

4. Coverage shall cease immediately upon termination of the Plan.

Prohibition on Rescission

In accordance with the requirements in the Affordable Care Act, the Plan will not retroactively cancel coverage except when contributions are not timely paid, or in cases of fraud or intentional misrepresentation of material fact.

F. HIPAA Certification Of Creditable Coverage When Coverage Ends

When your coverage ends under the Plan, the Plan Administrator will automatically provide you and/or your covered Family Members (free of charge) with a Certificate of Coverage that indicates the period of time you and/or they were covered under the Plan. If your coverage under this Plan ends, and you and/or your covered Family Members become eligible for coverage under another group health plan, or if you buy, for yourself and/or your covered Family Members, a health insurance policy, you may need this certificate (to prove that you did not have a break in coverage of 63 consecutive days or more) in order to reduce any exclusion for Pre-Existing Conditions that may apply to you and/or your covered Family Members in that new group health plan or health insurance policy. The certificate will indicate the period of time you and/or they were covered under this Plan, and certain additional information that is required by law.

The certificate will be sent to you (or to any of your covered Family Members) by first class mail shortly after your (or their) coverage under this Plan ends. This certificate will be in addition to any certificate provided to you after your pre-COBRA group health coverage terminated. In addition, a certificate will be provided to you and/or any covered Dependent upon receipt of a written request for such a certificate if that request is received by the Plan Administrator within two years after the later of the date your coverage under this Plan ended or the date COBRA coverage ended. See Article 9, Section 9.01.C. for the procedure for requesting a certificate of coverage.

G. Medicare Eligible Retired Members who are Eligible to Continue Coverage under the Plan beyond age 65 as per the Memorandum of Understanding in effect at the time of Employee's Retirement.

A Medicare eligible Retired Employee and their Medicare eligible Spouse/Registered Domestic Partner must, as a condition of continued membership in the Plan, file a written election with the Social Security Administration to receive Medicare Part A and Part B coverage (which will be their primary health coverage).

H. Premiums

The City shall determine, and may modify at its discretion at any time and from time to time, the monthly premium, if any, required from Employees for coverage under the Plan.

Section 2.02 COBRA Continuation Coverage

A. Entitlement to COBRA Continuation Coverage

In compliance with a federal law commonly called COBRA, the City offers its eligible Employees, eligible Retirees and their covered Family Members (called "Qualified Beneficiaries") the opportunity to elect a temporary continuation of the group health coverage ("COBRA Continuation Coverage") sponsored by the City when that coverage would otherwise end because of certain events (called "Qualifying Events" by the law).

Qualified Beneficiaries who elect COBRA Continuation Coverage must pay for it at their own expense.

This Plan provides no greater COBRA rights than what is required by law and nothing in this Section 2.02 is intended to expand a person's COBRA rights.

B. COBRA Administrator

Under this Plan the COBRA Administrator is the Plan Administrator. The name, address and telephone number of the Plan Administrator, and to whom you can direct questions about COBRA, is shown in the Quick Reference Chart in the front of this document.

C. Who Is Entitled to COBRA Continuation Coverage, When and For How Long

Each Qualified Beneficiary has an independent right to elect COBRA Continuation Coverage when a Qualifying Event occurs, and as a result of that Qualifying Event, that person's health care coverage ends, either as of the date of the Qualifying Event or as of some later date. A parent or legal guardian may elect COBRA for a minor child. A Qualified Beneficiary also has the same rights and enrollment opportunities under the Plan as other covered individuals including Special Enrollment.

1. **Qualified Beneficiary.** Under the law, a Qualified Beneficiary is any Employee or the Spouse, Registered Domestic Partner or Dependent Child of an Employee who was covered by the Plan when a Qualifying Event occurs, and who is therefore entitled to elect COBRA Continuation Coverage. A child who becomes an enrolled Family Member by birth, adoption or placement for adoption with the covered

Employee during a period of COBRA Continuation Coverage is also a Qualified Beneficiary.

- a. A child of the covered Employee who is receiving benefits under the Plan because of a Qualified Medical Child Support Order (QMCSO), is entitled to the same rights under COBRA as an eligible dependent child.
- b. A person who becomes the new spouse or Registered Domestic Partner of an existing COBRA participant during a period of COBRA Continuation Coverage is not a Qualified Beneficiary.

2. **Qualifying Event.** Qualifying Events are those shown in the chart below. Qualified Beneficiaries are entitled to COBRA Continuation Coverage when Qualifying Events (which are specified in the law) occur, and, as a result of the Qualifying Event, coverage of that Qualified Beneficiary ends. A Qualifying Event triggers the opportunity to elect COBRA when the covered individual loses health care coverage under this Plan.

The following chart lists the COBRA Qualifying Events, who can be a Qualified Beneficiary and the maximum period of COBRA coverage based on that Qualifying Event:

Qualifying Event Causing Health Care Coverage to End	Duration of COBRA for Qualified Beneficiaries		
	Employee	Spouse or Domestic Partner	Dependent Child(ren)
Employee terminated (for other than gross misconduct)	18 months	18 months	18 months
Employee reduction in hours worked (making employee ineligible for the same coverage)	18 months	18 months	18 months
Employee dies	N/A	36 months	36 months
Employee becomes divorced or legally separated	N/A	36 months	36 months
Dependent Child ceases to meet the Plan's eligibility requirements	N/A	N/A	36 months

Note: When a covered Employee's qualifying event (e.g. termination of employment or reduction in hours) occurs within the 18-month period after the employee becomes entitled to Medicare (entitlement means the employee is eligible for and enrolled in Medicare), the employee's covered spouse, Registered Domestic Partner and dependent children who are Qualified Beneficiaries (but not the employee) may become entitled to COBRA coverage for a maximum period that ends 36 months after the Medicare entitlement.

D. Failure to Elect COBRA Continuation Coverage

In considering whether to elect COBRA, you should take into account that failure to continue your group health coverage will affect your future rights under federal law, as noted below:

1. You can lose the right to avoid having pre-existing condition exclusions applied to you by other group health plans if you have more than a 63-day gap in health coverage; and electing COBRA may help you not have such a gap; and

2. You will also lose the guaranteed right to purchase individual health insurance policies that do not impose such pre-existing condition exclusions if you do not get COBRA continuation coverage for the maximum time available to you.

E. Special Enrollment Rights

You have special enrollment rights under federal law that allows you to request special enrollment under another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your group health coverage ends because of the qualifying events listed in this section. The special enrollment right is also available to you if you continue COBRA for the maximum time available to you.

F. Maximum Period of COBRA Continuation Coverage

The maximum period of COBRA Continuation Coverage is generally either 18 months or 36 months, depending on which Qualifying Event occurred, measured from the date the Qualifying Event occurs. The 18-month period of COBRA Continuation Coverage may be extended for up to 11 months under certain circumstances (described later in this section on extending COBRA in cases of disability). The maximum period of COBRA coverage may be cut short for the reasons described in "Early Termination of COBRA Continuation Coverage" that appears later in this section.

G. Procedure for Notifying the Plan of a Qualifying Event

In order to have the chance to elect COBRA Continuation Coverage after a divorce, legal separation, or a child ceasing to meet the eligibility requirements under the Plan, you and/or a family member must inform the COBRA Administrator (Plan Administrator) in writing of that event no later than 60 days after that event occurs.

That written notice should be sent to the Plan Administrator whose address is listed on the Quick Reference Chart in the front of this document. The written notice can be sent via first class mail, or be hand-delivered, and is to include your name, the qualifying event, the date of the event, and appropriate documentation in support of the qualifying event, such as divorce documents.

<p style="text-align: center;">NOTE: If such a notice is <u>not</u> received by the City within the 60-day period, the Qualified Beneficiary will <u>not</u> be entitled to choose COBRA Continuation Coverage.</p>

The City's Human Resources Department is usually aware of an employee's death, termination of employment, or reduction in hours. However, you or your family should also promptly notify the Plan Administrator in writing if any such event occurs in order to avoid confusion over the status of your health care in the event there is a delay or oversight in providing that notification.

Once timely notified, the Plan Administrator will give you and/or your covered Family Members notice of the date on which your coverage ends and the information and forms needed to elect COBRA Continuation Coverage. Under the law, you and/or your covered Family Members will then have only **60 days** from the date of receipt of that notice, to elect COBRA Continuation Coverage.

NOTE:
If you and/or any of your covered Family Members do not choose COBRA coverage within 60 days after receiving notice, you and/or they will have no group health coverage from this Plan after the date coverage ends.

H. The COBRA Continuation Coverage That Will Be Provided

If you elect COBRA Continuation Coverage, you will be entitled to the same health coverage (this does not include life insurance or disability coverage) that you had when the event occurred that caused your health coverage under the Plan to end, but you must pay for it. See the section on Paying for COBRA Continuation Coverage that appears later in this section for information about how much COBRA Continuation Coverage will cost you and about grace periods for payment of those amounts. If there is a change in the health coverage provided by the Plan to similarly situated Employees and their Family Members, that same change will apply to your COBRA Continuation Coverage.

I. Paying for COBRA Continuation Coverage

1. By law, the City is permitted to charge the full cost of coverage for similarly situated Employees and Family Members (including both the City's and Employee's share), plus an additional 2%. If the 18-month period of COBRA Continuation Coverage is extended because of disability, the Plan may add an additional 50% applicable to the COBRA family unit (but only if the disabled person is covered) during the 11-month additional COBRA period.

Each person will be told the exact dollar charge for the COBRA Continuation Coverage that is in effect at the time he or she becomes entitled to it. The cost of the COBRA Continuation Coverage may be subject to future increases during the period it remains in effect.

2. The initial payment for the COBRA Continuation Coverage is due to the COBRA Administrator 45 days after COBRA Continuation Coverage is elected. If this payment is not made when due, COBRA Continuation Coverage will not take effect. After the initial COBRA payment, subsequent payments are due on the first day of each month, but there will be a 30-day grace period to make those payments. If payments are not made within the time indicated in this paragraph, COBRA Continuation Coverage will be canceled as of the due date. Payment is considered made when it is postmarked.

J. Confirmation of Coverage Before Election or Payment of the Cost of COBRA Continuation Coverage

If a health care provider requests confirmation of coverage and you, your Spouse, Registered Domestic Partner or other Family Member(s) have elected COBRA Continuation Coverage and the amount required for COBRA Continuation Coverage has not been paid while the grace period is still in effect or you, your Spouse, Registered Domestic Partner or other Family Member(s) are within the COBRA election period but have not yet elected COBRA, COBRA Continuation Coverage will be confirmed, but with notice to the health care provider that the cost of the COBRA Continuation Coverage has not been paid, that no

claims will be paid until the amounts due have been received, and that the COBRA Continuation Coverage will terminate effective as of the due date of any unpaid amount if payment of the amount due is not received by the end of the grace period.

K. Addition of Newly Acquired Family Members

If, while you (the Employee) are enrolled for COBRA Continuation Coverage, you marry, acquire a Registered Domestic Partner, have a newborn child, adopt a child, or have a child placed with you for adoption, you may enroll that spouse, Registered Domestic Partner or child for coverage for the balance of the period of COBRA Continuation Coverage if you do so within 31 days after the marriage, birth, adoption, or placement for adoption. Adding a Spouse, Registered Domestic Partner, or Dependent Child may cause an increase in the amount you must pay for COBRA Continuation Coverage. Contact the Plan Administrator to add a dependent.

L. Loss of Other Group Health Plan Coverage

1. If, while you (the Employee) are enrolled for COBRA Continuation Coverage your spouse, Registered Domestic Partner or dependent loses coverage under another group health plan, you may enroll the spouse, Registered Domestic Partner or dependent for coverage for the balance of the period of COBRA Continuation Coverage. The spouse, Registered Domestic Partner or dependent must have been eligible but not enrolled in coverage under the terms of the pre-COBRA plan and, when enrollment was previously offered under that pre-COBRA healthcare plan and declined, the spouse, Registered Domestic Partner or dependent must have been covered under another group health plan or had other health insurance coverage.

2. The loss of coverage must be due to exhaustion of COBRA Continuation Coverage under another plan, termination as a result of loss of eligibility for the coverage, or termination as a result of employer contributions toward the other coverage being terminated. Loss of eligibility does not include a loss due to failure of the individual or participant to pay premiums on a timely basis or termination of coverage for cause. You must enroll the spouse, Registered Domestic Partner or dependent within 31 days after the termination of the other coverage. Adding a Spouse, Registered Domestic Partner or other Family Member may cause an increase in the amount you must pay for COBRA Continuation Coverage.

M. Notice of Unavailability of COBRA Coverage

In the event the COBRA Administrator is notified of a Qualifying Event but determines that an individual is not entitled to the requested COBRA coverage, the individual will be sent, by the COBRA Administrator, an explanation indicating why COBRA coverage is not available. This notice of the unavailability of COBRA coverage will be sent according to the same timeframe as a COBRA election notice.

N. Extended COBRA Continuation Coverage When a Second Qualifying Event Occurs During an 18-Month COBRA Continuation Period

1. If, during an 18-month period of COBRA Continuation Coverage resulting from loss of coverage because of your termination of employment or reduction in hours, you die, become divorced, your domestic partner relationship is dissolved, become entitled to

Medicare, or if a covered child ceases to be an eligible Family Member under the Plan, the maximum COBRA Continuation period for the affected spouse, Registered Domestic Partner and/or child is extended to 36 months measured from the date of your termination of employment or reduction in hours (or the date you first became entitled to Medicare, if that is earlier, as described below). Medicare entitlement is not a qualifying event under this Plan and as a result, Medicare entitlement following a termination of coverage or reduction in hours will not extend COBRA to 36 months for spouses, Registered Domestic Partner and Family Members who are qualified beneficiaries.

2. To extend COBRA when a second qualifying event occurs, you must notify the Plan Administrator in writing within 60 days of a second qualifying event. Failure to notify The Plan Administrator in a timely fashion may jeopardize an individual's rights to extended COBRA coverage. The written notice can be sent via first class mail, or be hand-delivered, and is to include your name, the second qualifying event, the date of the second qualifying event, and appropriate documentation in support of the second qualifying event, such as divorce documents.

3. This extended period of COBRA Continuation Coverage is not available to anyone who became your spouse or Registered Domestic Partner after the termination of employment or reduction in hours. This extended period of COBRA Continuation Coverage is available to any child(ren) born to, adopted by or placed for adoption with you (the covered employee) during the 18-month period of COBRA Continuation Coverage.

4. In no case is an Employee whose employment terminated or who had a reduction in hours entitled to COBRA Continuation Coverage for more than a total of 18 months (unless the Employee is entitled to an additional period of up to 11 months of COBRA Continuation Coverage on account of disability as described in the following section). As a result, if an Employee experiences a reduction in hours followed by termination of employment, the termination of employment is not treated as a second qualifying event and COBRA may not be extended beyond 18 months from the initial qualifying event.

O. Extended COBRA Coverage in Certain Cases of Disability During an 18-Month COBRA Continuation Period

1. If, at any time before or during the first 60 days of an 18-month period of COBRA Continuation Coverage, the Social Security Administration makes a formal determination that you or a covered Spouse, Registered Domestic Partner or other Family Member become totally and permanently disabled so as to be entitled to Social Security Disability Income benefits (SSDI), the disabled person and any covered Family Members who so choose, may be entitled to keep the COBRA Continuation Coverage for up to 29 months (instead of 18 months) or until the disabled person becomes entitled to Medicare or ceases to be disabled (whichever is sooner).

2. This extension is available only if:

- a. the Social Security Administration determines that the individual's disability began no later than 60 days after the termination of employment or reduction in hours; and
- b. you or another family member notify the Plan Administrator by sending a written notification to the Plan Administrator of the Social Security Administration determination within 60 days after that determination was received by you or another covered family member. Failure to notify the Plan Administrator in a timely fashion may jeopardize an individual's rights to extended COBRA coverage. The written

notice can be sent via first class mail, or be hand-delivered, and is to include your name, the request for extension of COBRA due to a disability, the date the disability began and appropriate documentation in support of the disability including a copy of the written Social Security Administration disability award documentation, and that notice must be received by the Plan Administrator before the end of the 18-month COBRA Continuation period.

3. The cost of COBRA Continuation Coverage during the additional 11-month period of COBRA Continuation Coverage will be higher than the cost for that coverage during the 18-month period.
4. The Plan Administrator must also be notified in writing within 30 days of the determination by the Social Security Administration that you are no longer disabled.

P. Early Termination of COBRA Continuation Coverage

Once COBRA Continuation Coverage has been elected, it may be cut short (terminated early) on the occurrence of any of the following events:

1. The date on which the City no longer provides group health coverage to any of its employees;
2. The first day of the time period for which the amount due for the COBRA Continuation Coverage is not paid on time;
3. The date, after the date of the COBRA election, on which the covered person first becomes entitled to Medicare;
4. The date, after the date of the COBRA election, on which the covered person first becomes covered under another group health plan and that plan does not contain any legally applicable exclusion or limitation with respect to a Pre-Existing Condition that the covered person may have;
5. The date the City has determined that the covered person must be terminated from the Plan for cause;
6. During an extension of the maximum coverage period to 29 months due to the disability of the covered person, the disabled person is determined by the Social Security Administration to no longer be disabled.

The Plan Administrator will notify a qualified beneficiary if COBRA coverage terminates earlier than the end of the maximum period of coverage applicable to the qualifying event that entitled the individual to COBRA coverage. This written notice will explain the reason COBRA terminated earlier than the maximum period, the date COBRA coverage terminated and any rights the qualified beneficiary may have under the Plan to elect alternate or conversion coverage, if any. The notice will be provided as soon as practicable after the Plan Administrator determines that COBRA coverage will terminate early.

Q. No Entitlement to Convert to an Individual Health Plan after COBRA Ends

There is no opportunity to convert to an individual health plan after COBRA ends under this Plan.

R. COBRA Questions or To Give Notice of Changes in Your Circumstances

If you have any questions about your COBRA rights, please contact the Plan Administrator whose address is listed on the Quick Reference Chart in the front of this document.

Also, remember that to avoid loss of any of your rights to obtain or continue COBRA Continuation Coverage, you must notify the Plan Administrator within 31 days but no later than 60 days after:

1. a change in marital status (e.g. marry, divorce); change in domestic partner relationship; or have a new dependent child; or
2. the date you or a covered dependent spouse, Registered Domestic Partner or child has been determined to be totally and permanently disabled by the Social Security Administration; or
3. a covered child ceases to be an eligible Family Member as that term is defined by the Plan (refer to Article 1); or
4. an individual has changed their address, becomes entitled to Medicare, or is no longer disabled.

S. FMLA and COBRA

Taking a leave under the Family & Medical Leave Act (FMLA) is not a COBRA qualifying event. A qualifying event can occur after the FMLA period expires, if the employee does not return to work and thus loses coverage under their group health plan. Then, the COBRA period is measured from the date of the qualifying event—in most cases, the last day of the FMLA leave. Note that if the employee notifies the City that they are not returning to employment prior to the expiration of the maximum FMLA 12-week period, a loss of coverage could occur earlier.

T. HIPAA Certification Of Creditable Coverage When Coverage Ends

When your COBRA coverage ends, the Plan Administrator will automatically provide you and/or your covered Family Members (free of charge) with a Certificate of Coverage that indicates the period of time you and/or they were covered under the Plan. If your coverage under this Plan ends, and you and/or your covered Family Members become eligible for coverage under another group health plan, or if you buy, for yourself and/or your covered Family Members, a health insurance policy, you may need this certificate (to prove that you did not have a break in coverage of 63 consecutive days or more) in order to reduce any exclusion for Pre-Existing Conditions that may apply to you and/or your covered Family Members in that new group health plan or health insurance policy. The certificate will indicate the period of time you and/or they were covered under this Plan, and certain additional information that is required by law.

The certificate will be sent to you (or to any of your covered Family Members) by first class mail shortly after your (or their) coverage under this Plan ends. This certificate will be in addition to any certificate provided to you after your pre-COBRA group health coverage terminated. In addition, a certificate will be provided to you and/or any covered Dependent upon receipt of a written request for such a certificate if that request is received by the Plan Administrator within two years after the later of the date your coverage under this Plan ended or the date COBRA coverage ended. See Section 9.01.C. for the procedure for requesting a certificate of coverage.

Section 2.03 Extension of Benefits Provision for Disabling Condition

A. General

If a Member is Totally Disabled when coverage under the Plan ends and is under the treatment of a Physician, the benefits of this Plan may continue to be provided for services treating the totally disabling illness or injury for up to a maximum of 12 consecutive months. No benefits are provided for services treating any other illness, injury, or condition.

B. Certification of Disability

A Member confined as an inpatient in a Hospital or Skilled Nursing Facility is considered Totally Disabled as long as the inpatient stay is Medically Necessary. No written certification of the total disability is required when confined as an inpatient. A Member who is not confined as an inpatient who wishes to apply for total disability benefits must submit written certification by the Physician of the total disability. The Plan Administrator must receive this certification within 90 days of the date coverage ends under the Plan. At least once every 90 days while benefits are extended, the Plan Administrator must receive proof that the Member's total disability is continuing.

C. Duration of Coverage

Benefits to Totally Disabled Members are provided until the earliest of the following occurs:

1. The Member is no longer Totally Disabled;
2. The Member becomes covered under another group health plan that provides coverage for the disabling illness or injury; or
3. A period of 12 consecutive months has passed since the date the Member's regular coverage ended.

Section 2.04 Other Coverage Extensions

Refer to Article 9 for other coverage extensions available under the Plan.

ARTICLE 3. COMPREHENSIVE MEDICAL BENEFITS

Comprehensive Medical Benefits are provided for Medically Necessary Covered Services, subject to the applicable exclusions and limitations.

The Plan described in this document does not require the selection or designation of a primary care provider. You have the ability to visit any Participating or Non-Participating Provider; however, payment by the Plan will, in most cases, be substantially less for the use of a Non-Participating Provider. You also do not need prior authorization from the Plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional who specializes in obstetrics or gynecology.

Filing a Claim

Most providers will send their bill directly to the Plan Administrator. However, for those providers who do not bill the Plan directly, you may be sent a bill. In that case, follow these steps.

Where to Get Claim Forms: Obtain a claim form from the Administrator (see the Quick Reference Chart in the front of this document for details on the address.).

How to Complete a Claim Form

1. Complete the employee part of the claim form in full. Answer every question, even if the answer is “none” or “not applicable (N/A).”
2. The instructions on the claim form will tell you what documents or medical information are necessary to support the claim. Your Physician or other health Care practitioner can complete the Health Care Provider part of the claim form, or you can attach the bill for professional services if it contains all of the following data elements/information:
 - A description of the services or supplies provided using appropriate medical coding such as CPT, CDT, HCPCS, etc.
 - Details of the charges for those services or supplies.
 - Diagnosis code(s).
 - Date(s) the services or supplies were provided.
 - Location where services were rendered.
 - Patient’s name, social security number or ID number, address and date of birth.
 - Provider’s name, address, phone number, professional degree or license, and federal tax identification number or appropriate provider identifier number.
3. If a claim is submitted without the above required information and all data elements are not provided, this plan cannot consider that claim for payment under the Plan. Please review your bills to be sure they are appropriate and correct.

Report any discrepancies in billing to the Plan Administrator. This can reduce costs to you and the Plan.

4. Complete a separate claim form for each person for whom Plan benefits are being requested.
5. If another plan is the primary payer, send a copy of the other plan's Explanation of Benefits (EOB) along with the claim you submit to this Plan.
6. Claim forms must be received by the Plan Administrator within 12 months of the date services are received for medical claims and within 90 days of the date of purchase for prescription drug claims. The Plan is not liable for the benefits of this Plan if claims are not filed within this time period. Canceled checks or receipts are not acceptable documentation for claims processing.

Where to Send the Claim Form: Send the completed claim form, the bill you received (you keep a copy too) and any other required information to the Administrator whose address is listed on the Quick Reference Chart in the front of this document.

If your claim is denied in whole or in part, refer to Article 7 for the Plan's Claims Appeal Procedures.

Section 3.01 Deductible Amount

The Deductible is the out-of-pocket Covered Expense for Covered Services Incurred during any one Calendar Year before Comprehensive Medical Benefits subject to the Deductible become payable. Any co-payments such as the \$75 inpatient Hospital co-payment does not apply towards satisfaction of the deductible amount.

A. Individual Deductible: The amount of the Individual Deductible for each Member is:

1. Covered Services rendered or obtained from Participating Providers - the first \$500 of out-of-pocket Allowable Charges incurred in a Calendar Year.
2. Covered Services rendered or obtained from Non-Participating Providers – the first \$1,500 of out-of-pocket Allowable Charges incurred in a Calendar Year.

B. Family Deductible: The Deductible will be considered satisfied for a Calendar Year for all Members of the same Family if the Family Deductible is met. The amount of the Family Deductible is:

1. Covered Services rendered or obtained from Participating Providers – the first \$1,500 of out-of-pocket Allowable Charges incurred, in the aggregate, by a Family in a Calendar Year.
2. Covered Services rendered or obtained from Non-Participating Providers – the first \$3,000 of out-of-pocket Allowable Charges incurred, in the aggregate, by a Family in a Calendar Year.

C. Benefits subject to the Deductible: All Comprehensive Medical Benefits set forth in Section 3.06 are subject to the Deductible except Preventive Care Services rendered by Participating Providers as set forth in item L of Section 3.06.

Section 3.02 Maximum Annual Out-of-Pocket Limit - only for Services and Supplies Rendered or Obtained from Participating Providers

Benefits for Allowable Charges made by Participating Providers are payable at the applicable percentage stated under Covered Services in Section 3.06 until an individual Member or Family reach the maximum annual out-of-pocket expense, after which the Plan shall pay 100% for all Allowable Charges Incurred by the individual Member or Family during the remainder of that Calendar Year. The maximum annual out-of-pocket expense is reached as follows:

A. for an individual Member – when the Member has paid \$5,000 in out-of-pocket Allowable Charges for Covered Services (deductibles, co-insurance and co-payments) Incurred during any one Calendar Year.

B. for a Family – when Members of the same Family have paid a combined total of \$10,000 in out-of-pocket Allowable Charges for Covered Services (deductibles, co-insurance and co-payments) Incurred during any one Calendar Year.

There is no maximum annual out-of-pocket limit when Covered Services are rendered or obtained from Non-Participating Providers.

Exception: The following item of Covered Expenses shall never be payable at the 100% level: emergency room treatment for non-Emergencies.

Section 3.03 Lifetime Maximum Amounts Payable

There are no lifetime dollar limits under this Plan.

Section 3.04 Utilization Review Program (UR)

The benefits of this Plan are provided only for services that are Medically Necessary as determined by the Plan Administrator or its designee. The services must be ordered by the attending Physician for the direct care and treatment of a covered illness, injury, condition, or service. Services must be standard medical practice where received for the illness, injury, or condition being treated, and must be legal in the United States.

A. Hospitalization: All Hospital admissions are reviewed for Medical Necessity. That review may be undertaken before or during a Hospital stay, or following discharge from the Hospital. All Hospital admissions are subject to the Plan's utilization review program which includes but is not limited to:

1. Pre-admission Review to determine if a scheduled inpatient admission is Medically Necessary. Pre-admission review is available and required on all non-

emergency Hospital admissions. Members should confirm with the Hospital at the time of admission that pre-authorization has been obtained by the Physician.

2. Admission Review to determine if an admission is Medically Necessary when pre-admission authorization was not obtained.

3. Continued Stay Review to determine if a continued inpatient stay is Medically Necessary. If the Plan Administrator or its designee determines that a Hospital confinement or continued stay is not Medically Necessary, the Member and his or her attending Physician shall be notified in writing by the Plan Administrator.

THE MEMBER IS RESPONSIBLE FOR ANY EXPENSE INCURRED AFTER THE TIME SPECIFIED IN SUCH NOTICE.

4. Retrospective Review to determine after discharge, whether a Hospital admission or stay was Medically Necessary.

5. Ambulatory Review to determine if outpatient services were Medically Necessary.

B. Utilization Review for Services, excluding Hospitalization: Other services, such as chiropractic treatment, physical, speech or occupational therapy, where treatment or services may exceed or are not in accordance with accepted medical industry standards/practices, may be subject to UR.

C. All claims are subject to final review by the Plan Administrator. That review may result in a determination that part, or all, of the services were not Medically Necessary, and a reduction or denial of benefits may occur.

D. The payment of benefits is subject to all the terms, conditions, limitations, and exclusions of the Plan. Benefits are not payable for services not covered under the Plan.

E. Restrictions and Limitations of the Utilization Review Program

1. The fact that your Physician recommends surgery, hospitalization, confinement in a health care facility, or that your Physician or other health care provider proposes or provides any other medical services or supplies doesn't mean that the recommended services or supplies will be an eligible expense or be considered Medically Necessary for determining coverage under the Plan.

2. The Utilization Review Program is not intended to diagnose or treat medical conditions, validate eligibility for coverage, or guarantee payment of Plan benefits. The Plan Administrator's (or its designee) certification that a service is Medically Necessary doesn't mean that a benefit payment is guaranteed. Eligibility for and actual payment of benefits are subject to the terms and conditions of the Plan as described in this document. For example, benefits would not be payable if your eligibility for coverage ended before the services were rendered or if the services were not covered by the Plan either in whole or in part.

3. All treatment decisions rest with you and your Physician (or other health care provider). You should follow whatever course of treatment you and your physician

(or other health care provider) believe to be the most appropriate, even if the Plan Administrator does not certify proposed surgery/treatment/service or admission as Medically Necessary or as an eligible expense. However, the benefits payable by the Plan may be affected by the determination of the Plan Administrator.

4. With respect to the administration of this Plan, the City, the Administrator and its designee, if any, are not engaged in the practice of medicine, and none of them takes responsibility either for the quality of health care services actually provided, even if they have been certified by the Plan Administrator or its designee as Medically Necessary, or for the results if the patient chooses not to receive health care services that have not been certified by the Plan Administrator or its designee as Medically Necessary.

Section 3.05 Benefits

If a Member incurs Allowable Charges for Covered Services during a Calendar Year which exceed the Deductible for the Calendar Year, the Plan will, subject to the terms and conditions hereafter stated, pay the percentage of Allowable Charges to be borne by the Plan in accordance with Article 3, Section 3.06. The Member is responsible for payments of the Deductible and any remaining Allowable Charges not borne by the Plan (the co-insurance and/or copayment) plus any other charges not paid by the Plan. The Member's obligation to pay co-insurance and/or copayments for a Calendar Year shall be subject to the Maximum Annual Out-of-Pocket Limit and the Plan's obligation to pay shall be subject to any maximum benefits set forth in this Article 3.

Section 3.06 Covered Services

Covered Services are those listed in this Section 3.06 which are certified by the attending Physician and determined by the Plan Administrator or its designee to be Medically Necessary.

A. Inpatient Hospital Benefits

The following inpatient Hospital benefits are payable for Medically Necessary Covered Services provided during an inpatient Hospital confinement:

1. Participating Provider Hospital – 80% of Allowable Charges after a Member co-payment of \$75 per admission

2. Non-Participating Provider Hospital – 50% of Allowable Charges after a Member co-payment of \$200 per admission, subject to the exception below.

a. Exception: If a Member is confined in a Non-Participating Hospital in an area where a Participating Hospital is NOT available the Plan will pay 80% of Allowable Charges after a Member co-payment of \$75 per admission.

3. Covered Services include but are not limited to, the following items:

a. Accommodations in a room of two or more beds, or the prevailing charge for two-bed room accommodations in that Hospital if a private room is used.

- b. Services in Special Care Units.
- c. Operating, delivery and special treatment rooms.
- d. Supplies and ancillary services including laboratory, cardiology, pathology, radiology and any professional component of these services.
- e. Physical therapy, speech therapy, radiation therapy, chemotherapy, and hemodialysis treatment.
- f. Drugs and medicines approved for general use by the Food and Drug Administration which are supplied by the Hospital for use during the Member's stay.
- g. Blood transfusions, but not the cost of blood, blood products or blood processing.

4. Conditions of Service

- a. Services must be those which are regularly provided by a Hospital.
- b. Services are provided only for the number of days required to treat the Member's illness, injury, or condition.

5. Admissions for Dental Care

Benefits are payable in accordance with Subsection 1 or 2 above for the following Covered Services:

a. Covered Services

Listed inpatient Hospital services, when a Hospital stay of three days or less for dental treatment is required due to an unrelated medical condition of the Member, and has been ordered by a Physician (M.D.) or Dentist (D.D.S.).

b. Conditions of Service

- i. The Plan Administrator makes the final determination as to whether the dental treatment could have been safely rendered in another setting due to the nature of the procedure and the Member's medical condition.
- ii. Hospital stays for the purpose of administering general anesthesia are not considered Medically Necessary and are therefore not covered by the Plan.

B. Outpatient Hospital Benefits

The following outpatient Hospital benefits are payable for all Medically Necessary services and supplies provided in the outpatient department or emergency room of a Hospital and billed by the Hospital.

1. Covered Services

a. Hospital emergency room – 80% of Allowable Charges for emergency room use, supplies, ancillary services, drugs and medicines as listed in Section 3.06 A. (2)(a) including but not limited to diagnostic laboratory and x-ray, and exams. The 80% benefit level applies to both Participating and Non-Participating Provider Hospitals and is subject to the existence of an Emergency (refer to Article 1 for the definition of Emergency). However, benefits for a Non-Participating Hospital will be provided only until the patient can be stabilized for transfer to a Participating Hospital. The admission to a Non-Participating Hospital in the case of an Emergency, must occur through the emergency room facilities of the Hospital. There is no requirement to precertify (prior authorize) the use of a Hospital-based emergency room visit.

b. Outpatient surgery in a Participating Provider Hospital – 80% of Allowable Charges for operating room use, supplies, ancillary services, drugs and medicines as listed in Section 3.06 A. (2)(a). These services are also payable when outpatient surgery is performed at a Participating Provider Ambulatory Surgical Facility/Center.

c. Outpatient surgery in a Non-Participating Provider Hospital – 50% of Allowable Charges for operating room use, supplies, ancillary services, drugs and medicines as listed in Section 3.06 A. (2)(a). These services are also payable when outpatient surgery is performed at a Non-Participating Provider Ambulatory Surgical Facility/Center.

d. Outpatient pre-admission testing, radiation therapy, chemotherapy, or dialysis treatment in a Participating Provider Hospital – 80% of Allowable Charges

e. Outpatient pre-admission testing, radiation therapy, chemotherapy, or dialysis treatment in a Non-Participating Provider Hospital – 50% of Allowable Charges

2. Conditions of Service

a. Services must be those which are regularly provided by a Hospital or Ambulatory Surgical Facility/Center.

b. Emergency room care must be for the first treatment of a medical Emergency.

c. Emergency room care for an Accidental Injury must be received within 72 hours of the injury date.

3. Limitation

If a Member receives treatment in an emergency room for a non-Emergency illness/injury, the Plan will pay 50% of Allowable Charges for Covered Services for that treatment, whether obtained in a Participating or Non-Participating facility.

C. Skilled Nursing Facility

The following inpatient Skilled Nursing Facility benefits are payable for Medically Necessary Covered Services provided during an inpatient confinement.

1. Participating Provider – 80% of Allowable Charges after a Member co-payment of \$75 per admission

2. Non-Participating Provider – 50% of Allowable Charges after a Member co-payment of \$200 per admission.

3. Covered Services

a. Accommodations in a room of two or more beds, or the prevailing charge for two-bed room accommodations in that facility if a private room is used.

b. Special treatment rooms.

c. Laboratory exams.

d. Physical, occupational, respiratory and speech therapy. Oxygen and other gas therapy.

e. Drugs and medicines approved for general use by the Food and Drug Administration which are used in the facility.

f. Blood transfusions, but not the cost of blood, blood products or blood processing.

4. Conditions of Service

a. The Member must be transferred directly from a covered inpatient stay to the Skilled Nursing Facility.

b. The Member must be referred to the Skilled Nursing Facility by a Physician for further care and treatment of the illness or injury for which he or she was hospitalized.

c. Services must be those which are regularly provided by a Skilled Nursing Facility.

d. The services must be consistent with the illness, injury, degree of disability and medical needs of the Member. Benefits are provided only for the number of days required to treat the Member's illness or injury.

e. The Member must remain under the active medical supervision of a Physician. The Physician must be treating the illness or injury for which the Member is confined in the Skilled Nursing Facility.

D. Outpatient Therapy Benefits

The following benefits are payable for short-term physical, speech, respiratory and cardiac therapy when provided on an outpatient basis by a registered therapist and prescribed by a Physician as Medically Necessary. Benefits are subject to utilization review and pre-authorization as well as the Conditions of Service outlined below.

1. Participating Provider – 80% of Allowable Charges
2. Non-Participating Provider – 50% of Allowable Charges
3. Conditions of Service

a. Benefits for speech therapy are allowed only after surgery, injury, non-congenital organic disease, or for non-curable developmental disorders, such as autism and mental retardation, in which a child or adult is capable of learning as determined by a qualified Physician that specializes in those disorders. In order to be covered under this Plan, services must be provided by a licensed speech pathologist from the American Speech-Language-Hearing Association (ASHA) with a Certificate of Clinical Competence (CCC). The speech therapist must conduct an initial evaluation and provide a treatment plan to the referring Physician after the initial visit. Progress reports must be provided to the referring Physician every three (3) months. Care that is recommended beyond the original estimate course of treatment shall require an additional Physician referral.

b. Not more than one outpatient therapy visit is allowable per day.

c. In order for Outpatient Therapy Benefits to be payable, the services must be for the purpose of restoration of a disability for which there is a reasonable expectation of significant improvement in the status of that disability as determined by the Plan Administrator or its designee.

E. Home Health Care Benefit

The Plan will pay 80% of Allowable Charges for the following Covered Services when rendered by a Participating Provider. **No benefits are provided if services are rendered by a Non-Participating Provider.**

1. Covered Services
 - a. Services of a registered nurse.
 - b. Services of a licensed therapist for physical therapy, occupational therapy, respiratory therapy or speech therapy.
 - c. Services of a health aide who is employed by (or under arrangement with) a Home Health Agency or Visiting Nurse Association. Health Aide services must be ordered and supervised by a registered nurse employed by the Home Health

Agency or Visiting Nurse Association as professional coordinator. The Member must be receiving the services listed in (a) or (b) above.

d. Medically Necessary supplies provided by the Home Health Agency or Visiting Nurse Association.

2. Conditions of Service

The Plan will only recognize charges for Home Health Care services subject to the following conditions:

a. The Member must be confined at home under the active medical supervision of the Physician (M.D. or D.O.) ordering home health care and treating the illness, injury or condition for which the Member was confined.

b. Services must be provided and billed by the Home Health Agency or Visiting Nurse Association.

c. Services must be Medically Necessary and consistent with the illness, injury and degree of disability and medical needs of the Member. Benefits are provided only for the number of visits required to treat the Member's illness or injury.

d. Services are subject to the Plan's Utilization Review Program.

F. Hospice Benefit

If a Member is terminally ill with a life expectancy of six months or less as diagnosed by the attending Physician (M.D. or D.O.), and the Physician prescribes services and supplies furnished directly by a hospice, the Plan will pay 80% of Allowable Charges for the following Covered Services when rendered by a Participating Provider. **No benefits are provided if services are rendered by a Non-Participating Provider.**

1. Covered Services

a. Room and board for Member's confinement in a hospice facility.

b. Services and supplies furnished by the hospice while the Member is confined therein.

c. Part-time nursing care by or under the supervision of a registered nurse (R.N.) for the Member.

d. Home health aid services for the Member.

e. Nutrition services for the Member.

f. Special meals for the Member.

g. Counseling services for the Member that are provided by a licensed social worker or licensed pastoral counselor.

h. Bereavement counseling by a licensed social worker or a licensed pastoral counselor for the Member's immediate family shall be covered provided the services occur during the six-month period following the Member's death.

2. Conditions of Service

The Plan will only recognize charges for hospice facilities or services which meet the following conditions:

- a. It has obtained any required state or governmental Certificate of Need approval.
- b. It provides services 24 hours a day, 7 days a week.
- c. It is under the direct supervision of a Physician.
- d. It has a nurse coordinator who is a registered nurse (R.N.)
- e. Services are subject to the Plan's Utilization Review Program.

G. Mental or Nervous Disorders Benefit

Plan benefits for inpatient services for the following covered services incurred at a Hospital, Psychiatric Health Care Facility, or Day Care Center are payable on the same basis as Inpatient Hospital Benefits set forth in Section 3.06 A. Outpatient services are payable as set forth in item 2 below. Inpatient and outpatient benefits are subject to the Conditions of Service set forth in item 3 below.

1. Covered Inpatient Services

Covered services shall include, but are not limited to, the following when determined by the Plan Administrator or its designee to be Medically Necessary:

- a. Psychiatry;
- b. Clinical psychology;
- c. Psychiatric nursing;
- d. Social work;
- e. Rehabilitation;
- f. Drug administration;
- g. Appropriate food services; and
- h. Facility fee (room and board)

2. Covered Outpatient Services

The following benefits are payable for Medically Necessary treatment of a mental or nervous disorder when provided on an outpatient basis by a Physician.

- a. Participating Provider – 80% of Allowable Charges
- b. Non-Participating Provider – 50% of Allowable Charges

3. Conditions of Service

- a. Services must be for treatment of a Mental or Nervous Disorder which can be improved by standard medical practice.
- b. Inpatient services must be for treatment of the acute phase of the Mental or Nervous Disorder. The acute phase is the recent, severely intensified stage of the disorder.
- c. The Member must be under the direct care and treatment of a Physician (M.D.) for admission for inpatient psychiatric care.
- d. Services must be those which are regularly provided by a Hospital, Psychiatric Health Care Facility or Day Care Center, as applicable.
- e. Benefits are provided only for the number of days required to treat the Member's illness, injury or condition.

H. Substance Abuse Benefit

Plan benefits for inpatient services for the following covered services incurred at a Hospital or Substance Abuse Treatment Center are payable on the same basis as Inpatient Hospital Benefits set forth in Section 3.06 A. Outpatient services are payable as set forth in item 2 below. Inpatient and outpatient benefits are subject to the Conditions of Service set forth in item 3 below.

Substance abuse benefits are provided only to Active Employees and their Family Members. Substance abuse benefits are not provided to Retired Employees or their Family Members.

1. Covered Inpatient Services

Covered services shall include, but are not limited to, the following when determined by the Plan Administrator or its designee to be Medically Necessary:

- a. Psychiatry;
- b. Clinical psychology;
- c. Psychiatric nursing;
- d. Social work;

- e. Detoxification;
- f. Drug administration;
- g. Appropriate food services; and
- h. Facility fee (room and board)

2. Covered Outpatient Services

The following benefits are payable for Medically Necessary treatment of a substance abuse disorder when provided on an outpatient basis by a Physician.

- a. Participating Provider – 80% of Allowable Charges
- b. Non-Participating Provider – 50% of Allowable Charges

3. Conditions of Service

- a. Inpatient confinement must be for detoxification.
- b. The Member must be under the direct care and treatment of a Physician (M.D.) for admission for inpatient care.
- c. Services must be those which are regularly provided by a Hospital or Substance Abuse Treatment Center, as applicable.
- d. Benefits are provided only for the number of days required to treat the Member's condition.
- e. Benefits are provided only for Active Employees and their Family Members.

I. Outpatient Diagnostic Radiology/Laboratory Benefits

The following benefits are payable for diagnostic radiology and laboratory services when provided on an outpatient basis and prescribed by a Physician.

- 1. Participating Provider – 80% of Allowable Charges
- 2. Non-Participating Provider – 50% of Allowable Charges

J. Radiation/Chemotherapy/Dialysis Benefit

The following benefits are payable for radiation therapy, chemotherapy and dialysis treatment when provided on an outpatient basis and prescribed by a Physician.

- 1. Participating Provider – 80% of Allowable Charges
- 2. Non-Participating Provider – 50% of Allowable Charges

It is important that individuals with end stage kidney/renal disease (ESRD) promptly apply for Medicare coverage, regardless of age.

K. Physician Services

The following benefits are payable for Physician services, including but not limited to, office visits, hospital visits, surgical services and the administration of anesthesia.

1. Participating Provider – 80% of Allowable Charges
2. Non-Participating Provider – 50% of Allowable Charges except 80% of Allowable Charges for services of a Physician that are rendered in the emergency room of a Hospital in connection with a medical Emergency.

L. Preventive Care Services (including immunizations)

The Preventive Care Services payable by this Plan are designed to comply with Health Reform regulations and the current recommendations of the United States Preventive Services Task Force (USPSTF), the Health Resources and Services Administration (HRSA), and the Centers for Disease Control and Prevention (CDC). This website lists the types of payable preventive services: <http://www.healthcare.gov/law/about/provisions/services/lists.html>.

The annual Deductible does not apply to Allowable Charges for Preventive Care Services when such services are rendered by a Participating Provider. If services are rendered by a Non-Participating Provider, the Deductible will apply.

The Plan will pay for Preventive Care Services as follows:

1. Participating Provider - 100% of Allowable Charges
2. Non-Participating Provider - 50% of Allowable Charges
3. Conditions of Service
 - a. Services rendered by a Participating Provider - When both preventive services and diagnostic or therapeutic services occur at the same visit, the Member pays the cost share (e.g. coinsurance and deductible) for the diagnostic or therapeutic services but not for the preventive services.
 - b. Services rendered by a Participating Provider - When a preventive visit turns into a diagnostic or therapeutic service in the same visit, then cost-sharing (e.g. coinsurance and deductible) will apply to the diagnostic or therapeutic services provided.
 - c. Preventive services are considered for payment when billed under the appropriate preventive service codes (benefit adjudication depends on accurate claim coding by the providers). The Plan Administrator will use reasonable medical management techniques for consideration of payable preventive services such as age, location for service and test frequency. Services not

covered under this Preventive Care Services benefit may be covered under another portion of the Plan.

M. Dental Injury

The Plan will pay for services of a Physician (M.D.) or Dentist (D.D.S.) for treatment of an Accidental Injury to natural teeth as follows:

1. Participating Provider – 80% of Allowable Charges
2. Non-Participating Provider – 50% of Allowable Charges

Conditions of Service

1. Services must be initiated within six months following the date of injury.
2. Damage to natural teeth during chewing or biting is not Accidental Injury.
3. Accidental Injury does not include illness or infection, except infection of a cut or wound.

N. Chiropractic Services

The Plan will pay for chiropractic treatment as follows:

1. Participating Provider – 80% of Allowable Charges
2. Non-Participating Provider – 50% of Allowable Charges
3. This benefit is subject to the Plan's Utilization Review Program.

O. Pregnancy

The Plan will pay for Allowable Charges for Covered Services in connection with pregnancy or termination of pregnancy on the same basis as an illness. Covered services include but are not limited to, prenatal care, delivery, routine nursery care of the newborn child and the initial pediatric exam. If Covered Services are rendered in a Birthing Center, benefits will be payable on the same basis as if services were rendered in a Hospital.

Eligibility for this coverage is limited to an Employee or Spouse/Registered Domestic Partner.

P. Infertility

The Plan will pay for infertility treatment as follows:

1. Participating Provider – 80% of Allowable Charges
2. Non-Participating Provider – 50% of Allowable Charges

3. Covered services include, but are not limited to Physician services, diagnostic tests, medication, surgery, and gamete and intrafallopian transfer (GIFT).

4. In-vitro fertilization, which is the actual laboratory process involving the fertilization of the egg, is not a covered benefit. See Section 3.06, (Y), "Exclusions and Limitations".)

Q. Organ and Tissue Transplants

The Plan will pay for Allowable Charges for covered services in connection with a non-Experimental and/or Investigational organ or tissue transplant on the same basis as any other illness. Coverage shall be provided for:

1. A Member who receives the organ or tissue, and
2. A Member who donates the organ or tissue, and
3. An organ or tissue donor who is not a Member, if the organ or tissue recipient is a Member, but in such case, benefits are reduced by any amounts paid or payable by the donor's own coverage, and
4. Organ/tissue Procurement. Procurement includes expenses to find the donated organ/tissue (donor search fees), tests on the potential organ/tissue for compatibility, surgery/procedures to remove the organ/tissue, preservation of the organ/tissue until it can be transplanted and transportation fees to deliver the organ/tissue to the patient/recipient.

R. Additional Services and Supplies

The Plan will pay 80% of Allowable Charges for the following services and supplies when rendered or obtained from a Participating Provider or 50% of Allowable Charges when rendered or obtained from a Non-Participating Provider:

1. The following ambulance service in an Emergency or when prescribed by a Physician:
 - a. Base charge, mileage and non-reusable supplies of a licensed ambulance company for ground service to transport a Member to and from Hospital or a Skilled Nursing Facility.
 - b. Base charge, mileage and non-reusable supplies of a licensed air ambulance company to transport a Member from point where first disabled to the nearest Hospital providing adequate medical care.
 - c. Monitoring, electrocardiograms (EKG's or ECG's), cardiac defibrillation, cardiopulmonary resuscitation (CPR) and administration of oxygen and intravenous (IV) solutions in connection with ambulance service. An appropriately licensed person must render the services.

2. Surgical implants

3. Artificial limbs or eyes. Benefits do not extend to the repair or replacement of prosthetic devices occasioned by misuse or loss.
4. The first pair of contact lenses and the first pair of eyeglasses when required as a result of eye surgery.
5. Rental or purchase of dialysis equipment, dialysis supplies and rental or purchase of other medical equipment and supplies (including the cost of maintenance agreements) which are:
 - a. Ordered by a Physician, and
 - b. Of no further use when medical need ends, and
 - c. Usable only by the patient, and
 - d. Not primarily for the Member's comfort or hygiene, and
 - e. Not for environmental control, and
 - f. Not for exercise, and
 - g. Manufactured specifically for medical use.

Rental charges that exceed the reasonable purchase price of the equipment are not covered. Repair costs are covered only if the cost of replacing the equipment would be more costly.

6. Blood transfusions, including blood processing and the cost of unreplaced blood and blood products.
7. Disposable syringes, needles or kits necessary for insulin or injectable prescription drugs.
8. Nutritional counseling if prescribed by a Physician to reduce health risk factors.
9. Acupuncture when provided by an Acupuncturist who is licensed by the state where services are rendered.
10. Circumcision.

Section 3.07 Exclusions and Limitations

Benefits shall not be payable under this Article 3 for the following:

- A. Services or supplies that are determined by the Plan Administrator or its designee to be not Medically Necessary.
- B. Any charge in excess of the Allowable Charge.
- C. All Experimental and/or Investigational procedures.

D. Services received before the Member's effective date of coverage under the Plan or during an inpatient stay that began before the Member's effective date of coverage under the Plan.

E. Services received after the Member's coverage ends, except as expressly provided under the Extension of Benefits provisions described in Article 2.

F. Services not specifically listed in this Plan as a Covered Service.

G. Services for which a Member is not legally obligated to pay or for which no charge is made.

H. Services for which no charge would be made to the Member in the absence of health coverage, except services received at a non-governmental charitable research Hospital.

I. Work-related conditions, if benefits are covered or can be recovered, either by adjudication, settlement or otherwise, under any workers' compensation, employer's liability law or occupational disease law, even if the Member does not claim those benefits.

J. Conditions caused by an act of war or by release of nuclear energy, whether or not the result of war.

K. In instances where Medicare is primary and this Plan is secondary in accordance with the coordination of benefits rules in Article 5, any services to the extent that the Member is entitled to receive Medicare benefits for those services, whether or not Medicare benefits are actually paid.

L. Charges for services, supplies or treatments furnished by or covered under a government plan, Workers' Compensation law, county, state, or federal program, or veteran and military facilities, or where otherwise required by law.

M. Inpatient Hospital room and board charges in connection with a Hospital stay primarily for diagnostic testing which could have been performed safely on an outpatient basis, rehabilitative care, environmental change, physical therapy or treatment of chronic pain.

N. Custodial Care or rest cures except Custodial Care as specifically provided for under the Plan's Hospice Benefit.

O. Services provided by a rest home, a home for the aged, a nursing home or any similar facility.

P. Services provided by a Skilled Nursing Facility, except as specifically provided for under the Plan's Skilled Nursing Facility benefit.

Q. Professional services received from a person who lives in the Member's home or who is related to the Member by blood or marriage.

R. Braces, other orthodontic appliances or orthodontic services. Dental plates, bridges, crowns, caps or other dental prostheses, dental appliances (e.g. occlusals, bite guards) dental services, extraction of teeth or treatment to the teeth or gums, except as provided for Dental Injury under Section 3.06 M.

S. Optometric services, eye exercise including orthoptics, routine eye exams and routine eye refractions. Any eye surgery solely for the purpose of correcting refractive defects of the eye such as nearsightedness (myopia) and astigmatism. Eyeglasses or contact lenses, except as specifically provided under Section 3.06 S.(4).

T. Outpatient occupational therapy, except following surgery, injury or non-congenital organic disease.

U. Outpatient speech therapy, except as specifically provided under the Plan's Outpatient Therapy Benefits.

V. Cosmetic Treatment or other services for beautification.

W. Services primarily for weight reduction or for the treatment of obesity, unless surgical treatment is necessary due to life-threatening conditions resulting from morbid obesity. Morbid obesity is defined as having a Body Mass Index (BMI) of 40 or greater. The life-threatening conditions requiring surgical intervention may include: i. Established Coronary Heart Disease; ii. Other Atherosclerotic Disease; iii. Type Two Diabetes; iv. Sleep Apnea.

X. Procedures or treatments to change characteristics of the body to those of the opposite sex.

Y. Sterilization reversal, artificial insemination and in-vitro fertilization (actual fertilization of egg in laboratory.)

Z. Orthopedic shoes (except when joined to braces) or shoe inserts.

AA. Education services or food supplements.

BB. Holistic or homeopathic type medicine, biofeedback or exercise programs, exercise equipment.

CC. Smoking control.

DD. Supplies for comfort, hygiene or beautification.

EE. Air purifiers, air conditioners, humidifier.

FF. Outpatient prescription drugs, except as specifically provided in Section 3.06. Refer to Article 4 for outpatient Prescription Drug benefits.

GG. A dependent Child's pregnancy or termination of pregnancy.

HH. Telephone consultations.

II. services or supplies for which a third party is required to pay are not covered. See the provisions relating to Third Party Liability in Article 6 of this document for an explanation of the circumstances under which the Plan will advance the payment of benefits until it is determined that the third party is required to pay for those services or supplies.

JJ. Military service related injury/illness: If a Member receives services in a U.S. Department of Veterans Affairs Hospital or other military medical facility on account of a military service-related illness or injury, benefits are not payable by the Plan.

KK. Injuries resulting from or sustained as a result of commission, or attempted commission by the Member, of an illegal act that the Plan Administrator determines, on the advice of legal counsel, involves violence or the threat of violence to another person or in which a firearm, explosive or other weapon likely to cause physical harm or death is used by the Member, unless such injury or illness is the result of domestic violence or the commission or attempted commission of an assault or felony is the direct result of an underlying health factor. The Plan Administrator's discretionary determination that this exclusion applies will not be affected by any subsequent official action or determination with respect to prosecution of the Member (including, without limitation, acquittal, or failure to prosecute) in connection with the acts involved.

LL. Construction or modification to a home, residence or vehicle required as a result of an injury, illness or disability of a Member, including, without limitation, construction or modification of ramps, elevators, hand rails, chair lifts, spas/hot tubs, air conditioning, dehumidification devices, asbestos removal, air filtration/purification, swimming pools, emergency alert system, etc.

MM. Services of a medical student or intern or resident.

NN. Charges for any Physician or other health care provider who did not directly provide or supervise medical services to the patient, even if the Physician or health care provider was available to do so on a stand-by basis.

OO. Medical services or supplies rendered or provided outside the United States, except for treatment for a medical Emergency as defined in Article 1 of this document or an unexpected medical condition which occurs while the Member is temporarily outside the United States.

PP. Medical or surgical treatment of severe underweight, including, but not limited to high calorie and/or high protein food supplements or other food or nutritional supplements, except in conjunction with Medically Necessary treatment of anorexia, bulimia or acute starvation. Severe underweight means a weight more than 25 percent under normal body weight for the patient's age, sex, height and body frame based on weight tables generally used by Physicians to determine normal body weight.

QQ. Treatment of complications arising from a surgery or other treatment that is excluded under the Plan.

RR. Any services or supplies related to temporomandibular joint dysfunction, including surgery performed on the temporomandibular joint.

SS. Prophylactic surgery, which is a surgical procedure performed for the purpose of:

1. avoiding the possibility or risk of an illness, disease, physical or mental disorder or condition based on Genetic Information or Genetic Testing, or
2. treating the consequences of chromosomal abnormalities or genetically transmitted characteristics, when there is an absence of objective medical evidence of the presence of disease or physical or mental disorder, even at its earliest stages. An example of Prophylactic Surgery is a mastectomy performed on a woman who has been diagnosed as having a genetic predisposition to breast cancer and/or has a history of breast cancer among her family members when, at the time the surgery is to be performed, there is no objective medical evidence of the presence of the disease, [even if] [except when] there is medical evidence of a chromosomal abnormality or genetically transmitted characteristic indicating a significant risk of breast cancer coupled with a history of breast cancer among family members of the woman.

TT. Genetic testing except when pregnancy related and ordered by a Physician.

UU. Routine foot care, (including but not limited to trimming of toenails, removal or reduction of corns and callouses, removal thick/cracked skin on heels, foot massage, hygienic/preventive care (hygienic/preventive care includes cleaning and soaking of the feet, applying skin creams to help maintain skin tone and other services that are performed when there is no evidence of a localized illness, injury or symptoms involving the foot). Expenses for hand care including manicure and skin conditioning and other hygienic/preventive care performed in the absence of localized illness, injury or symptoms involving the hand.

VV. Hearing aids, including cochlear implants.

ARTICLE 4. PRESCRIPTION DRUG PROGRAM

The following prescription drug benefits are provided for outpatient prescriptions.

Filing a Claim

There is no need for a Member to file a claim for the benefits provided under this Article 4 when the Member obtains covered drugs at a Participating Pharmacy using his/her ID card. The Plan will pay the Participating Pharmacy directly for its share of the cost of covered drugs.

If the Participating Pharmacy denies coverage of your prescription drug or supply or coverage is otherwise denied by the Plan in whole or in part, refer to Article 6 for the Plan's Claims Appeal Procedures.

Section 4.01 Benefits

If medicines or insulin are prescribed for a Member by a Physician the Plan will pay as follows:

A. Benefits for maintenance prescription drugs (drugs that are taken on an on-going regular basis) are only provided when the maintenance prescription drug is dispensed through the Participating Mail Service Pharmacy except that benefits will be provided for the initial prescription when the maintenance drug is dispensed at a retail Participating Pharmacy.

B. When Members present their identification card at a retail Participating Pharmacy, the Plan pays 100% of the cost after a \$10 co-payment for each covered generic prescription drug, or a \$35 co-payment for each covered non-generic formulary prescription drug, or a \$35 co-payment plus the cost difference between formulary and non-formulary for each covered non-formulary non-generic drug, up to a 30-day supply.

C. When Members do not present their identification card, or go to a Non-Participating Pharmacy, no benefits are provided by the Plan.

D. When Members receive their covered prescription drugs through the Participating Mail Service Pharmacy, the Plan pays 100% of the cost after a \$20 co-payment for each covered generic prescription drug, or a \$70 co-payment for each covered non-generic formulary prescription drug, or a \$70 co-payment plus the cost difference between formulary and non-formulary for each covered non-formulary non-generic drug, up to a 90-day supply.

Section 4.02 Covered Prescription Drugs

Unless specifically excluded, the following items are covered under the Prescription Drug Program provided they are prescribed by a Physician and dispensed by a licensed Pharmacist for the treatment of an injury, illness or condition:

A. Drugs and medicines approved for general use by the Food and Drug Administration that are available only if prescribed by a Physician (M.D. or D.O.).

B. Insulin and injectable drugs. Related supplies are covered at 80% (see Article 3, Comprehensive Medical Benefits, Section 3.06 S.(7)).

Section 4.03 Exclusions and Limitations

No benefits are payable under this Prescription Drug program for:

A. Charges for prescriptions which are covered by Workers Compensation laws, or other county, state, or federal programs.

B. Drugs taken while in a Hospital, Skilled Nursing Facility, Nursing Home, or similar inpatient facility or outpatient facility unless it is not usually supplied by or used in that facility.

C. Oxygen.

D. Blood and blood plasma; blood glucose test strips.

E. Drugs labeled "Caution: Limited by Federal Law to Investigational Use."

F. Drugs used for Cosmetic Treatment.

G. Topical Minoxidil.

H. Drugs dispensed for smoking control or cessation beyond three treatment plans.

I. Drugs for weight loss, control or management or dietary supplements.

J. Devices, appliances and medical supplies.

K. Vitamins except prenatal vitamins that require a Physician's prescription in order to be dispensed.

ARTICLE 5. COORDINATION OF BENEFITS

All of the benefits provided in Article 3 are subject to the following provisions and limitations regardless of any other provisions of this Plan. These coordination of benefits rules do not apply to the Plan's prescription drug coverage provided in Article 4.

This coordination of benefits provision applies to this Plan when an Employee or the Employee's covered Family Members have medical care coverage under more than one Plan. The benefits of this Plan may be reduced if the Member has any other group health, dental or vision coverage so that the benefits and services the Member receives from all group coverages do not exceed 100 percent of the Allowable Expense (as defined below).

Section 5.01 Definitions

A. "Coordination of Benefits" (COB) means coordination of the benefits of this Plan with any other contract which provides full or partial benefits or services for Hospital, surgical, medical, vision, prescription or dental, for a Member, including but not limited to:

1. Group, blanket or franchise insurance coverage;
2. Group service plan contract, group practice, group individual practice and other group prepayment coverage; and
3. Any group coverage under labor-management trusteed plan, union welfare plans, employer organization plans, employee benefit organization plans or self-insured employee benefit plans. The term Plan refers separately to each agreement, policy, contract or other arrangement for services and benefits, and only to that portion of any such agreement, policy, contract or other arrangement which reserves the right to take the services and benefits or Plans into consideration in determining its benefits.
4. Group coverage provided to employees who enter into full-time military duty with the armed forces.

B. "Allowable Expense" means, for purposes of this Article 5 only, a health care service or expense, including deductibles, coinsurance or copayments, which is covered in full or in part by any of the plans covering the person, except as provided below or where a statute applicable to this Plan requires a different definition. This means that an expense or service (or any portion of 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 an Allowable Expense:

1. The difference between the cost of a semi-private room in a Hospital and a private room, unless the patient's stay in a private Hospital room is determined (by the Plan Administrator or its designee) to be Medically Necessary.
2. If the coordinating plans determine benefits on the basis of an Allowed charge amount, any amount in excess of the highest allowed charge is not an Allowable Expense.

3. If the coordinating plans provide benefits or services on the basis of negotiated fees, any amount in excess of the highest of the negotiated fees is not an Allowable Expense.
4. If one coordinating plan determines benefits on the basis of an allowed charge amount and the other coordinating plan provides benefits or services on the basis of negotiated fees, the primary plan's payment arrangement is the Allowable Expense for all plans.
5. When benefits are reduced by a primary plan because a Member did not comply with the primary plan's provisions, such as provisions related to utilization management, the amount of those reductions will not be considered an Allowable Expense by this Plan when it pays second.

Allowable Expenses do not include expenses for services received because of an occupational sickness or injury, or expenses for services that are excluded or not covered under this Plan.

Section 5.02 Effect on the Benefits of this Plan

This section applies when, in accordance with the Order of Benefit Determination Rules, this Plan is a secondary plan as to one or more other plans. In that event, the benefits of this Plan may be reduced under this Section. Such other plan or plans are referred to as "the other plans" in the following paragraphs. The benefits of this Plan shall be reduced when the sum of:

- A. The benefits that would be payable for the Covered Services under this Plan, in the absence of this coordination of benefits provision; and
- B. The benefits that would be payable for the Covered Services under the other plans, in the absence of provisions with a purpose like that of this coordination of benefits provision, whether or not claim is made, exceeds those Covered Expenses. In that case, the benefits of this Plan shall be reduced so that they and the benefits payable under the other plans do not total more than those Allowable Expenses. When the benefits of this Plan are reduced, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of this Plan. In no event will this Plan pay more than what it would have paid in the absence of another plan nor will it pay more than what the patient would have been responsible to pay in the absence of this Plan.

Section 5.03 Order of Benefit Determination Rules

- A. The benefits of a plan that does not contain a coordination of benefits provision or a provision similar to the intent of a coordination of benefits provision, are determined before those of a plan which has such a provision.
- B. The benefits of the plan which covers the person as an employee, (rather than as a dependent) are determined before those of the plan which covers the person as a dependent.
- C. Birthday Rule for Children – Except as stated in (D) below, the plan of the parent whose birthday falls earlier in the calendar year pays before the plan of the parent whose birthday falls later in the calendar year. If both parents have the same birthday, the plan which covered the parent longer pays before the plan which covered the parent for a shorter time.

However, if the other plan does not have this Birthday Rule for Children, 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 shall determine the order of benefits.

D. Children of Divorce or Separation – If two or more plans cover a dependent Child of divorced or separated parents, and the specific terms of a court decree state that one of the parents is responsible for health care expenses of the Child, the benefits of that plan are determined first. If the court decree does not specify which parent is responsible for health care expenses, benefits for the child are determined in this order:

1. First, the plan of the parent with custody of the child;
2. Then, the plan of the spouse of the parent with custody of the Child; and
3. Finally, the plan of the parent not having custody of the Child.

E. The benefits of a plan which covers a person as an active employee (or an active employee's dependent) are determined before those of a plan which covers that person as a laid off or retired 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 is ignored.

F. The benefits of a plan which covers a person other than under an extension required by the Consolidated Omnibus Budget Reconciliation Act (COBRA) are determined before those of a plan which covers that person under a COBRA extension.

G. If none of the above rules determines the order of benefits, the benefits of the plan which covered the individual for the longer period of time are determined before those of the plan which covered that individual for the shorter period of time.

1. Two successive plans shall be considered one continuous plan if an individual is eligible for coverage under the second plan within 24 hours after the first plan terminated. A change in the amount or scope of benefits provided by a plan, a change in the carrier insuring the plan or a change from one type of plan to another does not, of itself, establish the start of a new plan.

2. If an individual became effective after the effective date of the current group plan and there is no information to the contrary, the length of time for such individual shall be measured from his/her effective date under the current plan. If an individual became effective on the effective date of current group plan, the length of time for such individual shall be measured from his/her original effective date under any prior plans the group may have had. If such date cannot be determined, the length of time shall be measured from his/her effective date under the current plan.

Section 5.04 Rights to Receive and Release Necessary Information

Certain facts are needed to apply these coordination of benefits provisions. The Plan Administrator has the right to decide which facts it needs. The Plan Administrator may get the needed facts from or give them to any other organization or person. The Plan Administrator need not tell, or get the consent of, any person to do this. Each person claiming benefits under this Plan must give the Plan Administrator any facts it needs to pay the claim.

Section 5.05 Responsibility for Timely Notice

The Plan is not responsible for payment to Members or other insurers under coordination of benefits unless information has been provided by the Member or other insurer regarding the application of this provision within twelve months of service.

Section 5.06 Reasonable Cash Value

When another Plan provides benefits in the form of services rather than cash payment, the customary and reasonable cash value of services provided shall be considered to be a benefit paid. The customary and reasonable cash value of any service provided to the individual by any service or organization shall be considered expense incurred by that individual, and the liability of the Plan shall be reduced accordingly.

Section 5.07 Facility of Payment

Whenever payments, which should have been under this Plan, have been made under any other Plan, the Plan will have the right to pay to the other Plan any amount his/her Plan Administrator determines to be warranted to satisfy the intent of this provision. Any amount so paid shall be considered to be benefits paid under this Plan, and with that payment, the Plan will fully satisfy its liability under this provision.

Section 5.08 Right of Recovery

Whenever payments for covered benefits have been made by this Plan, and those payments are more than the maximum payment necessary to satisfy the intent of this provision, regardless of who was paid, the Plan has the right to recover the excess amount from any persons to or for whom those payments were made, or from any insurance company, service plan, or any other organization or persons.

Section 5.09 Coordination of Benefits with Medicare

A. If you are covered under this Plan as an Active Employee who is actively employed with the City or are a Family Member of an Active Employee who is actively employed with the City and are also covered by Medicare, generally this Plan will pay its normal benefits and Medicare will provide secondary coverage. However, if your entitlement to Medicare is because you have end stage renal disease (ESRD), this Plan will pay its normal benefits and Medicare will provide secondary coverage for 30 months starting the **earlier** of the month in which Medicare ESRD coverage begins, or the first month in which the individual receives a kidney transplant. Then, starting with the 31st month after the start of Medicare coverage, Medicare pays its normal benefits and this Plan will pay provide secondary coverage.

B. If you are covered under this Plan as a Retired Employee or are a Family Member of a Retired Employee and are also covered by Medicare, generally Medicare will pay its normal benefits and this Plan will provide secondary coverage as described in Section 5.02.

COORDINATION OF BENEFITS WITH MEDICARE

To comply with federal Medicare coordination of benefit regulations, you must promptly furnish to the Plan Administrator, or its designee, the Social Security Number (SSN) of your Family Members for which you have elected, or are electing, Plan coverage, and information on whether you or any of such dependents are currently enrolled in Medicare or have disenrolled from Medicare. This information will be requested when you first enroll for Plan coverage but may also be requested at a later date.

Failure to provide the SSN or complete the Centers for Medicare and Medicaid (CMS) model form

(form is available from the Claims Administrator or

<https://www.cms.gov/MandatoryInsRep/Downloads/RevisedHICNSSNForm081809.pdf>)

means that claims for eligible individuals cannot be processed for the affected individuals.

ARTICLE 6. THIRD PARTY LIABILITY

Section 6.01 Advance on Account of Plan Benefits

The Plan does not cover expenses for services or supplies for which a third party pays or is liable to pay due to any recovery, whether by settlement, judgment or otherwise but it will advance payment on account of Plan benefits (hereafter called an "Advance"), subject to its right to be reimbursed to the full extent of any Advance payment from the Member and/or a representative, guardian, conservator, or trustee of the Member if and when there is any recovery from any third party. The right of reimbursement will apply:

- A. even if the recovery is not characterized in a settlement or judgment as being paid on account of the medical or dental expenses for which the Advance was made; and
- B. even if the recovery is not sufficient to make the ill or injured employee and/or family member whole pursuant to state law or otherwise (sometimes referred to as the "make-whole" rule); and
 - 1. without any reduction for legal or other expenses incurred by the employee and/or family Member in connection with the recovery against the third party or that third party's insurer pursuant to state law or otherwise (sometimes referred to as the "common fund" rule); and
 - 2. regardless of the existence of any state law or common law rule that would bar recovery from a person or entity that caused the illness or injury, or from the insurer of that person or entity (sometimes referred to as the "collateral source" rule);
 - 3. even if the recovery was reduced due to the negligence of the covered Employee or covered Family Member (sometimes referred to as "contributory negligence") or any other common law defense.

Section 6.02 Reimbursement [and/or Subrogation] Agreement

The covered Employee and/or any covered Family Member on whose behalf the Advance is made, must sign and deliver a reimbursement [and/or subrogation] agreement (hereafter called the "Agreement") in a form provided by or on behalf of the Plan. If the ill or injured family member is a minor or incompetent to execute that Agreement, that person's parent (in the case of a minor dependent child) or Spouse or legal representative (in the case of an incompetent adult) must execute that Agreement upon request by the Plan Administrator or its designee.

If the Agreement is not executed at the Plan Administrator's request, the Plan may refuse to make any Advance, but if, at its sole discretion, the Plan makes an Advance in the absence of an Agreement, that Advance will not waive, compromise, diminish, release, or otherwise prejudice any of the Plan's rights.

Section 6.03 Cooperation with the Plan by All Covered Members

By accepting an Advance, regardless of whether or not an Agreement has been executed, the covered Employee and/or covered Family Members each agree:

- A. to reimburse the Plan for all amounts paid or payable to the covered Employee and/or covered Family Member or that third party's insurer for the entire amount Advanced; and
- B. that the Plan has the first right of reimbursement from any judgment or settlement; and
- C. to do nothing that will waive, compromise, diminish, release, or otherwise prejudice the Plan's reimbursement [and/or subrogation] rights; and
- D. to not assign the right of recovery to any third party without the specific consent of the Plan; and
- E. to notify and consult with the Plan Administrator or designee before starting any legal action or administrative proceeding against a third party alleged to be responsible for the injury or illness that resulted in the Advance, or entering into any settlement Agreement with that third party or third party's insurer based on those acts; and
- F. to inform the Plan Administrator or its designee of all material developments with respect to all claims, actions, or proceedings they have against the third party.

Section 6.04 Subrogation

A. By accepting an Advance, the covered Employee and/or covered Family Member(s) jointly agree that the Plan will be subrogated to the covered Employee and/or covered Family Member's right of recovery from a third party or that third party's insurer for the entire amount Advanced, regardless of any state or common law rule to the contrary, including without limitation, a so-called collateral source rule (that would have the effect of prohibiting the Plan from recovering any amount). This means that, in any legal action against a third party who may have been responsible for the injury or illness that resulted in the Advance, the Plan may be substituted in place of the covered Employee and/or covered Family Member(s), but only to the extent of the amount of the Advance. The Plan is subrogated in any and all actions against third parties for the portion of all recoveries that the Plan is entitled.

B. Under its subrogation rights, the Plan may, at its discretion:

1. start any legal action or administrative proceeding it deems necessary to protect its right to recover its Advances, and try or settle that action or proceeding in the name of and with the full cooperation of the covered Employee and/or covered Family Member(s), but in doing so, the Plan will not represent, or provide legal representation for the covered Employee and/or covered Dependent(s) with respect to their damages that exceed any Advance; or
2. intervene in any claim, legal action, or administrative proceeding started by the covered Employee or covered Family Member(s) against any third party or third party's insurer concerning the injury or illness that resulted in the Advance.

Section 6.05 Application to Any Fund

A. The Plan's right to reimbursement [and subrogation] shall apply to any fund, account or other asset created:

1. pursuant to the judgment of any court awarding damages against any third party in favor of the ill or injured Employee and/or Family Member(s) payable by any third party on account of an illness or injury alleged to have been caused by that third party; or
2. as a result of any settlement paid by any third party on account of any claim by or on behalf of the ill or injured Employee and/or Family Member(s).

Section 6.06 Lien and Segregation of Recovery

By accepting the Advance the covered Employee and/or covered Family Member agrees to the following:

A. The Plan will automatically have an equitable lien, to the extent of the Advance, upon any recovery, whether by settlement, judgment or otherwise, by the covered Employee and/or covered Family Member. The Plan's lien extends to any recovery from the third party, the third party's insurer, and the third party's guarantor and to any recovery received from the insurer under an automobile, uninsured motorist, underinsured motorist, medical or health insurance or other policy. The Plan's lien exists regardless of the extent to which the actual proceeds of the recovery are traceable to particular funds or assets.

B. The Plan holds in a constructive trust that portion of the recovery that is the extent of the Advance. The covered Employee, covered Family Member, and those acting on their behalf, shall place and maintain such portion of any recovery in a separate segregated account until the reimbursement obligation to the plan is satisfied. The location of the account and the account number must be provided to the Plan.

C. Should the covered Employee, covered Family Member or those acting on their behalf, fail to maintain this segregated account or comply with any of the Plan's reimbursement requirements, they stipulate to the entry of a temporary or preliminary injunction requiring the placement and maintenance of any reimbursable or disputed portion of any recovery in an escrow account until any dispute concerning reimbursement is resolved and the Plan receives all amounts that must be reimbursed.

Section 6.07 Remedies Available to the Plan

In addition to the remedies discussed above, if the covered Employee or covered Family Member(s) does not reimburse the Plan as required by this provision, the Plan may, at its sole discretion:

A. apply any future Plan benefits that may become payable on behalf of the covered Employee and/or covered Family Member(s) to the amount not reimbursed; or

B. obtain a judgment against the covered Employee and/or covered Family Member(s) for the amount Advanced and not reimbursed, and garnish or attach the wages or earnings of the covered Employee and/or covered Family(s).

ARTICLE 7. CLAIM REVIEW AND APPEAL PROCEDURES

Section 7.01 Definitions

Unless otherwise indicated by the context of this Article or of the Plan rules, the following definitions shall apply to the claims procedures of the City:

- A. A "Concurrent Claim" means any claim that is reconsidered after an initial approval was made and which results in a reduced or a terminated benefit.
- B. A "Post-Service Claim" means any claim for benefits that is not a Pre- Service Claim.
- C. A "Pre-Service Claim" means any claim for benefits under these Plan rules for which the City conditions the receipt of the benefit for such claim, in whole or in part, on approval of the benefit in advance of obtaining medical care.
- D. An "Urgent Claim" means a claim for medical care or treatment, with respect to which the application of the time periods for making other non-urgent care determinations under these Plan rules could seriously jeopardize the life or health of the claimant or the claimant's ability to regain maximum function or, in the opinion of a physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that could not be adequately managed without the care or treatment that is the subject of the claim.

Section 7.02 Claim Review Procedures

A. General Rules

No Active Employee, Retired Employee, eligible Family Member, or other person shall have any right or claim to benefits under the Plan or any right or claim to payments from the City other than as specified in the provisions of the Modified Employee Medical Plan, and in such claims procedures as the City may adopt. The claims provisions set forth in this Section are intended to comply with, and shall be construed in accord with, applicable federal law and regulations. Any dispute as to eligibility, type, amount or duration of such benefits or any right or claim to payments from the City, shall be resolved under and pursuant to the terms of the Plan, and the City's decision of the dispute, right or claim shall be final and binding upon all parties thereto unless a timely claim for external review is filed with the City. Any person who makes a claim for benefits from the City may designate an authorized representative to take all necessary actions with respect to such claim if such designation is in writing or if it otherwise satisfies the procedures established by the City. The term "Agent" used herein means any insurance company, insurance service or similar organization, any consultant or pre-authorization service, any committee selected by the City, or the Administrator of the Plan which is designated to pay the benefits provided by the City or the Plan or to make claims determinations pursuant to this Section.

B. Initial Benefit Determinations

1. An Employee, Family Member or other claimant who wishes to apply for benefits from the Plan shall file such claim in writing with the Plan Administrator. The written claim shall contain sufficient information to identify the claimant, the nature of the benefits claimed and such other information as required by the Plan's claims procedures. The Plan Administrator, or designee, shall make an initial determination whether such claim will be approved or denied as follows:

- a. as soon as possible, taking into account the medical exigencies, but not later than 72 hours from the receipt of an Urgent Claim;
- b. within 15 days from the receipt of a Pre-Service Claim;
- c. within 30 days from the receipt of a Post-Service Claim; and
- d. within 45 days from the receipt of a claim for disability benefits.

2. If the Plan Administrator, or designee, determines that an extension of time is required to render an initial determination on a Pre-Service or a Post-Service Claim due to matters beyond the control of the Plan Administrator, the time limit within which such initial determination must be made by the Plan Administrator may be extended for 15 days if the Plan Administrator notifies the claimant of the extension within the time limit initially set for processing such claim.

3. If the Plan Administrator, or designee, determines that an extension of time is required to render an initial determination on a disability claim due to matters beyond the control of the Plan Administrator, the time limit within which such initial determination must be made by the Plan Administrator may be extended for two (2) periods of 30 days each if the Plan Administrator notifies the claimant of the extension within the time limit initially set for processing such claim.

4. No such extensions as provided in subsections 2 and 3 above shall be allowed for the initial determination of an Urgent Claim.

5. If the Plan Administrator determines that additional information is needed in order to render an initial determination of a claim for benefits submitted by an Employee, Family Member or other claimant, the Plan Administrator shall notify the claimant as follows:

- a. For an Urgent Claim, the Plan Administrator or designee shall notify the claimant if the claimant has failed to provide necessary information, and such notice shall specify the information required as soon as possible, taking into account the medical exigencies, but not later than 24 hours of the receipt of such claim, and the claimant shall be given not less than 48 hours to respond to such request for information. The time limit within which such Urgent Claim must be resolved shall be suspended for 48 hours or until the requested information is received, whichever occurs first; and
- b. For a Pre-Service Claim, a Post-Service Claim, or a disability claim, the Plan Administrator shall notify the claimant if the claimant has failed to provide necessary information, and such notice shall specify the information required. The claimant shall be

given not less than 45 days to submit such additional information. The time limit within which such claims must be resolved shall be suspended for 45 days or until the requested information is received, whichever occurs first.

Section 7.03 Claim Appeal Procedures

A. Any person whose application for benefits or for an initial benefit determination under the Plan has been denied in whole or in part by the Plan Administrator, or designee, or whose coverage has been rescinded, whether or not the rescission has an adverse effect on any particular benefit at the time of the rescission, shall be notified in writing of such denial within the applicable time limits set forth in subsection b above, except a rescission of coverage requiring advance written notice of at least thirty days, and except for Urgent Claims, which may be denied orally within such applicable time limits, if the oral notification is confirmed in writing within three (3) calendar days after such oral notice.

The notice of the denial of initial benefit determination shall be written in a manner which is culturally and linguistically appropriate and calculated to be understood by the petitioner and shall state the specific reason or reasons for the adverse determination, a reference to the provision in the Plan rules upon which the determination was based, a statement of any additional information or material required for the processing of the claim, the reason such additional information is needed, a statement of information sufficient to apprise the claimant of the Plan's procedures for the appeal of denied claims, and shall provide copies of any internal rules, guidelines, protocols or other criteria relied upon by the Plan Administrator or designee in denying the claim unless the claimant is notified in writing that such material is available and will be provided to him at no cost upon his request. In addition, all such notices must include information sufficient to clearly identify the claim involved, including the date of service, the health care provider, the claim amount, if applicable, and the denial code and its corresponding meaning, as well as a description of the standard that was used in denying the claim and a discussion of the decision.

The notice shall describe the right to obtain, upon request, the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning. All notices must provide a description of available internal appeals and external review processes, including information regarding how to initiate an appeal. The petitioner or his duly authorized representative shall be permitted to review pertinent documents and to submit issues and comments in writing. The petitioner shall be provided, free of charge, with any new or additional evidence, or additional rationale, considered by, relied upon, or generated by the Plan in connection with the claim, and such evidence shall be provided as soon as possible and sufficiently in advance of any date on which the City will consider the claim to give the petitioner a reasonable opportunity to respond prior to that time.

B. Any person whose claim is denied, may petition the City for review of the denial of an initial benefit determination. A petition for review shall be in writing, except for the appeal of the denial of an Urgent Claim which may be oral. Such petition shall state in clear and concise terms the reason or reasons for disputing the denial, shall be accompanied by any pertinent documentary material not already furnished, and shall be filed with the Plan Administrator within 180 days after the petitioner receives notice of the denial of his claim. The petitioner or his duly authorized representative shall be permitted to review pertinent documents and to submit issues and comments in writing. The petitioner shall be provided, free of charge, any new or additional evidence, or additional rationale, considered by, relied upon, or generated by the City in connection with the claim after the initial notice, and such

evidence or rationale must be provided as soon as possible and sufficiently in advance of any date on which the City will consider the claim to give the petitioner a reasonable opportunity to respond prior to that time.

C. Upon good cause shown, the City, or its designee, shall permit the petition to be amended or supplemented and may, in its sole discretion, in accord with federal law and regulations, grant a hearing on the petition before an appeals hearing committee to receive and hear any evidence or argument which cannot be presented satisfactorily by correspondence. The failure to file a petition for review within such one hundred and eighty day period or to appear and participate in any such hearing shall constitute a waiver of the claimant's right to review the denial, provided that the appeals hearing committee may relieve a claimant of any such waiver for good cause if application for such relief is made within one year after the date shown on the notice of denial.

D. A decision by the appeals hearing committee, or its designee, shall be made promptly, but in no event shall it exceed the following time limits:

1. For Urgent Claims, within 72 hours from receipt of the petition for review;
2. For Pre-Service Claims, within 30 days from the receipt of the petition for review;
3. For Post-Service Claims, within 60 days from the receipt of the petition for review;
4. For disability claims, within 45 days from the receipt of the petition for review. The City may extend this period by an additional period of 45 days if the City provides notice to the claimant of the circumstances requiring the extension within the first 45-day period.
5. For Concurrent Claims, sufficiently in advance to allow the appeal and consideration of such appeal before termination of the benefit.

E. The petitioner shall be notified of the decision of the appeals hearing committee, or designee, in writing. The decision shall include all of the same information which is required to be provided by the City for an initial benefit determination under section 7.02 above. All notices must provide a description of available internal appeals and external review processes, including information regarding how to initiate an appeal.

F. The decision of the appeals hearing committee with respect to the petition for review shall be final and binding upon all parties, including the applicant, claimant or petitioner, subject only to external review as provided by federal law and regulations and by these Rules.

G. The provisions of this Section 7.03 shall apply to and include each and every claim to benefits from the Plan, and any claim or right asserted under the Plan or against the City, regardless of the basis asserted for the claim and regardless of when the act or omission upon which the claim is based occurred, and regardless of whether the claimant is a participant or beneficiary of the Plan.

H. If the Member disagrees with the decision rendered by the appeals hearing committee and the Member's appeal is regarding the Plan's non-payment for service(s), and the

Member's claims are for less than the jurisdictional limit of small claims court (which is \$7,500 as of November 1, 2006) or if a Member's appeal is regarding services requested and not yet performed, or any other type of non-monetary appeal, the Member may request arbitration by making written demand for arbitration to the Plan Administrator. The arbitration shall be held before a designated neutral arbitrator appointed by the county medical association of the county in which the services were provided. The decision of the arbitrator shall be final.

I. External review

1. The petitioner shall have the right to file a request for an external review of any claim denied by the City if the request is filed within four months after the date of receipt of a notice of an adverse benefit determination or final internal adverse benefit determination or denial of petition. If there is no corresponding date four months after the date of receipt of such a notice, then the request must be filed by the first day of the fifth month following the receipt of the notice. If the last date for filing a request for external review falls on a Saturday, Sunday, or federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday, or federal holiday.

2. Preliminary review. Within five business days following the date of receipt of the external review request, the City or its designee shall complete a preliminary review of the request to determine whether:

- a. The petitioner is or was eligible under these Plan rules at the time the health care item or service was requested or, in the case of a retrospective review, was eligible under these Plan rules at the time the health care item or service was provided;
- b. The adverse benefit determination or the final adverse benefit determination involves a medical judgment or a rescission of coverage;
- c. The petitioner has exhausted the internal appeal process set forth in this Article unless the petitioner is not required to exhaust such appeals process under applicable federal law and regulations; and
- d. The petitioner has provided all the information and forms required to process an external review.

Within one business day after completion of the preliminary review, the City shall notify the petitioner in writing as follows: If the request for external review is complete but not eligible for external review, such notification must include the reasons for its ineligibility and contact information for the Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272)). If the request is not complete, such notification must describe the information or materials needed to make the request complete, and the City shall allow the petitioner to perfect the request for external review within the four-month filing period or within the 48 hour period following the receipt of the notification, whichever is later.

3. Referral to Independent Review Organization. The City shall assign an independent review organization ("IRO") that is accredited by URAC (formerly known as the Utilization Review Accreditation Commission) or by a similar nationally-recognized accrediting organization to conduct the external review. The City shall take action against bias and to

ensure independence of the IRO and the external review process. The City will contract with at least three (3) IROs for assignments under the Plan and rotate claims assignments among them (or incorporate other independent, unbiased methods for selection of IROs, such as random selection). The IRO may not be eligible for any financial incentives based on the likelihood that the IRO will support the denial of benefits.

4. Any agreement between the City and an IRO shall provide the following:

a. The assigned IRO will utilize legal experts where appropriate to make coverage determinations under the Plan rules.

b. The assigned IRO will timely notify the petitioner in writing of the request's eligibility and acceptance for external review. The notice will include a statement that the petitioner may submit in writing to the assigned IRO within ten business days following the date of receipt of the notice additional information that the IRO must consider when conducting the external review. The IRO is not required to, but may, accept and consider additional information submitted after ten business days.

c. Within five business days after the date of assignment of the IRO, the City must provide to the assigned IRO the documents and any information considered in making the adverse benefit determination or final internal adverse benefit determination. Failure by the City to timely provide the documents and information shall not delay the conduct of the external review. If the City fails to timely provide the documents and information, the assigned IRO may terminate the external review and make a decision to reverse the adverse benefit determination or final internal adverse benefit determination. Within one business day after making the decision, the IRO must notify the petitioner and the City.

d. Upon receipt of any information submitted by the petitioner, the assigned IRO must, within one business day, forward the information to the City. Upon receipt of any such information, the City may reconsider its adverse benefit determination or final internal adverse benefit determination that is the subject of the external review. Reconsideration by the City must not delay the external review. The external review may be terminated as a result of the reconsideration only if the City decides, upon completion of its reconsideration, to reverse its adverse benefit determination or final internal adverse benefit determination and provide coverage or payment. Within one business day after making such a decision, the City must provide written notice of its decision to the petitioner and the assigned IRO. The assigned IRO must terminate the external review upon receipt of such notice from the City.

e. The IRO shall review all of the information and documents timely received. In reaching a decision, the assigned IRO shall review the claim de novo and not be bound by any decisions or conclusions reached during the City's internal claims and appeals process applicable under this section 7.02 and in accord with federal law and regulations. In addition to the documents and information provided, the assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the following in reaching a decision:

i. The petitioner's medical records;

- ii. The attending health care professional's recommendation;
- iii. Reports from appropriate health care professionals and other documents submitted by the City, the petitioner and the petitioner's treating provider;
- iv. The applicable provisions of these Plan rules to ensure that the IRO's decision is not contrary to the terms of this Plan, unless such provisions are inconsistent with applicable federal law and regulations;
- v. Appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the federal government, national or professional medical societies, boards, and associations;
- vi. Any applicable clinical review criteria developed and used by the City, unless such criteria are inconsistent with these Plan rules or with applicable federal law and regulations;
- vii. The opinion of the IRO's clinical reviewer or reviewers after considering the information described in these Plan rules to the extent the information or documents are available and the clinical reviewer or reviewers consider them to be appropriate.
- viii. The assigned IRO shall provide written notice of the final external review decision within 45 days after the IRO receives the request for the external review. The IRO must deliver the notice of final external review decision to the petitioner and to the City.
- ix. The assigned IRO's decision notice shall contain:
 - (A) A general description of the reason for the request for external review, including information sufficient to identify the claim (including the date or dates of service, the health care provider, the claim amount (if applicable), and the reason for the previous denial);
 - (B) The date the IRO received the assignment to conduct the external review and the date of the IRO's decision;
 - (C) References to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision;
 - (D) A discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;
 - (E) A statement that the determination is binding except to the extent that other remedies may be available under state or federal law to either the City or to the petitioner;

(F) A statement that judicial review may be available to the petitioner; and

(G) To the extent required by applicable federal law and regulations, current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under federal law.

x. After a final external review decision, the IRO shall maintain records of all claims and notices associated with the external review process for six years. The IRO shall make such records available for examination by the petitioner, the City, or federal oversight agency upon request, except where such disclosure would violate federal privacy laws.

5. Reversal of the City's decision. Upon receipt of a notice of a final external review decision reversing the adverse benefit determination or final internal adverse benefit determination, the City shall immediately provide coverage or payment (including immediately authorizing or immediately paying benefits) for the claim.

6. Expedited external review

a. Request for expedited external review. The City shall allow a petitioner to make a request for an expedited external review with the City at the time the petitioner receives:

i. An adverse benefit determination if the adverse benefit determination involves a medical condition of the petitioner for which the timeframe for completion of an expedited internal appeal under applicable federal law and regulations would seriously jeopardize the life or health of the petitioner or would jeopardize the petitioner's ability to regain maximum function and the petitioner has filed a request for an expedited internal appeal; or

ii. A final internal adverse benefit determination, if the petitioner has a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the life or health of the petitioner or would jeopardize the petitioner's ability to regain maximum function, or if the final internal adverse benefit determination concerns an admission, availability of care, continued stay, or health care item or service for which the petitioner received emergency services, but has not been discharged from a facility.

b. Preliminary review. Immediately upon receipt of the request for expedited external review, the City shall determine whether the request meets the reviewability requirements set forth above for standard external review. The City shall immediately send a notice that meets the requirements set forth above for standard external review to the petitioner of its eligibility determination.

c. Referral to independent review organization. Upon a determination that a request is eligible for external review following the preliminary review, the City shall assign an IRO pursuant to the requirements set forth above for standard review. The City shall provide or transmit all necessary documents and information considered in making the adverse

benefit determination or final internal adverse benefit determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method.

The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the information or documents described above under the procedures for standard review. In reaching a decision, the assigned IRO must review the claim de novo and is not bound by any decisions or conclusions reached during the City's internal claims and appeals process.

d. Notice of final external review decision. The City's agreement with the assigned IRO shall require the IRO to provide notice of the final external review decision, in accordance with the requirements set forth above, as expeditiously as the petitioner's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review. If the notice is not in writing, within 48 hours after the date of providing that notice, the assigned IRO must provide written confirmation of the decision to the petitioner and to the City.

ARTICLE 8. GENERAL PROVISIONS

Section 8.01 Workers' Compensation

The Plan does not affect any requirement for workers' compensation. It also does not replace workers' compensation. Members must notify the Plan Administrator of any workers' compensation application filed on the Member's behalf.

Section 8.02 Clerical and Administrative Errors

Clerical and Administrative errors of the Plan do not deprive any Member of his or her coverage. Also, clerical and administrative errors of the Plan do not create, authorize, or continue coverage or benefits which would not otherwise be provided by the Plan.

Section 8.03 Providing of Care

This Plan is not responsible for providing any type of hospital, medical or similar care. Also, this Plan is not responsible for the quality of any type of hospital, medical or similar care received.

Section 8.04 Non-Regulation of Providers

Benefits provided under this Plan do not regulate the amounts charged by providers of medical care.

Section 8.05 Benefits Not Transferable

Only eligible Members are entitled to receive benefits under this Plan. The right to benefits cannot be transferred.

Section 8.06 Independent Contractors

All providers are independent contractors. The Plan is not liable for any claim or demand for damages connected with injury resulting from any treatment.

Section 8.07 Medical Necessity

In addition to any other provision in this Plan respecting medical necessity, the benefits of this Plan are provided only for services that are Medically Necessary. The services must be ordered by the attending Physician for the direct care and treatment of a covered illness, injury or condition. They must be standard medical practice where received for the illness, injury or condition being treated and must be legal in the United States. When an inpatient stay is necessary, services are limited to those which could not have been performed before admission.

Section 8.08 Expense in Excess of Benefits

The City is not liable for any expenses the Member incurs in excess of benefits of this Plan.

Section 8.09 Payment to Providers

Plan benefits are paid directly to Participating Providers. The Plan may in its discretion pay other providers of service directly when the Member assigns benefits in writing. These payments fulfill the obligation of the City to the Member for these services.

Section 8.10 Notice of Claim

Claim forms must be received by the Plan Administrator within 12 months of the date services are received for medical claims and within 90 days of the date of purchase for prescription drug claims. The City is not liable for the benefits of this Plan if claims are not filed within this time period. Canceled checks or receipts are not acceptable documentation for claims processing.

Section 8.11 Right of Recovery

When the amount paid by the Plan exceeds the amount for which the City is liable under the Plan, the Plan Administrator, on behalf of the City, has the right to recover the excess amount. This amount may be recovered from the Employee, the person to whom payment was made, any other plan, or any other person or entity.

Section 8.12 Free Choice of Hospital and Physician

This Plan does not interfere with the right of a Member entitled to hospital benefits to select the hospital. That person may choose any physician who holds a valid physician and surgeon's certificate and who is a member of, or acceptable to, the attending staff and board of directors of the hospital where services are received. However, benefits payable according to the terms of this Plan may be different for each of the following categories: participating hospitals, physicians, pharmacies, laboratories and other providers and non-participating hospitals, physicians, pharmacies, laboratories and other providers.

Section 8.13 Member Duties

When a Member is a Child, the duties of that Member under this Plan must be carried out by the Employee.

Section 8.14 Amendment and Termination

In order that the Plan may carry out its obligation to maintain within the limits of its resources, a program dedicated to providing benefits for all employees, the City reserves the right, at any time to amend either the amount or condition with respect to any benefit payable, and to terminate the Plan.

Section 8.15 Discretionary Authority of Plan Fiduciaries and Designees

In carrying out their respective responsibilities under the Plan, the Plan fiduciary or its designees, have been delegated and have discretionary authority to interpret the terms of the Plan including, but not limited to, the discretionary authority to resolve ambiguities or inconsistencies in the Plan and to determine the extent to which a person is eligible and entitled to any Plan benefits. Any interpretation or determination made under that

discretionary authority will be given full force and effect, unless it can be shown that the interpretation or determination was arbitrary and capricious.

ARTICLE 9. FEDERAL AND STATE LAWS AFFECTING GROUP HEALTH PLANS

The Plan recognizes that federal and or state laws, rules, regulations, and codes, governing group health plans, may add, change, or modify the provisions of this Plan. It is the intent of this Plan to comply with such requirements, even if those federal and state laws are not specifically referenced in this Plan document.

Section 9.01 Certificate of Creditable Coverage and Preexisting Conditions

A. General Rules

A group health plan (or issuer) may not impose preexisting condition exclusion with respect to a Member before notifying the Member, in writing, of the existence and terms of any preexisting condition exclusion under the Plan, the rights of individuals to demonstrate creditable coverage (and any applicable waiting periods), the right of the individual to request a certificate from a prior plan or issuer, if necessary, and that the current Plan (or issuer) shall assist in obtaining a certificate from any prior plan or issuer, if necessary.

B. Preexisting Conditions

The Plan may impose preexisting conditions for certain benefits. You can determine whether a particular benefit is subject to a preexisting condition or a waiting period by looking at the applicable Section describing the Plan and by referring to any Plan document that are incorporated into the Section by reference. Before the Administrator shall impose preexisting condition exclusion, the Administrator shall provide you in writing a description of its determination of the period of creditable coverage, including the source and substance of any information on which the Plan or issuer relied, the remaining preexisting condition exclusion period that shall apply, and any appeal procedures. The Plan shall also give you a reasonable opportunity to submit additional evidence of creditable coverage.

C. Certificates of Creditable Coverage

A certificate of creditable coverage shall be provided when your coverage under the Employee Modified Medical Program or the Employee Medical Program ends. In addition, you may also request a certificate of creditable coverage at any time while you are enrolled in either of these Medical Programs, or within 24 months from the date coverage ends, by contacting the City of Stockton Human Resources Benefits Department. The City of Stockton Human Resources Department-Benefits Section will also help you obtain a certificate of creditable coverage from any prior plan or issuer, if necessary.

Procedure for Requesting and Receiving a Certificate of Creditable Coverage: A certificate will be provided upon receipt of a written request for such a certificate that is received by the Plan Administrator within two years after the date coverage ended under this Plan. The written request must be mailed, faxed, or e-mailed to the Plan Administrator and should include the names of the individuals for whom a certificate is requested (including spouse and dependent children) and the address where the certificate should be mailed. The address, fax and e-mail of the Plan Administrator is on the Quick Reference Chart in the front of this document. A copy of the certificate will be mailed by the Plan to the address indicated. See the chapter on COBRA continuation coverage for an explanation of

when and how certification of creditable coverage will be provided to you by the Plan when coverage terminates.

Section 9.02 Newborns' and Mothers' Health Protection Act

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable.) In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the Plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). Plans and health insurance issuers subject to California law, the mother or her newborn may be discharged earlier than 48 hours (or 96 hours following a cesarean section) only if a follow-up visit is provided within 24 hours of discharge.

Section 9.03 Women's Health & Cancer Rights Act

If a Member has had or is going to have a mastectomy, she may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For members receiving mastectomy-related benefits, coverage shall be provided in a manner determined in consultation with the attending Physician and the patient for:

- A. All stages of reconstruction of the breast on which the mastectomy was performed;
- B. Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- C. Prostheses; and
- D. Treatment of physical complications of the mastectomy, including lymphedemas.

These benefits shall be provided subject to the same Deductibles, coinsurance and copayments applicable to other medical and surgical benefits under the Plan. Consult the applicable Plan Section for more information.

Section 9.04 Health Insurance Portability and Accountability Act (HIPAA)

A. Introduction

The City of Stockton (the Plan Sponsor) sponsors the following health plans:

1. The City of Stockton Medical Plans
2. The Employee Assistance Program (EAP)

In certain circumstances as described below, the Plan shall disclose to the Plan Sponsor Protected Health Information of Plan participants and other persons covered by the Plan (the Covered Individual).

The HIPAA of 1996, and the privacy regulations hereunder found at 45 C.F.R. Parts 160 and 164, as amended from time to time require the Plan to restrict the Plan Sponsor's ability to Use and Disclose Protected Health Information that is received from the Plan. One of the requirements is that the Plan Sponsor shall amend the Plan as set forth in 45 C.F.R. § 164.504(f)(2). In accordance with such requirements, the Plan was amended effective as of April 14, 2003. This Section contains that amendment. The Plan will not Use or Disclose Protected Health Information (PHI) to the Plan Sponsor in circumstances in which the HIPAA Privacy Rule would prohibit such Uses and Disclosures.

B. Definitions

1. The term "Business Associate" has the meaning set forth in 45 C.F.R. § 160.103.
2. The term "Disclose" or "Disclosure" means the release or transfer of, provision of access to, or divulging in any other manner individually identifiable health information to persons outside the Plan Sponsor.
3. The term "HIPAA Privacy Rule" means the applicable requirements of the privacy rules of Health Insurance Portability and Accountability Act of 1996 and related regulations, Title 45 Parts 160 and 164 of the Code of Federal Regulations, as amended from time to time.
4. The term "Plan Administration Functions" means administrative functions performed by the Plan Sponsor on behalf of the Plan and excludes functions performed by the Plan Sponsor in connection with any other benefit or benefit plan of the Plan Sponsor.
5. The term "Privacy Official" means the person who is responsible for the development and implementation of the HIPAA Privacy Rule policies and procedures of the Plan.
6. The term "Privacy Official" means the person who is responsible for the development and implementation of the HIPAA Privacy Rules policies and procedures of the Plan.
7. The term "Protected Health Information" (PHI) will have the meaning set forth in 45 C.F.R. § 164.501.
8. The term "Use" means the sharing, employment, application, utilization, examination, or analysis of individually identifiable health information by the Plan Sponsor or any Business Associate of the Plan.

C. Permitted Uses and Disclosures of Protected Health Information (PHI) by the Plan Sponsor

1. General

The Plan will Disclose PHI to the Plan Sponsor only to enable the Plan Sponsor to carry out Plan Administration functions described in Section C.2 below, and such Disclosures shall be consistent with the requirement of the HIPAA Privacy Rule. The Plan will not Disclose PHI to the Plan Sponsor unless the Disclosures are explained in a Notice of Privacy Practices that is distributed to covered individuals.

2. Description of Uses of Protected Health Information (PHI) by the Plan Sponsor

The Plan may disclose PHI to employees of the Plan Sponsor solely for purposes of performing Plan Administration functions, and only to the extent necessary for such purposes. Such Plan Administration functions may include, but are not limited to, the design, administration, financial operations, or legal defense of the Plan. For example, PHI may be disclosed to the employees of the Human Resources Department to determine eligibility for Plan benefits and to facilitate the payment of benefits claims. PHI may also be disclosed to Appeals Hearing Committee Members, the City Manager, the City Attorney and their respective staff members in connection with a claim denial or an appeal and the Benefit Section Analyst in connection with a Use or Disclosure of PHI permitted or required by the HIPAA privacy rule. PHI may also be disclosed to the City Auditor, the Administrative Services Officer and their respective staff members for financial purposes such as reconciling bank accounts, performing financial audits, and processing COBRA premium payments. The Plan Sponsor will not use or further disclose the PHI other than as permitted or required in accordance with this stated purpose or as required by applicable law.

D. Agents

The Plan Sponsor will ensure that any agents (including any subcontractors) to whom it provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to the PHI.

E. Employment Actions

The Plan Sponsor will not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan that is sponsored by the Plan Sponsor, except to the extent that such employee benefit plan is part of an organized health care arrangement (as defined in 45 C.F.R. § 164.501). The Plan and the EAP are part of an organized health care arrangement.

F. Reporting

The Plan Sponsor shall report to the Privacy Official any use or disclosure of information that is inconsistent with the purposes set forth in Section C above.

G. Access to the Information

The Plan Sponsor shall make PHI available to covered individuals for inspection and copying in accordance with 45 C.F.R. 164.524.

H. Amendment of PHI

The Plan Sponsor shall make PHI available to covered individuals for amendment and incorporate any amendment to PHI in accordance with 45 C.F.R. § 164.526.

I. Accounting of Disclosures of PHI

The Plan Sponsor shall make available the PHI required for the Plan to provide an accounting of disclosure of covered individuals in accordance with 45 C.F.R. § 164.528.

J. Information Available to the Secretary of Health and Human Services

The Plan Sponsor shall make its internal practices, books, and records relating to the Use and Discloser of PHI received from the Plan available to the Secretary of Health and Human Services for purposes of determining the Plan's compliance with the HIPAA Privacy Rule.

K. Return or Destroy PHI

If feasible, the Plan Sponsor will return or destroy all PHI received from the Plan that it maintains in any form and retain no copies of such information when no longer needed for the purpose for which the disclosure was made, except that, if such return or destruction is not feasible, the Plan Sponsor shall limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.

L. Adequate Separation

1. The Plan Sponsor shall ensure that there is adequate separation between the Plan and the Plan Sponsor as required by the HIPAA Privacy Rule.

2. The following is a description of the employees or classes of employees or other persons under the control of the Plan Sponsor that shall be given access to PHI:

- a. Human Resources Department: Director of Human Resources, Assistant Director of Human Resources, Deputy Director of Human Resources and their support staff.
- b. Human Resources Department–Benefits Section: Analysts, Technicians, Specialists
- c. Administrative Services Department: Administrative Services Officer, Supervising Accountant, Accountant and Administrative Analyst
- d. City Manager, Deputy City Manager, and Executive Assistant
- e. City Auditor, Senior Internal Auditor, Auditor I and II and Audit Assistant
- f. City Attorney, Assistant City Attorney, Deputy City Attorney, and Secretary
- g. Members of the Appeals Hearing Committee

3. The access to the use by the persons described in Section L.2 above shall be restricted to the Plan Administration functions that the Plan Sponsor performs for the Plan.

4. In the event there are any issues of noncompliance by the persons described in Section L.2, the Plan Sponsor shall take all necessary and appropriate action that is consistent with its disciplinary policy.

M. Certification by the Plan Sponsor

The Plan shall not disclose PHI to the Plan Sponsor unless the Plan Sponsor certifies that the Plan has been amended as required by the HIPAA Privacy Rule.

N. Miscellaneous

1. Rights

This Section 9.04 shall not be construed to establish requirements or obligations beyond those required by the HIPAA Privacy Rule. Any portion of this Amendment that appears to grant any additional rights not required by the HIPAA Privacy Rule shall not be binding upon the Plan Sponsor.

2. Amendment

The Plan Sponsor reserves the right to amend or terminate any and all provisions set forth in this Amendment at any time to the extent permitted under the HIPAA Privacy Rule.

3. Delegation

The Plan Sponsor may delegate or allocate any authority or responsibility with respect to this amendment. The Plan Sponsor (or its delegate) has the discretion to construe and interpret the terms, provisions, and requirements of this amendment. All decisions of the Plan Sponsor (or its delegate) with respect to this amendment shall be given the maximum deference permitted by law.

4. Document Retention

If a communication under this amendment is required by the HIPAA Privacy Rule to be in writing, the Plan Sponsor shall maintain such writing, or electronic copy, as documentation. If an action, activity, or designation is required by the HIPAA Privacy Rule to be documented, the Plan Sponsor shall maintain a written or electronic record of such action, activity or designation. The Plan Sponsor shall retain the required documentation for six (6) years from the date of its creation or the date it was last in effect, whichever is later.

5. Construction

The terms of this amendment shall be construed in accordance with the requirements of the HIPAA Privacy Rule and in accordance with any applicable guidance on the HIPAA Privacy Rule issued by the Department of Health and Human Resources.

O. In compliance with HIPAA Security regulations, the Plan Sponsor will:

1. Implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of electronic PHI that it creates, receives, maintains or transmits on behalf of the group health plan,
2. Ensure that the adequate separation discussed in L above, specific to electronic PHI, is supported by reasonable and appropriate security measures,
3. Ensure that any agent, including a subcontractor, to whom it provides electronic PHI agrees to implement reasonable and appropriate security measures to protect the electronic PHI, and
4. Report to the Plan any security incident of which it becomes aware concerning electronic PHI.

Section 9.05 Special Enrollment

A. Newly Acquired Spouse, Registered Domestic Partner and/or Family Member (as these terms are defined under this Plan)

1. If you are enrolled for individual coverage and if you acquire a Spouse by marriage, a Registered Domestic Partner or if you acquire any Child by birth, adoption or placement for adoption, you may request enrollment for your newly acquired Spouse, Registered Domestic Partner and/or any Child(ren) no later than 31 days after the date of marriage, date of domestic partnership, birth, adoption or placement for adoption. Enrollment forms may be obtained from the City's Human Resources Department – Benefits Section.
2. If you are not enrolled for individual coverage and if you acquire a Spouse by marriage, Registered Domestic Partner, or if you acquire any Child(ren) by birth, adoption or placement for adoption, you may request enrollment for yourself and/or your newly acquired Spouse, Registered Domestic Partner and/or any Child(ren) no later than 31 days after the date of marriage, date of domestic partnership, birth, adoption or placement for adoption. If you, the Employee, are not already enrolled for coverage, you must request enrollment for yourself in order to enroll a newly acquired Family Member.
3. If you did not enroll your Spouse or Registered Domestic Partner for coverage within 31 days of the date on which he or she became eligible for coverage, and if you subsequently acquire a Child by birth, adoption or placement for adoption, you may request enrollment for your Spouse or Registered Domestic Partner and/or your newly acquired Child and/or any other eligible Family Member no later than 31 days after the date of your newly acquired Child's birth, or placement for adoption. If you, the Employee, are not already enrolled for coverage, you must request enrollment for yourself in order to enroll a newly acquired Family Member.
4. To request Special Enrollment, a written application must be filed with the City's Human Resources Department – Benefits Section.

B. Loss Of Other Coverage

If you did not request enrollment under this Plan for yourself, your Spouse or Registered Domestic Partner and/or any other Family Member within 31 days after the date on which coverage under the Plan was previously offered because you or they had health care coverage under any other health insurance policy or program or employer plan, including COBRA continuation coverage, individual insurance, Medicare, or other public program and you, your Spouse or Registered Domestic Partner and/or any other Family Member lose coverage under that other health insurance policy or plan, you may request enrollment for yourself and/or your Spouse or Registered Domestic Partner and/or other Family Members within 31 days after the termination of that other health insurance policy or plan but only if that other coverage terminated because:

1. of loss of eligibility for that coverage including loss resulting from legal separation, divorce, death, voluntary or involuntary termination of employment or reduction in hours (but does not include loss due to failure of employee to pay premiums on a timely basis or termination of the other coverage for cause); or
2. of termination of employer contributions toward that other coverage (an employer's reduction but not cessation of contributions does not trigger a special enrollment right);
or

3. the health insurance was provided under COBRA Continuation Coverage, and the COBRA coverage was “exhausted” or
4. of moving out of an HMO service area if HMO coverage terminated for that reason and, for group coverage, no other option is available under the other plan; or
5. of the other plan ceasing to offer coverage to a group of similarly situated individuals; or
6. of the loss of dependent status under the other plan’s terms; or
7. of the termination of a benefit package option under the other plan, unless substitute coverage offered.

COBRA continuation coverage is “exhausted” if it ceases for any reason other than either the failure of the individual to pay the applicable COBRA premium on a timely basis or for cause (such as making a fraudulent claim or an intentional misrepresentation of material fact in connection with that COBRA continuation coverage). Exhaustion of COBRA continuation coverage can also occur if the coverage ceases:

1. due to the failure of the employer or other responsible entity to remit premiums on a timely basis;
2. when the employer or other responsible entity terminates the health care plan and there is no other COBRA continuation coverage available to the individual;
3. when the individual no longer resides, lives, or works in a service area of an HMO or similar program (whether or not by the choice of the individual) and there is no other COBRA continuation coverage available to the individual; or
4. because the 18-month or 36-month period of COBRA continuation coverage has expired.

Medicaid and State Children’s Health Insurance Programs (CHIP):

You and your Family Members may also enroll in this Plan if you (or your eligible Family Members):

1. have coverage through Medicaid or a State Children’s Health Insurance Program (CHIP) and you (or your Family Members) lose eligibility for that coverage. However, you must request enrollment in this Plan within 60 days after the Medicaid or CHIP coverage ends; or
2. become eligible for a premium assistance program through Medicaid or CHIP. However, you must request enrollment in this Plan within 60 days after you (or your Family Members) are determined to be eligible for such premium assistance.

C. Start of Coverage Following Special Enrollment

If a completed written enrollment form has been submitted on a timely basis (except with respect to coverage of a newborn or newly adopted Child or Medicaid or CHIP opportunity discussed below), your coverage, your Spouse’s coverage, and/or the coverage of any of your other Family Members will become effective on the first day of the month following the date the City receives the completed written enrollment form.

Coverage of a newborn or newly adopted newborn Child who is properly enrolled within 31 days after birth will become effective as of the date of the child’s birth. Coverage of a newly adopted Child who is enrolled more than 31 days after birth, but within 31 days after the child is adopted or placed for adoption, will become effective as of the date of the child’s adoption or placement for adoption, whichever occurs first.

Individuals enrolled during Special Enrollment have the same opportunity to select plan benefit options (when such options exist) at the same costs and the same enrollment requirements, including any pre-existing condition limitations the Plan may require, as are available to similarly-situated employees at initial enrollment.

If the individual requests Special Enrollment within 60 days of the date of the Special Enrollment opportunity related to Medicaid or a State Children's Health Insurance Program (CHIP), generally coverage will become effective on the first day of the month following the date of the event that allowed this Special Enrollment opportunity.

D. Failure to Enroll During Special Enrollment

If you fail to request enrollment for yourself and/or any of your eligible Family Members within 31 days (or as applicable 60 days) after the date on which you and/or they first become eligible for special enrollment, you will not be able to enroll them until the next open enrollment period.

Section 9.06 Family and/or Medical Leave (FMLA)

A. If you have completed 12 months of employment with the City in addition to completing at least 1,250 hours of work for the City in the year preceding the start of leave, you are entitled by law to up to 12 weeks each year (in some cases, up to 26 weeks) of unpaid family or medical leave for specified family or medical purposes, such as the birth or adoption of a child, to provide care of a husband, wife including a domestic partner, child or parent who is seriously ill, or for your own serious illness.

For the calculation of the 12-month period used to determine employee eligibility for FMLA, this Plan uses a rolling 12 month period measured backward in time from the date the employee uses any FMLA leave.

B. While you are officially on such a family or medical leave, you can keep medical, dental, and vision coverage for yourself and your eligible Family Members including Domestic Partner in effect during that family or medical leave period by continuing to pay your contributions during that period.

If you are not using paid sick and/or vacation leave, you may pay your contributions as they come due on the dates you would have been paid had you not taken family or medical leave, in which case your contributions will be made on an after-tax basis. If you are using paid sick and/or vacation leave, your contributions will be deducted from your payroll check.

Whether or not you keep your coverage while you are on family or medical leave, if you return to work promptly at the end of that leave, your health care coverage will be reinstated without any additional limits or restrictions imposed on account of your leave. This is also true for any of your eligible Family Members including Domestic Partner who were covered by the Plan at the time you took your leave.

Any changes in the Plan's terms, rules or practices that went into effect while you were away on that leave will apply to you and your Family Members in the same way they apply to all other Employees and their Family Members. To find out more about your entitlement to family or medical leave as required by federal and/or state law, and the terms on which you may be entitled to it, contact the City's Human Resources Department – Benefits Section.

Section 9.07 Leave for Military Service/Uniformed Services Employment and Reemployment Rights Act (USERRA)

A participant who enters military service will be provided continuation and reinstatement rights in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), as amended from time to time. This section contains important information about your rights to continuation coverage and reinstatement of coverage under USERRA.

A. USERRA Continuation Coverage is a temporary continuation of coverage when it would otherwise end because the employee has been called to active duty in the uniformed services. USERRA protects employees who leave for and return from any type of uniformed service in the United States armed forces, including the Army, Navy, Air Force, Marines, Coast Guard, National Guard, National Disaster Medical Service, the reserves of the armed forces, and the commissioned corps of the Public Health Service.

B. An Employee's coverage under this Plan will terminate when the Employee enters active duty in the uniformed services.

1. If the Employee elects USERRA temporary continuation coverage, the Employee (and any eligible Family Members covered under the Plan on the day the leave started) may continue Plan coverage for up to 24 months measured from the last day of the month in which the Employee stopped working.

2. If the Employee goes into active military service for up to 31 days, the Employee (and any eligible Family Members covered under the Plan on the day the leave started) can continue health care coverage under this Plan during that leave period if the Employee continues to pay the appropriate contributions for that coverage during the period of that leave.

C. The City will offer the Employee USERRA continuation coverage only after the City has been notified by the Employee in writing that they have been called to active duty in the uniformed services and provides a copy of the orders. The Employee must notify the City (contact information is on the Quick Reference Chart in the front of this document) as soon as possible but no later than 60 days after the date on which the Employee will lose coverage due to the call to active duty, unless it is impossible or unreasonable to give such notice.

D. Once the City receives notice that the Employee has been called to active duty, the City will offer the right to elect USERRA coverage for the Employee (and any eligible Family Members covered under the Plan on the day the leave started). Unlike COBRA Continuation Coverage, if the Employee does not elect USERRA for the Family Members, those Family Members cannot elect USERRA separately. Additionally, the Employee (and any eligible Family Members covered under the Plan on the day the leave started) may also be eligible to elect COBRA temporary continuation coverage. Note that USERRA is an alternative to COBRA therefore either COBRA or USERRA continuation coverage can be elected and that coverage will run simultaneously, not consecutively. Contact the City's Human Resources Department – Benefits Section to obtain a copy of the COBRA or USERRA election forms. Completed USERRA election forms must be submitted to the City in the same timeframes as is permitted under COBRA.

E. Paying for USERRA Coverage

1. If the Employee goes into active military service for up to 31 days, the Employee (and any eligible Family Members covered under the Plan on the day the leave started) can continue health care coverage under this Plan during that leave period if the Employee continues to pay the appropriate contributions for that coverage during the period of that leave.
2. If the Employee elects USERRA temporary continuation coverage, the Employee (and any eligible Family Members covered under the Plan on the day the leave started) may continue Plan coverage for up to 24 months measured from the last day of the month in which the employee stopped working. USERRA continuation coverage operates in the same way as COBRA coverage and premiums for USERRA coverage will be 102% of the cost of coverage. Payment of USERRA and termination of coverage for non-payment of USERRA works just like with COBRA coverage.

F. In addition to USERRA or COBRA coverage, an Employee's eligible Family Members may be eligible for health care coverage under TRICARE (the Department of Defense health care program for uniformed service members and their families). This Plan coordinates benefits with TRICARE. You should carefully review the benefits, costs, provider networks and restrictions of the TRICARE plan as compared to USERRA or COBRA to determine whether TRICARE coverage alone is sufficient or if temporarily continuing this Plan's benefits under USERRA or COBRA is the best choice.

G. After Discharge from the Armed Forces

When the Employee is discharged from military service (not less than honorably), eligibility will be reinstated on the day the Employee returns to work provided the Employee returns to employment within:

1. 90 days from the date of discharge from the military if the period of services was more than 180 days; or
2. 14 days from the date of discharge if the period of service was 31 days or more but less than 180 days; or
3. at the beginning of the first full regularly scheduled working period on the first calendar day following discharge (plus travel time and an additional 8 hours), if the period of service was less than 31 days.

If the Employee is hospitalized or convalescing from an injury caused by active duty, these time limits are extended up to two years.

The Employee must notify the City in writing within the time periods listed above. Upon reinstatement, the Employee's coverage will not be subject to any exclusions or waiting periods other than those that would have been imposed had the coverage not terminated.

Questions regarding your entitlement to USERRA leave and to continuation of health care coverage should be referred to the City's Human Resources Department – Benefits Section.

Section 9.08 Reinstatement of Coverage After Leaves of Absence

A. If your coverage ends while you are on an approved leave of absence for family, medical or military leave, your coverage will be reinstated on the first day of the month following your return to active employment, if you return immediately after your leave of absence ends, subject to any limitations for pre-existing conditions that existed before the start of the leave

of absence, and subject to all accumulated benefit maximums that were incurred prior to the leave of absence.

B. Special Administrative Leaves: If your coverage ends while you are on an approved leave of absence other than family, medical, or military leave, your coverage will be reinstated on the first day of the month following your return to active employment, if you return immediately after your leave of absence ends, subject to any applicable exclusions or limitations for pre-existing conditions as well as all accumulated overall and annual maximum Plan benefits that were incurred prior to the leave of absence

Section 9.09 Limitation on When a Lawsuit May be Started

You or any other claimant may not start a lawsuit or other legal action to obtain Plan benefits, including proceedings before administrative agencies, until after all administrative procedures have been exhausted (including this Plan's claim appeal review procedures described in this document) for every issue deemed relevant by the claimant, or until 90 days have elapsed since you filed a request for appeal review if you have not received a final decision or notice that an additional 60 days will be necessary to reach a final decision. No lawsuit may be started more than three years after the end of the year in which services were provided.