Summary Plan Description

24/7 NurseLine

Your *plan* includes 24/7 NurseLine, a 24-hour nurse assessment service to help you make decisions about your medical care. When you call 24/7 NurseLine toll free at **800-977-0027**, be prepared to provide your name, the patient's name (if you're not calling for yourself), the *beneficiary's* identification number, and the patient's phone number.

The nurse will ask you some questions to help determine your health care needs. Based on the information you provide, the advice may be:

- Try home self-care. You may receive a follow-up phone call to determine how well home self-care is working.
- Schedule a routine appointment within the next two weeks, or an appointment at the earliest time available (within 64 hours), with your *physician*. If you do not have a *physician,* the nurse will help you select one by providing a list of *physicians* who are *participating providers* in your geographical area.
- Call your *physician* for further discussion and assessment.
- To go to an emergency room in a *participating provider hospital*.
- Call 911 immediately.

In addition to providing a nurse to help you make decisions about your health care, 24/7 NurseLine gives you free unlimited access to its AudioHealth Library featuring recorded information on hundreds of health care topics in English and Spanish. To access the AudioHealth Library, call toll free 800-977-0027 and follow the instructions given.

We have made arrangements with an independent company to make 24/7 NurseLine available to you as a special service. It may be discontinued without notice.

Note: 24/7 NurseLine is an optional service. Remember, the best place to go for medical care is your *physician.*

ConditionCare

Your *plan* includes ConditionCare to help you better understand and manage specific chronic health conditions and improve your overall quality of life. ConditionCare provides you with current and accurate data about Asthma, Diabetes, Congestive Heart Failure (CHF), Coronary Artery Disease (CAD) and Chronic Obstructive Pulmonary Disease (COPD) plus education to help you better manage and monitor your condition. ConditionCare also provides depression screening.

You may be identified for participation through paid claims history, hospital discharge reports, physician referral, or Case Management, or you may request to participate by calling ConditionCare toll free at **1-800-621-2232**. Participation is voluntary and confidential. These programs are available at no cost to you. Once identified as a potential participant, a ConditionCare representative will contact you. If you choose to participate, a program to meet your specific needs will be designed. A team of health professionals will work with you to assess your individual needs, identify lifestyle issues, and support behavioral changes that can help resolve these issues. Your program may include:

- Mailing of educational materials outlining positive steps you can take to improve your health; and/or
- Phone calls from a nurse or other health professional to coach you through self-management of your condition and to answer questions.

ConditionCare offers you assistance and support in improving your overall health. It is not a substitute for your *physician's* care.

Dear Plan Beneficiary:

The benefits of this *plan* are provided for *medically necessary* services and supplies for the *employee* and enrolled *dependents* for a covered condition, subject to all of the terms and conditions of this *plan*, the *participation agreement* between the *participating employers* and SISC III, and the eligibility rules of SISC III.

This Summary Plan Description provides a complete explanation of your benefits, limitations and other *plan* provisions which apply to you.

Employees and covered dependents ("beneficiaries") are referred to in this booklet as "you" and "your". The *plan administrator* is referred to as "we", "us" and "our".

All italicized words have specific definitions. These definitions can be found either in the specific section or in the DEFINITIONS section of this booklet.

Please read this Summary Plan Description ("*plan description*") carefully so that you understand all the benefits your *plan* offers. Keep this Summary Plan Description handy in case you have any questions about your coverage.

Important: This is not an insured benefit plan. The benefits described in this Summary Plan Description or any rider or amendments hereto are funded by the *plan administrator* who is responsible for their payment. Anthem Blue Cross Life and Health Insurance Company provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.

Anthem Blue Cross Life and Health Insurance Company is an independent licensee of the Blue Cross Association (BCA).

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TYPES OF PROVIDERS

PLEASE READ THE FOLLOWING INFORMATION SO YOU WILL KNOW FROM WHOM OR WHAT GROUP OF PROVIDERS HEALTH CARE MAY BE OBTAINED. IF YOU HAVE SPECIAL CARE NEEDS, YOU SHOULD CARFULLY READ THOSE SECTIONS THAT APPLY TO THOSE NEEDS. THE MEANINGS OF WORDS AND PHRASES IN ITALICS ARE DESCRIBED IN THE SECTION OF THIS PLAN DESCRIPTION ENTITLED DEFINITIONS.

Participating Providers. The *plan* has made available to the *beneficiaries* a network of various types of "Participating Providers". These providers are called "participating" because they have agreed to participate in the *claims administrator's* preferred provider organization program (PPO), called the Prudent Buyer Plan. They have agreed to provide our *beneficiaries* with health care at a special low cost. The amount of benefits payable under this *plan* will be different for *non-participating providers* than for *participating providers*. See the definition of "Participating Providers" in the DEFINITIONS section for a complete list of the types of providers which may be *participating providers.*

The *claims administrator* publishes a directory of Participating Providers. You can get a directory from your *plan administrator* (usually your employer) or from the *claims administrator*. The directory lists all *participating providers* in your area, including health care facilities such as *hospitals* and *skilled nursing facilities*, *physicians*, laboratories, and diagnostic x-ray and imaging providers. You can request a copy of the directory from your employer or you may call the *claims administrator* at the customer service number listed on your ID card and ask them to send you a directory. You may also search for a *participating provider* using the "Provider Finder" function on our website at **www.anthem.com/ca/sisc**. The listings include the credentials of the *claims administrator's participating providers* such as specialty designations and board certification.

Non-Participating Providers. *Non-participating providers* are providers which have not agreed to participate in the Prudent Buyer Plan network. They have not agreed to the *negotiated rates* and other provisions of a Prudent Buyer Plan contract.

Physicians. "Physician" means more than an M.D. Certain other practitioners are included in this term as it is used throughout the *plan*. This doesn't mean they can provide every service that a medical doctor could; it just means that the *plan* will cover expense you incur from them when they're practicing within their specialty the same as if the care were provided by a medical doctor. As with the other terms, be sure to read the definition of "Physician" to determine which providers' services are covered. Only providers listed in the definition are covered as *physicians*. Please note also that certain providers' services are covered only upon referral of an M.D. (medical doctor) or D.O. (doctor of osteopathy). Providers for whom referral is required are indicated in the definition of "physician" by an asterisk (*).

Other Health Care Providers. "Other Health Care Providers" are neither *physicians* nor *hospitals*. They are mostly free-standing facilities or service organizations, such as ambulance companies. See the definition of "Other Health Care Providers" in the DEFINITIONS section for a complete list of those providers. *Other health care providers* are not part of the Prudent Buyer Plan provider network.

Contracting and Non-Contracting Hospitals. Another type of provider is the "contracting hospital". This is different from a *hospital* which is a *participating provider*. The *claims administrator* has contracted with most hospitals in California to obtain certain advantages for patients covered under the *plan*. While only some *hospitals* are *participating providers*, all eligible California hospitals are invited to be *contracting hospitals* and most--over **90%**--accept.

Reproductive Health Care Services. Some *hospitals* and other providers do not provide one or more of the following services that may be covered under your *plan* contract and that you or your *dependent* might need: family planning; contraceptive services, including emergency contraception; sterilization, including tubal ligation at the time of labor and delivery; infertility treatments; or abortion. You should obtain more information before you enroll. Call your *physician* or clinic, or call the customer service telephone number listed on your ID card to ensure that you can obtain the health care services that you need.

SUMMARY OF BENEFITS

THE BENEFITS OF THIS PLAN ARE PROVIDED ONLY FOR THOSE SERVICES THAT ARE CONSIDERED TO BE MEDICALLY NECESSARY AS DEFINED IN THE PLAN DESCRIPTION. THE FACT THAT A PHYSICIAN PRESCRIBES OR ORDERS A SERVICE DOES NOT, IN ITSELF, MEAN THAT THE SERVICE IS MEDICALLY NECESSARY OR THAT THE SERVICE IS A COVERED EXPENSE. CONSULT THIS PLAN DESCRIPTION OR TELEPHONE THE CLAIMS ADMINISTRATOR AT THE NUMBER SHOWN ON YOUR IDENTIFICATION CARD IF YOU HAVE ANY QUESTIONS REGARDING WHETHER SERVICES ARE COVERED.

THIS PLAN CONTAINS MANY IMPORTANT TERMS (SUCH AS "MEDICALLY NECESSARY" AND "COVERED EXPENSE") THAT ARE DEFINED IN THE DEFINITIONS SECTION. WHEN READING THROUGH THIS PLAN DESCRIPTION, CONSULT THE DEFINITIONS SECTION TO BE SURE THAT YOU UNDERSTAND THE MEANINGS OF THESE ITALICIZED WORDS.

For your convenience, this summary provides a brief outline of your benefits. You need to refer to the entire *plan description*, following this summary, for more complete information about the benefits, conditions, limitations and exclusions of your *plan*.

Second Opinions. If you have a question about your condition or about a plan of treatment which your *physician* has recommended, you may receive a second medical opinion from another *physician*. This second opinion visit will be provided according to the benefits, limitations, and exclusions of this *plan*. If you wish to receive a second medical opinion, remember that greater benefits are provided when you choose a *participating provider*. You may also ask your *physician* to refer you to a *participating provider* to receive a second opinion.

All benefits are subject to coordination with benefits under certain other plans.

The benefits of this *plan* are subject to the REIMBURSEMENT FOR ACTS OF THIRD PARTIES section.

MEDICAL BENEFITS

CALENDAR YEAR DEDUCTIBLES

- Individual Deductible **$200**
- Family Deductible **$500**

Exceptions:

– The Calendar Year Deductible will not apply to office visits to a *physician* who is a *participating provider*.

Note: This exception only applies to the charge for the visit itself. It does not apply to any other charges made during that visit, such as for testing procedures, surgery, etc.

– The Calendar Year Deductible will not apply to diabetes education program services provided by a *physician* who is a *participating provider*.

– The Calendar Year Deductible will not apply to the following services provided by a *participating provider*: (a) *physician's* services for routine examinations and immunizations under the Well Baby and Well Child Care benefit; (b) the Physical Exam benefit; (c) the Adult Preventive Services benefit; and (d) the Other Cancer Screening Tests benefit.

– The Calendar Year Deductible will not apply to consultations or second opinions provided by the *claims administrators* Telemedicine Network Specialty Center. The Calendar Year Deductible will apply to all other services provided by a Telemedicine Network Presentation Site or Specialty Center.

CO-PAYMENTS

Co-Payments.* After you have met your Calendar Year Deductible, you will be responsible for the following percentages of *covered expense* you incur:

- *Participating Providers*..... **10%**
- *Other Health Care Providers* **10%**
- *Non-Participating Providers* subject to *Scheduled Amounts* (See the SCHEDULES FOR NON-PARTICIPATING PROVIDERS) or Maximum Dollar Amounts for services or supplies, as shown under MEDICAL BENEFIT MAXIMUMS .....**No Co-Payment** except *beneficiary* is responsible for any amount exceeding *covered expense*
- All other *Non-Participating Providers* **10%**

Note: In addition to the Co-Payment shown above, you will be required to pay any amount in excess of *covered expense* for the services of an *other health care provider* or *non-participating provider*.

***Exceptions:**

– Your Co-Payment for office visits to a *physician* who is a *participating provider* will be **$10**. This Co-Payment will not apply toward the satisfaction of the Calendar Year Deductible, nor will it apply toward satisfaction of the Out-of-Pocket Amount.

Note: This exception applies only to the charge for the visit itself. It does not apply to any other charges made during that visit, such as testing procedures, surgery, etc.

– Your Co-Payment for diabetes education program services provided by a *physician* who is a *participating provider* will be **$10**. This Co-Payment will not apply toward the satisfaction of the Calendar Year Deductible, nor will it apply toward satisfaction of the Out-of-Pocket Amount.

– Your Co-Payment for covered outpatient services and supplies provided by a *non-participating hospital,* including outpatient surgery will be **50%** of *covered expense*. This Co-Payment does not apply to *emergencies* as defined in the DEFINITIONS section.

– Your Co-Payment for consultations or second opinions provided by the *claims administrators* Telemedicine Network Specialty Center will be **$10**. This Co-Payment will not apply toward the satisfaction of the Calendar Year Deductible, nor will it apply toward satisfaction of the Out-of-Pocket Amount.

Note: This exception applies only to the consultation or second opinion portion of the Specialty Center's bill. It does not apply to any other charges made.

– No Co-Payment will be required for services provided by a *participating provider* or *non-participating provider* under the Well Baby Well Child Care and Adult Preventive Services benefits.

– No Co-Payment will be required for services provided by a *participating provider* under the Physical Exam (Beneficiaries Age 7 and Over) benefit.

Important Note About Covered Expense And Your Co-Payment: *Covered expense* for *non-participating providers* is significantly lower than what providers customarily charge. (See the SCHEDULES FOR NON-PARTICIPATING PROVIDERS.) You must pay all of this excess amount in addition to your Co-Payment.

Out-of-Pocket Amount.* After you have made the following total out-of-pocket payments for *covered expense* incurred during a *calendar year,* you will no longer be required to pay a Co-Payment for the remainder of that *year,* but will remain responsible for costs in excess of *covered expense*.

- *Beneficiary* Out-of-Pocket Maximum.....**$600**
- Family Out-of-Pocket Maximum.....**$1,800**

***Exceptions:**

– Your Co-Payment for office visits to a *physician* who is a *participating provider* will not be applied toward the satisfaction of your Out-of-Pocket Amount. In addition, you will be required to continue to pay your Co-Payment for such visits even after you have reached that amount.

– Your Co-Payment for diabetes education program services provided by a *physician* who is a *participating provider* will not be applied toward the satisfaction of your Out-of-Pocket Amount. In addition, you will be required to continue to pay your Co-Payment for such services even after you have reached that amount.

– Your Co-Payment for covered outpatient services and supplies provided by a *non-participating hospital,* including outpatient surgery will not be applied toward the satisfaction of your Out-of-Pocket Amount. In addition, you will be required to continue to pay your Co-Payment for such services even after you have reached that amount.

– Your Co-Payment for consultations or second opinions provided by the *claims administrators* Telemedicine Network Specialty Center will not be applied toward the satisfaction of your Out-of-Pocket Amount. In addition, you will be required to continue to pay your Co-Payment for such services even after you have reached that amount.

– Expense which is applied toward the Calendar Year Deductible, which is incurred for non-covered services or supplies, or which is in excess of the amount of *covered expense,* will not be applied toward your Out-of-Pocket Amount, and is always your responsibility.

MEDICAL BENEFIT MAXIMUMS

The *plan* will pay for the following services and supplies, up to the maximum amounts, or for the maximum number of days or visits shown below:

Skilled Nursing Facility

- For covered *skilled nursing facility* care ..... **100 days**
  per *confinement period*

- For covered *skilled nursing facility* care
  in a *non-participating provider* facility **$600**
  per day

Home Health Care

- For covered home health services ..... **100 visits**
  per *calendar year*

Home Infusion Therapy

- For all covered services and supplies
  received during any one day **$600***

  ***Non-participating providers* only

Hospice Care

- For bereavement counseling **$25**
  per visit; up to four visits during
  the 12 months following your death

Ambulatory Surgical Center

- For all covered services and supplies **$350***

  ***Non-participating providers* only

Acupuncture

- For covered services provided by *participating physicians* **$50**
  per visit

- For covered services provided by *non-participating physicians* **$25**
  per visit

- For covered services provided by *participating* and *non-participating physicians* ..... **12 visits**
  per *calendar year*

Chiropractic Care

- For covered outpatient services provided by *participating physicians* ..... **$50** per visit
- For covered outpatient services provided by *non-participating physicians* ..... **$25** per visit
- For outpatient services provided by *participating* and *non-participating physicians* ..... **26 visits** per *calendar year*

Hearing Aid Services

- Hearing aids ..... **$700** in a 24-month period

Lifetime Maximum

- For all medical benefits ..... **$5,000,000** during your lifetime

YOUR MEDICAL BENEFITS

HOW COVERED EXPENSE IS DETERMINED

The *plan* will pay for *covered expense* you incur. A charge is incurred when the service or supply giving rise to the charge is rendered or received. *Covered expense* for medical benefits is based on a maximum charge for each covered service or supply that will be accepted for each different type of provider. It is not necessarily the amount a provider bills for the service.

Participating Providers. The maximum *covered expense* for services provided by a *participating provider* will be the lesser of the billed charge or the *negotiated rate*. *Participating providers* have agreed not to charge you more than the *negotiated rate* for covered services. When you choose a *participating provider,* you will not be responsible for any amount in excess of the *negotiated rate*.

If you go to a *hospital* which is a *participating provider,* you should not assume all providers in that *hospital* are also *participating providers*. To receive the greater benefits afforded when covered services are provided by a *participating provider,* you should request that all your provider services be performed by *participating providers* whenever you enter a *hospital*.

If you are planning to have outpatient surgery, you should first find out if the facility where the surgery is to be performed is an *ambulatory surgical center.* An *ambulatory surgical center* is licensed as a separate facility even though it may be located on the same grounds as a *hospital* (although this is not always the case). If the center is licensed separately, you should find out if the facility is a *participating provider* before undergoing the surgery.

Non-Participating Providers. The maximum *covered expense* for services provided by a *non-participating provider* will always be the lesser of the billed charge or the *scheduled amount*. See the SCHEDULES FOR NON-PARTICIPATING PROVIDERS, and the definition of "Scheduled Amount" in the DEFINITIONS section. You will be responsible for any billed charge which exceeds the *scheduled amount* for services provided by a *non-participating provider.*

Other Health Care Providers. The maximum *covered expense* for services provided by an *other health care provider* will always be the lesser of the billed charge or the *reasonable charge*. You will be responsible for any billed charge which exceed the *reasonable charge* for the services of an *other health care provider*.

Exception: If Medicare is the primary payor, *covered expense* does not include any charge:

1. By a *hospital,* in excess of the approved amount as determined by Medicare; or
2. By a *physician* who is a *participating provider* who accepts Medicare assignment, in excess of the approved amount as determined by Medicare; or
3. By a *physician* who is a *non-participating provider* or *other health care provider* who accepts Medicare assignment, in excess of the lesser of maximum *covered expense* stated above, or the approved amount as determined by Medicare; or
4. By a *physician* or *other health care provider* who does not accept Medicare assignment, in excess of the lesser of the maximum *covered expense* stated above, or the limiting charge as determined by Medicare.

You will always be responsible for expense incurred which is not covered under this *plan*.

CALENDAR YEAR DEDUCTIBLE, CO-PAYMENTS, OUT-OF-POCKET AMOUNTS AND MEDICAL BENEFIT MAXIMUMS

After subtracting your Calendar Year Deductible and your Co-Payment, benefits will be paid up to the amount of *covered expense,* not to exceed the applicable Medical Benefit Maximum. The Calendar Year Deductible amounts, Co-Payments, Out-of-Pocket Amounts and Medical Benefit Maximums are set forth in the SUMMARY OF BENEFITS.

CALENDAR YEAR DEDUCTIBLES

Each *year*, you will be responsible for satisfying the Individual Calendar Year Deductible before benefits are paid. If *beneficiaries* of an enrolled family pay deductible expense in a *year* equal to the Family Deductible, the Calendar Year Deductible for all family members will be considered to have been met. No further Calendar Year Deductible expense will be required for any enrolled *beneficiary* of your family.

Covered expense applied to your Calendar Year Deductible during October through December will also be applied toward your Calendar Year Deductible for the next *year*.

CO-PAYMENTS

After you have satisfied the Calendar Year Deductible, your Co-Payment will be subtracted from the amount of *covered expense* remaining.

If your Co-Payment is a percentage, the applicable percentage will be applied to the amount of *covered expense* remaining after the Calendar Year Deductible has been met. This will determine the dollar amount of your Co-Payment.

OUT-OF-POCKET AMOUNTS

Satisfaction of the Out-of-Pocket Amount. If, after you have met your Calendar Year Deductible, you pay Co-Payments equal to your *beneficiary* or family Out-of-Pocket amount during a *calendar year*, you will no longer be required to make Co-Payments for any *covered expense* you incur during the remainder of that *year*, other than for covered outpatient services and supplies provided by a *non-participating hospital,* including outpatient surgery, services and supplies provided by a *non-participating ambulatory surgical center* for non-emergency surgery, office visits to a *physician* who is a *participating provider*, diabetic education program services provided by a *physician* who is a *participating provider* and consultations or second opinions provided by the *claims administrators* Telemedicine Network Specialty Center.

Charges Which Do Not Apply Toward the Out-of-Pocket Amount. The following charges will not be applied toward satisfaction of an Out-of-Pocket Amount:

- Charges which are not considered *covered expense;*
- Any expense applied to the Calendar Year Deductible;
- Charges for office visits to a *physician* who is a *participating provider*;
- Charges for diabetic education program services provided by a *physician* who is a *participating provider*;
- Charges for consultations or second opinions provided by the *claims administrators* Telemedicine Network Specialty Center; and
- Charges for covered outpatient services and supplies provided by a *non-participating hospital,* including outpatient surgery.

In addition, you will continue to be required to pay your Co-Payment for covered outpatient services and supplies provided by a *non-participating hospital*, including outpatient surgery, office visits to a *physician* who is a *participating provider*, diabetic education program services provided by a *physician* who is a *participating provider* and consultations or second opinions provided by the *claims administrators* Telemedicine Network Specialty Center even after the Out-of-Pocket Amount is reached.

MEDICAL BENEFIT MAXIMUMS

The *plan* does not make benefit payments for any *beneficiary* in excess of any of the Medical Benefit Maximums. Your Lifetime Maximum under this *plan* will be reduced by any benefits paid to you on your behalf under any other health plan provided by SISC III.

CONDITIONS OF COVERAGE

The following conditions of coverage must be met for expense incurred for services or supplies to be considered as *covered expense*.

1. You must incur this expense while you are covered under this *plan*. Expense is incurred on the date you receive the service or supply for which the charge is made.
2. The expense must be for a medical service or supply furnished to you as a result of illness or injury or pregnancy, unless a specific exception is made.
3. The expense must be for a medical service or supply included in MEDICAL CARE THAT IS COVERED. Additional limits on *covered expense* are included under specific benefits and in the SUMMARY OF BENEFITS.
4. The expense must not be for a medical service or supply listed in MEDICAL CARE THAT IS NOT COVERED. If the service or supply is partially excluded, then only that portion which is not excluded will be considered *covered expense*.
5. The expense must not exceed any of the maximum benefits or limitations of this *plan*.
6. Any services received must be those which are regularly provided and billed by the provider. In addition, those services must be consistent with the illness, injury, degree of disability and your medical needs. Benefits are provided only for the number of days required to treat your illness or injury.
7. All services and supplies must be ordered by a *physician.*

MEDICAL CARE THAT IS COVERED

Subject to the Medical Benefit Maximums in the SUMMARY OF BENEFITS, the requirements set forth under CONDITIONS OF COVERAGE and the exclusions or limitations listed under MEDICAL CARE THAT IS NOT COVERED, the *plan* will provide benefits for the following services and supplies:

Hospital

1. Inpatient services and supplies, provided by a *hospital*. *Covered expense* will not include charges in excess of the *hospital's* prevailing two-bed room rate unless there is a negotiated per diem rate with the *hospital,* or unless your *physician* orders, and the *claims administrator* authorizes, a private room as *medically necessary*.
2. Services in *special care units*.
3. Outpatient services and supplies provided by a *hospital,* including outpatient surgery.

Skilled Nursing Facility. Inpatient services and supplies provided by a *skilled nursing facility.* The amount by which your room charge exceeds the prevailing two-bed room rate of the *skilled nursing facility* is not considered *covered expense*

The *plan* will pay up to a maximum of 100 days per *confinement period*. When 28 days pass without care, the 100-day allowance renews. When fewer than 28 days pass between care those *days* are in the same *confinement period*.

For services and supplies provided by a *non-participating provider* facility, our maximum payment is limited to **$600** per day.

Skilled nursing facility services and supplies are subject to pre-service review to determine medical necessity. Please refer to UTILIZATION REVIEW PROGRAM for information on how to obtain the proper reviews.

Home Health Care. The following services provided by a *home health agency:*

1. Services of a registered nurse or licensed vocational nurse under the supervision of a registered nurse or a *physician*.
2. Services of a licensed therapist for physical therapy, occupational therapy, speech therapy, or respiratory therapy.
3. Services of a medical social service worker.
4. Services of a health aide who is employed by (or who contracts with) a *home health agency*. Services must be ordered and supervised by a registered nurse employed by the *home health agency* as professional coordinator. These services are covered only if you are also receiving the services listed in 1 or 2 above.
5. *Medically necessary* supplies provided by the *home health agency*.

In no event will benefits exceed 100 visits during a *calendar year*. A visit of four hours or less by a home health aide shall be considered as one home health visit.

Home health care services are subject to pre-service review to determine medical necessity. Please refer to UTILIZATION REVIEW PROGRAM for information on how to obtain the proper reviews.

Home health care services are not covered if received while you are receiving benefits under the "Hospice Care" provision of this section.

Hospice Care. The services and supplies listed below are covered when provided by a *hospice* for the palliative treatment of pain and other symptoms associated with a terminal disease. You must be suffering from a terminal illness for which the prognosis of life expectancy is one year or less, as certified by your *physician* and submitted to the *claims administrator*. Covered services are available on a 24-hour basis for the management of your condition.

1. Interdisciplinary team care with the development and maintenance of an appropriate plan of care.
2. Short-term inpatient *hospital* care when required in periods of crisis or as respite care. Coverage of inpatient respite care is provided on an occasional basis and is limited to a maximum of five consecutive days per admission.
3. Skilled nursing services provided by or under the supervision of a registered nurse. Certified home health aide services and homemaker services provided under the supervision of a registered nurse.
4. Social services and counseling services provided by a qualified social worker.
5. Dietary and nutritional guidance. Nutritional support such as intravenous feeding or hyperalimentation.
6. Physical therapy, occupational therapy, speech therapy, and respiratory therapy provided by a licensed therapist.
7. Volunteer services provided by trained *hospice* volunteers under the direction of a *hospice* staff member.
8. Pharmaceuticals, medical equipment, and supplies necessary for the management of your condition. Oxygen and related respiratory therapy supplies.
9. Bereavement services, including assessment of the needs of the bereaved family and development of a care plan to meet those needs, both prior to and following your death. Bereavement services are available to surviving members of the immediate family. Benefits are limited to four visits during a period of 12-months after your death. Your immediate family means your spouse, children, step-children, parents, and siblings. Benefits are limited to **$25** for each visit

10. Palliative care (care which controls pain and relieves symptoms, but does not cure) which is appropriate for the illness.

Your *physician* must consent to your care by the *hospice* and must be consulted in the development of your treatment plan. The *hospice* must submit a written treatment plan to the *claims administrator* every 30 days.

Home Infusion Therapy. The following services and supplies when provided by a *home infusion therapy provider* in your home for the intravenous administration of your total daily nutritional intake or fluid requirements, medication related to illness or injury, chemotherapy, antibiotic therapy, aerosol therapy, tocolytic therapy, special therapy, intravenous hydration, or pain management:

1. Medication, ancillary medical supplies and supply delivery, (not to exceed a 14-day supply); however, medication which is delivered but not administered is not covered;

2. Pharmacy compounding and dispensing services (including pharmacy support) for intravenous solutions and medications;

3. *Hospital* and home clinical visits related to the administration of infusion therapy, including skilled nursing services including those provided for: (a) patient or alternative caregiver training; and (b) visits to monitor the therapy;

4. Rental and purchase charges for durable medical equipment (as shown below); maintenance and repair charges for such equipment;

5. Laboratory services to monitor the patient's response to therapy regimen.

The *plan's* maximum payment will not exceed **$600** for the services or supplies received during any one day when provided by a *home infusion therapy provider* which is not a *participating provider*.

Home infusion therapy provider services are subject to pre-service review to determine medical necessity. See UTILIZATION REVIEW PROGRAM for details.

Ambulatory Surgical Center. Services and supplies provided by an *ambulatory surgical center* in connection with outpatient surgery.

For the services of a *non-participating provider* facility only, the *plan* will pay up to **$350** each time you have outpatient surgery at an *ambulatory surgical center*.

Professional Services

1. Services of a *physician*.

2. Services of an anesthetist (M.D. or C.R.N.A.).

Reconstructive Surgery. Reconstructive surgery performed to correct deformities caused by congenital or developmental abnormalities, illness, or injury for the purpose of improving bodily function or symptomatology or creating a normal appearance.

Ambulance. The following ambulance services:

1. Base charge, mileage and non-reusable supplies of a licensed ambulance company for ground service to transport you to and from a *hospital*.

2. Emergency services or transportation services that are provided to you by a licensed ambulance company as a result of a "911" emergency response system* request for assistance if you believe you have an *emergency* medical condition requiring such assistance.

3. Base charge, mileage and non-reusable supplies of a licensed air ambulance company to transport you from the area where you are first disabled to the nearest *hospital* where appropriate treatment is provided if, and only if, such services are *medically necessary* and ground ambulance service is inadequate.

4. Monitoring, electrocardiograms (EKGs; ECGs), 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.

∗ If you have an *emergency* medical condition that requires an emergency response, please call the "911" emergency response system if you are in an area where the system is established and operating.

Diagnostic Services. Outpatient diagnostic imaging and laboratory services. Certain imaging procedures, including, but not limited to, Magnetic Resonance Imaging (MRI), Computerized Axial Tomography (CAT scans), Positron Emission Tomography (PET scan), Magnetic Resonance Spectroscopy (MRS scan), Magnetic Resonance Angiogram (MRA scan) and nuclear cardiac imaging are subject to pre-service review to determine medical necessity. You may call the toll-free customer service telephone number on your identification card to find out if an imaging procedure requires pre-service review. See UTILIZATION REVIEW PROGRAM for details.

Radiation Therapy

Chemotherapy.

Hemodialysis Treatment

Prosthetic Devices

1. Breast prostheses following a mastectomy.
2. *Prosthetic devices* to restore a method of speaking when required as a result of a covered *medically necessary* laryngectomy.
3. The *plan* will pay for other *medically necessary prosthetic devices,* including:
    a. Surgical implants;
    b. Artificial limbs or eyes;
    c. The first pair of contact lenses or eye glasses when required as a result of a covered *medically necessary* eye surgery;
    d. Therapeutic shoes and inserts for the prevention and treatment of diabetes-related foot complications; and
    e. Orthopedic footwear used as an integral part of a brace; shoe inserts that are custom molded to the patient.

Durable Medical Equipment. Rental or purchase of dialysis equipment; dialysis supplies. Rental or purchase of other medical equipment and supplies which are:

1. Of no further use when medical needs end;
2. For the exclusive use of the patient;
3. Not primarily for comfort or hygiene;
4. Not for environmental control or for exercise; and
5. Manufactured specifically for medical use.

Rental charges that exceed the reasonable purchase price of the equipment are not covered. The *claims administrator* will determine whether the item satisfies the conditions above.

Pediatric Asthma Equipment and Supplies. The following items and services when required for the *medically necessary* treatment of asthma in a dependent *child*:

1. Nebulizers, including face masks and tubing, inhaler spacers, and peak flow meters.

2. Education for pediatric asthma, including education to enable the *child* to properly use the items listed above. This education will be covered under the *plan's* benefits for office visits to a *physician*.

Blood. Blood transfusions, including blood processing and the cost of unreplaced blood and blood products. Charges for the collection, processing and storage of self-donated blood are covered, but only when specifically collected for a planned and covered surgical procedure.

Dental Care

1. **Admissions for Dental Care.** Listed inpatient *hospital* services for up to three days during a *hospital stay,* when such *stay* is required for dental treatment and has been ordered by a *physician* (M.D.) and a dentist (D.D.S. or D.M.D.). The *claims administrator* will make the final determination as to whether the dental treatment could have been safely rendered in another setting due to the nature of the procedure or your medical condition. *Hospital stays* for the purpose of administering general anesthesia are not considered necessary and are not covered except as specified in #2, below.

2. **General Anesthesia.** General anesthesia and associated facility charges when your clinical status or underlying medical condition requires that dental procedures be rendered in a *hospital* or a*mbulatory surgical center*. This applies only if (a) the *beneficiary* is less than seven years old, (b) the *beneficiary* is developmentally disabled, or (c) the *beneficiary's* health is compromised and general anesthesia is *medically necessary*. Charges for the dental procedure itself, including professional fees of a dentist, are not covered.

3. **Dental Injury.** Services of a *physician* (M.D.) or dentist (D.D.S. or D.M.D.) solely to treat an *accidental injury* to natural teeth. Coverage shall be limited to only such services that are *medically necessary* to repair the damage done by *accidental injury* and/or restore function lost as a direct result of the *accidental injury*. Damage to natural teeth due to chewing or biting is not *accidental injury*.

Pregnancy and Maternity Care

1. All medical benefits when provided for pregnancy or maternity care, including diagnosis of genetic disorders in cases of high-risk pregnancy. Inpatient *hospital* benefits in connection with childbirth will be provided for at least 48 hours following a normal delivery or 96 hours following a cesarean section, unless the mother and her *physician* decide on an earlier discharge.

2. Medical *hospital* benefits for routine nursery care of a newborn *child,* if the *child's* natural mother is an *employee,* an enrolled *spouse,* or a *domestic partner*.

Organ and Tissue Transplants. Services provided in connection with a non-investigative organ or tissue transplant, if you are: (1) the organ or tissue recipient; or (2) the organ or tissue donor.

If you are the recipient, an organ or tissue donor who is not a *beneficiary* is also eligible for services as described. Benefits are reduced by any amounts paid or payable by that donor's own coverage.

Covered expense does not include charges for services received without first obtaining the *claims administrator's* prior authorization. See UTILIZATION REVIEW PROGRAM for details.

Physical Exam (Beneficiaries Age 7 and Over). The *plan* will pay for the following services when provided for *beneficiaries* age 7 or over by a *participating provider.* The *calendar year* deductible will not apply to these services.

1. A *physician's* services for routine physical examinations.

2. Immunizations given as standard medical practice.

3. Radiology and laboratory services and tests ordered by the examining *physician* in connection with a routine physical examination, excluding any such tests related to an illness or injury. Those radiology and laboratory services and tests related to an illness or injury will be covered as any other medical service available under the terms and conditions of the provision “Diagnostic Services”.

Services under the Physical Exam benefit are covered only if provided by a *participating provider*. Prostate cancer screenings, cervical cancer screenings including human papillomavirus (HPV) screening, breast cancer screenings, colorectal cancer screenings, and other cancer screenings are not covered under this “Physical Exam” benefit but are covered under the medical care provisions of this *plan* as described under "Adult Preventive Services", "Breast Cancer" and "Other Cancer Screening Tests", subject to the terms and conditions of this *plan* that apply to those benefits.

Adult Preventive Services. FDA-approved cancer screenings and the office visit related to:

1. Cervical cancer, including human papillomavirus (HPV) screening, limited to one screening per *year*.
2. Mammography testing and appropriate screening for breast cancer, limited to one screening per *year*.
3. Prostate cancer screenings, limited to one screening per *year*.
4. Colorectal cancer screenings, limited to one screening per *year*.

The Calendar Year Deductible will not apply to these services.

Well Baby and Well Child Care. The following services for a dependent *child* under 7 years of age:

1. A *physician's* services for routine physical examinations.
2. Immunizations given as standard medical practice for children.
3. Radiology and laboratory services in connection with routine physical examinations.

Breast Cancer. Services and supplies provided in connection with the screening for, diagnosis of and treatment for breast cancer whether due to illness or injury, including:

1. Diagnostic mammogram examinations for the treatment of a diagnosed illness or injury, limited to one examination per *year*. Routine mammograms will be covered initially with Adult Preventive Services benefits (see "Adult Preventive Services").
2. Mastectomy and lymph node dissection; complications from a mastectomy including lymphedema.
3. Reconstructive surgery performed to restore and achieve symmetry following a *medically necessary* mastectomy.
4. Breast prostheses following a mastectomy (see “Prosthetic Devices”).

This coverage is provided according to the terms and conditions of this *plan* that apply to all other medical conditions.

Other Cancer Screening Tests. Services and supplies provided in connection with all generally medically accepted cancer screening tests. This coverage is provided according to the terms and conditions of this *plan* that apply to all other medical conditions.

Physical Therapy, Physical Medicine and Occupational Therapy. The following services provided by a *physician* under a treatment plan which offers a reasonable expectation of significant improvement:

1. Physical therapy and physical medicine provided on an outpatient basis for the treatment of illness or injury including the therapeutic use of heat, cold, exercise, electricity, ultra violet radiation, manipulation of the spine, or massage for the purpose of improving circulation, strengthening muscles, or encouraging the return of motion. (This includes many types of care which are customarily provided by physical therapists and osteopaths.)

2. Occupational therapy provided on an outpatient basis when the ability to perform daily life tasks has been lost or reduced by illness or injury including programs which are designed to rehabilitate mentally, physically or emotionally handicapped persons. Occupational therapy programs are designed to maximize or improve a patient's upper extremity function, perceptual motor skills and ability to function in daily living activities.

Benefits are not payable for care provided to relieve general soreness or for conditions that may be expected to improve without treatment. For the purposes of this benefit, the term "visit" shall include any visit by a *physician* in that *physician's* office, or in any other outpatient setting, during which one or more of the services covered under this limited benefit are rendered, even if other services are provided during the same visit.

Chiropractic Care. Services and supplies provided by a *physician* in connection with outpatient chiropractic care provided to treat a disease, illness or injury. This includes care, such as the therapeutic use of heat, cold, exercise, electricity, ultra violet radiation, manipulation of the spine, or massage for the purpose of improving circulation, strengthening muscles, or encouraging the return of motion which is provided by osteopaths and chiropractors within the chiropractic scope of practice. A Chiropractic care visit shall include any and all *physician* services provided during each visit, (including the office visit charge) other than radiology, diagnostic laboratory services and durable medical equipment.

Contraceptives. Services and supplies provided in connection with the following methods of contraception:

- Injectable drugs and implants for birth control, administered in a *physician's* office, if *medically necessary*.
- Intrauterine contraceptive devices (IUDs) and diaphragms, dispensed by a *physician* if *medically necessary*.
- Professional services of a *physician* in connection with the prescribing, fitting, and insertion of intrauterine contraceptive devices or diaphragms.

Outpatient Speech Therapy. Outpatient speech therapy following injury or organic disease.

HIV Testing. Human immunodeficiency virus (HIV) testing, regardless of whether the testing is related to a primary diagnosis. This coverage is provided according to the terms and conditions of this *plan* that apply to all other medical conditions.

Acupuncture. The services of a *physician* for acupuncture treatment to treat a disease, illness or injury, including a patient history visit, physical examination, treatment planning and treatment evaluation, electroacupuncture, cupping and moxibustion. The *plan* will pay for up to 12 visits during a *calendar year,* and for up to a maximum of **$50**, including the office visit, for all covered services rendered during each visit by a *participating physician* and **$25** for all covered services, including the office visit**,** rendered during each visit by a *non-participating physician*.

Hearing Aid Services. The following hearing aid services are covered when provided by or purchased as a result of a written recommendation from a otolaryngologist or a state-certified audiologist.

1. Audiological evaluations to measure the extent of hearing loss and determine the most appropriate make and model of hearing aid.
2. Hearing aids (monaural or binaural) including ear mold(s), the hearing aid instrument, batteries, cords and other ancillary equipment up to a maximum payment of **$700** per *beneficiary* once in a twenty-four (24) month period.
3. Visits for fitting, counseling, adjustments and repairs for a one year period after receiving the covered hearing aid.

No benefits will be provided for the following:

1. Charges for a hearing aid which exceeds specifications prescribed for the correction of hearing loss.

2. Surgically implanted hearing devices (i.e., cochlear implants, audient bone conduction devices). *Medically necessary* surgically implanted hearing devices may be covered under your *plan's* benefits for prosthetic devices (see “Prosthetic Devices”).

Diabetes. Services and supplies provided for the treatment of diabetes, including:

1. The following equipment and supplies:

   a. Blood glucose monitors, including monitors designed to assist the visually impaired.

   b. Insulin pumps.

   c. Pen delivery systems for insulin administration (non-disposable).

   d. Visual aids (but not eyeglasses) to help the visually impaired to properly dose insulin.

   e. Podiatric devices, such as therapeutic shoes and shoe inserts, to treat diabetes-related complications.

   Items a through d above are covered under your *plan's* benefits for durable medical equipment (see “Durable Medical Equipment”). Item e above is covered under your *plan's* benefits for prosthetic devices (see "Prosthetic Devices").

2. Diabetes education program which:

   a. Is designed to teach a *beneficiary* who is a patient and covered members of the patient's family about the disease process and the daily management of diabetic therapy;

   b. Includes self-management training, education, and medical nutrition therapy to enable the *beneficiary* to properly use the equipment, supplies, and medications necessary to manage the disease; and

   c. Is supervised by a *physician*.

   Diabetes education services are covered under *plan* benefits for office visits to *physicians*.

3. The following item is covered as a medical supply:

   a. alcohol swabs.

   Insulin an other prescriptive medications, insulin syringes, lancets, urine testing strips, blood glucose testing strips and disposable pen delivery systems for insulin administration are covered under your drug card plan.

Christian Science Benefits. The following provisions relate only to charges for Christian Science treatment**:**

1. A Christian Science sanatorium will be considered a hospital for purposes of this *plan*. The sanatorium must be accredited by the Department of Care of the First Church of Christ, Scientist; Boston, Massachusetts.

2. The term physician includes a Christian Science practitioner approved and accredited by the Mother Church, The First Church of Christ, Scientist; Boston, Massachusetts.

3. Benefits for the following services will be provided when you manifest symptoms of a covered illness or injury and receive Christian Science treatment for such symptoms.

   a. **Christian Science Sanatorium**. Services provided by a Christian Science sanatorium if you are admitted for active care of any illness or injury.

b. **Christian Science Practitioner**. Office visits for services of a Christian Science practitioner providing treatment for a diagnosed illness or injury according to the healing practices of Christian Science.

NO BENEFITS ARE AVAILABLE FOR SPIRITUAL REFRESHMENT. All other provisions under the section of this *plan description* entitled YOUR MEDICAL BENEFITS: MEDICAL CARE THAT IS NOT COVERED apply equally to Christian Science benefits as to all other benefits and providers of care.

Jaw Joint Disorders (TMJ). The *plan* will pay for splint therapy or surgical treatment for disorders or conditions of the joints linking the jawbones and the skull (the temporomandibular joints), including the complex of muscles, nerves and other tissues related to those joints. Prior authorization is available for (i) surgical treatment of jaw joint disorders or conditions.

Special Food Products. Special food products and formulas that are part of a diet prescribed by a *physician* for the treatment of phenylketonuria (PKU). These items will be covered as medical supplies.

Telemedicine Program. Coverage will be provided for *telemedicine*, as defined in the DEFINITIONS section, for *beneficiaries* only when provided by the *claim administrators* Telemedicine Network of designated providers specifically equipped and trained to provide *telemedicine* health care services.

Specialty Pharmacy Program. Medications that are categorized as *specialty drugs* must be obtained through the specialty pharmacy program unless an exception is authorized**.** This applies to *specialty drugs* that are obtained for home use or to be administered in the *physician's* office during the office visit.

Anthem Blue Cross Life and Health - Specialty Pharmacy Program is administered by the *claims administrators* preferred specialty pharmacy. *Specialty drugs* are limited to a maximum supply of 30-days per order or the treatment needed during the office visit, whichever is less. The specialty pharmacy can deliver *specialty drugs* to your home or *physician's* office by mail or common carrier (you cannot pick up your medication at Anthem Blue Cross Life and Health).

If your *physician* orders the *specialty drug* to be administered in the office, only the medication needed for that visit will be delivered. Your *physician* will be responsible for ordering the *specialty drug* for administration in their office.

To obtain a *specialty drug* for home use, you must have a valid prescription for the drug that contains all the required information, such as, the drug name, dosage, directions for use, quantity, the *physician's* name and phone number and the patient's name and address. The prescription must be signed by a *physician*. If you are receiving services from a *home infusion therapy* provider in your home, such as home clinical visits and medications, those medications that are considered *specialty drugs* must also be obtained through the specialty pharmacy program unless an exception has been authorized. Either you or the *home infusion therapy* provider can order the *specialty drug* from the *claims administrators* preferred specialty pharmacy to be delivered to your home.

Non-duplication of benefits applies to the specialty pharmacy program under this *plan*. When benefits are provided for *specialty drugs* under the *plan's* medical benefits, they will not be provided under any prescription drug plan sponsored by SISC III. Conversely, if benefits are provided for *specialty drugs* under any prescription drug plan sponsored by SISC III, they will not be provided under the *plan's* medical benefits.

You or your *physician* may order your *specialty drugs* from the preferred specialty pharmacy by calling 1-800-870-6419. When you or your *physician* calls the specialty pharmacy program, a Dedicated Care Coordinator will guide you or your *physician* through the process, including the delivery of your *specialty drugs* to you or to your *physician's* office.

Specialty drugs are subject to all applicable benefit cost sharing. Once you have met your deductible, if any, you will only have to pay your co-payment, if any. If your *physician* orders the *specialty drug* for administration in the office, you will also be responsible for any applicable co-payments. At the time of ordering and prior to shipping, the specialty pharmacy may require you to pay your applicable deductible or co-payment, by credit card, debit card, or other forms of payment.

The first time you or your *physician* orders a *specialty drug*, an Intake Referral Form must be completed. The Intake Referral Form can be completed by telephone by calling 1-800-870-6419. This form gathers the necessary information to set up your account for the specialty pharmacy to process your order correctly. For subsequent orders, you only need to mail the prescription or refill notice and the appropriate payment to the address below or call the toll-free number, 1-800-870-6419. Co-payments can be made by check, money order, credit card or debit card.

You or your *physician* may obtain a list of *specialty drugs* subject to the terms of the specialty pharmacy program and order forms by contacting the number shown below or online at www.anthem.com/ca/sisc.

Anthem Blue Cross Life and Health – Specialty Pharmacy Program
2825 W. Perimeter Road
Indianapolis, IN 46241
Phone 1-800-870-6419
Fax 1-800-824-2642

Prior Authorization. Certain *specialty drugs* require written prior authorization in order for you to receive them. Prior authorization criteria will be based on the *claims administrator's* medical policies and clinical guidelines as established by its review committees. You may need to try a drug other than the one originally prescribed if the *claims administrator* determines that it should be clinically effective for you. However, if the *claims administrator* determines through prior authorization that the drug originally prescribed is *medically necessary*, you will be provided the drug originally requested. (If, when you first become a *beneficiary*, you are already being treated for a medical condition by a drug that has been appropriately prescribed and is considered safe and effective for your medical condition, the *claims administrator* will not require you to try a drug other than the one you are currently taking). However, the request may be subject to review for medical necessity. If approved, *specialty drugs* requiring prior authorization will be provided to you after you make the required co-payment.

In order for you to get a *specialty drug* that requires prior authorization, your *physician* must submit a request to the *claims administrator* for review and approval. The request may be made by either telephone or facsimile to the *claims administrator*. At the time the request is initiated, specific clinical information will be requested from your *physician,* based on the *claims administrator's* medical policies and/or clinical guidelines.

If the request is for urgently* needed drugs, after the *claims administrator* receives the request from the *physician*:

- The *claims administrator* will review it and decide if medical necessity can be approved within 72-hours or less. The *claims administrator* will tell you and your *physician* what has been decided - by telephone and in writing by facsimile to your *physician*, and in writing by mail to you.
- If more clinical information is needed to make a decision, or the *claims administrator* cannot make a decision for any reason, the *claims administrator* will tell your *physician* what information is missing and why they cannot make a decision within 24-hours after receiving the request. If, for reasons beyond the *claims administrator's* control, the *claims administrator* cannot tell your *physician* what information is missing within 24-hours, the *claims administrator* will tell your *physician* that there is a problem as soon as they know that they cannot respond within 24-hours. In either event, the *claims administrator* will tell you and your *physician* that there is a problem – in writing by facsimile, and by telephone, to your *physician*, and in writing by mail to you.
- As soon as the *claims administrator* can, based on your medical condition, approve the request as *medically necessary*, but, not more than 48-hours after the *claims administrator* has all the information they need to make a decision, the *claims administrator* will tell you and your *physician* what has been decided in writing - by fax to the *physician* and by mail to you.

  ***Urgent is defined as when the *beneficiary's* medical condition is such that the *beneficiary* faces an imminent and serious threat to his or her health including, but not limited to, the potential loss of life, limb, or other major bodily function.

If the request is not for urgently needed drugs, after the *claims administrator* receives the *specialty drug* request form from the *physician*:

- Based on your medical condition, as *medically necessary*, the *claims administrator* will review it and decide if the request will be approved within 5-business days. The *claims administrator* will tell you and your *physician* what has been decided in writing - by fax to your *physician*, and by mail, to you.

- If more clinical information is needed to make a decision, the *claims administrator* will tell your *physician* in writing within 5-business days after they get the request what information is missing and why the *claims administrator* cannot make a decision. If, for reasons beyond the *claims administrator's* control, the *claims administrator* cannot tell your *physician* what information is missing within 5-business days, the *claims administrator* will tell your *physician* that there is a problem as soon as they know that they cannot respond within 5-business days. In any event, the *claims administrator* will tell you and your *physician* that there is a problem by telephone, and in writing by facsimile, to your *physician*, and in writing to you by mail.

- As soon as the *claims administrator* can, based on your medical condition, as *medically necessary*, within 5-business days after the *claims administrator* has all the information they need to decide if the request will be approved, the *claims administrator* will tell you and your *physician* what has been decided in writing - by fax to your *physician* and by mail to you.

While the *claims administrator* is reviewing the request for a *specialty drug* and it is an urgent (as defined above) situation, the *claims administrator* may authorize an administrative override for you to receive the *specialty drug*. You may have to pay the applicable co-payment, if any, shown in SUMMARY OF BENEFITS: MEDICAL BENEFITS: CO-PAYMENTS.

If you have any questions regarding whether a *specialty drug* requires prior authorization, please call customer service at 1-800-274-7767 or visit www.anthem.com/ca/sisc.

If the *claims administrator* denies a request for prior authorization of a *specialty drug*, you or your prescribing *physician* may appeal the *claims administrator's* decision by calling 1-800-274-7767.

Exceptions to the Specialty Pharmacy Program. This program does not apply to:

a. The first two orders for home use or administered by your *physician* that are supplied by another vendor other than Anthem Blue Cross Life and Health preferred specialty pharmacy. (*Specialty drugs* are limited to a 30-day supply per order or the supply needed for the office visit.); or

b. Drugs, which due to medical necessity in an urgent situation, must be administered to the *beneficiary* immediately.

How to obtain an exception to the Specialty Pharmacy Program. If you believe that you should not be required to get your *specialty drugs* through the specialty pharmacy program, for any of the reasons listed above or others, you or your *physician* must complete an Exception to Specialty Pharmacy Program form to request an exception and send it to the *claims administrator*. The form can be faxed or mailed to the *claims administrator*. If you need a copy of the form, you may call customer service at 1-800-274-7767 to request one. You can also get the form on-line at www.anthem.com/ca/sisc. If the *claims administrator* has given you an exception, it will be in writing and will be good for a specified time frame, not to exceed 6 months. After the exception approval expires, if you believe that you should still not be required to get your medication through the specialty pharmacy program, you must again request an exception. If the *claims administrator* denies your request for an exception, it will be in writing and will tell you why the *claims administrator* did not approve the exception.

Urgent or emergency need of a specialty drug subject to the specialty pharmacy program. If you are out of a *specialty drug* which must be obtained through the specialty pharmacy program or your *specialty drug* order from the specialty pharmacy did not arrive, (if your *physician* decides it is *medically necessary* for you to have the drug immediately), the *claims administrator* will authorize an administrative override of the specialty pharmacy program requirement for a 30-day supply or less. You can call 1-800-870-6419 and the specialty pharmacy can also help you locate a participating pharmacy close to you to provide you with the medication. You may have to pay the applicable co-payment shown in SUMMARY OF BENEFITS: MEDICAL BENEFITS: CO-PAYMENTS.

For orders that were not delivered to you and for which you have paid the applicable co-payment to the specialty pharmacy, you will not be required to make additional co-payments.

Unless you qualify for an exception, if you don't get your *specialty drug* through the specialty pharmacy program, you will not receive any benefits under this *plan* for them.

MEDICAL CARE THAT IS NOT COVERED

No payment will be made under this *plan* for expenses incurred for or in connection with any of the items below. (The titles given to these exclusions and limitations are for ease of reference only; they are not meant to be an integral part of the exclusions and limitations and do not modify their meaning.

Not Medically Necessary. Services or supplies that are not *medically necessary,* as defined.

Experimental or Investigative. Any *experimental* or *investigative* procedure or medication.

Crime or Nuclear Energy. Conditions that result from: (1) your commission of or attempt to commit a felony, as long as any injuries are not a result of a medical condition or an act of domestic violence; or (2) any release of nuclear energy, whether or not the result of war, when government funds are available for treatment of illness or injury arising from such release of nuclear energy.

Not Covered. Services received before your *effective date* or after your coverage ends, except as specifically stated under EXTENSION OF BENEFITS.

Excess Amounts. Any amounts in excess of *covered expense* or the Lifetime Maximum.

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

If there is a dispute or substantial uncertainty as to whether benefits may be recovered for those conditions pursuant to workers' compensation, benefits will be provided subject to our right of recovery and reimbursement under California Labor Code Section 4903, and as described in REIMBURSEMENT FOR ACTS OF THIRD PARTIES.

Government Treatment. Any services provided by a local, state or federal government agency, except when payment under this *plan* is expressly required by federal or state law.

Services of Relatives. Professional services received from a person who lives in your home or who is related to you by blood or marriage, except as specifically stated in the "Home Infusion Therapy" provision of MEDICAL CARE THAT IS COVERED.

Voluntary Payment. Services for which you have no legal obligation to pay, or for which no charge would be made in the absence of insurance coverage or other health plan coverage, except services received at a non-governmental charitable research *hospital*. Such a *hospital* must meet the following guidelines:

1. It must be internationally known as being devoted mainly to medical research;
2. At least **10%** of its yearly budget must be spent on research not directly related to patient care;
3. At least one-third of its gross income must come from donations or grants other than gifts or payments for patient care;

4. It must accept patients who are unable to pay; and

5. Two-thirds of its patients must have conditions directly related to the *hospital's* research.

Not Specifically Listed. Services not specifically listed in this *plan* as covered services.

Private Contracts. Services or supplies provided pursuant to a private contract between the *beneficiary* and a provider, for which reimbursement under the Medicare program is prohibited, as specified in Section 1802 (42 U.S.C. 1395a) of Title XVIII of the Social Security Act.

Inpatient Diagnostic Tests. Inpatient room and board charges in connection with a *hospital stay* primarily for diagnostic tests which could have been performed safely on an outpatient basis.

Mental or Nervous Disorders. Academic or educational testing, counseling, and remediation. *Mental or nervous disorders* or substance abuse, including rehabilitative care in relation to these conditions.

Mental or nervous disorders or substance abuse benefits are provided by SISC III through Anthem Blue Cross Life and Health Insurance Company (the *claims administrator*) or by another carrier. If provided through Anthem Blue Cross Life and Health Insurance Company, refer to the BEHAVIORAL HEALTH PROGRAM RIDER attached to the end of this *plan description* for information on how treatment can be obtained. If provided through another carrier, please contact you *participating employer* for information regarding your benefits for these conditions.

Nicotine Use. Smoking cessation programs or treatment of nicotine or tobacco use. Smoking cessation *drugs*.

Orthodontia. Braces and other orthodontic appliances or services.

Dental Services or Supplies. Dental plates, bridges, crowns, implants, caps or other dental prostheses, dental services, extraction of teeth, or treatment to the teeth or gums, or treatment to or for any disorders for the jaw joint, except as specifically stated in the "Dental Care" or "Jaw Joint Disorders" provisions of MEDICAL CARE THAT IS COVERED. Cosmetic dental surgery or other dental services for beautification.

Hearing Aids or Tests. Hearing aids, except as specifically stated in the "Hearing Aid Services" provision of MEDICAL CARE THAT IS COVERED. Routine hearing tests, except as specifically provided under "Physical Exam (Beneficiaries Age 7 and Over)" and "Hearing Aid Services" provisions of MEDICAL CARE THAT IS COVERED.

Optometric Services or Supplies. Optometric services, eye exercises including orthoptics. Routine eye exams and routine eye refractions. Eyeglasses or contact lenses, except as specifically stated in the "Prosthetic Devices" provision of MEDICAL CARE THAT IS COVERED.

Outpatient Occupational Therapy. Outpatient occupational therapy, except by a *home health agency, hospice* or *home infusion therapy provider* as specifically stated in the "Home Health Care", "Hospice Care", "Home Infusion Therapy", "Physical Therapy, Physical Medicine, Occupational Therapy" or "Chiropractic Care" provisions of MEDICAL CARE THAT IS COVERED.

Outpatient Speech Therapy. Outpatient speech therapy except as stated in the "Outpatient Speech Therapy" provision of MEDICAL CARE THAT IS COVERED.

Cosmetic Surgery. Cosmetic surgery or other services performed solely for beautification or to alter or reshape normal (including aged) structures or tissues of the body to improve appearance. This exclusion does not apply to reconstructive surgery (that is, surgery performed to correct deformities caused by congenital or developmental abnormalities, illness, or injury for the purpose of improving bodily function or symptomatology or to create a normal appearance), including surgery performed to restore symmetry following mastectomy. Cosmetic surgery does not become reconstructive surgery because of psychological or psychiatric reasons.

Obesity. Services primarily for weight reduction or treatment of obesity. This exclusion will not apply to treatment of morbid obesity, as determined by the *claims administrator*, if the treatment is determined in advance as *medically necessary* and appropriate.

Scalp hair prostheses. Scalp hair prostheses, including wigs or any form of hair replacement.

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

Sterilization Reversal. Reversal of sterilization.

Infertility Treatment. Any services or supplies furnished in connection with the diagnosis and treatment of *infertility,* including, but not limited to, diagnostic tests, medication, surgery, artificial insemination, in vitro fertilization, sterilization reversal, and gamete intrafallopian transfer.

Orthopedic Supplies. Orthopedic shoes (other than shoes joined to braces) or non-custom molded and cast shoe inserts, except for therapeutic shoes and inserts for the prevention and treatment of diabetes-related foot complications as specifically stated in the "Prosthetic Devices" provision of MEDICAL CARE THAT IS COVERED.

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

Custodial Care or Rest Cures. Inpatient room and board charges in connection with a *hospital stay* primarily for environmental change or physical therapy. *Custodial care* or rest cures, except as specifically provided under the "Hospice Care" or "Home Infusion Therapy" provisions of MEDICAL CARE THAT IS COVERED. Services provided by a rest home, a home for the aged, a nursing home or any similar facility. Services provided by a *skilled nursing facility,* except as specifically stated in the "Skilled Nursing Facility" provision of MEDICAL CARE THAT IS COVERED.

Chronic Pain. Treatment of chronic pain, except as specifically provided under the "Hospice Care" or "Home Infusion Therapy" provisions of MEDICAL CARE THAT IS COVERED.

Exercise Equipment. Exercise equipment, or any charges for activities, instrumentalities, or facilities normally intended or used for developing or maintaining physical fitness, including, but not limited to, charges from a physical fitness instructor, health club or gym, even if ordered by a *physician*.

Personal Items. Any supplies for comfort, hygiene, beautification or incontinence.

Education or Counseling. Educational services or nutritional counseling, except as specifically provided or arranged by the *plan*, or as stated in the "Home Infusion Therapy", "Pediatric Asthma Equipment and Supplies" or "Diabetes" provisions of MEDICAL CARE THAT IS COVERED.

Food or Dietary Supplements. Food or dietary supplements, except as specifically stated in the "Special Food Products" or "Home Infusion Therapy" provisions of MEDICAL CARE THAT IS COVERED.

Telephone, Facsimile Machine and Web Consultations. Consultations provided by telephone, facsimile machine or by internet, except as provided under the "Christian Science Benefits" and "Telemedicine Program" provisions of MEDICAL CARE THAT IS COVERED.

Routine Exams or Tests. Routine physical exams or tests which do not directly treat an actual illness, injury or condition, including those required by employment or government authority, except as specifically stated in the "Well Baby and Well Child Care", "Physical Exam (Beneficiaries Age 7 and Over", "Adult Preventive Services" or "Breast Cancer" provisions of MEDICAL CARE THAT IS COVERED. Executive physical examinations and routine full body scans.

Acupuncture. Acupuncture treatment except as specifically stated in the "Acupuncture" provision of MEDICAL CARE THAT IS COVERED. Acupressure, or massage to control pain, treat illness or promote health by applying pressure to one or more specific areas of the body based on dermatomes or acupuncture points.

Eye Surgery for Refractive Defects. Any eye surgery solely or primarily for the purpose of correcting refractive defects of the eye such as nearsightedness (myopia) and/or astigmatism. Contact lenses and eyeglasses required as a result of this surgery.

Physical Therapy or Physical Medicine. Services of a *physician* for physical therapy or physical medicine, except when provided during a covered inpatient confinement, or as specifically stated in the "Home Health Care", "Hospice Care", "Home Infusion Therapy", "Physical Therapy, Physical Medicine and Occupational Therapy" or “Chiropractic Care” provisions of MEDICAL CARE THAT IS COVERED.

Outpatient Prescription Drugs and Medications. Outpatient prescription drugs or medications and insulin, except as specifically stated in the "Home Infusion Therapy" provision of MEDICAL CARE THAT IS COVERED. Non-prescription, over-the-counter patent or proprietary drugs or medicines. Cosmetics, health or beauty aids.

Specialty Pharmacy Program Drugs. Lost or stolen *specialty drugs*. *Specialty drugs* that must be obtained from the specialty pharmacy program, but, which are obtained from another vendor, including but not limited to retail pharmacies are not covered by this *plan*. You will have to pay the full cost of the *specialty drugs* you get that you should have obtained from the specialty pharmacy program. This does not apply to exceptions that have been approved.

Contraceptive Devices. Contraceptive devices prescribed for birth control except as specifically stated in the “Contraceptives” provision in MEDICAL CARE THAT IS COVERED.

Private Duty Nursing. Inpatient or outpatient services of a private duty nurse.

Lifestyle Programs. Programs to alter one’s lifestyle which may include but are not limited to diet, exercise, imagery or nutrition. This exclusion will not apply to cardiac rehabilitation programs approved by the *claims administrator*.

REIMBURSEMENT FOR ACTS OF THIRD PARTIES

Under some circumstances, a *beneficiary* may need services under this *plan* for which a third party may be liable or legally responsible by reason of negligence, an intentional act or breach of any legal obligation. In that event, we will provide the benefits of this *plan* subject to the following:

1. We will automatically have a lien, to the extent of benefits provided, upon any recovery, whether by settlement, judgment or otherwise, that you receive from a third party, a third party's insurer, or a third party's guarantor that you receive as a result of a third party’s actions and/or liability. The lien will be in the amount of benefits paid under this *plan* for the treatment of the illness, disease, injury or condition for which a third party is responsible, but not more than the amount allowed by California Civil Code Section 3040.

2. You must advise us in writing, within 60 days of filing a claim against the third party and take necessary action, furnish such information and assistance, and execute such papers as we may require to facilitate enforcement of our rights. You must not take action which may prejudice our rights or interests under your *plan*. Failure to give us such notice or to cooperate with us, or actions that prejudice our rights or interests will be a material breach of the *plan* and will result in your being personally responsible for reimbursing us.

3. We will be entitled to collect on our lien even if the amount you or anyone recovered for you (or your estate, parent or legal guardian) from or for the account of such third party as compensation for the injury, illness or condition is less than the actual loss you suffered.

COORDINATION OF BENEFITS

If you are covered by more than one group health plan, your benefits under This Plan will be coordinated with the benefits of those Other Plans, as shown below. These coordination provisions apply separately to each *beneficiary,* per *calendar year,* and are largely determined by California law. Any coverage you have for medical or dental benefits will be coordinated as shown below.

DEFINITIONS

The meanings of key terms used in this section are shown below. Whenever any of the key terms shown below appear in these provisions, the first letter of each word will be capitalized. When you see these capitalized words, you should refer to this "Definitions" provision.

Allowable Expense is any necessary, reasonable and customary item of expense which is at least partially covered by at least one Other Plan. For the purposes of determining our payment, the total value of Allowable Expense as provided under This Plan and all Other Plans will not exceed the greater of: (1) the amount which the *plan* would determine to be eligible expense, if you were covered under This Plan only; or (2) the amount any Other Plan would determine to be eligible expenses in the absence of other coverage.

Other Plan is any of the following:

1. Group, blanket or franchise insurance coverage;
2. Group service plan contract, group practice, group individual practice and other group prepayment coverages;
3. Group coverage under labor-management trusteed plans, union benefit organization plans, employer organization plans, employee benefit organization plans or self-insured employee benefit plans.
4. Medicare. This does not include Medicare when, by law, its benefits are secondary to those of any private insurance program or other non-governmental program.

The term "Other Plan" refers separately to each agreement, policy, contract, or other arrangement for services and benefits, and only to that portion of such agreement, policy, contract, or arrangement which reserves the right to take the services or benefits of other plans into consideration in determining benefits.

Principal Plan is the plan which will have its benefits determined first.

This Plan is that portion of this *plan* which provides benefits subject to this provision.

EFFECT ON BENEFITS

1. If This Plan is the Principal Plan, then its benefits will be determined first without taking into account the benefits or services of any Other Plan.
2. If This Plan is not the Principal Plan, then its benefits may be reduced so that the benefits and services of all the plans do not exceed Allowable Expense.
3. The benefits of This Plan will never be greater than the sum of the benefits that would have been paid if you were covered under This Plan only.

ORDER OF BENEFITS DETERMINATION

The following rules determine the order in which benefits are payable:

1. A plan which has no Coordination of Benefits provision pays before a plan which has a Coordination of Benefits provision. This would include Medicare in all cases, except when the law requires that This Plan pays before Medicare.

2. A plan which covers you as an *employee* pays before a plan which covers you as a dependent. But, if you are retired and eligible for Medicare, Medicare pays (a) after the plan which covers you as a dependent of an active employee, but (b) before the plan which covers you as a retired *employee*.

   For example: You are covered as a retired *employee* under this plan and eligible for Medicare (Medicare would normally pay first). You are also covered as a dependent of an active employee under another plan (in which case Medicare would pay second). In this situation, the plan which covers you as a dependent will pay first and the plan which covers you as a retired employee would pay last.

3. For a dependent *child* covered under plans of two parents, 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*. But if one plan does not have a birthday rule provision, the provisions of that plan determine the order of benefits.

   Exception to rule 3: For a dependent *child* of parents who are divorced or separated, the following rules will be used in place of Rule 3:

   a. If the parent with custody of that *child* for whom a claim has been made has not remarried, then the plan of the parent with custody that covers that *child* as a dependent pays first.

   b. If the parent with custody of that *child* for whom a claim has been made has remarried, then the order in which benefits are paid will be as follows:

      i. The plan which covers that *child* as a dependent of the parent with custody.

      ii. The plan which covers that *child* as a dependent of the stepparent (married to the parent with custody).

      iii. The plan which covers that *child* as a dependent of the parent without custody.

      iv. The plan which covers that *child* as a dependent of the stepparent (married to the parent without custody).

   c. Regardless of a and b above, if there is a court decree which establishes a parent's financial responsibility for that *child's* health care coverage, a plan which covers that *child* as a dependent of that parent pays first.

4. The plan covering you as a laid-off or retired employee or as a dependent of a laid-off or retired employee pays after a plan covering you as other than a laid-off or retired employee or the dependent of such a person. But, if either plan does not have a provision regarding laid-off or retired employees, provision 6 applies.

5. The plan covering you under a continuation of coverage provision in accordance with state or federal law pays after a plan covering the you as an employee, a dependent or otherwise, but not under a continuation of coverage provision in accordance with state or federal law. If the order of benefit determination provisions of the Other Plan do not agree under these circumstances with the Order of Benefit Determination provisions of This Plan, this rule will not apply.

6. When the above rules do not establish the order of payment, the plan on which you have been enrolled the longest pays first unless two of the plans have the same effective date. In this case, Allowable Expense is split equally between the two plans.

OUR RIGHTS UNDER THIS PROVISION

Responsibility For Timely Notice. We are not responsible for coordination of benefits unless timely information has been provided by the requesting party regarding the application of this provision.

Reasonable Cash Value. If any Other Plan provides benefits in the form of services rather than cash payment, the reasonable cash value of services provided will be considered Allowable Expense. The reasonable cash value of such service will be considered a benefit paid, and our liability reduced accordingly.

Facility of Payment. If payments which should have been made under This Plan have been made under any Other Plan, we have the right to pay that Other Plan any amount we determine to be warranted to satisfy the intent of this provision. Any such amount will be considered a benefit paid under This Plan, and such payment will fully satisfy our liability under this provision.

Right of Recovery. If payments made under This Plan exceed the maximum payment necessary to satisfy the intent of this provision, we have the right to recover that excess amount from any persons or organizations to or for whom those payments were made, or from any insurance company or service plan.

BENEFITS FOR MEDICARE ELIGIBLE BENEFICIARIES

For Active Employees and Dependents. *Beneficiaries* entitled to Medicare receive the full benefits of this *plan*, except for those *beneficiaries* listed below who are eligible for Medicare Part A because they have worked the required amount of time under the Social Security System:

1. *Beneficiaries* who are receiving treatment for end-stage renal disease following the first 30 months such *beneficiaries* are entitled to end-stage renal disease benefits under Medicare; and

2. *Beneficiaries* who are entitled to Medicare benefits as disabled persons; unless, the *beneficiaries* have a current employment status, as determined by Medicare rules, through a group of 100 or more employees (according to federal OBRA legislation).

In cases where exceptions 1 or 2 apply, payment will be determined according to the provisions in the section entitled COORDINATION OF BENEFITS and the provision “Coordinating Benefits With Medicare”, below.

For Retired Employees and Their Spouses. If you are a *retired employee* or the spouse of a *retired employee* and you are eligible for Medicare Part A because you made the required number of quarterly contributions to the Social Security System, your benefits under this *plan* will be subject to the section entitled COORDINATION OF BENEFITS and the provision “Coordinating Benefits With Medicare”, below.

Coordinating Benefits With Medicare. The *plan* will not provide benefits that duplicate any benefits to which you would be entitled under full Medicare coverage (Medicare Parts A and B), whether or not you are actually enrolled in Medicare Parts A or B, and whether or not the benefits to which you are entitled are actually paid by Medicare.

If you are entitled to Medicare, your Medicare coverage will not affect the services covered under this *plan* except as follows:

1. Medicare must provide benefits first to any services covered both by Medicare and under this *plan*.

2. For services you receive that are covered both by Medicare and under this *plan*, coverage under this *plan* will apply only to Medicare deductibles, coinsurance, and other charges for covered services over and above what Medicare pays.

3. For any given claim, the combination of benefits provided by Medicare and the benefits provided under this *plan* will not exceed *covered expense* for the covered services.

The *plan* will apply any charges paid by Medicare for services covered under this *plan* toward your *plan* deductible, if any.

REQUIRED MONTHLY CONTRIBUTIONS FOR MEDICARE ELIGIBLE BENEFICIARIES

For Active Employees and Dependents Entitled to but not enrolled under Medicare Part A and/or Medicare Part B. The required monthly contribution for coverage under this *plan* will be the required monthly contribution due for *beneficiaries* covered under this *plan* who are not entitled to Medicare.

For Retired Employees and Their Spouses Entitled to but not enrolled under Medicare Part A and/or Medicare Part B. The required monthly contribution for coverage under this *plan* will be increased by an amount necessary to provide the hospital and/or medical benefits of this *plan*.

UTILIZATION REVIEW PROGRAM

Benefits are provided only for medically necessary and appropriate services. Utilization Review is designed to work together with you and your provider to ensure you receive appropriate medical care and avoid unexpected out of pocket expense.

No benefits are payable, however, unless your coverage is in force at the time services are rendered, and the payment of benefits is subject to all the terms and requirements of this *plan*.

Important: The Utilization Review Program requirements described in this section do not apply when coverage under this *plan* is secondary to another plan providing benefits for you or your insured *dependents*.

The utilization review program evaluates the medical necessity and appropriateness of care and the setting in which care is provided. You and your *physician* are advised if the *claims administrator* has determined that services can be safely provided in an outpatient setting, or if an inpatient *stay* is recommended. Services that are *medically necessary* and appropriate are certified by the *claims administrator* and monitored so that you know when it is no longer *medically necessary* and appropriate to continue those services.

It is your responsibility to see that your *physician* starts the utilization review process before scheduling you for any service subject to the utilization review program. If you receive any such service, and do not follow the procedures set forth in this section, benefits will not be paid for those services as shown in the "Effect on Benefits".

UTILIZATION REVIEW REQUIREMENTS

Utilization reviews are conducted for the following services:

- All inpatient *hospital stays*.
- Organ and tissue transplants.
- Home infusion therapy.
- Home health care.
- Admissions to a *skilled nursing facility*.
- Select imaging procedures, including but not limited to: Magnetic Resonance Imaging (MRI), Computerized Axial Tomography (CAT scan), Positron Emission Tomography (PET scan), Magnetic Resonance Spectroscopy (MRS scan), Magnetic Resonance Angiogram (MRA scan) and Nuclear Cardiac Imaging. You may call the toll-free customer service telephone number on your identification card to find out if an imaging procedure requires pre-service review.

Exceptions: Utilization review is not required for inpatient *hospital stays* for the following services:

- Maternity care of 48 hours or less following a normal delivery or 96 hours or less following a cesarean section; and
- Mastectomy and lymph node dissection.

The stages of utilization review are:

1. **Pre-service review** determines in advance the medical necessity and appropriateness of certain procedures or admissions and the appropriate length of stay, if applicable. Pre-service review is required for the following services:
    - Scheduled, non-emergency inpatient *hospital stays* (except inpatient *stays* for maternity care or mastectomy and lymph node dissection).
    - Organ and tissue transplants.

- Home infusion therapy.
- Home health care.
- Admissions to a *skilled nursing facility*.
- Select imaging procedures, including but not limited to: Magnetic Resonance Imaging (MRI), Computerized Axial Tomography (CAT scan), Positron Emission Tomography (PET scan), Magnetic Resonance Spectroscopy (MRS scan), Magnetic Resonance Angiogram (MRA scan) and Nuclear Cardiac Imaging.

2. **Concurrent review** determines whether services are *medically necessary* and appropriate when we are notified while service is ongoing, for example, an emergency admission to the hospital.

3. **Retrospective review** is performed to review services that have already been provided. This applies in cases when pre-service or concurrent review was not completed, or in order to evaluate and audit medical documentation subsequent to services being provided. Retrospective review may also be performed for services that continued longer than originally certified.

EFFECT ON BENEFITS

In order for the full benefits of this *plan* to be payable, the following criteria must be met:

1. The appropriate utilization reviews must be performed in accordance with this *plan*.

2. When pre-service review is performed and the admission, procedure or service is determined to be *medically necessary* and appropriate, benefits will be provided for the following:

   - Organ and tissue transplants as follows:

     For bone, skin or cornea transplants, transplantation of kidney, liver, heart, heart-lung, lung, kidney-pancreas or bone morrow, including autologous bone marrow transplant, peripheral stem cell replacement and similar procedures.

   - Services of a home infusion therapy provider if the attending *physician* has submitted both a prescription and a plan of treatment before services are rendered.

   - Home health care services if:

     a. The services can be safely provided in your home, as certified by your attending *physician*;

     b. Your attending *physician* manages and directs your medical care at home; and

     c. Your attending *physician* has established a definitive treatment plan which must be consistent with your medical needs and lists the services to be provided by the *home health agency*.

   - Services provided in a *skilled nursing facility* if you require daily skilled nursing or rehabilitation, as certified by your attending *physician*.

   - Select imaging procedures, including, but not limited to: Magnetic Resonance Imaging (MRI), Computerized Axial Tomography (CAT scans), Positron Emission Tomography (PET scan), Magnetic Resonance Spectroscopy (MRS scan), Magnetic Resonance Angiogram (MRA scan) and nuclear cardiac imaging.

     If you proceed with any services that have been determined to be not *medically necessary* and appropriate at any stage of the utilization review process, benefits will not be provided for those services.

3. Services that are not reviewed prior to or during service delivery will be reviewed retrospectively when the bill is submitted for benefit payment. If that review results in the determination that part or all of the services were not *medically necessary* and appropriate, benefits will not be paid for those services.

HOW TO OBTAIN UTILIZATION REVIEWS

Remember, it is always your responsibility to confirm that the review has been performed.

Pre-service Reviews

1. For all scheduled services that are subject to utilization review, you or your *physician* must initiate the pre-service review at least three working days prior to when you are scheduled to receive services.

2. You must tell your *physician* that this *plan* requires pre-service review. *Physicians* who are *participating providers* will initiate the review on your behalf. A *non-participating provider* may initiate the review for you, or you may call the *claims administrator* directly. The toll-free number for pre-service review is printed on your identification card.

3. If you do not receive the certified service within 60 days of the certification, or if the nature of the service changes, a new pre-service review must be obtained.

4. The *claims administrator* will certify services that are *medically necessary* and appropriate. For inpatient *hospital* stays, the *claims administrator* will, if appropriate, certify a specific length of *stay* for approved services. You, your *physician* and the provider of the service will receive a written confirmation showing this information.

Concurrent Reviews

1. If pre-service review was not performed, you, your *physician* or the provider of the service must contact the *claims administrator* for concurrent review. For an *emergency* admission or procedure, the *claims administrator* must be notified within one working day of the admission or procedure, unless extraordinary circumstances* prevent such notification within that time period.

2. When *participating providers* have been informed of your need for utilization review, they will initiate the review on your behalf. You may ask a *non-participating provider* to call the toll free number printed on your identification card or you may call directly.

3. When it is determined that the service is *medically necessary* and appropriate, the *claims administrator* will, depending upon the type of treatment or procedure, certify the service for a period of time that is medically appropriate. The *claims administrator* will also determine the medically appropriate setting.

4. If it is determined that the service is not *medically necessary* and appropriate, your *physician* will be notified by telephone no later than 24 hours following the decision. The *claims administrator* will send written notice to you and your *physician* within two business days following the decision. However, care will not be discontinued until your *physician* has been notified and a plan of care that is appropriate for your needs has been agreed upon.

***Extraordinary Circumstances.** In determining "extraordinary circumstances," the *claims administrator* may take into account whether or not your condition was severe enough to prevent you from notifying the *claims administrator*, or whether or not a member of your family was available to notify the *claims administrator* for you. You may have to prove that such "extraordinary circumstances" were present at the time of the *emergency*.

Retrospective Reviews

1. Retrospective review is performed when the *claims administrator* is not notified of the service you received, and is therefore unable to perform the appropriate review prior to your discharge from the *hospital* or completion of outpatient treatment. It is also performed when pre-service or concurrent review has been done, but services continue longer than originally certified.

   It may also be performed for the evaluation and audit of medical documentation after services have been provided, whether or not pre-service or concurrent review was performed.

2. Such services which have been retroactively determined to not be *medically necessary* and appropriate will be retrospectively denied certification.

THE MEDICAL NECESSITY REVIEW PROCESS

The *claims administrator* will work with you and your health care providers to cover *medically necessary* and appropriate care and services. While the types of services requiring review and the timing of the reviews may vary, the *claims administrator* is committed to ensuring that reviews are performed in a timely and professional manner. The following information explains our review process.

1. A decision on the medical necessity of a pre-service request will be made no later than 5 business days from receipt of the information reasonably necessary to make the decision, and based on the nature of your medical condition.

2. A decision on the medical necessity of a concurrent request will be made no later than one business day from receipt of the information necessary to make the decision, and based on the nature of your medical condition. However, care will not be discontinued until your *physician* has been notified and a plan of care that is appropriate for your needs has been agreed upon.

3. A decision on the medical necessity of a retrospective review will be made and communicated in writing no later than 30 days from receipt of the information necessary to make the decision to you and your *physician*.

4. If the *claims administrator* does not have the information it needs, the *claims administrator* will make every attempt to obtain that information from you or your *physician*. If unsuccessful and a delay is anticipated, the *claims administrator* will notify you and your *physician* of the delay and what is needed to make a decision. The *claims administrator* will also inform you of when a decision can be expected following receipt of the needed information.

5. All pre-service, concurrent and retrospective reviews for medical necessity are screened by clinically experienced, licensed personnel (called "Review Coordinators") using pre-established criteria and the *claims administrator's* medical policy. These criteria and policies are developed and approved by practicing providers not employed by the *claims administrator*, and are evaluated at least annually and updated as standards of practice or technology changes. Requests satisfying these criteria are certified as *medically necessary*. Review Coordinators are able to approve most requests.

6. A written confirmation including the specific service determined to be *medically necessary* will be sent to you and your provider no later than 2 business days after the decision, and your provider will be initially notified by telephone within 24 hours of the decision for pre-service and concurrent review.

7. If the request fails to satisfy these criteria or medical policy, the request is referred to a Peer Clinical Reviewer. Peer Clinical Reviewers are health professionals clinically competent to evaluate the specific clinical aspects of the request and render an opinion specific to the medical condition, procedure and/or treatment under review. Peer Clinical Reviewers are licensed in California with the same license category as the requesting provider. When the Peer Clinical Reviewer is unable to certify the service, the requesting *physician* is contacted by telephone for a discussion of the case. In many cases, services can be certified after this discussion. If the Peer Clinical Reviewer is still unable to certify the service, your provider will be given the option of having the request reviewed by a different Peer Clinical Reviewer.

8. Only the Peer Clinical Reviewer may determine that the proposed services are not *medically necessary* and appropriate. Your *physician* will be notified by telephone within 24 hours of a decision not to certify and will be informed at that time of how to request reconsideration. Written notice will be sent to you and the requesting provider within 2 business days of the decision. This written notice will include:

    - an explanation of the reason for the decision,
    - reference of the criteria used in the decision to modify or not certify the request,
    - the name and phone number of the Peer Clinical Reviewer making the decision to modify or not certify the request,
    - how to request reconsideration if you or your provider disagrees with the decision.

9. Reviewers may be plan employees or an independent third party chosen at the sole and absolute discretion of the *claims administrator.*

10. You or your *physician* may request copies of specific criteria and/or medical policy by writing to the address shown on your plan identification card. The *claims administrator* discloses its medical necessity review procedures to health care providers through provider manuals and newsletters.

A determination of medical necessity does not guarantee payment or coverage. The determination that services are *medically necessary* is based on the clinical information provided. Payment is based on the terms of your coverage at the time of service. These terms include certain exclusions, limitations, and other conditions. Payment of benefits could be limited for a number of reasons, including:

- The information submitted with the claim differs from that given by phone;
- The service is excluded from coverage; or
- You are not eligible for coverage when the service is actually provided.

Revoking or modifying an authorization. An authorization for services or care may be revoked or modified prior to the services being rendered for reasons including but not limited to the following:

- Your coverage under this *plan* ends;
- The *agreement* with the *group* terminates;
- You reach a benefit maximum that applies to the services in question;
- Your benefits under the *plan* change so that the services in question are no longer covered or are covered in a different way.

PERSONAL CASE MANAGEMENT

The personal case management program enables you to obtain medically appropriate care in a more economical, cost-effective and coordinated manner during prolonged periods of intensive medical care. The *claims administrator*, through a case manager, may recommend an alternative plan of treatment which may include services not covered under this *plan*. The *claims administrator* does not have an obligation to provide personal case management. These services are provided at the sole and absolute discretion of the *claims administrator*.

HOW PERSONAL CASE MANAGEMENT WORKS

You may be identified for possible personal case management through the *plan's* utilization review procedures, by the attending *physician, hospital* staff, or the *claims administrator's* claims reports. You or your family may also call the *claims administrator*.

Benefits for personal case management will be considered only when all of the following criteria are met:

1. You require extensive long-term treatment;

2. The *claims administrator* anticipates that such treatment utilizing services or supplies covered under this *plan* will result in considerable cost;

3. A cost-benefit analysis determines that the benefits payable under this *plan* for the alternative plan of treatment can be provided at a lower overall cost than the benefits you would otherwise receive under this *plan* while maintaining the same standards of care*;* and

4. You (or your legal guardian) and your *physician* agree, in a letter of agreement, with the *claims administrator's* recommended substitution of benefits and with the specific terms and conditions under which alternative benefits are to be provided.

Alternative Treatment Plan. If the *claims administrator* determines that your needs could be met more efficiently, an alternative treatment plan may be recommended. This may include providing benefits not otherwise covered under this *plan*. A case manager will review the medical records and discuss your treatment with the attending *physician,* you, and your family.

The *claims administrator* makes treatment recommendations only; any decision regarding treatment belongs to you and your *physician*. The *plan* will, in no way, compromise your freedom to make such decisions.

EFFECT ON BENEFITS

1. Any alternative benefits are accumulated toward the Lifetime Maximum.

2. Benefits are provided for an alternative treatment plan on a case-by-case basis only. The *claims administrator* has absolute discretion in deciding whether or not to authorize services in lieu of benefits for any *beneficiary,* which alternatives may be offered and the terms of the offer.

3. Any authorization of services in lieu of benefits in a particular case in no way commits the *claims administrator* to do so in another case or for another *beneficiary*.

4. The personal case management program does not prevent the *claims administrator* from strictly applying the expressed benefits, exclusions and limitations of this *plan* at any other time or for any other *beneficiary*.

Note: The *claims administrator* reserve the right to use the services of one or more third parties in the performance of the services outlined in the letter of agreement. No other assignment of any rights or delegation of any duties by either party is valid without the prior written consent of the other party.

DISAGREEMENTS WITH MEDICAL MANAGEMENT DECISIONS

1. If you and/or your *physician* disagrees with a decision, or questions how it was reached, you or your *physician* may request reconsideration. Requests for reconsideration (either by telephone or in writing) must be directed to the reviewer making the determination. The address and the telephone number of the reviewer are included on your written notice of determination. Written requests must include medical information that supports the medical necessity of the services.

2. If you, your representative, or your *physician* acting on your behalf finds the reconsidered decision still unsatisfactory, a request for an appeal of a reconsidered decision may be submitted in writing to the *claims administrator*.

3. If the appeal decision is still unsatisfactory, your remedy is binding arbitration. (See BINDING ARBITRATION.)

QUALITY ASSURANCE

Utilization review programs are monitored, evaluated, and improved on an ongoing basis to ensure consistency of application of screening criteria and medical policy, consistency and reliability of decisions by reviewers, and compliance with policy and procedure including but not limited to timeframes for decision making, notification and written confirmation. The *claims administrator's* Board of Directors is responsible for medical necessity review processes through its oversight committees including the Strategic Planning Committee, Quality Management Committee, and Physician Relations Committee. Oversight includes approval of policies and procedures, review and approval of self-audit tools, procedures, and results. Monthly process audits measure the performance of reviewers and Peer Clinical Reviewers against approved written policies, procedures, and timeframes. Quarterly reports of audit results and, when needed, corrective action plans are reviewed and approved through the committee structure.

HOW COVERAGE BEGINS AND ENDS

HOW COVERAGE BEGINS

PARTICIPATION REQUIREMENTS

1. **Full-Time Employees**

   All eligible full-time *employees* or *employees* who receive 100% of the amount contributed towards the cost of a full-time *employee* must enroll under the *plan*.

2. **Less Than Full-Time Employees**

   Employees who work less than full-time, or who receive less than the amount contributed toward the cost of a full-time *employee*, but are eligible according to SISC III guidelines and the *participating employer* requirements may decline coverage. Except as stated under SPECIAL ENROLLMENT PERIODS, *employees* who decline coverage when first eligible or at any subsequent Open Enrollment Period may not re-enroll under the *plan* until the next Open Enrollment Period.

   Less than full-time *employees* or *employees* who receive less than the amount contributed toward the cost of a full-time *employee* who declined coverage and subsequently become full-time *employees* or begin to receive 100% of the amount contributed toward the cost of a full-time *employee* must enroll immediately. Such *employees* cannot wait until the next Open Enrollment Period to enroll. Coverage will become effective on the first day of the month following the date they become full-time *employees* or begin to receive 100% of the amount contributed toward the cost of a full-time *employee*.

3. **Non-Eligible Employees**

   Employees who do not receive contributions towards the cost of the *plan* based on a pro-rata share of the number of hours worked or *employees* who work less than half-time are not eligible to enroll under the *plan*.

ELIGIBLE STATUS

1. **Employee's**

   a. A non-temporary *employee* who works the minimum number of hours required by SISC III and the *participating employer*.

   b. A *retired employee* who retired from active employment and was covered under a *plan* sponsored by SISC III immediately prior to retirement.

2. **Dependent's**

   The following persons are eligible to enroll as *dependents*: (a) Either the *employees spouse* or *domestic partner*; and (b) An unmarried child.

Definition of Dependent

1. **Spouse** is the *employee's spouse* under a legally valid marriage between persons of the opposite sex. Spouse does not include any person who is in active service in the armed forces.

2. **Domestic partner** is the *employee's* domestic partner. Domestic partner does not include any person who is in active service in the armed forces. In order for the *employee* to include their domestic partner as a *dependent*, the *employee* and domestic partner must meet the following requirements:

   a. Both persons have a common residence.

   b. Both persons agree to be jointly responsible for each other's basic living expenses incurred during their domestic partnership.

   c. Neither person is married or a member of another domestic partnership.

d. The two persons are not related by blood in a way that would prevent them from being married to each other in California.

e. Both persons are at least 18 years of age.

f. Either of the following:

   i. Both persons are members of the same sex; or

   ii. One or both of the persons meet the eligibility criteria under Title II of the Social Security Act as defined in 42 U.S.C. Section 402(a) for old-age insurance benefits or Title XVI of the Social Security Act as defined in 42 U.S.C. Section 1381 for aged individuals. Notwithstanding any other provision of this section, persons of opposite sexes may not constitute a domestic partnership unless one or both of the persons are over the age of 62.

g. Both persons are capable of consenting to the domestic partnership.

h. Neither person has previously filed: (1) a Declaration of Domestic Partnership with the California Secretary of State, or a similar form with another governing jurisdiction, that has not been terminated pursuant to the laws of California, or of that other jurisdiction; or, if (1) does not apply, (2) an affidavit with SISC III declaring they are part of a domestic partnership that they have not been terminated by giving SISC III written notice that it has.

i. It has been at least six months since: (1) the date that the Notice of Termination of Domestic Partnership was filed with the California Secretary of State, or similar form was filed with another governing authority; or, if (1) does not apply, (2) either person has given written notice to SISC III that the domestic partnership they declared in an affidavit, given to SISC III, has terminated. This item does not apply if the previous domestic partnership ended because one of the partners died or married.

j. Both partners:

   i. If they reside in the State of California, must file a Declaration of Domestic Partnership with the California Secretary of State pursuant to Division 2.5 of the California Family Code to establish their domestic partnership. The *employee* must provide SISC III with a certified copy of the Declaration of Domestic Partnership that was filed with the California Secretary of State;

   ii. If they reside in another state or governing jurisdiction that registers domestic partnerships, they must register their domestic partnership with that state or governing jurisdiction. The *employee* must provide SISC III with a certified copy of the document that was filed with the governing jurisdiction registering their domestic partnership; or

   iii. If the *employee* and their domestic partner do not reside in a city, county or state that allows them to register as domestic partners, they must provide SISC III with a signed, notarized, affidavit certifying they meet all of the requirements set forth in 2.a through 2.i above, inclusive.

   Note: For the purposes of 2.j.i above, if the *employee* and their domestic partner registered their relationship prior to July 1, 2000, with a local governing jurisdiction in California, in lieu of supplying SISC III with a certified copy of the Declaration of Domestic Partnership (a State of California form), the *employee* may provide SISC III with a certified copy of the form filed with the local governing jurisdiction.

For the purposes of this provision, the following definitions apply:

"Have a common residence" means that both domestic partners share the same residence. It is not necessary that the legal right to possess the common residence be in both of their names. Two people have a common residence even if one or both have additional residences. Domestic partners do not cease to have a common residence if one leaves the common residence but intends to return.

"Basic living expenses" means shelter, utilities, and all other costs directly related to the maintenance of the common household of the common residence of the domestic partners. It also means any other cost, such as medical care, if some or all of the cost is paid as a benefit because a person is another person's domestic partner.

"Joint responsibility" means that each partner agrees to provide for the other partner's basic living expenses if the partner is unable to provide for herself or himself. Persons to whom these expenses are owed may enforce this responsibility if, in extending credit or providing goods or services, they relied on the existence of the domestic partnership and the agreement of both partners to be jointly responsible for those specific expenses.

3. **Child** is the *employee's*, *spouse's* or *domestic partner's* unmarried natural child, stepchild, legally adopted child, or a child for whom the *employee*, *spouse* or *domestic partner* has been appointed legal guardian by a court of law, subject to the following:

   a. The child depends on the *employee*, *spouse* or *domestic partner* for financial support or the *employee*, *spouse* or *domestic partner* is legally required to provide group health coverage for the child pursuant to an administrative or court order. A child is considered financially dependent if he or she qualifies as a dependent for federal income tax purposes.

   b. The unmarried child is under 19 years of age, or if age 19 or over, that child is eligible until his or her 25th birthday, provided: (i) he or she is enrolled as a full-time student (for 12 or more credits) in a properly accredited secondary or post-secondary educational or vocational institution (a college, university, or trade or technical school); (ii) he or she is enrolled (for 9 or more credits) in a graduate school; **OR** (iii) he or she continues to be dependent for financial support as defined by IRS rules. A child is considered financially dependent if he or she qualifies as a dependent for federal income tax purposes. SISC III must receive this information annually in writing. A break in the school calendar will not disqualify a child from coverage under this provision. An unmarried child 19 years of age, but, less than 25 years of age who enters or returns to an eligible status will become eligible for coverage on the first day of the month following the date an enrollment application is filed on their behalf.

   c. The unmarried child is 25 years of age, or more and: (i) was covered under the *prior plan*, or has six or more months of *creditable coverage*; (ii) continues to be dependent for financial support as defined by IRS rules; or (iii) is incapable of self-sustaining employment due to a physical or mental condition. A *physician* must certify in writing that the child is incapable of self-sustaining employment due to a physical or mental condition. SISC III must receive the certification, at no expense to itself, within 60-days of the date the *employee* receives the request from SISC III. SISC III may request proof of continuing dependency and that a physical or mental condition still exists, but not more often than once each year after the initial certification. This exception will last until the child is no longer chiefly dependent for financial support as defined by IRS rules. A child is considered chiefly dependent for support and maintenance if he or she qualifies as a dependent for federal income tax purposes.

   d. A child who is in the process of being adopted is considered a legally adopted child if SISC III receives legal evidence of both: (i) the intent to adopt; and (ii) that the *employee*, *spouse* or *domestic partner* have either: (a) the right to control the health care of the child; or (b) assumed a legal obligation for full or partial financial responsibility for the child in anticipation of the child's adoption.

      Legal evidence to control the health care of the child means a written document, including, but not limited to, a health facility minor release report, a medical authorization form, or relinquishment form, signed by the child's birth parent, or other appropriate authority, or in the absence of a written document, other evidence of the *employee's*, the *spouse's* or *domestic partner's* right to control the health care of the child.

   e. A Child for whom the *employee*, *spouse* or *domestic partner* is a legal guardian is considered eligible on the date of the court decree. SISC III must receive legal evidence of the decree. Such Child must be enrolled as set forth in the ENROLLMENT and EFFECTIVE DATE provisions below.

   f. The term "Child" does not include any person who is: (a) covered as an *employee*; or (b) in active service in the armed forces.

Important Note: Before a *dependent's* enrollment is processed, SISC III reserves the right to request documentation or proof of his or her eligibility (that is a marriage certificate, a birth certificate, a court decree or adoption papers). In addition, before you can enroll your domestic partner, SISC III reserves the right to request documentation or proof to support the domestic partnership (that is a Declaration of Domestic Partnership or properly executed affidavit as noted above under **Domestic Partner**).

ELIGIBILITY DATE

1. For *employees,* you become eligible for coverage on the first day of the month following the date you meet the enrollment requirement of your *participating employer* and SISC III guidelines.

2. For *dependents,* you become eligible for coverage on the later of: (a) the date the *employee* becomes eligible for coverage; or, (b) the date you meet the *dependent* definition.

ENROLLMENT

To enroll as an e*mployee,* or to enroll *dependents,* the *employee* must properly file an application with SISC III. An application is considered properly filed, only if it is personally signed, dated, and given to SISC III within 31 days from your eligibility date. If any of these steps are not followed, your coverage may be denied or you may have to wait until the next Open Enrollment Period to enroll.

EFFECTIVE DATE

Your effective date of coverage is subject to the timely payment of required monthly contributions as stated in the *participation agreement*. The date you become covered is determined as follows:

1. **Timely Enrollment:** If you enroll for coverage before, on, or within 31 days after your eligibility date, then your coverage will begin as follows: (a) for *employees,* on the first day of the month following your date of hire or the first day of your hire month if your hire date is the first working day of the month; and (b) for *dependents,* on the later of (i) the date the *employee's* coverage begins, or (ii) the first day of the month after the *dependent* becomes eligible. If you become eligible before the *plan* takes effect, coverage begins on the effective date of the *plan,* provided the enrollment application is on time and in order.

2. **Late Enrollment:** If you enroll more than 31 days after your eligibility date, you must wait until the next Open Enrollment Period to enroll.

3. **Disenrollment:** If you voluntarily choose to disenroll from coverage under this *plan*, you will be eligible to reapply for coverage as set forth in the "Enrollment" provision above, during the next Open Enrollment Period (see OPEN ENROLLMENT PERIOD).

For late enrollees and disenrollees: You may enroll earlier than the next Open Enrollment Period if you meet any of the conditions listed under SPECIAL ENROLLMENT PERIODS.

Important Note for Newborn and Newly-Adopted Children. If the *employee* (or *spouse* or *domestic partner*, if the *spouse* or *domestic partner* is enrolled) is already covered: (1) any *child* born to the *employee*, *spouse* or *domestic partner* will be covered from the moment of birth; and (2) any *child* being adopted by the *employee*, *spouse* or *domestic partner* will be covered from the date on which either: (a) the adoptive *child's* birth parent, or other appropriate legal authority, signs a written document granting the *employee*, *spouse* or *domestic partner* the right to control the health care of the *child* (in the absence of a written document, other evidence of the *employee's*, *spouse's* or *domestic partner's* right to control the health care of the *child* may be used)*;* or (b) the *employee*, *spouse* or *domestic partner* assumed a legal obligation for full or partial financial responsibility for the *child* in anticipation of the *child's* adoption. The written document referred to above includes, but is not limited to, a health facility minor release report, a medical authorization form, or relinquishment form.

In both cases, coverage will be in effect for 31 days. For coverage to continue beyond this 31-day period, the *employee* must enroll the *child* within the 31-day period by submitting a membership change form to SISC III. Any membership change form not filed within the 31-day period must be submitted to SISC III during the Open Enrollment Period generally held during September of each year for an effective date of October 1.

Special Enrollment Periods

You may enroll without waiting for the next Open Enrollment Period if you are otherwise eligible under any one of the circumstances set forth below:

1. For less than full-time *employees* or *employees* who receive less than the amount contributed toward the cost of a full-time *employee:*

    a. If you declined coverage you must file an application with SISC III to enroll within a time period ending 31 days after: (a) the date of an increase in the number of hours worked; or (b) the date of an increase in amount contributed by the *participating employer.* Coverage will become effective on the first day of the month following the date of the event.

    b. If you declined coverage because you were covered elsewhere, you must file an application with SISC III to enroll within a time period ending 31 days after the date you lose coverage. You must have signed a declination of coverage form when first eligible or during the Open Enrollment Period stating you declined coverage because you were covered elsewhere and evidence of loss of coverage must be submitted to SISC III with your application for enrollment. Coverage will become effective on the first day of the month following the date you lost coverage.

2. For all other *employees* and eligible *dependents:*

    a. You have met all of the following requirements:

        i. You were covered under another health plan as an individual or dependent, including coverage under a COBRA or CalCOBRA continuation, the Healthy Families Program, or no share-of-cost Medi-Cal coverage.

        ii. You certified in writing at the time you became eligible for coverage under this *plan* that you were declining coverage under this *plan* or disenrolling because you were covered under another health plan as stated above and you were given written notice that if you choose to enroll later, you may be required to wait until the next open enrollment period to do so.

        iii. Your coverage under the other health plan wherein you were covered as an individual or dependent ended because you lost eligibility under the other plan or employer contributions toward coverage under the other plan terminated, or your coverage under a COBRA or CalCOBRA continuation was exhausted, you lost coverage under the Healthy Families Program as a result of exceeding the program's income or age limits, or you lost no share-of-cost Medi-Cal coverage.

        iv. You properly file an application with SISC III within 31 days from the date on which you lose coverage.

    b. A court has ordered coverage be provided under your employee health plan for: (i) a *spouse*; (ii) a *domestic partner*; or (iii) a dependent *child*, but only if the *spouse*, *domestic partner* and/or dependent *child* meets the eligibility requirements of the *plan.* Application must be filed within 31 days from the date the court order is issued.

    c. You have a change in family status through either marriage or domestic partnership, or the birth, adoption, or placement for adoption of a *child*:

        i. If you are enrolling following marriage or domestic partnership, you and your new *spouse* or *domestic partner*, must enroll within 31 days of the date of marriage or domestic partnership. Your new *spouse* or *domestic partner's* children may also enroll at that time. Other children may not enroll at that time unless they qualify under another of these circumstances listed above. Coverage will be effective on the first day of the month following the date you file the enrollment application.

ii. If you are enrolling following the birth, adoption, or placement for adoption of a *child*, your *spouse* (if you are already married) or *domestic partner*, who is eligible but not enrolled, may also enroll at that time. Other children may not enroll at that time unless they qualify under another of these circumstances listed above. Application must be made within 31 days of the birth or date of adoption or placement for adoption; coverage will be effective as of the date of birth, adoption, or placement for adoption.

3. You meet or exceed a lifetime limit on all benefits under another health plan. Application must be made within 31 days of the date a claim or a portion of a claim is denied due to your meeting or exceeding the lifetime limit on all benefits under the other plan. Coverage will be effective on the first day of the month following the date you file the enrollment application.

OPEN ENROLLMENT PERIOD

There is an open enrollment period once each *year*. This period of time is generally held during the month of September. During that time, an individual who meets the eligibility requirements as an e*mployee* under this *plan* may enroll. An e*mployee* may also enroll any eligible *dependents* at that time. Persons eligible to enroll as *dependents* may enroll only under the *employee's plan*.

For anyone so enrolling, coverage under this *plan* will begin on the first day of October following the end of the Open Enrollment Period. Coverage under the former plan ends when coverage under this *plan* begins.

HOW COVERAGE ENDS

Coverage may be cancelled without notice from SISC III for any of the reasons listed below. SISC III does not provide notice of cancellation to individuals, but will notify the *participating employer*.

1. **Employee**

   a. If the *participation agreement* between the *participating employer* and SISC III terminates, the *employee's* coverage ends at the same time. Either the *participating employer* or SISC III may cancel or change the *participation agreement* without notice to *employees*.

   b. If the *participating employer* no longer provides coverage for the class of individuals to which the *employee* belongs, the *employee's* coverage ends when coverage for that class ends.

   c. If the *employee* no longer meets the eligibility requirements established by SISC III in the *participation agreement*, the *employee's* coverage ends as of the next required monthly contribution due date. This is usually the first of the month.

   d. If required monthly contributions are not paid on the *employee's* behalf, the *employee's* coverage will end on the first day of the period for which required monthly contributions are not paid.

   e. If less than full-time *employees* or *employees* who receive less than the amount contributed toward the cost of a full-time *employee* voluntarily cancel coverage, coverage ends on the first day of the month following a 30-day notice.

   f. If a *retired employee* does not elect coverage upon his or her retirement, coverage ends on the first day of the month immediately following his or her retirement date. If a *retired employee* declines district coverage, the *retired employee* may not elect coverage at a future date.

   Exception to item c.:

   If required monthly contributions are paid, coverage may continue for an *employee* who is granted a temporary leave of absence up to six months, a sabbatical year's leave of absence of up to 12 months, or an extended leave of absence due to illness certified annually by the *participating employer*.

2. **Dependents**

a. If coverage for the *employee* ends, coverage for *dependents* ends at the same time.

b. If coverage for *dependents* ceases to be available to the *employee*, *dependent's* coverage ends on that date.

c. If the *participating employer* fails to pay the required monthly contributions on behalf of a *dependent*, coverage ends on the last date for which the *participating employer* made this payment.

d. If a *dependent's* coverage is canceled, coverage ends on the first day of the month following a written notice.

e. If a *dependent* no longer meets the requirements set forth in the "Eligible Status" provision of HOW COVERAGE BEGINS, coverage ends on the first day of the month following that date.

Exceptions to item e.:

a. **Handicapped Children**: If a *child* reaches the age limits shown in the "Eligible Status" provision of this section, the *child* will continue to qualify as a *dependent* if he or she is (i) covered under this *plan,* (ii) still chiefly dependent for support and maintenance as defined by IRS rules. A *physician* must certify in writing that the *child* has a physical or mental condition that makes the child incapable of obtaining self-sustaining employment. SISC III will notify the *employee* that the *child's* coverage will end when the *child* reaches the *plan's* upper age limit at least 90-days prior to the date the *child* reaches that age. The *employee* must send SISC III proof of the *child's* physical or mental condition within 60-days of the date the *employee* receives SISC III's request. If SISC III does not complete their determination of the *child's* continuing eligibility by the date the *child* reaches the *plan's* upper age limit, the *child* will remain covered pending determination by SISC III. When a period of two years has passed, SISC III may request proof of continuing dependency due to a continuing physical or mental condition, but not more often than once each year. This exception will last until the *child* is no longer chiefly dependent for support and maintenance or a physical or mental condition no longer exists. A *child* is considered chiefly dependent for support and maintenance if he or she qualifies as a dependent for federal income tax purposes.

b. **Full time students taking a medical leave of absence from school**: If a *child* who is 19 years of age, but under 25 years of age, is enrolled as a full-time student (for 12 or more units or credits) in a properly accredited secondary or post-secondary educational or vocational institution (a college, university, or trade or technical school) or enrolled (for 9 or more credits) in a graduate school, and covered under this *plan* in accordance with the "Eligible Status" provision of this section, the *child* may remain covered under this *plan* for a period not to exceed 12 months or until the date the *child's* coverage would normally end in accordance with the terms and conditions of this *plan*, whichever comes first, during a medical leave of absence from school. The period of coverage during this medical leave of absence will begin on the first day of the leave or on the date a *physician* determines the child's illness, injury, or condition prevented the *child* from attending school, whichever comes first. Any break in the school calendar will not disqualify the *child* from maintaining coverage under this provision. A *physician* must certify in writing that the leave of absence from school is medically necessary. This certification must be submitted to SISC III at least 30 days prior to the date the leave begins if the medical reason for the leave and the leave itself are foreseeable. If the medical reason for the leave and the leave itself are not foreseeable, the certification must be submitted to SISC III within 30 days after the date the leave begins.

All conditions of eligibility shall be in accordance with the eligibility rules adopted by SISC III.

Note: If a marriage or domestic partnership terminates, the *employee* must give or send to SISC III written notice of the termination. Coverage for a former *spouse* or *domestic partner*, if any, ends according to the "Eligible Status" provisions. If SISC III suffers a loss as a result of the *employee* failing to notify them of the termination of their marriage or domestic partnership, SISC III may seek recovery from the *employee* for any actual loss resulting thereby. Failure to provide written notice to SISC III will not delay or prevent termination of the marriage or domestic partnership.

You may be entitled to continued benefits under terms which are specified elsewhere under CONTINUATION OF COVERAGE, CALCOBRA CONTINUATION OF COVERAGE, CONTINUATION FOR DISABLED DISTRICT EMPLOYEES, COVERAGE FOR SURVIVING SPOUSES OF CERTIFICATED EMPLOYEES, CONTINUATION DURING LABOR DISPUTE, EXTENSION OF BENEFITS, and HIPAA COVERAGE AND CONVERSION.

CONTINUATION OF COVERAGE

Most employers who employ 20 or more people on a typical business day are subject to The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). If the employer who provides coverage under the *plan* is subject to the federal law which governs this provision (Title X of P. L. 99-272), you may be entitled to continuation of coverage. Check with your *plan administrator* for details.

DEFINITIONS

The meanings of key terms used in this section are shown below. Whenever any of the key terms shown below appear in these provisions, the first letter of each word will appear in capital letters. When you see these capitalized words, you should refer to this “Definitions” provision.

Initial Enrollment Period is the period of time following the original Qualifying Event, as indicated in the "Terms of COBRA Continuation" provisions below.

Qualified Beneficiary means: (a) a person enrolled for this COBRA continuation coverage who, on the day before the Qualifying Event, was covered under this *plan* as either an *employee* or *dependent;* and (b) a *child* who is born to or placed for adoption with the *employee* during the COBRA continuation period. Qualified Beneficiary does not include any person who was not enrolled during the Initial Enrollment Period, including any *dependents* acquired during the COBRA continuation period, with the exception of newborns and adoptees as specified above.

Qualifying Event means any one of the following circumstances which would otherwise result in the termination of your coverage under the *plan*. The events will be referred to throughout this section by number.

1. **For Employees and Dependents:**
    a. The *employee’s* termination of employment, for any reason other than gross misconduct; or
    b. A reduction in the *employee’s* work hours.
2. **For Retired Employees and their Dependents.** Cancellation or a substantial reduction of retiree benefits under the *plan* due to SISC III or the *participating employer* filing for Chapter 11 bankruptcy, provided that:
    a. The *plan* expressly includes coverage for retirees; and
    b. Such cancellation or reduction of benefits occurs within one year before or after SISC III or the *participating employer’s* filing for bankruptcy.
3. **For Dependents:**
    a. The death of the *employee;*
    b. The *spouse’s* divorce or legal separation from the *employee;*
    c. The end of a *domestic partner’s* partnership with the *employee;*
    d. The end of a *child’s* status as a dependent *child,* as defined by the *plan;* or
    e. The *employee’s* entitlement to Medicare.

ELIGIBILITY FOR COBRA CONTINUATION

An *employee* or *dependent* may choose to continue coverage under the *plan* if your coverage would otherwise end due to a Qualifying Event.

TERMS OF COBRA CONTINUATION

Notice. The *participating employer* or its administrator (we are not the administrator) will notify either the *employee* or *dependent* of the right to continue coverage under COBRA, as provided below:

1. For Qualifying Events 1, or 2, the *participating employer* or its administrator will notify the *employee* of the right to continue coverage.

2. For Qualifying Events 3(a) or 3(e) above, a *dependent* will be notified of the COBRA continuation right.

3. You must inform the *participating employer* within 60 days of Qualifying Events 3(b), 3(c) or 3(d) above if you wish to continue coverage. The *participating employer* in turn will promptly give you official notice of the COBRA continuation right.

If you choose to continue coverage you must notify the *participating employer* within 60 days of the date you receive notice of your COBRA continuation right. The COBRA continuation coverage may be chosen for all *beneficiaries* within a family, or only for selected *beneficiaries*.

If you fail to elect the COBRA continuation during the Initial Enrollment Period, you may not elect the COBRA continuation at a later date.

Notice of continued coverage, along with the initial required monthly contribution, must be delivered to the *participating employer* within 45 days after you elect COBRA continuation coverage.

Additional Dependents. A *spouse, domestic partner* or *child* acquired during the COBRA continuation period is eligible to be enrolled as a *dependent*. The standard enrollment provisions of the *plan* apply to enrollees during the COBRA continuation period.

Cost of Coverage. The *participating employer* may require that you pay the entire cost of your COBRA continuation coverage. This cost, called the "required monthly contribution", must be remitted to the *participating employer* each month during the COBRA continuation period. SISC III must receive payment of the required monthly contribution each month from the *participating employer* in order to maintain the coverage in force.

Besides applying to the *employee,* the *employee's* rate also applies to:

1. A *spouse* whose COBRA continuation began due to divorce, separation or death of the *employee;*

2. A *domestic partner* whose COBRA continuation began due to the end of the domestic partnership or death of the *employee;*

3. A *child* if neither the *employee* nor the *spouse* has enrolled for this COBRA continuation coverage (if more than one *child* is so enrolled, the required monthly contribution will be the two-party or three-party rate depending on the number of *children* enrolled); and

4. A *child* whose COBRA continuation began due to the person no longer meeting the dependent *child* definition.

Subsequent Qualifying Events. Once covered under the COBRA continuation, it's possible for a second Qualifying Event to occur. If that happens, a *beneficiary,* who is a Qualified Beneficiary, may be entitled to an extended COBRA continuation period. This period will in no event continue beyond 36 months from the date of the first qualifying event.

For example, a *child* may have been originally eligible for this COBRA continuation due to termination of the *employee's* employment, and enrolled for this COBRA continuation as a Qualified Beneficiary. If, during the COBRA continuation period, the *child* reaches the upper age limit of the *plan,* the *child* is eligible for an extended continuation period which would end no later than 36 months from the date of the original Qualifying Event (the termination of employment).

When COBRA Continuation Coverage Begins. When COBRA continuation coverage is elected during the Initial Enrollment Period and the required monthly contribution is paid, coverage is reinstated back to the date of the original Qualifying Event, so that no break in coverage occurs.

For *dependents* properly enrolled during the COBRA continuation, coverage begins according to the enrollment provisions of the *plan*.

When the COBRA Continuation Ends. This COBRA continuation will end on the earliest of:

1. The end of 18 months from the Qualifying Event, if the Qualifying Event was termination of employment or reduction in work hours;*
2. The end of 36 months from the Qualifying Event, if the Qualifying Event was the death of the *employee,* divorce or legal separation, the end of a domestic partnership, or the end of dependent *child* status;*
3. The end of 36 months from the date the *employee* became entitled to Medicare, if the Qualifying Event was the *employee's* entitlement to Medicare. If entitlement to Medicare does not result in coverage terminating and Qualifying Event 1 occurs within 18 months after Medicare entitlement, coverage for Qualified Beneficiaries other than the *employee* will end 36 months from the date the *employee* became entitled to Medicare;
4. The date the *plan* terminates;
5. The end of the period for which required monthly contributions are last paid;
6. The date, following the election of COBRA, the *beneficiary* first becomes covered under any other group health plan, unless the other group health plan contains an exclusion or limitation relating to a pre-existing condition of the *beneficiary,* in which case this COBRA continuation will end at the end of the period for which the pre-existing condition exclusion or limitation applied; or
7. The date, following the election of COBRA, the *beneficiary* first becomes entitled to Medicare. However, entitlement to Medicare will not preclude a person from continuing coverage which the person became eligible for due to Qualifying Event 2.

*For a *beneficiary* whose COBRA continuation coverage began under a *prior plan,* this term will be dated from the time of the Qualifying Event under that *prior plan*. Additional note: If your COBRA continuation under this *plan* began on or after January 1, 2003 and ends in accordance with item 1, you may further elect to continue coverage for medical benefits only under CalCOBRA for the balance of 36 months (COBRA and CalCOBRA combined). All COBRA eligibility must be exhausted before you are eligible to further continue coverage under CalCOBRA. Please see CALCOBRA CONTINUATION OF COVERAGE in this *plan description* for more information.

Subject to the *plan* remaining in effect, a retired *employee* whose COBRA continuation coverage began due to Qualifying Event 2 may be covered for the remainder of his or her life; that person's covered *dependents* may continue coverage for 36 months after the *employee's* death. But coverage could terminate prior to such time for either the *employee* or *dependent* in accordance with items 4, 5 or 6 above.

If your COBRA continuation under this *plan* ends in accordance with items 1, 2 or 3, you may be eligible for medical conversion coverage. If your COBRA continuation under this *plan* ends in accordance with items 1, 2, 3, or 4 you may be eligible for HIPAA coverage. The *participating employer* will provide notice of these options within 180 days prior to your COBRA termination date. Please see HIPAA COVERAGE AND CONVERSION in this *plan description* for more information.

EXTENSION OF CONTINUATION DURING TOTAL DISABILITY

If at the time of termination of employment or reduction in hours, or at any time during the first 60 days of the COBRA continuation, a Qualified Beneficiary is determined to be disabled for Social Security purposes, all covered *beneficiaries* may be entitled to up to 29 months of continuation coverage after the original Qualifying Event.

Eligibility for Extension. To continue coverage for up to 29 months from the date of the original Qualifying Event, the disabled *beneficiary* must:

1. Satisfy the legal requirements for being totally and permanently disabled under the Social Security Act; and

2. Be determined and certified to be so disabled by the Social Security Administration.

Notice. The *beneficiary* must furnish the *plan administrator* with proof of the Social Security Administration's determination of disability during the first 18 months of the COBRA continuation period and no later than 60 days after the later of the following events:

1. The date of the Social Security Administration's determination of the disability;

2. The date on which the original Qualifying Event occurs;

3. The date on which the Qualified Beneficiary loses coverage; or

4. The date on which the Qualified Beneficiary is informed of the obligation to provide the disability notice.

Cost of Coverage. For the 19th through 29th months that the total disability continues, the *participating employer* must remit the cost for the extended continuation coverage to SISC III. This cost (called the "required monthly contribution") shall be subject to the following conditions:

1. If the disabled *beneficiary* continues coverage during this extension, this charge shall be **150%** of the applicable rate for the length of time the disabled *beneficiary* remains covered, depending upon the number of covered dependents. If the disabled *beneficiary* does not continue coverage during this extension, this charge shall remain at **102%** of the applicable rate.

2. The cost for extended continuation coverage must be remitted to SISC III by the *participating employer* each month during the period of extended continuation coverage. SISC III must receive timely payment of the required monthly contribution each month from the *participating employer* in order to maintain the extended continuation coverage in force.

3. The *participating employer* may require that you pay the entire cost of the extended continuation coverage.

If a second Qualifying Event occurs during this extended continuation, the total COBRA continuation may continue for up to 36 months from the date of the first Qualifying Event. The required monthly contribution shall then be **150%** of the applicable rate for the 19th through 36th months if the disabled *beneficiary* remains covered. The charge will be **102%** of the applicable rate for any periods of time the disabled *beneficiary* is not covered following the 18th month.

When The Extension Ends. This extension will end at the earlier of:

1. The end of the month following a period of 30 days after the Social Security Administration's final determination that you are no longer totally disabled;

2. The end of 29 months from the Qualifying Event*;

3. The date the *plan* terminates;

4. The end of the period for which required monthly contributions are last paid;

5. The date, following the election of COBRA, the *beneficiary* first becomes covered under any other group health plan, unless the other group health plan contains an exclusion or limitation relating to a pre-existing condition of the *beneficiary*, in which case this COBRA extension will end at the end of the period for which the pre-existing condition exclusion or limitation applied; or

6. The date, following the election of COBRA, the *beneficiary* first becomes entitled to Medicare. However, entitlement to Medicare will not preclude a person from continuing coverage which the person became eligible for due to Qualifying Event 2.

You must inform the *participating employer* within 30 days of a final determination by the Social Security Administration that you are no longer totally disabled.

*Note: If your COBRA continuation under this *plan* began on or after January 1, 2003 and ends in accordance with item 2, you may further elect to continue coverage for medical benefits only under CalCOBRA for the balance of 36 months (COBRA and CalCOBRA combined). All COBRA eligibility must be exhausted before you are eligible to further continue coverage under CalCOBRA. Please see CALCOBRA CONTINUATION OF COVERAGE in this *plan description* for more information.

CALCOBRA CONTINUATION OF COVERAGE

If your continuation coverage under federal COBRA began on or after January 1, 2003, you have the option to further continue coverage under CalCOBRA for medical benefits only if your federal COBRA ended following:

1. 18 months after the qualifying event, if the qualifying event was termination of employment or reduction in work hours; or

2. 29 months after the qualifying event, if you qualified for the extension of COBRA continuation during total disability.

All federal COBRA eligibility must be exhausted before you are eligible to further continue coverage under CalCOBRA. You are not eligible to further continue coverage under CalCOBRA if you (a) are entitled to Medicare; (b) have other coverage or become covered under another group plan, as long as you are not subject to a pre-existing condition limitation under that coverage; or (c) are eligible for or covered under federal COBRA. Coverage under CalCOBRA is available for medical benefits only.

TERMS OF CALCOBRA CONTINUATION

Notice. Within 180 days prior to the date federal COBRA ends, your *participating employer* will notify you of your right to further elect coverage under CalCOBRA. If you choose to elect CalCOBRA coverage, you must notify your *participating employer* in writing within 60 days of the date your coverage under federal COBRA ends or when you are notified of your right to continue coverage under CalCOBRA, whichever is later.

Please examine your options carefully before declining this coverage. You should be aware that companies selling individual health insurance typically require a review of your medical history that could result in higher cost or you could be denied coverage entirely.

Additional Dependents. A dependent acquired during the CalCOBRA continuation period is eligible to be enrolled as a *dependent*. The standard enrollment provisions of the *plan* apply to enrollees during the CalCOBRA continuation period.

Cost of Coverage. You will be required to pay the entire cost of your CalCOBRA continuation coverage (this is the “required monthly contribution”). This cost will be:

1. 110% of the applicable group rate if your coverage under federal COBRA ended after 18 months; or

2. 150% of the applicable group rate if your coverage under federal COBRA ended after 29 months.

You must make payment to your *participating employer* within the timeframes specified below. Your *participating employer* must receive payment of your required monthly contribution each month to maintain your coverage in force.

CalCOBRA Continuation Coverage Under the Prior Plan. If you were covered through CalCOBRA continuation under the *prior plan*, your coverage may continue under this *plan* for the balance of the continuation period. However your coverage shall terminate if you do not comply with the enrollment requirements and required monthly contribution payment requirements of this *plan* within 30 days of receiving notice that your continuation coverage under the *prior plan* will end.

When CalCOBRA Continuation Coverage Begins. When you elect CalCOBRA continuation coverage and pay the required monthly contribution, coverage is reinstated back to the date federal COBRA ended, so that no break in coverage occurs.

For *dependents* properly enrolled during the CalCOBRA continuation, coverage begins according to the enrollment provisions of the *plan*.

When the CalCOBRA Continuation Ends. This CalCOBRA continuation will end on the earliest of:

1. The date that is 36 months after the date of your qualifying event under federal COBRA*;
2. The date the *plan* terminates;
3. The end of the period for which required monthly contributions are last paid;
4. The date you become covered under any other health plan, unless the other health plan contains an exclusion or limitation relating to a pre-existing condition that you have. In this case, this continuation will end at the end of the period for which the pre-existing condition exclusion or limitation applied;
5. The date you become entitled to Medicare; or
6. The date you become covered under a federal COBRA continuation.

CalCOBRA continuation will also end if you move out of our service area or if you commit fraud.

*If your CalCOBRA continuation coverage began under a *prior plan,* this term will be dated from the time of the qualifying event under that *prior plan*.

If your CalCOBRA continuation under this *plan* ends in accordance with item 1, you may be eligible for medical conversion coverage. If your CalCOBRA continuation under this *plan* ends in accordance with items 1 or 2, you may be eligible for HIPAA coverage. You will receive notice of these options within 180 days prior to your CalCOBRA termination date. Please see HIPAA COVERAGE AND CONVERSION in this *plan description* for more information.

CONTINUATION FOR DISABLED DISTRICT EMPLOYEES

If you become disabled as a result of a violent act directed at you while performing duties in the scope of employment as a district employee, your benefits under this *plan* may be continued.

Eligibility. You must be a member of the State Teachers' Retirement System or a classified school employee member of the Public Employees' Retirement System and be covered under the *participation agreement* at the time of the violent act causing the disability.

Cost of Coverage. The *participating employer* may require that you pay the entire cost of your continuation coverage. This cost (called the "required monthly contribution") must be remitted to the *participating employer* each month during your continuation. SISC III must receive payment of the required monthly contribution each month from the *participating employer* in order to maintain the coverage in force. SISC III will accept required monthly contributions only from the *participating employer*. Payment made by you directly to SISC III will not continue coverage.

When Continuation Coverage Begins. When continuation coverage is elected and the required monthly contribution is paid, coverage is reinstated back to the date you became disabled, so that no break in coverage occurs, but only if you elect to continue coverage within sixty (60) days after your coverage terminates. For *dependents* acquired and properly enrolled during the continuation, coverage begins according to the enrollment provisions of the *participation agreement*.

When Continuation Coverage Ends. This continuation coverage ends for the *employee* on the earliest of:

1. The date the *participation agreement* terminates;
2. The end of the period for which required monthly contributions are last paid; or
3. The date the maximum benefits of this *plan* are paid.

For *dependents,* this continuation coverage ends according to the provisions of the section entitled HOW COVERAGE BEGINS AND ENDS.

COVERAGE FOR SURVIVING SPOUSES OF CERTIFICATED EMPLOYEES

If the *employee* dies while covered under this *plan* as a certificated *employee* or a certificated *retired employee,* coverage continues for an enrolled spouse until one of the following occurs:

1. The *spouse* becomes covered under another group health plan, or
2. The *spouse's* coverage ends as described under HOW COVERAGE BEGINS AND ENDS: HOW COVERAGE ENDS.

Exception: If the *employee* dies while covered under this *plan* as a classified *employee* or a classified *retired employee*, the enrolled *spouse* may be eligible to continue coverage under this benefit. Please consult your *participating employer* for details regarding their policy.

CONTINUATION DURING LABOR DISPUTE

If you are an eligible *employee* who stops working because of a labor dispute, the *participating employer* may arrange for coverage to continue as follows:

1. **Required Monthly Contributions**: Required monthly contributions are determined by SISC III as stated in the *participation agreement*. These required monthly contributions become effective on the required monthly contribution due date after work stops.
2. **Collection of Required Monthly Contributions:** The *participating employer* is responsible for collecting required monthly contributions from those *employees* who choose to continue coverage. The *participating employer* is also responsible for submitting required monthly contributions to SISC III on or before each required monthly contribution due date.
3. **Cancellation if participation falls below 75%:** SISC III must receive premium for at least **75%** of the *employees* who stop work because of the labor dispute. If at any time participation falls below **75%**, coverage may be cancelled. This cancellation is effective 10 days after written notice to the *participating employer*. The *participating employer* is responsible for notifying the *employees*.
4. **Length of coverage:** Coverage during a labor dispute may continue up to six months. After six months, coverage is cancelled automatically without notice from SISC III.

EXTENSION OF BENEFITS

If you are a *totally disabled employee* or a *totally disabled dependent* and under the treatment of a *physician* on the day your coverage under this *plan* ends, your benefits may be continued for treatment of the totally disabling condition. This extension of benefits is not available if you become covered under another group health plan that provides coverage without limitation for your disabling condition. Extension of benefits is subject to the following conditions:

1. If you are confined as an inpatient in a *hospital* or *skilled nursing facility*, you are considered totally disabled as long as the inpatient *stay* is *medically necessary*, and no written certification of the total disability is required. If you are discharged from the *hospital* or *skilled nursing facility*, you may continue your total disability benefits by submitting written certification by your *physician* of the total disability within 90 days of the date of your discharge. Thereafter, the *claims administrator* must receive proof of your continuing total disability at least once every 90 days while benefits are extended.

2. If you are not confined as an inpatient but wish to apply for total disability benefits, you must do so by submitting written certification by your *physician* of the total disability. The *claims administrator* must receive this certification within 90 days of the date coverage ends under the *participation agreement*. At least once every 90 days while benefits are extended, the *claims administrator* must receive proof that your total disability is continuing.

3. Your extension of benefits will end when any one of the following circumstances occurs:

   a. You are no longer totally disabled.

   b. The maximum benefits available to you under this *plan* are paid.

   c. You become covered under another group health plan that provides benefits without limitation for your disabling condition.

   d. A period of up to 12 months has passed since your extension began.

HIPAA COVERAGE AND CONVERSION

If your coverage for medical benefits under this *plan* ends, you may be eligible to enroll for coverage with any carrier or health plan that offers individual medical coverage. HIPAA coverage and Conversion coverage are available upon request if you meet the requirements stated below. Both HIPAA coverage and conversion are available for medical benefits only. Please note that the benefits and cost of these plans will differ from your *participating employer's plan*.

HIPAA Coverage

The Health Insurance Portability and Accountability Act (HIPAA) is a federal law that provides an option for individual coverage when coverage under the *plan* ends. To be eligible for HIPAA coverage, you must meet all of the following requirements:

1. You must have a minimum of 18 months of continuous health coverage, most recently under an employer-sponsored health plan, and have had coverage within the last 63 days.

2. Your most recent coverage was not terminated due to nonpayment of required monthly contributions or fraud.

3. If continuation of coverage under the *plan* was available under COBRA, CalCOBRA, or a similar state program including Senior COBRA, such coverage must have been elected and exhausted.

4. You must not be eligible for Medicare, Medi-Cal, or any group medical coverage and cannot have other medical coverage.

You must apply for HIPAA coverage within 63 days of the date your coverage under the *plan* ends. Any carrier or health plan that offers individual medical coverage must make HIPAA coverage available to qualified persons without regard to health status. If you decide to enroll in HIPAA coverage, you will no longer qualify for conversion coverage.

Conversion Coverage

To apply for a conversion plan, you must submit an application to us and make the first required monthly contribution within 63 days of the date your coverage under the *participating employer's plan* ends. Under certain circumstances you are not eligible for a conversion plan. They are:

1. You are not eligible if your coverage under this *plan* ends because the *participation agreement* between your *participating employer* and SISC III terminates and is replaced by another group plan within 15 days.

2. You are not eligible if your coverage under this *plan* ends because required monthly contributions are not paid when due because you (or the *employee* who enrolled you as a dependent) did not contribute your part, if any.

3. You are not eligible for a conversion plan if you are eligible for health coverage under another group plan when your coverage ends.

4. You are not eligible for a conversion plan if you are eligible for Medicare coverage when your coverage under this *plan* ends, whether or not you have actually enrolled in Medicare.

5. You are not eligible for a conversion plan if you are covered under an individual health plan.

6. You are not eligible for a conversion plan if you were not covered for medical benefits under the *plan* for three consecutive months immediately prior to the termination of your coverage.

If you decide to enroll in a conversion plan, you will no longer qualify for HIPAA coverage.

Important: The intention of conversion coverage is not to replace the coverage you have under this *plan,* but to make available to you a specified amount of coverage for medical benefits until you can find a replacement. The conversion plan provides lesser benefits than this *plan* and the provisions and rates differ.

When coverage under your *participating employer's* group *plan* ends, you will receive more information about how to apply for HIPAA coverage or conversion, including a postcard for requesting an application and a telephone number to call if you have any questions.

GENERAL PROVISIONS

Description of Coverage. This *plan description* is not a *participation agreement*. It does not change the coverage under the *participation agreement* in any way. This *plan description*, which is evidence of coverage under the *participation agreement*, is subject to all of the terms and conditions of that *participation agreement***.**

Providing of Care. SISC III is not responsible for providing any type of *hospital,* medical or similar care, nor is SISC III responsible for the quality of any such care received.

Independent Contractors. The *claims administrator's* relationship with providers is that of an independent contractor. *Physicians,* and other health care professionals, *hospitals, skilled nursing facilities* and other community agencies are not the *claims administrator's* agents nor is *claims administrator*, or any of the employees of the *claims administrator*, an employee or agent of any *hospital,* medical group or medical care provider of any type.

Non-Regulation of Providers. The benefits of this *plan* do not regulate the amounts charged by providers of medical care, except to the extent that rates for covered services are regulated with *participating providers*.

Out-of-California Providers. The Blue Cross and Blue Shield Association, of which the *claims administrator* is a member, has a program (called the "BlueCard Program") which allows our *beneficiaries* to have the reciprocal use of participating providers contracted under other states' Blue Cross and/or Blue Shield Licensees. If you are outside of California and require medical care or treatment, you may use a local Blue Cross and/or Blue Shield provider. If you use one of these providers, your out-of-pocket expenses may be lower than those incurred when using a provider that does not participate in the BlueCard Program. The rules for the BlueCard Program, including those described below, are set by The Blue Cross and Blue Shield Association. In order for you to receive access to whatever discounts may be available, the *claims administrator* must abide by those rules.

When you obtain covered health care services thru the BlueCard Program outside of California, your payment for such services, if it is not a flat dollar amount, is usually calculated on the lower of the:

- Billed charges for your covered services, or
- Negotiated price that the on-site Blue Cross and/or Blue Shield Licensee ("Host Blue") passes on to the *claims administrator*.

Often, the “negotiated price,” referred to above, will consist of a simple discount, which reflects the actual price paid by the Host Blue. But, sometimes it is an estimated price that factors in expected settlements, withholds, any other contingent payment arrangements and non-claims transactions with your health care provider or with a specified group of providers. The negotiated price may also be billed charges reduced to reflect **average** expected savings with your health care provider or with a specified group of providers. If the negotiated price reflects average expected savings, it may result in greater variation (more or less) from the actual price paid than will the estimated price. The estimated or average price may be adjusted in the future to correct for over or underestimation of past prices. Regardless of how the negotiated price is determined, the amount you pay is considered a final price.

Statutes in a small number of states may require the Host Blue to use a basis for calculating *beneficiary* liability for covered services that does not reflect the entire savings realized, or expected to be realized, on a particular claim or to add a surcharge. Should any state statutes mandate *beneficiary* liability calculation methods that differ from the usual BlueCard Program method noted above in the second paragraph of this section, or require a surcharge, the *claims administrator* would then calculate your co-payment for any covered health care services using the methods outlined by the applicable state statute in effect at the time you received your care.

Providers available to you through the BlueCard Program have not entered into contracts with Anthem Blue Cross Life and Health. If you have any questions or complaints about the BlueCard Program, please call the customer service telephone number listed on your ID card.

Terms of Coverage

1. In order for you to be entitled to benefits under the *plan,* both the *participation agreement* and your coverage under the *plan* must be in effect on the date the expense giving rise to a claim for benefits is incurred.

2. The benefits to which you may be entitled will depend on the terms of coverage in effect on the date the expense giving rise to a claim for benefits is incurred. An expense is incurred on the date you receive the service or supply for which the charge is made.

3. The *plan* is subject to amendment, modification or termination according to the provisions of the *plan* without your consent or concurrence.

Protection of Coverage. SISC III does not have the right to cancel your coverage under this *plan* while: (1) this *plan* is in effect; (2) you are eligible; (3) your required monthly contributions are paid according to the terms of the *plan*; and (4) the *participation agreement* is still in effect.

Free Choice of Provider. This *plan* in no way interferes with your right as a *beneficiary* entitled to *hospital* benefits to select a *hospital*. You 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. You may also choose any other health care professional or facility which provides care covered under this *plan,* and is properly licensed according to appropriate state and local laws. However, your choice may affect the benefits payable according to this *plan*.

Provider Reimbursement. *Physicians* and other professional providers are paid on a fee-for-service basis, according to an agreed schedule. A participating *physician* may, after notice from the *claims administrator*, be subject to a reduced negotiated rate in the event the participating *physician* fails to make routine referrals to *participating providers*, except as otherwise allowed (such as for *emergency services*). *Hospitals* and other health care facilities may be paid either a fixed fee or on a discounted fee-for-service basis.

Availability of Care. If there is an epidemic or public disaster and you cannot obtain care for covered services, SISC III refunds the unearned part of the required monthly contribution paid. A written request for that refund and satisfactory proof of the need for care must be sent to us within 31 days. This payment fulfills the obligations of SISC III under the *participation agreement*.

Medical Necessity. The benefits of this *plan* are provided only for services which the *claims administrator* determines to be *medically necessary*. The services must be ordered by the attending *physician* for the direct care and treatment of a covered condition. They must be standard medical practice where received for the condition being treated and must be legal in the United States. The process used to authorize or deny health care services under this *plan* is available to you upon request.

Expense in Excess of Benefits. SISC III is not liable for any expense you incur in excess of the benefits of this *plan*.

Benefits Not Transferable. Only the *beneficiary* is entitled to receive benefits under this *plan*. The right to benefits cannot be transferred.

Notice of Claim. You or the provider of service must send properly and fully completed claim forms to the *claims administrator* within 90 days of the date you receive the service or supply for which a claim is made. Services received and charges for the services must be itemized, and clearly and accurately described. If it is not reasonably possible to submit the claim within that time frame, an extension of up to 12 months will be allowed. SISC III is not liable for the benefits of the *plan* if you do not file claims within the required time period. Claim forms must be used; canceled checks or receipts are not acceptable.

Payment to Providers. The benefits of this *plan* will be paid directly to *contracting hospitals*, *participating providers*, and medical transportation providers. Also, *non-contracting hospitals* and other providers of service will be paid directly when you assign benefits in writing. If you are a MediCal member and you assign benefits in writing to the State Department of Health Services, the benefits of this *plan* will be paid to the State Department of Health Services. These payments will fulfill the obligation of SISC III to you for those covered services.

Right of Recovery. When the amount paid by the claims administrator exceeds the amount for which SISC III is liable under this *plan*, SISC III has the right to recover the excess amount. This amount may be recovered from you, the person to whom payment was made or any other plan.

Workers' Compensation Insurance. The *participation agreement* does not affect any requirement for coverage by workers' compensation insurance. It also does not replace that insurance.

Prepayment Fees. Your *participating employer* is responsible for paying required monthly contributions to SISC III for all coverage provided to you and your *dependents*. Your *participating employer* may require that you contribute all or part of the costs of these required monthly contributions. Please consult your *participating employer* for details.

Renewal Provisions. The *plan* is subject to renewal at certain intervals. The required monthly contribution or other terms of the *plan* may be changed from time to time.

Financial Arrangements with Providers. The *claims administrator* or an affiliate has contracts with certain health care providers and suppliers (hereafter referred to together as "Providers") for the provision of and payment for health care services rendered to its members and *beneficiaries* entitled to health care benefits under individual certificates and group policies or contracts to which *claims administrator* or an affiliate is a party, including all persons covered under the *plan*.

Under the above-referenced contracts between Providers and *claims administrator* or an affiliate, the negotiated rates paid for certain medical services provided to persons covered under the *plan* may differ from the rates paid for persons covered by other types of products or programs offered by the *claims administrator* or an affiliate for the same medical services. In negotiating the terms of the *plan*, the *plan administrator* was aware that the *claims administrator* or its affiliates offer several types of products and programs. The members, *beneficiaries* and *plan administrator* are entitled to receive the benefits of only those discounts, payments, settlements, incentives, adjustments and/or allowances specifically set forth in the *plan*.

Certificate of Creditable Coverage. Certificates of creditable coverage are issued automatically when your coverage under this *plan* ends. We will also provide a certificate of creditable coverage in response to your request, or to a request made on your behalf, at any time while you are covered under this *plan* and up to 24 months after your coverage under this *plan* ends. The certificate of creditable coverage documents your coverage under this *plan*. To request a certificate of creditable coverage, please call the customer service telephone number listed on your ID card.

Transition Assistance for New *Beneficiaries*: Transition Assistance is a process that allows for completion of covered services for new *beneficiaries* receiving services from a *non-participating provider*. If you are a new *beneficiary*, you may request Transition Assistance if any one of the following conditions applies:

1. An acute condition. An acute condition is a medical condition that involves a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention and that has a limited duration. Completion of covered services shall be provided for the duration of the acute condition.

2. A serious chronic condition. A serious chronic condition is a medical condition caused by a disease, illness, or other medical problem or medical disorder that is serious in nature and that persists without full cure or worsens over an extended period of time or requires ongoing treatment to maintain remission or prevent deterioration. Completion of covered services shall be provided for a period of time necessary to complete a course of treatment and to arrange for a safe transfer to another provider, as determined by the *claims administrator* in consultation with you and the *non-participating provider* and consistent with good professional practice. Completion of covered services shall not exceed twelve (12) months from the time you enroll in this *plan*.

3. A pregnancy. A pregnancy is the three trimesters of pregnancy and the immediate postpartum period. Completion of covered services shall be provided for the duration of the pregnancy.

4. A terminal illness. A terminal illness is an incurable or irreversible condition that has a high probability of causing death within one (1) year or less. Completion of covered services shall be provided for the duration of the terminal illness.

5. The care of a newborn *child* between birth and age thirty-six (36) months. Completion of covered services shall not exceed twelve (12) months from the time the *child* enrolls in this *plan*.

6. Performance of a surgery or other procedure that the *claims administrator* have authorized as part of a documented course of treatment and that has been recommended and documented by the provider to occur within 180 days of the time you enroll in this *plan*.

Please contact customer service at the telephone number listed on your ID card to request Transition Assistance or to obtain a copy of the written policy. Eligibility is based on your clinical condition and is not determined by diagnostic classifications. Transition Assistance does not provide coverage for services not otherwise covered under the *plan*.

The *claims administrator* will notify you by telephone, and the provider by telephone and fax, as to whether or not your request for Transition Assistance is approved. If approved, you will be financially responsible only for applicable deductibles, coinsurance, and copayments under the *plan*. Financial arrangements with *non-participating providers* are negotiated on a case-by-case basis. The *claims administrator* will request that the *non-participating provider* agree to accept reimbursement and contractual requirements that apply to *participating providers*, including payment terms. If the *non-participating provider* does not agree to accept said reimbursement and contractual requirements, the *claims administrator* is not required to continue that provider's services. If you do not meet the criteria for Transition Assistance, you are afforded due process including having a *physician* review the request.

Continuity of Care after Termination of Provider: Subject to the terms and conditions set forth below, benefits will be provided at the *participating provider* level for covered services (subject to applicable copayments, coinsurance, deductibles and other terms) received from a provider at the time the provider's contract with the *claims administrator* terminates (unless the provider's contract terminates for reasons of medical disciplinary cause or reason, fraud, or other criminal activity).

You must be under the care of the *participating provider* at the time the provider's contract terminates. The terminated provider must agree in writing to provide services to you in accordance with the terms and conditions of his or her agreement with the *claims administrator* prior to termination. The provider must also agree in writing to accept the terms and reimbursement rates under his or her agreement with the *claims administrator* prior to termination. If the provider does not agree with these contractual terms and conditions, the provider's services will not be continued beyond the contract termination date.

Benefits for the completion of covered services by a terminated provider will be provided only for the following conditions:

1. An acute condition. An acute condition is a medical condition that involves a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention and that has a limited duration. Completion of covered services shall be provided for the duration of the acute condition.

2. A serious chronic condition. A serious chronic condition is a medical condition caused by a disease, illness, or other medical problem or medical disorder that is serious in nature and that persists without full cure or worsens over an extended period of time or requires ongoing treatment to maintain remission or prevent deterioration. Completion of covered services shall be provided for a period of time necessary to complete a course of treatment and to arrange for a safe transfer to another provider, as determined by the *claims administrator* in consultation with you and the terminated provider and consistent with good professional practice. Completion of covered services shall not exceed twelve (12) months from the date the provider's contract terminates.

3. A pregnancy. A pregnancy is the three trimesters of pregnancy and the immediate postpartum period. Completion of covered services shall be provided for the duration of the pregnancy.

4. A terminal illness. A terminal illness is an incurable or irreversible condition that has a high probability of causing death within one (1) year or less. Completion of covered services shall be provided for the duration of the terminal illness.

5. The care of a newborn *child* between birth and age thirty-six (36) months. Completion of covered services shall not exceed twelve (12) months from the date the provider's contract terminates.

6. Performance of a surgery or other procedure that the *claims administrator* has authorized as part of a documented course of treatment and that has been recommended and documented by the provider to occur within 180 days of the date the provider's contract terminates.

Such benefits will not apply to providers who have been terminated due to medical disciplinary cause or reason, fraud, or other criminal activity.

Please contact customer service at the telephone number listed on your ID card to request continuity of care or to obtain a copy of the written policy. Eligibility is based on your clinical condition and is not determined by diagnostic classifications. Continuity of care does not provide coverage for services not otherwise covered under the *plan*.

You will be notified by telephone, and the provider by telephone and fax, as to whether or not your request for continuity of care is approved. If approved, you will be financially responsible only for applicable deductibles, coinsurance, and copayments under the *plan*. Financial arrangements with terminated providers are negotiated on a case-by-case basis. The terminated provider will be asked to agree to accept reimbursement and contractual requirements that apply to *participating providers*, including payment terms. If the terminated provider does not agree to accept the same reimbursement and contractual requirements, that provider's services will not be continued. If you disagree with the determination regarding continuity of care, you may file an appeal as described in the CLAIMS REVIEW section.

CLAIMS REVIEW

This *plan* provides that treatment or services must be *medically necessary* and appropriate and satisfy all other terms and provisions of this *plan* in order to be eligible for coverage under this *plan*. The fact that an *employee's physician* may prescribe, order, recommend or approve a service or treatment does not, of itself, make it *medically necessary* and appropriate or make the service or treatment a covered expense, even though it is not specifically listed as an exclusion.

The *claims administrator* has responsibility for determining whether services are *medically necessary* and appropriate. That determination will be made during claims review, unless reviews for medical necessity already were conducted for those services that are subject to the UTILIZATION REVIEW PROGRAM.

When the claim is submitted for benefit payment, it is reviewed against guidelines established by the *claims administrator* for medical necessity, beginning with a preliminary screening against general guidelines designed to identify *medically necessary* and appropriate services. If there is a question as to the medical necessity of the services, the claim will be further reviewed against more detailed guidelines. If the medical necessity still cannot be clearly determined, the claim will be reviewed by a physician advisor for a final determination.

Action on a *beneficiary's* claim, including denial and reasons for denial, will be provided by the *claims administrator* to the *beneficiary* in writing.

Reconsiderations

If the *beneficiary* or the *beneficiary's physician* disagrees with an initial claims review determination, or questions how it was reached, reconsideration may be requested. The request may be made by the *beneficiary*, the *beneficiary's physician* or someone chosen to represent the *beneficiary*.

Appeals

If the reconsidered decision is not satisfactory, a request for an appeal of the reconsidered decision may be submitted in writing to the *claims administrator*. The request may be made by the *beneficiary*, the *beneficiary's physician* or someone chosen to represent the *beneficiary*.

In the event that the appeal decision still is unsatisfactory, the remedy is binding arbitration, which is explained below.

Requests for Reconsideration or Appeals

Requests for reconsiderations of claim denials, or appeals of reconsidered determinations, must be made of SISC III through the *claims administrator*. **Requests must be made as follows:**

1. in writing, and
2. within 60 days of receiving the original denial when the request is for reconsideration, or
3. within 30 days of receiving the reconsidered determination when the request is for an appeal.

Requests must include the following:

1. any medical information that supports the medical necessity of the services for which payment was denied, and any other information the *beneficiary* or the *beneficiary's physician* feels should be considered, and
2. a copy of the original denial.

The *claims administrator* must respond to the request for reconsideration or appeal within 60 days of receiving the request, **except** when the *claims administrator* indicates before the 60th day that additional time is required to review the request. In that event, the *claims administrator* is permitted a total of 120 days in which to respond to the request.

BINDING ARBITRATION

Any dispute or claim, of whatever nature, arising out of, in connection with, or in relation to this *plan* or breach or rescission thereof, or in relation to care or delivery of care, including any claim based on contract, tort, or statute, must be resolved by arbitration if the amount sought exceeds the jurisdictional limit of the small claims court. Any dispute or claim within the jurisdictional limits of the small claims court will be resolved in such court.

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

The *beneficiary* and the *plan administrator* agree to be bound by this Binding Arbitration provision and acknowledge that they are each giving up their right to a trial by court or jury.

The *beneficiary* and the *plan administrator* agree to give up the right to participate in class arbitration against each other. Even if applicable law permits class arbitration, the *beneficiary* waives any right to pursue, on a class basis, any such controversy or claim against the *plan administrator* and the *plan administrator* waives any right to pursue on a class basis any such controversy or claim against the *beneficiary*.

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

The arbitration is begun by the *beneficiary* making written demand on the *plan administrator*. Any demand for arbitration must be made within one (1) year from the issuance by the *claims administrator* of its decision following appeal. In cases where the amount in controversy is within the jurisdiction of small claims court, suit must be filed within one (1) year from the issuance by the *claims administrator* of its decision following appeal. Failure to demand arbitration or file in small claims court within one (1) year of the issuance by the *claims administrator* of its decision following appeal shall result in the forfeiture of any right to arbitration or to take any other legal action. Any written demand should be sent to the *plan administrator* at the address shown below:

SISC III
P.O. Box 1847
Bakersfield, CA 93303-1847

The arbitration will be conducted by Judicial Arbitration and Mediation Services ("JAMS") according to its applicable Rules and Procedures. If, for any reason, JAMS is unavailable to conduct the arbitration, the arbitration will be conducted by another neutral arbitration entity, by mutual agreement of the *beneficiary* and the *plan administrator*, or by order of the court, if the *beneficiary* and the *plan administrator* cannot agree. The arbitration will be held at a time and location mutually agreeable to the beneficiary and the *plan administrator*.

DEFINITIONS

The meanings of key terms used in this *plan description* are shown below. Whenever any of the key terms shown below appear, it will appear in italicized letters. When any of the terms below are italicized in this *plan description*, you should refer to this section.

Accidental injury is physical harm or disability which is the result of a specific unexpected incident caused by an outside force. The physical harm or disability must have occurred at an identifiable time and place. Accidental injury does not include illness or infection, except infection of a cut or wound.

Agreement Date. The Agreement Date is the date the Participation Agreement between SISC III and the Participating Employer comes into effect.

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

Authorized referral occurs when you, because of your medical needs, are referred to a *non-participating provider,* but only when:

1. There is no *participating provider* who practices in the appropriate specialty, which provides the required services, or which has the necessary facilities within a 50-mile radius of your residence.

2. You are referred in writing to the *non-participating provider* by the *physician* who is a *participating provider,* and

3. The referral has been authorized by the *claims administrator* before services are rendered.

Benefits for *medically necessary* and appropriate *authorized referral* services received from a *non-participating provider* will be payable as shown in the SCHEDULES FOR NON-PARTICIPATING PROVIDERS: NON-PARTICIPATING PROVIDER EXCEPTIONS.

In order for your service with a *non-participating provider* or facility to be considered for an out of network referral, you or your *physician* must call the toll-free telephone number printed on your identification card prior to receiving service.

Beneficiary is the *employee* or *dependent*.

Child meets the *plan's* eligibility requirements for children as outlined under HOW COVERAGE BEGINS AND ENDS.

Claims administrator refers to Anthem Blue Cross Life and Health Insurance Company. On behalf of Anthem Blue Cross Life and Health Insurance Company, Anthem Blue Cross shall perform all administrative services in connection with the processing of claims under the *plan*. The *claims administrator* is in no event the administrator for coverage as stated under CONTINUATION OF COVERAGE**,** nor is Anthem Blue Cross Life and Health Insurance Company the *plan* fiduciary or financially responsible for benefits. SISC III assumes full liability for payment of benefits described in the *plan* and thereby acts as *plan* fiduciary, and benefits are payable solely from the assets of SISC III.

Confinement period is one continuous *stay* or successive *stays* that are separated by fewer than 28 consecutive days during which the *beneficiary* is not confined as an inpatient in a *hospital*, *skilled nursing facility* or any other place of residence for ill or disabled persons, other than the *beneficiary's* home.

Contracting hospital is a *hospital* which has a Standard Hospital Contract in effect with the *claims administrator* to provide care to *beneficiaries*. A contracting hospital is not necessarily a *participating provider*. A list of contracting hospitals will be sent on request.

Covered expense is the expense you incur for a covered service or supply, but not more than the maximum amounts described in YOUR MEDICAL BENEFITS: HOW COVERED EXPENSE IS DETERMINED. Expense is incurred on the date you receive the service or supply.

Creditable coverage is any individual or group plan that provides medical, hospital and surgical coverage, including continuation or conversion coverage, coverage under Medicare or Medicaid, TRICARE, the Federal Employees Health Benefits Program, programs of the Indian Health Service or of a tribal organization, a state health benefits risk pool, coverage through the Peace Corps, the State Children's Health Insurance Program, or a public health plan established or maintained by a state, the United States government, or a foreign country. Creditable coverage does not include accident only, credit, coverage for on-site medical clinics, disability income, coverage only for a specified disease or condition, hospital indemnity or other fixed indemnity insurance, Medicare supplement, long-term care insurance, dental, vision, workers' compensation insurance, automobile insurance, no-fault insurance, or any medical coverage designed to supplement other private or governmental plans. Creditable coverage is used to set up eligibility rules for children who cannot get a self-sustaining job due to a physical or mental condition.

If your prior coverage was through an employer, you will receive credit for that coverage if it ended because your employment ended, the availability of medical coverage offered through employment or sponsored by the employer terminated, or the employer's contribution toward medical coverage terminated, and any lapse between the date that coverage ended and the date you become eligible under this *plan* is no more than 180 days.

If your prior coverage was not through an employer, you will receive credit for that coverage if any lapse between the date that coverage ended and the date you become eligible under this *plan* is no more than 63 days.

Custodial care is care provided primarily to meet your personal needs. This includes help in walking, bathing or dressing. It also includes preparing food or special diets, feeding, administration of medicine which is usually self-administered or any other care which does not require continuing services of medical personnel.

Customary and reasonable charge, as determined annually by the *claims administrator*, is a charge which falls within the common range of fees billed by a majority of *physicians* for a procedure in a given geographic region. If it exceeds that range, the expense must be justified based on the complexity or severity of treatment for a specific case.

Dependent meets the *plan's* eligibility requirements for dependents as outlined under HOW COVERAGE BEGINS AND ENDS.

Domestic partner meets the *plan's* eligibility requirements for domestic partners as outlined under HOW COVERAGE BEGINS AND ENDS: HOW COVERAGE BEGINS.

Effective date is the date your coverage begins under this *plan*.

Emergency is a sudden, serious, and unexpected acute illness, injury, or condition (including without limitation sudden and unexpected severe pain) which the *beneficiary* reasonably perceives could permanently endanger health if medical treatment is not received immediately. Final determination as to whether services were rendered in connection with an emergency will rest solely with the *claims administrator*.

Emergency services are services provided in connection with the initial treatment of a medical *emergency*.

Employee (Retired employee) is the person who, by meeting the *plan's* eligibility requirements for employees, is allowed to choose membership under this *plan* for himself or herself and his or her eligible *dependents*. Such requirements are outlined in HOW COVERAGE BEGINS AND ENDS.

Experimental procedures are those that are mainly limited to laboratory and/or animal research.

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

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

Hospice is an agency or organization primarily engaged in providing palliative care (pain control and symptom relief) to terminally ill persons and supportive care to those persons and their families to help them cope with terminal illness. This care may be provided in the home or on an inpatient basis. A hospice must be: (1) certified by Medicare as a hospice; (2) recognized by Medicare as a hospice demonstration site; or (3) accredited as a hospice by the Joint Commission on Accreditation of Hospitals. A list of hospices meeting these criteria is available upon request.

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

Infertility is: (1) the presence of a condition recognized by a *physician* as a cause of infertility; or (2) the inability to conceive a pregnancy or to carry a pregnancy to a live birth after a year or more of regular sexual relations without contraception.

Investigative procedures or medications are those that have progressed to limited use on humans, but which are not widely accepted as proven and effective within the organized medical community.

Medically necessary procedures, supplies equipment or services are those the *claims administrator* determines to be:

1. Appropriate and necessary for the diagnosis or treatment of the medical condition;
2. Provided for the diagnosis or direct care and treatment of the medical condition;
3. Within standards of good medical practice within the organized medical community;
4. Not primarily for your convenience, or for the convenience of your *physician* or another provider; and
5. The most appropriate procedure, supply, equipment or service which can safely be provided. The most appropriate procedure, supply, equipment or service must satisfy the following requirements:
    a. There must be valid scientific evidence demonstrating that the expected health benefits from the procedure, supply, equipment or service are clinically significant and produce a greater likelihood of benefit, without a disproportionately greater risk of harm or complications, for you with the particular medical condition being treated than other possible alternatives; and
    b. Generally accepted forms of treatment that are less invasive have been tried and found to be ineffective or are otherwise unsuitable; and
    c. For *hospital stays*, acute care as an inpatient is necessary due to the kind of services you are receiving or the severity of your condition, and safe and adequate care cannot be received by you as an outpatient or in a less intensified medical setting.

Mental or nervous disorders, for the purposes of this *plan*, are conditions that affect thinking and the ability to figure things out, perception, mood and behavior. A mental or nervous disorder is recognized primarily by symptoms or signs that appear as distortions of normal thinking, distortions of the way things are perceived (*e.g.*, seeing or hearing things that are not there), moodiness, sudden and/or extreme changes in mood, depression, and/or unusual behavior such as depressed behavior or highly agitated or manic behavior.

Any condition meeting this definition is a mental or nervous disorder no matter what the cause of the condition may be.

Negotiated rate is the amount *participating providers* agree to accept as payment in full for covered services. It is usually lower than their normal charge. Negotiated rates are determined by Prudent Buyer Plan Participating Provider Agreements. Note: If Medicare is the primary payor, the negotiated rate may be determined by Medicare's approved amount (see HOW COVERED EXPENSE IS DETERMINED).

Non-contracting hospital is a *hospital* which does not have a Standard Hospital Contract in effect with the *claims administrator* at the time services are rendered.

Non-participating provider is one of the following providers which does NOT have a Prudent Buyer Plan Participating Provider Agreement in effect with the *claims administrator* at the time services are rendered:

1. A *hospital;*
2. A *physician;*
3. An *ambulatory surgical center;*
4. A *home health agency;*
5. A facility which provides diagnostic imaging services;
6. A durable medical equipment outlet;
7. A *skilled nursing facility*;
8. A clinical laboratory; or
9. A *home infusion therapy provider*.

They are not *participating providers*. Remember that only a portion of the amount which a *non-participating provider* charges for services may be treated as *covered expense* under this *plan*. See YOUR MEDICAL BENEFITS: HOW COVERED EXPENSE IS DETERMINED.

Other health care provider is one of the following providers:

1. A certified registered nurse anesthetist;
2. A blood bank;
3. A licensed ambulance company; or
4. A *hospice*.

The provider must be licensed according to state and local laws to provide covered medical services.

Participating Employer is an employer that has a *participation agreement* in effect with SISC as of the *employees* effective date.

Participation Agreement is the agreement between Self-Insured Schools of California and the *participating employer* providing for the participation of specified employees in this *plan*.

Participating provider is one of the following providers which has a Prudent Buyer Plan Participating Provider Agreement in effect with the *claims administrator* at the time services are rendered:

1. A *hospital;*
2. A *physician;*
3. An *ambulatory surgical center;*
4. A *home health agency;*
5. A facility which provides diagnostic imaging services;
6. A durable medical equipment outlet;
7. A *skilled nursing facility*;
8 A clinical laboratory; or
9 A *home infusion therapy provider*.

Participating providers agree to accept the *negotiated rate* as payment for covered services. A directory of *participating providers* is available upon request.

Physician means:

1. A doctor of medicine (M.D.) or doctor of osteopathy (D.O.) who is licensed to practice medicine or osteopathy where the care is provided; or
2. 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, is providing a service for which benefits are specified in this *plan description*, and when benefits would be payable if the services were provided by a physician as defined above:
    a. A dentist (D.D.S. or D.M.D.)
    b. An optometrist (O.D.)
    c. A dispensing optician
    d. A podiatrist or chiropodist (D.P.M., D.S.P. or D.S.C.)
    e. A licensed clinical psychologist
    f. A chiropractor (D.C.)
    g. An acupuncturist (but only for acupuncture and for no other services) (A.C.)
    h. A clinical social worker (L.C.S.W.)
    i. A marriage and family therapist (M.F.T.)
    j. A physical therapist (P.T. or R.P.T.)*
    k. A speech pathologist*
    l. An audiologist*

m. An occupational therapist (O.T.R.)*
n. A respiratory care practitioner (R.C.P.)*
o. A nurse midwife**
p. A registered dietitian (R.D.)* for the provision of diabetic medical nutrition therapy only

***Note:** The providers indicated by asterisks (*) are covered only by referral of a physician as defined in 1 above.

**If there is no nurse midwife who is a *participating provider* in your area, you may call the Customer Service telephone number on your ID card for a referral to an OB/GYN.

Plan is the set of benefits described in this *plan description* or as amended hereafter and adopted by the *participating employer* through its *participation agreement* with Self-Insured Schools of California. These benefits are subject to the terms and conditions of the *plan.* If changes are made to the plan, an amendment or revised *plan description* will be issued to each *participating employer* affected by the change.

Plan administrator refers to Self-Insured Schools of California (SISC III), the entity which is responsible for the administration of the *plan.*

Plan description is this written description of the benefits provided under the *plan*.

Prior plan is a plan sponsored by SISC III which was replaced by this *plan* within 60 days. You are considered covered under the prior plan if you: (1) were covered under the prior plan on the date that plan terminated; (2) properly enrolled for coverage within 31 days of this *plan's* Effective Date; and (3) had coverage terminate solely due to the prior plan's termination.

Prosthetic devices are appliances which replace all or part of a function of a permanently inoperative, absent or malfunctioning body part. The term "prosthetic devices" includes orthotic devices, rigid or semi-supportive devices which restrict or eliminate motion of a weak or diseased part of the body.

Reasonable charge is a charge the *claims administrator* considers not to be excessive based on the circumstances of the care provided, including: (1) level of skill; experience involved; (2) the prevailing or common cost of similar services or supplies; and (3) any other factors which determine value.

Scheduled amount is determined according to the SCHEDULES FOR NON-PARTICIPATING PROVIDERS. Any amount by which a *non-participating provider's* charge exceeds this schedule will not be considered *covered expense*. **You are responsible for paying any such excess amount.**

Service area is the area in which the provider's principal place of business is located. The counties encompassed by each service area are listed in the SCHEDULES FOR NON-PARTICIPATING PROVIDERS.

SISC is Self-Insured Schools of California joint powers authority.

SISC III means the medical benefit plans developed by SISC.

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

Special care units are special areas of a *hospital* which have highly skilled personnel and special equipment for acute conditions that require constant treatment and observation.

Specialty drugs are generally high-cost, injectable, infused, oral or inhaled medications that usually require close supervision and monitoring of their effect(s) on the patient by a medical professional. These drugs often require special handling, such as temperature controlled packaging and overnight delivery, and are often unavailable at retail pharmacies.

Spouse meets the *plan's* eligibility requirements for spouses as outlined under HOW COVERAGE BEGINS AND ENDS.

Stay is inpatient confinement which begins when you are admitted to a facility and ends when you are discharged from that facility.

Telemedicine is the diagnosis, consultation, treatment, transfer of medical data and medical education through the use of advanced electronic communication technologies such as interactive audio, video or other electronic media that facilitates access to health care services or medical specialty expertise. Standard telephone, facsimile or electronic mail transmissions, or any combination therein, in the absence of other integrated information or data adequate for rendering a diagnosis or treatment, do not constitute telemedicine services.

Totally disabled dependent is a *dependent* who is unable to perform all activities usual for persons of that age.

Totally disabled employee is an e*mployee* who, because of illness or injury, is unable to work for income in any job for which he/she is qualified or for which he/she becomes qualified by training or experience, and who is in fact unemployed.

Urgent care is the services received for a sudden, serious, or unexpected illness, injury or condition, other than one which is life threatening, which requires immediate care for the relief of severe pain or diagnosis and treatment of such condition.

We (us, our) refers to Self-Insured Schools of California.

Year or **calendar year** is a 12 month period starting January 1 at 12:01 a.m. Pacific Standard Time.

You (your) refers to the *employee* and *dependents* who are enrolled for benefits under this *plan*.

SCHEDULES FOR NON-PARTICIPATING PROVIDERS

This section explains how the *claims administrator* determines the *scheduled amount* (the maximum amount considered *covered expense* for *non-participating providers*) and is subject to the maximums, conditions, exclusions and limitations of this *plan*.

SERVICE AREAS

A provider's *service area* is determined by the area in which the provider's principal place of business is located.

- **Service Area 1:** Counties of Alpine, Amador, Butte, Calaveras, Colusa, Del Norte, El Dorado, Glenn, Humboldt, Inyo, Kings, Lake, Lassen, Madera, Mariposa, Mendocino, Merced, Modoc, Mono, Nevada, Placer, Plumas, Sacramento, San Benito, Shasta, Sierra, Siskiyou, Solano, Sutter, Tehama, Trinity, Tulare, Tuolumne, Yolo and Yuba.
- **Service Area 2:** Counties of Alameda, Contra Costa, Monterey, Napa and Santa Cruz.
- **Service Area 3:** Counties of Marin, San Francisco, San Mateo and Santa Clara.
- **Service Area 4:** Counties of Los Angeles and Riverside (City of Palm Springs only).
- **Service Area 5:** Orange County.
- **Service Area 6:** Counties of Kern, Riverside (except City of Palm Springs), San Bernardino, San Luis Obispo, Santa Barbara and Ventura.
- **Service Area 7:** San Diego County.
- **Service Area 8:** Counties of Fresno, San Joaquin, Sonoma and Stanislaus.
- **Service Area 9:** Imperial County.
- **Service Area 10:** Outside California.

Important Note: The *claims administrator* has the right to adjust, without notice, all schedules found in this section in order to maintain the relationship between these *scheduled amounts* for *non-participating providers* and the fee schedule negotiated by the *claims administrator* with *participating providers*. Benefits are determined based on the schedule in effect at the time services are rendered.

CHARGES BY A PHYSICIAN WHO IS A NON-PARTICIPATING PROVIDER

1. Charges for services of a *physician* who is a *non-participating provider* are determined by multiplying the "Unit Value" of the service (listed in the Unit Value Schedule) by the appropriate "Unit Allowance" listed in the Unit Allowance Schedule. The "Unit Allowance" varies according to the *service area* of the provider.
2. For any procedure not listed in the Unit Value Schedule, the *claims administrator* will provide a benefit on the basis of comparable service.
3. The Unit Value Schedule listed in this *plan description* is only a partial listing.

For services provided by a *physician* who is a *non-participating provider, covered expense* will not exceed the amount determined by the following process. First, the *claims administrator* determines the appropriate "Unit Allowance" for the service by determining in which *service area* the *physician* performed the service. Then, the *claims administrator* multiplies the "Unit Value" of that service by the appropriate "Unit Allowance". The resulting amount is the maximum amount of *covered expense* the *claims administrator* will pay for that service under the *plan*.

The *claims administrator* has developed a Unit Value Schedule for covered services. An excerpt of this Schedule is set forth in this section. Notice that for each service listed in the Schedule, there is a "Procedure Code" and a "Unit Value". *Physicians* use these Procedure Codes to identify their services for billing purposes. These codes are published by the American Medical Association and are widely used throughout the medical profession.

Your *physician* should be able to identify for you which "Procedure Code(s)" applies to the service(s) to be performed. Remember, the maximum allowable *covered expense* may be less than the *physician's* charge for such services. You are responsible for paying any amount by which this charge exceeds the maximum allowable *covered expense,* in addition to any Deductible and Co-Payment required under this *plan*.

If you want assistance in determining the maximum allowable *covered expense* for services provided by a *physician* who is a *non-participating provider,* you may telephone the *claims administrator* at the number shown on your identification card and request a Disclosure of Allowable Reimbursement. The *non-participating provider* will need to provide the information necessary to complete the request.

Remember, if you obtain your health care services from a *participating provider,* you will be able to determine the amount of your financial responsibility more simply. *Participating providers* have agreed not to charge any more for their services than the *negotiated rate,* leaving you only the amount of your Calendar Year Deductible and Co-Payment described in the SUMMARY OF BENEFITS.

UNIT ALLOWANCE SCHEDULE

Service Area	Surgery	Anesthesia	Medicine	Radiology	Pathology
1	$110.00	$25.00	$4.80	$9.50	$1.05
2	110.00	25.00	4.80	9.50	1.05
3	120.00	26.00	5.10	10.50	1.15
4	120.00	26.00	5.10	10.50	1.15
5	120.00	26.00	5.10	10.50	1.15
6	110.00	25.00	4.80	9.50	1.05
7	110.00	25.00	4.80	9.50	1.05
8	110.00	25.00	4.80	9.50	1.05
9	110.00	25.00	4.80	9.50	1.05
10	120.00	26.00	5.10	10.50	1.15

UNIT VALUE SCHEDULE
(Partial Listing)

PROCEDURAL CODE	SURGICAL PROCEDURE (for each single procedure)	UNIT VALUE
Skin		
10060	Incision and drainage of abscess	0.58
11100	Biopsy of skin, including closure	0.50
11770	Excision of pilonidal cyst or sinus	1.43
Breast		
19120	Excision of breast tumor, unilateral	3.37
19305	Radical mastectomy, including pectoral muscles and axillary nodes	9.43

UNIT VALUE SCHEDULE - Continued
(Partial Listing)

PROCEDURAL CODE	SURGICAL PROCEDURE (for each single procedure)	UNIT VALUE
Fractures		
21315	Nasal, simple, closed reduction	1.97
25565	Closed radial and ulnar shafts, manipulative reduction	4.18
27232	Femur and neck, manipulative reduction, including traction	6.48
Heart		
33400	Aortic valvuloplasty, with bypass	17.38
33420	Valvotomy, mitral valve, closed	10.51
Throat		
42650	Dilation, salivary duct	0.45
42820	Tonsillectomy and adenoidectomy, under 12 years	2.23
Digestive		
43620	Total gastrectomy	15.58
44950	Appendectomy	4.72
47600	Cholecystectomy	7.49
Rectum		
46200	Fissurectomy	2.04
46250	Hemorrhoidectomy,external complete	2.15
Male		
55801	Prostatectomy, perineal (sub-total)	7.08
Female		
58180	Supracervical (sub-total) hysterectomy with or without tubes or ovaries	7.54
Maternity		
59510	Cesarean section, including antepartum and postpartum care	11.98
Thyroid		
60200	Local excision of cyst of thyroid	5.95
60240	Thyroidectomy, total or complete	9.00
Ear		
69420	Myringotomy	1.12
69501	Transmastoid antrotomy	4.53

SURGERY (two or more surgical procedures). When two or more surgical procedures are performed during the same operative session, the following Unit Values apply unless otherwise stated in this Schedule:

Major procedure.....**100%** of the Unit Value
Second procedure.....**50%** of the Unit Value
Third procedure.....**25%** of the Unit Value
Fourth procedure.....**25%** of the Unit Value
Fifth procedure.....**25%** of the Unit Value

SURGERY (assistant surgeon). The Unit Value for the services of an assistant surgeon is **20%** of the unit value for the primary surgeon.

ANESTHESIA (anesthesiologist or anesthetist). The total Unit Value for the services of an anesthesiologist or anesthetist is the basic anesthesia value for that procedure and a Unit Value for the actual time spent administering anesthesia.

PROCEDURAL CODE	BASIC ANESTHESIA	UNIT VALUE
01400	Knee Joint	4.2
01462	Lower leg, ankle, or foot	3.4
00566	Direct coronary artery bypass grafting without pump oxygenator	21.0
00740	Upper gastrointestinal endoscopic	54.0
00940	Vaginal	3.4
01961	Cesarean delivery	6.6

UNIT VALUE SCHEDULE

MEDICINE		UNIT VALUE
99205	Office Visit -- initial comprehensive exam	19.44
99212	Office Visit -- problem-focused examination evaluation, and/or treatment	4.61
99231	Hospital Visit -- problem-focused examination, evaluation, and/or treatment, same illness	5.24
99241	Consultation -- problem-focused examination and/or evaluation	6.89
RADIOLOGY		
Diagnostic		
70210	Sinuses and paranasal, limited	2.42
70250	Skull, limited	2.76
74241	Upper gastrointestinal tract	7.50
74415	Nephrotomography	8.70
Therapeutic		
77261	Therapeutic radiology treatment planning, simple	5.49
Nuclear Medicine		
78000	Thyroid uptake	4.10
79005	Radiopharmaceutical therapy, oral administration	13.57
PATHOLOGY		
81000	Urinalysis, routine, complete	4.33
87081	Microbiology - culture, bacterial screening	9.05

CHARGES BY A HOSPITAL WHICH IS A NON-PARTICIPATING PROVIDER

1. The maximum charge considered *covered expense* for outpatient care provided by a *hospital* which is a *non-participating provider* is a *reasonable charge*.

2. The maximum charge considered *covered expense* for inpatient care provided by a *hospital* which is a *non-participating provider* is **$600** per day.

CHARGES BY OTHER SPECIFIC PROVIDERS WHICH ARE NON-PARTICIPATING PROVIDERS

The maximum charge considered *covered expense* for services and supplies provided by the following providers which are *non-participating providers* is the lesser of the billed charge or the *reasonable charge:*

1. A *home health agency*;

2. A facility which provides diagnostic imaging services;

3. A *home infusion therapy provider*;

4. A *skilled nursing facility*;

5. A hearing aid equipment provider;

6. A dentist providing covered Jaw Joint Disorders (TMJ) treatment; or

7. A *ambulatory surgical center*.*

   *The *plan* will pay up to **$350** each time you have outpatient surgery.

NON-PARTICIPATING PROVIDER EXCEPTIONS

Subject to all other provisions of the *plan*, the *plan* will pay a greater amount of *covered expense* for the following:

- *Emergency services* provided by other than a *hospital*;
- The first 48 hours of *emergency services* provided by a *hospital* (this exception will continue beyond the first 48 hours if, in our judgment, you cannot be safely moved);
- A *authorized referral* from a *physician* who is a *participating provider* to a *non-participating provider* that is authorized by the *claims administrator*; or*
- Charges of a *physician* who has a specialty which is not represented in the Prudent Buyer Plan network (for example, an audiologist).

*A referral from a *physician* who is a *participating provider* to a *non-participating provider* must be authorized by the *claims administrator* before services are rendered. In order to initiate this process, you or your *physician* must call the toll-free telephone number printed on your identification card prior to scheduling an admission to, or receiving the services of a *non-participating provider*. Requests for approval after services are rendered will not be considered.

Determination of Covered Expense. For these exceptions, *covered expense* for the services of a *non-participating provider* is the lesser of the billed charge or the amount shown below.

Type of Provider	**Maximum Covered Expense is ..**
Physicians	**the Customary and Reasonable Charge**
All Other Non-Participating Providers	**a Reasonable Charge**

Claims Administered by:

ANTHEM BLUE CROSS

on behalf of

ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY