RIVERSIDE COMMUNITY COLLEGE DISTRICT

SELF-FUNDED PPO EMPLOYEE BENEFIT PLAN
PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION

EFFECTIVE JANUARY 1, 2014

AS RESTATED EFFECTIVE OCTOBER 1, 2025

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ESTABLISHMENT OF THE PLAN: ADOPTION OF THE PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION

THIS PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION ("Plan Document"), made by Riverside Community College District (the "Company" or the "Plan Sponsor") as of October 1, 2025, hereby amends and restates the Riverside Community College District Employee Benefit Plan (the "Plan"). Any wording which may be contrary to Federal Laws or Statutes is hereby understood to meet the standards set forth in such. Also, any changes in Federal Laws or Statutes which could affect the Plan are also automatically a part of the Plan, if required.

Effective Date

The Plan Document is effective as of the date first set forth above, and each amendment is effective as of the date set forth therein.

Adoption of the Plan Document

The Plan Sponsor, as the settlor of the Plan, hereby adopts this Plan Document as the written description of the Plan. This Plan Document represents both the Plan Document and the Summary Plan Description. This Plan Document amends and replaces any prior statement of the health care coverage contained in the Plan or any predecessor to the Plan.

IN WITNESS WHEREOF, the Plan Sponsor has caused this Plan Document to be executed.

Riverside Community College District

By:

Riverside Community College District

Name

Title: **Vice Chancellor, Human Resources and Employee Relations**

Date

Signature: 

Tammy Few (Dec 11, 2025 04:27:47 PST)

Email: tammy.few@rccd.edu

Name

Title

Date

DEFINITIONS

The following terms define specific wording used in this Plan. These definitions should not be interpreted to extend coverage unless specifically provided for under Covered Medical Expenses.

Adverse Benefit Determination

Any of the following:

- A denial in benefits;
- A reduction in benefits;
- A rescission of coverage;
- A termination of benefits; or
- A failure to provide or make payment (in whole or in part) for a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a Claimant's eligibility to participate in the Plan.

Allowed Amount

The maximum amount on which payment is based for covered health care services. The *allowed amount* for participating providers is based on the network negotiated price for health care services. Participating providers can only bill you for the difference between the benefit paid and the *allowed amount* for any service.

The *allowed amount* for non-participating providers is based on a fee schedule chosen by the *plan sponsor* for out-of-network health care services. Fee schedules can include the network negotiated fee schedule or other usual and customary-based fee schedules that value services based on the charge most frequently made to the majority of patients for the same service or procedure in the geographic area where the services or supplies are provided. Non-participating providers may bill you for the difference between the benefit paid and the actual amount billed for any service.

For claims subject to the No Surprises Act (see "No Surprises Act – Emergency Services and Surprises Bills" within the section "Medical Benefits,") if no negotiated rate exists, the *allowed amount* will be:

a. An amount determined by an applicable all-payer model agreement; or
b. If no such amount exists, an amount determined by applicable state law; or
c. If neither such amount exists, an amount deemed payable by a *Certified IDR Entity* or a court of competent jurisdiction, if applicable.

Alternate Recipient

Any child of a participant who is recognized under a medical child support order as having a right to enrollment under this Plan as the participant's eligible dependent. For purposes of the benefits provided under this Plan, an *alternate recipient* shall be treated as an eligible dependent, but for purposes of the reporting and disclosure requirements under *ERISA,* if applicable, an *alternate recipient* shall have the same status as a participant.

Ambulatory Surgical Facility

A public or private facility, licensed and operated according to the law, which does not provide services or accommodations for a patient to stay overnight. The facility must have an organized medical staff of *physicians*; maintain permanent facilities equipped and operated primarily for the purpose of performing surgical procedures; and supply registered professional nursing services whenever a patient is in the facility.

Approved Clinical Trial

A clinical trial that is conducted in relation to treatment of cancer or other life-threatening disease or condition that is:

A federally funded trial approved or funded by one or more of the following:

- The National Institutes of Health (NIH).
- The Centers for Disease Control and Prevention.
- The Agency for Health Care Research and Quality.
- The Centers for Medicare and Medicaid Services.
- Cooperative group or center of any of the entities described above or the Department of Defense or the Department of Veteran Affairs.
- A qualified non-governmental research entity identified in the guidelines issued by the NIH for center support grants.
- The Department of Defense, the Department of Energy, or the Department of Veteran Affairs if 1) the study has been approved through a system of peer review determined to be comparable to the system used by NIH and 2) assures unbiased review of the highest scientific standards by qualified individuals with no interest in the outcome of the review.

A study or investigation conducted under an *investigational* new drug application reviewed by the Food and Drug Administration.

A study or investigation is a drug trial that is exempt from having such an *investigational* new drug application.

Balance-billed

When a provider bills you for the balance remaining on the bill that your plan doesn't cover. This amount is the difference between the actual billed amount and the *allowed amount*. For example, if the provider's charge is $200 and the *allowed amount* is $110, the provider may bill you for the remaining $90. This happens most often when you see an out-of-network provider. An in-network provider may not bill you for covered services.

Benefit Year

The twelve (12) month period beginning January 1 and ending December 31. All annual deductibles and benefit maximums accumulate during the *benefit year*.

Birthing Center

A public or private facility, other than private offices or clinics of *physicians*, which meets the free standing *birthing center* requirements of the State Department of Health in the state where the covered person receives the services.

The *birthing center* must provide: A facility which has been established, equipped, and operated for the purpose of providing prenatal care, delivery, immediate postpartum care and care of a child born at the center; supervision of at least one (1) specialist in obstetrics and gynecology; a *physician* or certified *nurse* midwife at all births and immediate post partum period; extended staff privileges to *physicians* who practice obstetrics and gynecology in an area *hospital*; at least two (2) beds or two (2) birthing rooms; full-time nursing services directed by an R.N. or certified *nurse* midwife; arrangements for diagnostic x-ray and lab services; the capacity to administer local anesthetic or to perform minor *surgery*.

In addition, the facility must only accept patients with low risk pregnancies, have a written agreement with a *hospital* for *emergency* transfers, and maintain medical records on each patient and child.

Certified IDR Entity

An entity responsible for conducting determinations under the No Surprises Act and that has been properly certified by the Department of Health and Human Services, the Department of Labor, and the Department of the Treasury.

Claims Processor

HealthNow Administrative Services.

Coinsurance

Your share of the costs of a covered health care service, calculated as a percentage (for example, 20%) of the *allowed amount* for the service.

COBRA

The Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

Copayment or Co-pay

A fixed amount (for example, $15) you pay for a covered health care service, usually when you receive the service. The amount can vary by the type of covered health care service.

Cosmetic Surgery

Any expenses incurred in connection with the care and treatment of, or operations which are performed for plastic, reconstructive, or cosmetic purposes or any other service or supply which are primarily used to improve, alter, or enhance appearance of a physical characteristic which is within the broad spectrum of normal but which may be considered displeasing or unattractive, except when required by an *injury*.

Custodial Care

Services and supplies furnished primarily to assist an individual in the activities of daily living. Activities of daily living include such things as bathing, feeding, administration of oral medicines, or other services that can be provided by persons without the training of a *health care provider*.

Deductible

An amount you could owe during a coverage period (usually one year) for covered health care services before your plan begins to pay. An overall deductible applies to all or almost all covered items and services. A plan with an overall deductible may also have separate deductibles that apply to specific services or groups of services. A plan may also have only separate deductibles.

Dental Care Provider

A *dentist*, *dental hygienist*, *physician*, or *nurse* as those terms are specifically defined in this section.

Dental Hygienist

A person trained and licensed to perform dental hygiene services, such as prophylaxis (cleaning of teeth), under the direction of a licensed *dentist*.

Dentist

A person acting within the scope of his/her license, holding the degree of Doctor of Medicine (M.D.), Doctor of Dental Surgery (D.D.S.), or Doctor of Dental Medicine (D.M.D.), and who is legally entitled to practice dentistry in all its branches under the laws of the state or jurisdiction where the services are rendered.

Diagnostic Charges

The *allowed amount* for x-ray or laboratory examinations made or ordered by a *physician* in order to detect a medical condition.

Durable Medical Equipment

Equipment and/or supplies ordered by a *health care provider* for everyday or extended use which:

- Can withstand repeated use;

- Is primarily and customarily used to serve a medical purpose; and
- Generally is not useful to a person in the absence of an *illness* or *injury*.

Electronic Protected Health Information

Protected health information that is transmitted or maintained in any electronic media.

Emergency

A situation or medical condition with symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, would reasonably expect the absence of immediate medical attention to result in: (a) serious jeopardy to the health of the individual (or, with respect to a pregnant woman, the woman's unborn child); (b) serious impairment to bodily functions; or (c) serious dysfunction of any bodily organ or part.

An *emergency* includes, but is not limited to, suspected heart attack or severe chest pain, actual or suspected poisoning, unconsciousness, hemorrhage, acute appendicitis, heat exhaustion, convulsion, or such other acute medical conditions as determined to be *medical emergencies* by the *plan administrator*.

Emergency Services

Services that, with respect to an *emergency* medical condition, include the following:

1. An appropriate medical screening examination (as required under section 1867 of the Social Security Act, 42 U.S.C. 1395dd) that is within the capability of the emergency department of a *hospital* or of an *independent freestanding emergency department*, as applicable, including ancillary services routinely available to the emergency department to evaluate such *emergency* medical condition; and

2. Within the capabilities of the staff and facilities available at the *hospital* or the *independent freestanding emergency department*, as applicable, such further medical examination and treatment as are required under section 1867 of the Social Security Act (42 U.S.C. 1395dd), or as would be required under such section if such section applied to an *independent freestanding emergency department*, to stabilize the patient (regardless of the department of the *hospital* in which such further examination or treatment is furnished).

When furnished with respect to an *emergency* medical condition, *emergency services* shall also include an item or service provided by a non-network Provider or non-*participating health care facility* (regardless of the department of the *hospital* in which items or services are furnished) after the participant is stabilized and as part of *outpatient* observation or an *inpatient* or *outpatient* stay with respect to the visit in which the *emergency services* are furnished, until such time as the provider determines that the participant is able to travel using non-medical transportation or non-*emergency* medical transportation, and the participant is in a condition to, and in fact does, give informed consent to the Provider to be treated as a non-network Provider.

Employer

Riverside Community College District.

Experimental/Investigational

Any treatment, therapy, procedure, drug or drug usage, facility or facility usage, equipment or equipment usage, device or device usage, or supplies which are not recognized in accordance with generally accepted professional medical standards as being safe and effective for use in the treatment of the *illness*, *injury*, or condition at issue.

Services which require approval by the Federal government or any agency thereof, or by any State government agency, prior to use and where such approval has not been granted at the time the services or supplies were rendered, shall be considered *experimental* or *investigational* in nature. Services or supplies which themselves are not approved or recognized in accordance with accepted professional medical standards, but nevertheless are authorized by law or by a government agency for use in testing, trials, or other studies on human patients, shall be considered *experimental* or *investigational* in nature.

Experimental/*investigational* items and services are not covered under this Plan unless identified as a covered service elsewhere in this Plan.

FMLA

The Family and Medical Leave Act of 1993, as amended.

General Anesthesia

An agent introduced into the body which produces a condition of loss of consciousness.

Genetic Information

The information about genes, gene products and inherited characteristics that may derive from an individual or a family member. This includes information regarding carrier status and information derived from laboratory tests that identify mutations in specific genes or chromosomes, physical medical examinations, family histories and direct analysis of genes or chromosomes.

GINA

The Genetic Information Nondiscrimination Act of 2008 (Public Law No. 110-233), which prohibits group health plans, issuers of individual health care policies, and employers from discriminating on the basis of *genetic information*.

Habilitation Services

Health care services that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may

include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of *inpatient* and/or *outpatient* settings.

Health Care Provider

A *physician*, *practitioner*, *nurse, hospital* or *specialized treatment facility* as those terms are specifically defined in this section.

HIPAA

The Health Insurance Portability and Accountability Act of 1996, as amended.

Home Health Care Agency

An agency or organization that provides a program of home health care and that:

1. is approved as a *home health care agency* under *Medicare*;

2. is established and operated in accordance with the applicable laws in the jurisdiction in which it is located and, where licensing is required, has been licensed and approved by the regulatory authority having responsibility for licensing under the law; or

3. meets all of the following requirements:

    a. it is an agency which holds itself forth to the public as having the primary purpose of providing a home health care delivery system bringing supportive services to the home;

    b. it has a full-time administrator;

    c. it maintains written records of services provided to the patient;

    d. its staff includes at least one registered *nurse* or it has nursing care by a registered *nurse* available; and

    e. its employees are bonded and it provides malpractice and malplacement insurance.

Hospice Care

A program approved by the attending *physician* for care rendered in the home, *outpatient* setting or institutional facility to a terminally ill covered person with a medical prognosis that life expectancy is six (6) months or less.

Hospice Facility

A public or private organization, licensed and operated according to the law, primarily engaged in providing palliative, supportive, and other related care for a covered person diagnosed as terminally ill with a medical prognosis that life expectancy is six (6) months or less.

The facility must have an interdisciplinary medical team consisting of at least one (1) *physician*, one (1) registered *nurse*, one (1) social worker, one (1) volunteer and a volunteer program.

A *hospice facility* is not a facility or part thereof which is primarily a place for rest, *custodial care*, the aged, drug addicts, alcoholics, or a hotel or similar institution.

Hospital

The term *hospital* means:

1. an institution constituted, licensed, and operated in accordance with the laws pertaining to *hospitals*, which maintains on its premises all the facilities necessary to provide for the diagnosis and medical and surgical treatment of an *injury* or *illness*, and which provides such treatment for compensation, by or under the supervision of *physicians* on an *inpatient* basis with continuous 24-hour nursing service by registered *nurses*;

2. an institution which qualifies as a *hospital* and a provider of services under *Medicare*, and is accredited as a *hospital* by the Joint Commission on the Accreditation of Health Care Organizations;

3. a *rehabilitation facility*.

The term *hospital* shall also include a *residential treatment* facility specializing in the care and treatment of mental health conditions or substance abuse treatment, provided such facility is duly licensed if licensing is required, or otherwise lawfully operated if licensing is not required.

Regardless of any other Plan provision or definition, the term *hospital* will not include an institution which is other than incidentally, a place of rest, place for the aged or a nursing home.

Illness

Any bodily sickness, disease or mental health disorder. For the purposes of this Plan, pregnancy will be considered an *illness*.

Independent Freestanding Emergency Department

A health care facility that is geographically separate and distinct, and licensed separately, from a *hospital* under applicable state law, and which provides any *emergency services*.

Infertility

A disease, condition, or status characterized by:

- The inability to conceive after 12 months of regular, unprotected sexual intercourse or therapeutic donor insemination;
- The need for medical intervention to achieve pregnancy due to a person's medical, sexual, or reproductive history;
- The inability to reproduce either as an individual or with a partner, regardless of sexual orientation, gender identity, or marital status.

Injury

A condition which results independently of an *illness* and all other causes and is a result of an externally violent force or accident.

Inpatient

Treatment in an approved facility during the period when charges are made for room and board.

Intensive Care Unit

A section, ward, or wing within a *hospital* which is operated exclusively for critically ill patients and provides special supplies, equipment and constant observation and care by registered graduate *nurses* or other highly trained personnel. This excludes, however, any *hospital* facility maintained for the purposes of providing normal post-operative recovery treatment or service.

Late Enrollee

An individual who enrolls under the Plan other than during the first 31-day period in which the individual is eligible to enroll under the Plan or during a Special Enrollment Period.

Lifetime

The period of time you or your eligible dependents participate in this Plan.

Maintenance Care

Services and supplies primarily to maintain a level of physical or mental function.

Medically Necessary (Medical Necessity)

Medically necessary, *medical necessity*, and similar language refers to health care services ordered by a *physician* exercising prudent clinical judgment provided to a participant for the purposes of evaluation, diagnosis or treatment of that patient's *illness* or *injury*. *Medically necessary* services must be clinically appropriate in terms of type, frequency, extent, site, and duration for the diagnosis or treatment of the

patient's *illness* or *injury*. Further, to be considered *medically necessary,* services must be no more costly than alternative interventions, and are at least as likely to produce equivalent therapeutic or diagnostic results for the diagnosis or treatment of the patient's *illness* or *injury* without adversely affecting the patient's medical condition.

A *medically necessary* service must meet all of the following criteria:

- It must not be maintenance therapy or maintenance treatment;
- Its purpose must be to restore the patient's health;
- It must not be primarily custodial in nature; and
- It must not be a listed item or treatment not allowed for reimbursement by CMS (*Medicare*).

The Plan reserves the right to incorporate CMS (*Medicare*) guidelines in effect on the date of treatment as additional criteria for determination of *medical necessity*.

Merely because a *health care provider* recommends, approves, or orders certain care does not mean that it is *medically necessary*. The determination of whether a service, supply, or treatment is or is not *medically necessary* may include findings of the American Medical Association and the *plan administrator*'s own medical advisors.

Medicare

Title XVIII (Health Insurance for the Aged) of the United States Social Security Act as amended.

Morbid Obesity

A condition in which the body weight exceeds the normal weight by either 100 pounds, or is twice the normal weight of a person the same height, and conventional weight reduction measures have failed.

The excess weight must cause a medical condition such as physical trauma, pulmonary and circulatory insufficiency, diabetes, or heart disease.

Nurse

A person acting within the scope of his/her license and holding the degree of registered graduate *nurse* (R.N.), licensed vocational *nurse* (L.V.N.) or licensed practical *nurse* (L.P.N.).

Open Enrollment Period

A period of time designated by the *employer* prior to each *plan year* during which employees may elect benefits available under this *Plan*. Coverage elected during the *open enrollment period* will be effective the first day of the subsequent *plan year*.

Oral Surgery

Necessary procedures for *surgery* in the oral cavity, including pre- and post-operative care.

Other Plan

Plans including, but not limited to:

- Any primary payer besides the Plan;
- Any other group health plan;
- Any other coverage or policy covering a claimant;
- Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage;
- Any policy of insurance from any insurance company or guarantor of a responsible party;
- Any policy of insurance from any insurance company or guarantor of a third party;
- Workers' compensation or other liability insurance company; or
- Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

Out-of-Pocket Limit

Yearly amount the federal government sets as the most each individual or family can be required to pay in cost sharing during the *benefit year* for covered, in-network services. Applies to most types of health plans and insurance. This amount may be higher than the out-of-pocket limits stated for your plan.

Outpatient

Treatment either outside a *hospital* setting or at a *hospital* when room and board charges are not incurred.

Partial Hospitalization Treatment Facility

A public or private facility, licensed and operated according to the law, which provides intensive therapy daily by a *physician* and licensed mutual *health care providers* (five (5) days per week for no more than eight (8) hours per day). No room and board charges are incurred. This facility does not provide a place for rest, the aged or convalescent care.

Participating Health Care Facility

A *hospital* or *hospital outpatient* department, critical access *hospital*, *ambulatory surgical facility*, or other provider as required by law, which has a direct or indirect contractual relationship with the Plan with respect to the furnishing of a healthcare item or service. A single direct contract or case agreement between a health care facility and a plan constitutes a contractual relationship for purposes of this definition with respect to the parties to the agreement and particular individual(s) involved.

Pharmacy Benefit Manager

Express Scripts, Inc.

Physically or Mentally Handicapped

The inability of a person to be self-sufficient as the result of a condition such as, but not limited to, mental retardation, cerebral palsy, epilepsy or another neurological disorder and diagnosed by a *physician* as a permanent and continuing condition preventing the individual from being self- sufficient or other *illness* as approved by the *plan administrator*.

Physician

A person acting within the scope of his/her license and holding the degree of Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.), and who is legally entitled to practice medicine under the laws of the state or jurisdiction where the services are rendered.

Plan Administrator

The *plan administrator*, Riverside Community College District, is the sole fiduciary of the Plan, and exercises all discretionary authority and control over the administration of the Plan and the management and disposition of the Plan assets. The *plan administrator* shall have the sole discretionary authority to determine eligibility for Plan benefits or to construe the terms of the Plan.

The *plan administrator* has the right to amend, modify or terminate the Plan in any manner, at any time, regardless of the health status of any Plan participant or beneficiary.

The *plan administrator* may hire someone to perform claims processing and other specified services in relation to the Plan. Any such contractor will not be a fiduciary of the Plan and will not exercise any other discretionary authority and responsibility granted to the *plan administrator*, as described above.

Plan Sponsor

Riverside Community College District.

Plan Year

The twelve (12) month period for Riverside Community College District, beginning October 1 and ending September 30.

Practitioner

A *physician* or person acting within the scope of applicable state licensure/certification requirements and/or holding the degree of Doctor of Dental Surgery (D.D.S.), Doctor of Dental Medicine (D.M.D.), Doctor of Podiatric Medicine (D.P.M.), Doctor of Chiropractic (D.C.), Doctor of Optometry (O.D.), Optician, Certified Nurse Midwife (C.N.M.), Registered Physical Therapist (R.P.T.), Psychologist (Ph.D., Psy.D.), Licensed Clinical Social Worker (L.C.S.W.), Master of Social Work (M.S.W.), Speech Therapist or Registered Respiratory Therapist.

Professional Components

Services rendered by a professional technician (e.g. radiologist, pathologist, anesthesiologist) in conjunction with services rendered at a *hospital, ambulatory surgical facility* or *physician's* office.

Protected Health Information

Information that is created or received by the *Plan* and relates to the past, present, or future physical or mental health or condition of a *member*; the provision of health care to a *member*; or the past, present, or future payment for the provision of health care to a *member*; and that identifies the *member* or for which there is a reasonable basis to believe the information can be used to identify a *member*. Personal health information includes information of persons living or deceased. The following components of a *member's* information also are considered personal health information:

a. names;

b. street address, city, county, precinct, zip code;

c. dates directly related to a *member*, including birth date, health facility admission and discharge date, and date of death;

d. telephone numbers, fax numbers, and electronic mail addresses;

e. social security numbers;

f. medical record numbers;

g. health plan beneficiary numbers;

h. account numbers;

i. certificate/license numbers;

j. vehicle identifiers and serial numbers, including license plate numbers;

k. device identifiers and serial numbers;

l. web universal resource locators (URLs);

m. biometric identifiers, including finger and voice prints;

n. full face photographic images and any comparable images; and

o. any other unique identifying number, characteristic, or code.

Qualified Medical Child Support Order

A medical child support order that either creates or recognizes the right of an *alternate recipient* (i.e., a child of a covered participant who is recognized under the order as having a right to be enrolled under the Plan) or assigns to the *alternate recipient* the right to receive benefits for which a participant or other beneficiary is entitled under the Plan.

A medical child support order is a judgment, decree or order (including a settlement agreement) issued by a court of competent jurisdiction or through an administrative process established under state law that has the force and effect of law in that state, that provides for child support related to health benefits with respect to the child of a group health plan participant, or required health benefit coverage of such child in such plan, and is ordered under state domestic relations law, or that enforces a state medical child support law enacted under Section 1908 of the Social Security Act with respect to a group health plan.

Qualifying Payment Amount

The median of the contracted rates recognized by the Plan, or recognized by all plans serviced by the Plan's *claims processor* (if calculated by the *claims processor*), for the same or a similar item or service provided by a Provider in the same or similar specialty in the same geographic region. If there are insufficient (meaning at least three) contracted rates available to determine a *qualifying payment amount*, said amount will be determined by referencing a state all-payer claims database or, if unavailable, any eligible third-party database in accordance with applicable law.

Recognized Amount

Except for non-network air ambulance services, an amount determined under an applicable all-payer model agreement, or if unavailable, an amount determined by applicable state law. If no such amounts are available or applicable and for non-network air ambulance services generally, the *recognized amount* shall mean the lesser of a Provider's billed charge or the *qualifying payment amount*.

Rehabilitation Facility

A legally operating institution or distinct part of an institution which has a transfer agreement with one or more *hospitals*, and which is primarily engaged in providing comprehensive multidisciplinary physical restorative services, post acute *hospital* and rehabilitative *inpatient* care and is duly licensed by the appropriate governmental agency to provide such services. It does not include institutions which provide only minimal care, *custodial care*, ambulatory or part time care services, or an institution which primarily provides treatment of mental health conditions, substance abuse treatment or tuberculosis except if such facility is licensed, certified or approved as a *rehabilitative facility* for the treatment of medical conditions, mental health conditions or substance abuse treatment in the jurisdiction where it is located, or is credited as such a facility by the Joint Commission on the Accreditation of Health Care Organizations or the Commission for the Accreditation of Rehabilitation Facilities.

Respite Care

Respite care rendered through a licensed *hospice facility* for home *custodial care* which provides relief to an immediate family in caring for the day to day needs of a terminally ill individual.

Retiree

A former Academic/ certificated, Classified/ Confidential or Management employee of Riverside Community College District who:

- is at least 50 years of age but not yet 55 years of age and has a minimum of 10 years of service with the District;
- is at least 55 years of age and has a minimum of 10 years of service with the District; or
- is at least 55 years of age but does not have a minimum of 10 years of service with the District.

Second/Third Surgical Opinion

Examination by a *physician* who is certified by the American Board of Medical Specialists in a field related to the diagnosis of the proposed *surgery* to evaluate alternatives and/or the medical advisability of undergoing a surgical procedure.

Skilled Nursing Facility/Extended Care Facility

An institution that:

1. primarily provides skilled (as opposed to custodial) nursing service to patients;

2. is approved by the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) and/or *Medicare*.

In no event shall such term include any institution or part thereof that is used principally as a rest facility or facility for the aged or, any treatment facility for mental health condition or substance abuse treatment.

Special Enrollee

A *special enrollee* is an employee or dependent who is entitled to and who requests special enrollment:

1. within thirty (30) days of losing other health coverage because their *COBRA* coverage is exhausted, they cease to be eligible for other coverage, or *employer* contributions are terminated;

2. for a newly acquired dependent, within thirty (30) days of the marriage, birth, adoption, or placement for adoption; or

3. within sixty (60) days of losing other health coverage through Medicaid or CHIP.

Specialized Treatment Facility

Specialized treatment facilities as the term relates to this Plan include *birthing centers*, *ambulatory surgical facilities, hospice facilities*, or *skilled nursing facilities* as those terms are specifically defined.

Surgery

Any operative or diagnostic procedure performed in the treatment of an *injury* or *illness* by instrument or cutting procedure through any natural body opening or incision.

Third Party Administrator

HealthNow Administrative Services.

Total Disability (Totally Disabled)

The inability to perform all the duties of the covered person's occupation as the result of an *illness* or *injury*. *Total disability* means the inability to perform the normal duties of a person of the same age.

USERRA

The Uniformed Services Employment and Reemployment Rights Act of 1994.

Waiting Period

A period of continuous, full-time employment before a newly-enrolled employee or dependent is eligible to receive benefits.

Year

See *benefit year*.

SCHEDULE OF MEDICAL BENEFITS			
	In-Network Provider	**Out-of-Network Provider**	**Limitations and Explanations**
Individual Deductible	$100	$100	Includes deductible and coinsurance. The out-of-pocket limit is the most you could pay during a *benefit year* for your share of the cost of covered expenses. The out-of-pocket limit for this Plan is embedded. Once a member reaches their individual out-of-pocket maximum amount, the Plan will begin to pay at 100%. If you are enrolled in family coverage, the remainder of the family out-of-pocket limit amount can be satisfied by any one or more covered family members. However, no one family member can contribute more than their individual out-of-pocket amount toward the family out-of-pocket amount. Out-of-pocket limit is combined for in- and out-of-network services. Prescription drug expense, *balance-billed* charges and penalties do not apply to the out-of-pocket amount.
Family Deductible	$300	$300	
Coinsurance	0%, except where noted otherwise	20%	Coinsurance is your share of the costs of a covered service, calculated as a percent of the *allowed amount* for the service.
Individual Out-Of-Pocket Limit	$100	$100	Includes deductible and coinsurance. The out-of-pocket limit is the most you could pay during a *benefit year* for your share of the cost of covered expenses. The out-of-pocket limit for this Plan is embedded. Once a member reaches their individual out-of-pocket maximum amount, the Plan will begin to pay at 100%. If you are enrolled in family coverage, the remainder of the family out-of-pocket limit amount can be satisfied by any one or more covered family members. However, no one family member can contribute more than their individual out-of-pocket amount toward the family out-of-pocket amount. Out-of-pocket limit is combined for in- and out-of-network services. *Balance-billed* charges and penalties do not apply to the out-of-pocket amount.
Family Out-Of-Pocket Limit	$400	$400	
Annual Plan Maximum	None		

Co-pays are fixed dollar amounts you pay for covered health care, usually when you receive the service. Services that use a co-pay are payable at 100% after the applicable co-pay, unless noted otherwise in the Schedule of Medical Benefits.

Out-of-Network benefits are payable based on the *usual and customary charge* unless indicated otherwise.

Services		Your Cost for In-Network Providers	Your Cost for Out-of-Network Providers	Limitations and Explanations
Provider Office/Clinic	Preventive Care	No charge	Not covered	Eligible expenses include all mandated care under the Patient Protection and Affordable Care Act (PPACA).
	Physician Office Visit	No charge*	20% coinsurance*	For *medically necessary* treatment of a covered *illness* or *injury*.
	Telemedicine Consultations	No charge	N/A	Applicable to services available through the contracted vendor.
	Chiropractic/ Acupuncture Services	No charge*	20% coinsurance*	
	Allergy Testing	No charge*	20% coinsurance*	
	Allergy Injectables, Treatment and Serum	20% coinsurance*	20% coinsurance*	
Test	Outpatient Diagnostic Test (X-ray, Lab)	No charge*	20% coinsurance*	
	Outpatient Imaging – Non-hospital Facility	No charge*	20% coinsurance*	
Outpatient Surgery	Ambulatory Surgery Center	No charge*	No charge*	
	Facility Fee	No charge*	No charge*	
	Physician/Surgeon Fee	No charge*	No charge*	
Emergency Services	Emergency Room Services	No charge*	No charge*	
	Emergency Room Physician	No charge*	No charge*	
	Emergency Room Services- Non-emergency Treatment	20% coinsurance*	20% coinsurance*	Applicable to services that are not a true *emergency.*
*Deductible applies.				

Services		Your Cost for In-Network Providers	Your Cost for Out-of-Network Providers	Limitations and Explanations
Emergency Service, cont.	Emergency Medical Transportation-Ground	10% coinsurance*	10% coinsurance*	
	Emergency Medical Transportation - Air	10% coinsurance*	10% coinsurance*	
	Urgent Care Center	No charge*	20% coinsurance*	
	Urgent Office Visit	No charge*	20% coinsurance*	
Hospital Stay	Facility Fee	No charge*	No charge*	Precertification is required.
	Physician Fee	No charge*	No charge*	
	Surgeon Fee	No charge*	No charge*	
	Transplant Services	No charge*	Not covered	Includes travel and lodging expenses for the patient and a companion if the facility is more than 30 miles from the covered person's residence or place of employment. Benefits are limited to regular coach airfare (if travel by plane) and the current Federal Government per diem for mileage and hotel accommodations.
Mental Health/ Substance Abuse	Mental Health Outpatient Services	No charge*	20% coinsurance*	
	Mental Health Inpatient Services	No charge*	20% coinsurance*	
	Psychological Testing	No charge*	20% coinsurance*	
	Substance Use Disorder Outpatient Services	No charge*	20% coinsurance*	
	Substance Use Disorder Inpatient Services	No charge*	20% coinsurance*	
*Deductible applies.				

Services		Your Cost for In-Network Providers	Your Cost for Out-of-Network Providers	Limitations and Explanations
Pregnancy	Prenatal Care	No charge	20% coinsurance*	
	Postnatal Care	No charge*	20% coinsurance*	
	Delivery and Inpatient Services	No charge*	No charge*	Precertification is only required for stays exceeding the day limits outlined in the Newborns' and Mothers' Health Protection Act.
	Breast Pumps	No charge	No charge	
Special Health Needs	Home Health Care	20% coinsurance*	20% coinsurance*	Limited to 1 visit/day/ specialty.
	Rehabilitation Services	No charge*	20% coinsurance*	Includes physical, occupational, speech, and other rehabilitative therapies. Maintenance care and palliative care are excluded.
	Skilled Nursing Care	No charge*	20% coinsurance*	Precertification is required.
	Durable Medical Equipment	20% coinsurance*	20% coinsurance*	
	Hearing Aids	No charge*	No charge*	Limited to $2,500 per device, per ear, every 3 years.
	Hospice Care	20% coinsurance*	20% coinsurance*	
	Bariatric Surgery – Designated County	No charge*	Not covered	Precertification is required. Services provided by a Blue Distinction Center will be paid at the in-network benefit level. You will be responsible for 20%* for services provided by a Blue Shield provider that has not been designated as a Blue Distinction Center.
	Bariatric Surgery – Non-Designated County	No charge*	Not covered	Precertification is required.

*Deductible applies.

SCHEDULE OF PRESCRIPTION DRUG BENEFITS			
	Your Cost for Retail Pharmacy	**Your Cost for Mail Order Pharmacy**	**Limitations and Explanations**
Individual Out-Of-Pocket Limit	$200		Includes prescription drug co-pays. The out-of-pocket limit is the most you could pay during a *benefit year* for your share of the cost of covered prescription expenses. The out-of-pocket limit for this Plan is embedded. Once a member reaches their individual out-of-pocket maximum amount, the Plan will begin to pay at 100%. If you are enrolled in family coverage, the remainder of the family out-of-pocket limit amount can be satisfied by any one or more covered family members. However, no one family member can contribute more than their individual out-of-pocket amount toward the family out-of-pocket amount.
Family Out-Of-Pocket Limit	$400		
Generic Medications	$2 co-pay per prescription	$4 co-pay per prescription	For additional information, please call 866-832-9259 or log on to www.express-scripts.com. Keenan Pharmacy Care Management (KPCM) provides an independent, unbiased layer of clinical management by engaging *physicians* and participants directly to ensure that the best possible drug therapies are chosen, based on their clinical effectiveness and overall cost to participants and the Plan. KPCM may recommend modifications to a prescription drug order and, if approved by the prescribing *physician* and participant, a new prescription drug order is issued. All specialty prescriptions require prior authorization review through the Keenan Pharmacy Care Management Program. Physicians should contact US-Rx Care at 844-744-4410.
Brand Name Medications	$10 co-pay per prescription	$20 co-pay per prescription	
Maximum Supply	34 days or 100 units (whichever is greater)	90 days	

INTRODUCTION

Riverside Community College District has prepared this document to help you understand your benefits. **PLEASE READ IT CAREFULLY AS YOUR BENEFITS ARE AFFECTED BY CERTAIN LIMITATIONS AND CONDITIONS.** Also, benefits are not provided for certain kinds of treatments or services, even if your *health care provider* recommends them.

This document is written in simple, easy-to-understand language. Technical terms are printed in *italics* and defined in the Definitions section. The headings in the Plan are inserted for convenience of reference only and are not to be construed or used to interpret any of the provisions of the Plan.

As used in this document, the word *year* refers to the *benefit year* which is the twelve (12) month period beginning January 1 and ending December 31. All annual benefit maximums and deductibles accumulate during the *benefit year*. The word *lifetime* as used in this document refers to the period of time a covered person is a participant in this Plan sponsored by Riverside Community College District.

The Plan may be amended from time to time to comply with the requirements of applicable law or to reflect changes in your *employer's* benefits program. If the Plan is amended, you will be advised of any important changes.

ARTICLE I -- ELIGIBILITY AND PARTICIPATION

A. Who Is Eligible

You are eligible to participate in this Plan if you are:

1. a regularly scheduled full-time employee of the District who works a minimum of twenty (20) hours per week;

2. an early retiree; or

3. a *retiree. Retirees* that reside outside of the United States are not eligible for coverage.

Your eligible dependents may also participate. Eligible dependents include:

1. A legal spouse, until final decree of dissolution of marriage or divorce (unless court ordered).

2. A domestic partner that meets the State of California standards for registered domestic partners.

3. A child from birth to age twenty-six (26).

   The term child includes:

   a. your natural child or a natural child of your covered domestic partner;

   b. a step-child by legal marriage;

   c. a child who is adopted or has been placed with you for adoption by a court of competent jurisdiction;

   d. a child for whom legal guardianship has been awarded;

   e. a child who is the subject of a *Qualified Medical Child Support Order* (QMCSO) dated on or after August 10, 1993. To be "qualified," a state court medical child support order must specify: the name and last known mailing address of the plan participant and each *alternate recipient* covered by the order, a reasonable description of the type of coverage or benefit to be provided to the *alternate recipient*, the period to which the medical child support order applies, and each plan to which the order applies; and

   f. An unmarried child who is incapable of self-sustaining employment by reason of mental or physical disability and is primarily dependent on you for maintenance and support may continue to be covered under this Plan regardless of age, so long as the disability persists, and the disability began before the child reached age twenty-six (26).

In order to continue coverage, you must furnish written proof of the disability within thirty-one (31) days of the child's twenty-sixth (26th) birthday. The *plan administrator* may require you to furnish periodic proof of the child's continued disability but not more often than annually. If such proof is not satisfactory to the *plan administrator*, coverage for the child will end immediately.

No one who is on active duty with the armed forces will be eligible for coverage under this Plan.

B. Who Pays for Your Benefits

If you are an active employee or an early *retiree* that meets the criteria outlined in the Collective Bargaining Agreement, Riverside Community College District pays the entire cost of providing benefits for you and your dependents. If you are a *retiree*, Riverside Community College District shares the cost of providing benefits for retirees and retiree's spouse.

C. Enrollment Requirements

If you desire Plan benefits, you must enroll in the Plan by properly completing and returning an enrollment form to Riverside Community College District within thirty-one (31) days of your eligibility date. If you also desire dependent coverage, you must enroll your eligible dependents by this deadline.

If you do not have any eligible dependents at the time of initial enrollment but acquire eligible dependents at a later date, you must enroll dependents, including newborns, by properly completing and returning an enrollment form to Riverside Community College District within thirty-one (31) days of the date they become your dependent(s).

Failure to enroll by the deadline noted above will subject you and your dependents to the Late Enrollment, or Special Enrollment Period provisions below.

D. Late Enrollment

If an eligible employee or dependent declined coverage at the time initially eligible, coverage cannot become effective until the next annual *open enrollment period* unless application for coverage was due to a Special Enrollment as defined under the Special Enrollment Period provision below. The employee or dependent must request enrollment in this Plan within the *open enrollment period.* This provision does not apply to a dependent who becomes eligible for coverage as the result of a *Qualified Medical Child Support Order*, or who is adopted or is placed with you for adoption by a court of competent jurisdiction, as long as he is enrolled within thirty-one (31) days of his eligibility date.

The effective date for enrollment changes made during the *open enrollment* period is January 1.

E. Special Enrollment Periods

This Plan allows Special Enrollment Periods for eligible employees and dependents who experience certain qualified life events. Special Enrollment Periods apply, but are not limited to, the following:

1. Individuals losing other coverage. An employee or dependent that is eligible, but not enrolled in this Plan, may enroll if each of the following conditions is met:

    a. The employee or dependent was covered under a group health plan, Medicaid including coverage under state funded Children's Health Insurance Plan (CHIP) or had health insurance coverage at the time coverage under this Plan was previously offered to the individual.

    b. If required by the *plan administrator*, the employee stated in writing at the time that coverage was offered that the other health coverage was the reason for declining enrollment.

    c. The coverage of the employee or dependent who has lost the coverage was under *COBRA* and the *COBRA* coverage was exhausted, or was not under *COBRA* and either the coverage was terminated as a result of loss of eligibility for the coverage (including as a result of legal separation, divorce, death, termination of employment, or reduction in the number of hours of employment) or *employer* contributions toward the coverage were terminated.

    d. The employee requests enrollment in this Plan not later than:

        i. thirty (30) days following the termination of coverage or *employer* contributions, as described above;
        ii. thirty (30) days following the date *COBRA* coverage was exhausted;
        iii. sixty (60) days following the termination of Medicaid or CHIP.

Coverage begins on the day following the loss of coverage.

If the employee or dependent lost the other coverage as a result of the individual's failure to pay premiums or for cause (such as making a fraudulent claim), that individual does not have a special enrollment right.

2. Dependent beneficiaries. If:

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

    b. A person becomes a dependent of the employee through marriage, birth, adoption or placement for adoption then the dependent (and if not otherwise enrolled, the employee)

may be enrolled under this Plan as a covered dependent of the employee. In the case of the birth or adoption of a child, the spouse of the employee may be enrolled as a dependent of the employee if the spouse is otherwise eligible for coverage.

The special enrollment period is a period of thirty (30) days that begins on the date of the marriage, birth, adoption, placement for adoption. Coverage begins as of the date of the marriage, birth, adoption or placement for adoption.

F. When Coverage Begins

If you are hired or first eligible prior to the 15th day of the month, your coverage begins on the first day of the following month.

If you are hired or first eligible on or after the 15th day of the month, your coverage begins on the first day of the second following calendar month.

Coverage for your eligible dependents begins the later of when your coverage begins or the first day a dependent becomes your dependent.

However, should coverage commence under the Late Enrollment or Special Enrollment Period sections, the provision under these sections will apply.

Any time you or your eligible dependents have accumulated toward the satisfaction of a *waiting period* under the Riverside Community College District plan prior to the restatement date, October 1, 2025, will be counted toward the satisfaction of the *waiting period* of this Plan.

If you and your spouse are both employees and covered as employees under the plan and one of you terminates, the terminating spouse and any of their eligible and enrolled dependents will be permitted to immediately enroll under the remaining employee's coverage. Such new coverage will be deemed a continuation of prior coverage.

If you or an eligible dependent changes status from employee to dependent or vice versa, and you or your eligible dependent remains eligible and covered without interruption, Plan benefits will not be affected by your change in status.

G. Acquired Companies

Eligible employees of an acquired company who are actively at work and were covered under the prior plan of the acquired company will be eligible for the benefits under this Plan on the date of acquisition. Any *waiting period* previously satisfied under the prior health plan will be applied toward satisfaction of the *waiting period* of this Plan. In the event that an acquired company did not have a health plan, all eligible employees will be eligible on the date of the acquisition.

H. Genetic Information Nondiscrimination Act (GINA)

The Genetic Information Nondiscrimination Act, or *GINA*, prohibits group health plans, issuers of individual health care policies, and employers from discriminating on the basis of *genetic information*.

Genetic information is a form of protected health information as defined by the Health Insurance Portability and Accountability Act of 1996 (*HIPAA*), and is subject to applicable privacy and security standards.

GINA does not prohibit a *health care provider* who is treating an individual from requesting that the patient undergo genetic testing. The rules permit the Plan to obtain genetic test results and use them to make claims payment determinations when necessary to determine whether the treatment provided was medically advisable and/or necessary.

The Plan may request, but not require, genetic testing in certain very limited circumstances involving research, so long as the results are not used for underwriting purposes. Such requests, will be made with written notice to the individual that participation is voluntary and will not affect eligibility for benefits, premiums, or contributions. In addition, the Plan will notify the Health and Human Services secretary of its activities falling within this exception.

I. When Coverage Ends

Your coverage ends the earliest of:

- the last day of the month in which your last day of full-time regular employment occurs, if employment terminates prior to the 15th day of the month;
- the last day of the month following the month in which eligibility ceases if employment terminates on or after the 15th day of the month;
- the last day of the month following the month in which eligibility ceases;
- the date you are no longer eligible to participate in the Plan;
- the date you fail to make the required contributions; or
- the date the Plan ends.

If you are a Certificated Employee who terminates after June 30th of a *benefit year*, eligibility will be extended through September 30th of that *benefit year*.

Coverage for your dependents ends the earliest of:

- the date your coverage ends;
- the date a dependent no longer meets the eligibility requirements;
- the date you fail to make the required contributions; or
- the date the Plan ends.

Coverage for a *retiree* ends the earliest of:

- the date of the *retiree's* death;
- the date you are no longer eligible to participate in the Plan;
- the date you fail to make any required contributions; or
- the date the Plan ends.

Coverage for the dependent of a *retiree* ends the earliest of:

- the date your coverage ends;
- the date your dependent no longer meets the eligibility requirements;
- the date you fail to make any required contributions; or
- the date the Plan ends.

Survivor benefits are available for spouses or domestic partner of Certificated *Retirees* in accordance with Ed Code 7000. See the section entitled Survivor Benefits for more information.

J. Family and Medical Leave Act of 1993 (FMLA)

If you qualify for an approved family or medical leave of absence (as defined in the Family and Medical Leave Act of 1993 (*FMLA*), eligibility may continue for the duration of the leave. Failure to make payment within thirty (30) days of the due date established by your *employer* will result in the termination of coverage.

If you fail to return to work after the leave of absence, your *employer* has the right to recover from you any contributions that were made on your behalf toward the cost of coverage during the leave. In general, continuation coverage under COBRA will begin on the last day of the applicable maximum *FMLA* period, unless you qualify for other leaves permitted by this plan.

For more information regarding *FMLA* leave, please refer to your Employee Handbook.

K. Applicable State Mandated Leaves

If you qualify for a leave of absence required by state mandate, and the mandate requires that the plan continue coverage during the leave, your eligibility under this Plan may continue for the duration of the maximum leave indicated in the applicable state law. Failure to make payment within thirty (30) days of the due date established by your *employer* will result in the termination of coverage.

If you fail to return to work after the leave of absence, your *employer* has the right to recover from you any contributions that were made on your behalf toward the cost of coverage during the leave.

Extensions of coverage related to state mandated leave may be combined or in addition to FMLA, based on the specific requirements of the applicable state leave provisions. In general, continuation coverage under COBRA will begin on the last day of the applicable maximum leave period, unless you qualify for other leaves permitted by this plan.

L. Employer Continuation Coverage

If you cease to be eligible for coverage due to an approved leave of absence, you and your eligible dependents may continue to be covered under the Plan. Please refer to the Riverside Community College District policy in your employee handbook for additional information.

M. Severance Agreement

If your active service ends under the terms of a severance agreement, and you are covered under this Plan on the day your employment ends, you may continue to be covered under the Plan for the period specified in the severance agreement and under the terms and conditions specified.

If you fail to make any required contribution, when due, coverage will terminate at the end of the period for which you made the last required contribution. Continuation coverage under COBRA will begin the earlier of: 1) the date you fail to make any required contribution, or 2) the day after the date your severance period ends.

N. The Uniformed Services Employment and Re-employment Rights Act (USERRA)

This Plan will comply with the requirement of all the terms of The Uniformed Services Employment And Re-employment Rights Act of 1994 (*USERRA*). This is a federal law which gives members and former members of the U.S. armed forces (active and reserves) the right to return to their civilian job they held before military service.

O. Survivor Benefits

In accordance with Ed Code 7000, if you are a Certificated *Retiree* that dies while covered under the Plan, your eligible spouse or domestic partner (if also covered under the Plan) will remain covered until the earliest of the following:

1. the date your eligible spouse or domestic partner fails to make any required contributions; or

2. the date the Plan ends.

The benefit termination date will be considered the Qualifying Event with respect to COBRA Continuation of Benefits.

Coverage for your dependent children will end as described in the section entitled When Coverage Ends.

ARTICLE II -- BENEFITS MANAGEMENT PROGRAM

A. Benefits Management Program

The Benefits Management Program has been established to assist participants and their providers in identifying the most appropriate and cost-effective course of treatment for which certain benefits will be provided under this health plan and for determining whether the services are *medically necessary*. However, participants and their providers make the final decision concerning treatment. The Benefits Management Program includes: prior authorization review for certain services; *emergency* admission notification; *hospital inpatient* review, discharge planning, and case management if determined to be applicable and appropriate.

Failure to contact the Plan for authorization of services listed in the sections below or failure to follow the Plan's recommendations may result in non-payment if the Benefits Management Program Administrator determines the service was not a covered service. Please read the following sections thoroughly so you understand your responsibilities in reference to the Benefits Management Program. All provisions of the Benefits Management Program apply to all participants.

Preadmission review is required for all *inpatient hospital* and *skilled nursing facility* services (except for *emergency* services).

B. Prior Authorization

For services and supplies listed in the section below, participants and their providers can determine before the service is provided whether a procedure or treatment program is a covered service and may also receive a recommendation for an alternative service.

For services other than those listed in the sections below, participants or their providers should consult the Medical Benefits article of this booklet to determine whether a service is covered.

Participants or their providers must call the Customer Service telephone number indicated on the back of the participant's identification card for prior authorization for the services listed in this section.

Participants or their providers must call the Customer Service telephone number indicated on the back of the participant's identification card for prior authorization for the services listed in this section.

Prior authorization is required for the following services:

1. All bariatric *surgery*.

2. Non-emergency *hospital* admissions (see subsection **C. Hospital Admissions** for more information).

Failure to obtain prior authorization for the services described above may result in non-payment if the Benefits Management Program Administrator determines that the service is not a covered service.

Other specific services and procedures may require prior authorization. A list of services and procedures requiring prior authorization can be obtained by your *health care provider* by going to http://www.blueshieldca.com or by calling the Customer Service telephone number indicated on the back of the participant's identification card.

C. Hospital and Skilled Nursing Facility Admissions

Prior authorization must be obtained for all *hospital* and *skilled nursing facility* admissions (except for admissions required for *emergency* services). Included are hospitalizations for continuing *inpatient* rehabilitation and skilled nursing care, transplants, bariatric *surgery*, and *inpatient* mental health services if this health plan provides these benefits.

Prior Authorization for Other than Mental Health Admissions

Whenever a *hospital* or *skilled nursing facility* admission is recommended by your *physician*, participants or their providers must contact the Customer Service telephone number indicated on the back of the participant's identification card at least 5 business days prior to the admission. However, in case of an admission for *emergency* services, the Benefits Management Program Administrator should receive *emergency* admission notification within 24 hours or by the end of the first business day following the admission, or as soon as it is reasonably possible to do so. The Benefits Management Program Administrator will discuss the benefits available, review the medical information provided and may recommend that to obtain the full benefits of this health plan that the services be performed on an *outpatient* basis.

Examples of procedures that may be recommended to be performed on an *outpatient* basis if medical conditions do not indicate *inpatient* care include:

1. Biopsy of lymph node, deep axillary;
2. Hernia repair, inguinal;
3. Esophagogastroduodenoscopy with biopsy;
4. Excision of ganglion;
5. Repair of tendon;
6. Heart catheterization;
7. Diagnostic bronchoscopy;
8. Creation of arterial venous shunts (for hemodialysis).

Failure to contact the Benefits Management Program as described or failure to follow the recommendations of the Benefits Management Program Administrator may result in reduction or non-payment by the Benefits Management Program Administrator if it is determined that the admission is not a covered service.

Prior Authorization for Inpatient Mental Health Services, Outpatient Partial Hospitalization, Intensive Outpatient Care and Outpatient ECT Services

All *inpatient* mental health services, *outpatient* partial hospitalization, intensive *outpatient* care and *outpatient* ECT services, except for *emergency* services, must be prior authorized by the Benefits Management Program.

For an admission for *emergency* mental health services, the Benefits Management Program should receive *emergency* admission notification within 24 hours or by the end of the first business day following the admission, or as soon as it is reasonably possible to do so, or the participant may be responsible for the additional payment as described below.

For prior authorization of *inpatient* mental health services, intensive *outpatient* care, *outpatient* partial hospitalization and *outpatient* ECT services, call the Customer Service telephone number indicated on the back of the participant's identification card.

Failure to contact the Benefits Management Program as described above or failure to follow the recommendations of the Benefits Management Program Administrator may result in non-payment by the Benefits Management Program Administrator if it is determined that the admission is not a covered service.

Note: The Benefits Management Program Administrator will render a decision on all requests for prior authorization within 5 business days from receipt of the request. The treating provider will be notified of the decision within 24 hours followed by written notice to the provider and participant within 2 business days of the decision. For urgent services in situations in which the routine decision making process might seriously jeopardize the life or health of a participant or when the participant is experiencing severe pain, the Benefits Management Program Administrator will respond as soon as possible to accommodate the participant's condition not to exceed 72 hours from receipt of the request.

D. Hospital Inpatient Review

The Benefits Management Program Administrator monitors *inpatient* stays. The stay may be extended or reduced as warranted by your condition, except in situations of maternity admissions for which the length of stay is 48 hours or less for a normal, vaginal delivery or 96 hours or less for a Cesarean section unless the attending *physician*, in consultation with the mother, determines a shorter *hospital* length of stay is adequate. Also, for mastectomies or mastectomies with lymph node dissections, the length of *hospital* stays will be determined solely by your *physician* in consultation with you. When a determination is made that the participant no longer requires the level of care available only in an acute care *hospital*, written notification is given to

you and your Doctor of Medicine. You will be responsible for any *hospital* charges incurred beyond 24 hours of receipt of notification.

E. Discharge Planning

If further care at home or in another facility is appropriate following discharge from the *hospital*, the Benefits Management Program Administrator may work with you, your *physician* and the *hospital* discharge planners to determine whether benefits are available under this Plan to cover such care.

F. Case Management

The Benefits Management Program may also include case management, which provides assistance in making the most efficient use of plan benefits. Individual case management may also arrange for alternative care benefits in place of prolonged or repeated hospitalizations, when it is determined to be appropriate. Such alternative care benefits will be available only by mutual consent of all parties and, if approved, will not exceed the benefit to which you would otherwise have been entitled under this Plan. The Benefits Management Program Administrator is not obligated to provide the same or similar alternative care benefits to any other person in any other instance. The approval of alternative benefits will be for a specific period of time and will not be construed as a waiver of the Benefits Management Program Administrator's right to thereafter administer this health plan in strict accordance with its express terms.

ARTICLE III -- NETWORK PROVISIONS

Certain *hospitals* and *physicians* have agreements pertaining to payment of covered medical charges. These *hospitals* and *physicians* are called Network Providers. If you have any questions regarding *hospitals* and *physicians* who participate in the network, call the phone number indicated on your identification card.

This Plan pays for covered medical charges, made by both in-network and out-of-network providers. Network Providers may not bill for amounts considered to be over the *allowed amount*. Network Providers may bill for deductible and coinsurance amounts referred to in this Plan, if any. When you receive health care through a Network Provider, you incur lower out-of-pocket expenses, and there are no claim forms to fill out.

Benefits are also provided if you choose to receive health care through a Provider that is not a Network Provider. However, except as outlined in "No Surprises Act – Emergency Services and Surprise Bills", the level of benefits will be reduced, and you will be responsible for a greater share of out-of-pocket expenses, and the amount of your expenses could be substantial. You may have to reach a deductible before receiving benefits, and you may be required to file a claim form.

Except as outlined in "No Surprises Act – Emergency Services and Surprise Bills" below, referrals by in-network providers to out-of-network providers will be considered out-of-network services or supplies and will be payable at the out-of-network benefit level. In order to have services and supplies paid at the in-network benefit level, ask your *physician* to refer you to participating providers (e.g. x-ray specialists, etc.).

Exceptions

Benefits for treatment of an *injury* or *emergency* where you are unable to choose an in-network *health care provider* will be reimbursed at the in-network benefit level (*usual and customary charges* will be waived), regardless of who renders the services, until the patient is stabilized and can be moved to a network facility. All follow up care must be provided by an in-network *health care provider* in order to be paid at the in-network level of benefits.

Professional Components, assistant surgeon, and emergency room physician charges rendered in an in-network facility when the patient is under the treatment of an in-network provider will be reimbursed at the in-network benefit level (*usual and customary charges* will be waived).

If you receive information with respect to an item or service from the Plan, its representative, or a database maintained by the Plan or its representative indicating that a particular provider is a Network Provider and you receive such item or service in reliance on that information, your coinsurance, copayment, deductible, and out-of-pocket limit will be calculated as if the provider had been in-network despite that information proving inaccurate.

Continuity of Care

In the event you are a continuing care patient receiving a course of treatment from a provider which

is in-network or otherwise has a contractual relationship with the Plan governing such care and that contractual relationship is terminated, not renewed, or otherwise ends for any reason other than the provider's failure to meet applicable quality standards or for fraud, you shall have the following rights to continuation of care.

The Plan shall notify you in a timely manner after termination that the provider's contractual relationship with the Plan has terminated, and that you have rights to elect continued transitional care from the provider. If you elect in writing to receive continued transitional care, Plan benefits will apply under the same terms and conditions as would be applicable had the termination not occurred, beginning on the date the Plan's notice of termination is provided and ending 90 days later or when you cease to be a continuing care patient, whichever is sooner.

For purposes of this provision, "continuing care patient" means an individual who:

1) is undergoing a course of treatment for a serious and complex condition from a specific Provider,
2) is undergoing a course of institutional or *inpatient* care from a specific provider,
3) is scheduled to undergo non-elective *surgery* from a specific provider, including receipt of postoperative care with respect to the *surgery*,
4) is pregnant and undergoing a course of treatment for the pregnancy from a specific provider, or
5) is or was determined to be terminally ill and is receiving treatment for such *illness* from a specific provider.

Note that during continuation, Plan benefits will be processed as if the termination had not occurred, however, the provider may be free to pursue you for any amounts above the Plan's benefit amount.

ARTICLE IV -- MEDICAL BENEFITS

A. About Your Medical Benefits

All medical benefits provided under this Plan must satisfy some basic conditions. The following conditions which apply to your Plan's benefits are commonly included in medical benefit plans but often overlooked or misunderstood.

1. Medical Necessity

   The Plan provides benefits only with respect to covered services and supplies which are *medically necessary* in the specific treatment of a covered *illness* or *injury*, unless specifically mentioned in Covered Medical Expenses. *Medically necessary* means the treatment is generally accepted by medical professionals in the United States as proven, effective and appropriate for the condition based on recognized standards of the health care specialty involved.

   "Proven" means the care is not considered *experimental,* meets a particular standard of care accepted by the medical community and is approved by the Food and Drug Administration (FDA), if applicable.

   "Effective" means the treatment's beneficial effects can be expected to outweigh any harmful effects. Effective care is treatment proven to have a positive effect on your health, while addressing particular problems caused by disease, *injury, illness* or a clinical condition.

   "Appropriate" means the treatment's timing and setting are proper and cost effective.

   Medical treatments which are not proven, effective and appropriate are not covered by the Plan unless specifically mentioned.

2. Allowed Amount

   The *allowed amount* is the maximum amount on which payment is based for covered health care services. The *allowed amount* for participating providers is based on the network negotiated price for health care services. Participating providers can only bill you for the difference between the benefit paid and the *allowed amount* for any service.

   The *allowed amount* for non-participating providers is based on a fee schedule chosen by the *plan sponsor* for out-of-network health care services. Fee schedules can include the network negotiated fee schedule or other usual and customary-based fee schedules that value services using the charge most frequently made to the majority of patients for the same service or procedure in the geographic area where the services or supplies are provided. Non-participating providers may bill you for the difference between the benefit paid and the actual amount billed for any service.

For claims subject to the No Surprises Act (see "No Surprises Act – Emergency Services and Surprises Bills" within the section "Medical Benefits,") if no negotiated rate exists, the *allowed amount* will be:

- An amount determined by an applicable all-payer model agreement; or
- If no such amount exists, an amount determined by applicable state law; or
- If neither such amount exists, an amount deemed payable by a *Certified IDR Entity* or a court of competent jurisdiction, if applicable.

3. Health Care Providers

The Plan provides benefits only for covered services and supplies rendered by a *physician*, *practitioner, nurse, hospital,* or *specialized treatment facility* as those terms are specifically defined in the Definitions section.

4. Custodial Care

The Plan does not provide benefits for services and supplies furnished primarily to assist an individual in the activities of daily living. Activities of daily living include such things as bathing, feeding, administration of oral medicines, or other services that can be provided by persons without the training of a *health care provider.*

5. Benefit Year

The word *year,* as used in this document, refers to the *benefit year* which is the twelve (12) month period beginning January 1 and ending December 31. All annual benefit maximums and deductibles accumulate during the *benefit year.*

6. Alternate Benefit Provision

The *plan administrator*, with prior approval from the excess loss carrier, may elect to provide alternative benefits which are not listed as covered services in this contract. The alternative covered benefits should be determined on a case by case basis by the *plan administrator* for services which the *plan administrator* deems are *medically necessary*, cost effective and agreeable to the covered person and participating provider. The *plan administrator* shall not be committed to provide these same, or similar alternative benefits for another covered person nor shall the *plan administrator* lose the right to strictly apply the express provisions of this contract in the future.

7. No Surprises Act – Emergency Services and Surprise Bills

For non-network claims subject to the No Surprises Act ("NSA"), participant cost-sharing will be the same amount as would be applied if the claim was provided by a Network Provider and will be calculated as if the Plan's allowable expense was the *recognized amount*, regardless of the Plan's actual *allowed amount*. The NSA prohibits providers from pursuing participants for the difference between the *allowed amount* and the provider's billed

charge for applicable services, with the exception of valid Plan-appointed cost-sharing as outlined above. Any such cost-sharing amounts will accrue toward in-network deductibles and out of pocket maximums.

Benefits for claims subject to the NSA will be denied or paid within 30 days of receipt of an initial claim, and if approved will be paid directly to the provider.

Claims subject to the NSA are those which are submitted for:

- *Emergency services*;
- Non-*emergency services* rendered by a non-network Provider at a *participating health care facility*, provided the participant has not validly waived the applicability of the NSA; and
- Covered non-network air ambulance services.

B. Deductibles

A deductible is the amount of covered expenses you must pay during each *benefit year* before the Plan will consider expenses for reimbursement.

Any covered expenses that you or your dependents accumulated toward the deductible under the Riverside Community College District plan prior to the restatement date, October 1, 2025, will be counted toward the satisfaction of the deductible under this Plan.

If two (2) or more covered members of your family are injured in a common accident, the deductible will be applied only once to all involved persons for those injuries.

Additional detail about the annual deductible is indicated in the Schedule of Medical Benefits.

C. Deductible Carry-Over

When covered expenses incurred in the last three (3) months of the *benefit year* are applied to the deductible, that amount will also be used to satisfy the deductible for the following *benefit year*.

D. Coinsurance

Coinsurance percentages represent the portion of covered expenses paid by the Plan after satisfaction of any applicable deductible. These percentages apply only to covered expenses which do not exceed the *allowable amount.*

The coinsurance percentages are shown on the Schedule of Medical Benefits.

E. Out-of-Pocket Limit

An out-of-pocket limit is the maximum amount of covered expenses you must pay during a *benefit year*. When you reach the annual out-of-pocket limit applicable to you, the Plan will pay

one hundred percent (100%) of additional covered expenses during the remainder of that *benefit year.*

Any covered expenses that you or your dependents accumulated toward the out-of-pocket limit under the Riverside Community College District plan prior to the restatement date, October 1, 2025, will be counted toward the satisfaction of the out-of-pocket limit under this Plan.

Additional detail about the annual out-of-pocket limit is indicated in the Schedule of Medical Benefits.

F. Benefit Maximums

Total plan payments for each covered person are limited to certain maximum benefit amounts. A benefit maximum can apply to specific benefit categories or to all benefits. A benefit maximum amount also applies to a specific time period, such as annual or *lifetime.* Whenever the word *lifetime* appears in this Plan in reference to benefit maximums, it refers to the time you or your dependents are covered by this Plan.

Any benefit amounts that you or your dependents accumulated toward the benefit maximums and *lifetime* benefit maximums under the Riverside Community College District plan prior to the restatement date, October 1, 2025, will be counted toward the benefit maximums and *lifetime* benefit maximums under this Plan.

The benefit maximums applicable to this Plan are shown in the Schedule of Medical Benefits.

G. Covered Medical Expenses

When all of the requirements of this Plan are satisfied, the Plan will provide benefits as outlined on the Schedule of Medical Benefits but only for the services and supplies listed in this section.

Hospital Services

1. Room and board, not to exceed the cost of a semiprivate room or other accommodations unless the attending *physician* certifies the *medical necessity* of a private room. If a private room is the only accommodation available, the Plan will cover an amount equal to the prevailing semiprivate room rate in the geographic area.

   The Plan may not restrict benefits for any *hospital* length of stay in connection with childbirth for the mother or newborn child to less than forty-eight (48) hours following a normal vaginal delivery, or less than ninety-six (96) hours following a cesarean section, or require that a provider obtain authorization from the Plan for prescribing a length of stay not in excess of the above periods.

   The attending provider, after consulting with the mother, may discharge the mother and newborn earlier than forty-eight (48) hours following a vaginal delivery or ninety-six (96) hours following a cesarean section.

2. *Intensive care unit* and coronary care unit charges.

3. Miscellaneous *hospital* services and supplies required for treatment during a *hospital* confinement.

4. Well-baby nursery and *physician* expenses during the initial *hospital* confinement of a newborn.

5. *Hospital* confinement expenses for dental services if the attending *physician* certifies that hospitalization is necessary to safeguard the health of the patient.

6. *Outpatient hospital* services.

Emergency and Urgent Care Services

1. Treatment of an *emergency* in a *hospital* emergency room or other emergency care facility.

2. Treatment at an urgent care facility.

3. Ground transportation provided by a professional ambulance service to and from the nearest, most appropriate *hospital* or emergency care facility for covered *inpatient* treatment.

4. Transportation provided by a professional air ambulance service for the first trip to and from the nearest *hospital* or emergency care facility equipped to treat a condition that can be classified as an *emergency.*

Specialized Treatment Facilities

1. A *skilled nursing facility* or *extended care facility*.

2. An *ambulatory surgical facility*.

3. A *birthing center*.

4. A mental health treatment facility, including a residential treatment facility.

5. A substance abuse treatment facility, including a residential treatment facility.

6. A *hospice facility* when a *physician* certifies life expectancy is six (6) months or less. Bereavement counseling received within the six (6) month period following the patient's death for covered family members is included.

7. A *partial hospitalization treatment facility,* a public or private facility, licensed and operated according to the law, which provides intensive therapy daily by a *physician* and licensed

mutual *health care providers* (five (5) days per week for no more than eight (8) hours per day). No room and board charges are incurred.

Surgical Services

1. Surgeon's expenses for the performance of a surgical procedure.

2. Assistant surgeon's expenses not to exceed twenty percent (20%) of the *allowed amount* of the surgical procedure.

3. Two (2) or more surgical procedures performed during the same session through the same incision, natural body orifice or operative field. The amount eligible for consideration is the *allowed amount* for the largest amount billed for one (1) procedure plus fifty percent (50%) of the sum of *allowed amount* for all other procedures performed.

4. Anesthetic services, when performed in connection with a covered surgical procedure.

5. *Oral surgery*, limited to the removal bony cysts of the jaw, torus palatinus, leukoplakia, or malignant tissue; removal of stones from salivary glands; frenectomy; cleft lip and palate; protruding mandible; freeing of muscle attachments; and treatment of a fractured jaw, facial bones or other accidental *injury* to teeth that are stable, functional, free from decay and advanced periodontal disease, and in good repair at the time of the accident. Treatment of an accidental *injury* must be completed within six (6) months of the date of the *injury*.

6. Reconstructive *surgery:*

    a. when needed to correct damage caused by a birth defect resulting in the malformation or absence of a body part;

    b. when needed to correct damage caused by an *illness* or accidental *injury;* or

    c. breast reconstructive *surgery* in a manner determined in consultation with the attending *physician* and the patient. Coverage includes reconstruction of the breast on which the mastectomy was performed, *surgery* and reconstruction of the other breast to produce a symmetrical appearance, prostheses, nipple and areola reconstruction and repigmentation, and treatment of physical complications at all stages of the mastectomy, including lymphedemas. This Plan is in compliance with the Women's Health and Cancer Rights Act of 1998.

7. Non-experimental organ and tissue transplant services to an organ transplant recipient who is covered under this Plan. In addition, benefits will be provided for *inpatient hospital* expenses of the donor of an organ for transplant to a covered recipient and for *physician's* expenses for surgical removal of the donor organ if the donor is also covered under this plan.

    Benefits include travel and lodging expenses for the patient and a companion if the facility is more than 30 miles from the covered persons residence or place of employment. Benefits are

limited to regular coach airfare (if travel by plane) and the current Federal Government per diem for mileage and hotel accommodations.

No benefits will be provided for organ selection, transportation and storage costs, or when benefits are available through government funding of any kind, or when the recipient is not covered under this Plan.

8. Circumcision.

9. *Outpatient surgery*.

10. Amniocentesis when the attending *physician* certifies that the procedure is *medically necessary*.

11. Surgical treatment of *morbid obesity* limited to one (1) such procedure per *lifetime*.

    Services provided by a Blue Distinction Center will be paid at the in-network benefit level. You will be responsible for 20%* for services provided by a Blue Shield *health care provider* that has not been designated as a Blue Distinction Center.

    For members residing in Imperial, Kern, Los Angeles, Orange, Riverside, San Bernardino, San Diego, Santa Barbara and Ventura Counties ("Designated Counties"), bariatric surgery services are covered when performed at designated contracting bariatric surgery facilities, by designated contracting surgeons; and other preferred providers. Coverage is not available for bariatric services from non-preferred providers.

    Members who reside in designated counties (Imperial, Kern, Los Angeles, Orange, Riverside, San Bernardino, San Diego, Santa Barbara and Ventura) may be eligible to receive reimbursement for associated travel expenses. Submission of adequate documentation including receipts is required before travel reimbursement will be made. Travel reimbursement includes travel and lodging expenses for the patient and a companion if the facility is more than 30 miles from the covered persons residence or place of employment. Benefits are limited to coach airfare (if travel by plane) and the current Federal Government per diem for mileage and hotel accommodations.

    Participants who reside in non-designated counties, services are covered as any other medically necessary surgery.

12. Voluntary sterilization.

13. Voluntary termination of pregnancy and any complications arising from the termination of pregnancy.

14. Gender reassignment *surgery*, when *medically necessary*, for individuals with a documented diagnosis of gender dysphoria.

15. Cochlear implantation, when *medically necessary.*

Mental/Behavioral Health and Substance Abuse Treatment

1. *Inpatient* mental health and substance abuse treatment.

2. *Outpatient* mental health and substance abuse treatment.

3. Treatment of an eating disorder, following initial visit to a *physician* for diagnosis.

4. Partial hospitalization.

5. Biofeedback.

6. Behavioral health treatment for the treatment of autism spectrum disorder in an office, home. or other non-institutional setting. Services must be prescribed by a *physician* or licensed psychologist.

Medical Services

1. *Physician* office visits relating to a covered *illness* or *injury*.

2. *Inpatient physician* visits by the attending or non-attending *physician*.

3. *Second/third* (if *medically necessary*) *surgical opinions*.

4. Pregnancy and related maternity care for all covered females.

5. Diagnosis and treatment of *infertility*, including but not limited to:

    - In Vitro Fertilization (IVF): Coverage includes up to three (3) completed oocyte retrievals and unlimited embryo transfers using the patient's own eggs or donor eggs.

    - Fertility Preservation: Services related to fertility preservation for individuals undergoing medical treatments that may impair fertility.

    - Inclusive Definition of *Infertility*: *Infertility* is defined as a disease, condition, or status characterized by:

        - The inability to conceive after 12 months of regular, unprotected sexual intercourse or therapeutic donor insemination;
        - The need for medical intervention to achieve pregnancy due to a person's medical, sexual, or reproductive history;
        - The inability to reproduce either as an individual or with a partner, regardless of sexual orientation, gender identity, or marital status.

- Additional Covered Services:

    - Diagnostic testing and procedures
    - Ovulation induction and monitoring
    - Intrauterine insemination (IUI)
    - Cryopreservation and storage of gametes and embryos (if medically necessary)

  All services must be *medically necessary* and provided by a licensed provider.

  Regulatory Alignment Clause

  This benefit is intended to mirror the insured benefit mandated in California under Senate Bill 729 (SB 729). Coverage is subject to the definitions, limitations, and regulatory guidance established by the California Department of Insurance (CDI) and the Department of Managed Health Care (DMHC), including any future updates or clarifications issued by these agencies.

6. Private duty nursing care provided by a registered graduate *nurse* (R.N.) or a licensed practical *nurse* (L.P.N.) if *medically necessary*.

7. Dental services received after an accidental *injury* to sound and natural teeth including replacement of such teeth; and any related x-rays and dental services must be completed within six (6) months of the date of the *injury*.

8. Radiation therapy.

9. Chemotherapy.

10. Hemodialysis.

11. Chiropractic services excluding *maintenance care* and palliative treatment.

12. Podiatric services for treatment of an *illness or injury*, or due to metabolic or peripheral vascular disease.

13. Physical therapy, including cardiac rehabilitation therapy received from a qualified *practitioner* under the direct supervision of the attending *physician*, excluding *maintenance care* and palliative treatment.

14. Non-custodial services of a *nurse* which are not billed by a *home health care agency*.

15. Home health care that is provided by a *home health care agency* (four (4) hours = one (1) visit). The following are defined as covered home health care services and supplies upon referral of the attending *physician*:

    a. part-time nursing services provided by or supervised by a registered *nurse* (R.N.);

b. part-time or intermittent home health aide services;

c. physical, occupational, speech or respiratory therapy which is provided by a qualified therapist;

d. nutritional counseling that is provided by or under the supervision of a registered dietician;

e. laboratory services, drugs, medicines, IV therapy and medical supplies which are prescribed by the doctor.

16. *Hospice care* (including bereavement counseling) provided that the covered person has a life expectancy of six (6) months or less and subject to the maximums, if any, as set forth in the Schedule of Benefits. Covered *hospice care*, *respite care* and bereavement expenses are limited to:

a. room and board for confinement in a *hospice facility*;

b. ancillary charges furnished by the hospice while the patient is confined therein, including rental of *durable medical equipment* which is used solely for treating an *injury* or *illness*;

c. nursing care by a registered *nurse*, a licensed practical *nurse*, or a licensed vocational *nurse* (L.V.N.);

d. home health aide services;

e. home care charges for home care furnished by a *hospital* or *home health care agency*, under the direction of a hospice, including *custodial care* if it is provided during a regular visit by a registered *nurse*, a licensed practical *nurse*, or a home health aide;

f. laboratory services, drugs, medicines, IV therapy and medical supplies which are prescribed by the doctor.

g. medical social services by licensed or trained social workers, psychologists, or counselors;

h. nutrition services provided by a licensed dietician;

i. counseling and emotional support services by a licensed social worker or a licensed pastoral counselor;

j. bereavement counseling by a licensed social worker or a licensed pastoral counselor for the covered person's immediate family received within the six (6) month period following the patient's death;

k. *respite care*.

17. Speech therapy from a qualified *practitioner* to restore speech loss or for treatment of a mental health condition, excluding *maintenance care* and palliative care.

18. Occupational therapy, excluding *maintenance care* and palliative care, vocational, educational, recreational, art, dance or music therapy.

19. Initial examination for the treatment of eating disorders (e.g., bulimia, anorexia). Subsequent treatment is eligible for consideration as a mental health disorder.

20. Allergy testing and treatment.

21. Preparation of serum and injections for allergies.

22. Charges related to a provider discount for covered medical expenses resulting in savings to this Plan.

23. Diabetes education programs.

24. Insertion or removal of any contraceptive that is a covered expense under this medical or prescription drug plan.

25. *Medically necessary* services rendered in connection with an *approved clinical trial*.

26. Acupuncture.

27. Emergency, urgent care and any other medical treatment received outside of the United States.

28. Telemedicine consultations with a *physician* or *practitioner,* as available through the *employer's* contracted vendor for such services.

Diagnostic X-Ray and Laboratory Services

1. *Diagnostic charges* for x-rays.

2. *Diagnostic charges* for laboratory services.

3. Preadmission testing (PAT).

4. Ultrasounds, prenatal laboratory and pregnancy testing.

5. Genetic testing and counseling as deemed *medically necessary* by a *physician*.

Equipment and Supplies

1. *Durable medical equipment*, including expenses related to necessary repairs and maintenance. A statement is required from the prescribing *physician* describing how long the equipment is expected to be necessary. This statement will determine whether the equipment will be rented or purchased. Initial replacement equipment is covered if the replacement equipment is required due to a change in the patient's physical condition; or, purchase of new equipment is less expensive than repair of existing equipment.

2. Artificial limbs and eyes and replacement of artificial eyes and limbs if required due to a change in the patient's physical condition; or, replacement is less expensive than repair of existing equipment.

3. Oxygen and rental of equipment required for its use, not to exceed the purchase price of such equipment.

4. Blood and/or plasma, if not replaced, and the equipment for its administration including autologous blood transfusions.

5. Diabetic continuous glucose monitors and related supplies, and insulin infusion pumps and related supplies.

6. Initial prescription contact lenses or eye glasses, including the examination and fitting of the lenses, to replace the human lens lost through intraocular *surgery* or when required as the result of an *injury*.

7. The purchase or fitting of hearing aids.

8. Original fitting, adjustment and placement of orthopedic braces, casts, splints, crutches, cervical collars, head halters, traction apparatus, or prosthetic appliances, when prescribed by a *physician*, to replace lost body parts or to aid in their function when impaired. Replacement of such devices only will be covered if the replacement is necessary due to a change in the physical condition of the covered person.

9. Special footwear required for those who suffer from foot disfigurement, such as disfigurement from cerebral palsy, arthritis, polio, spina bifida, diabetes and disfigurement caused by an accident or developmental disability.

10. Sterile surgical supplies after *surgery*.

11. Compression garments limited to two (2) pair per *benefit year*.

12. Occupational therapy supplies related to covered occupational therapy.

13. Drugs, medicines, or supplies dispensed through the *physician's* office, for which the patient is charged.

14. Take home prescription drugs from a *hospital*, for which the patient is charged.

Preventive Care

Preventive care includes the following preventive care items and services as required under the Patient Protection and Affordable Care Act:

1. Evidence-based items or services that have a rating of "A" or "B" and are currently recommended by the U.S. Preventive Services Task Force.

2. Immunizations that are currently recommended by the Advisory Committee on Immunization Practices for the Centers for Disease Control and Prevention.

3. Evidence-informed preventive care and screenings as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration for infants, children and adolescents.

4. Additional preventive care and screenings as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration for women.

Preventive care also includes charges for a COVID-19 vaccine and its administration.

For additional information, please visit https://www.healthcare.gov/coverage/preventive-care-benefits/.

H. Medical Expenses Not Covered

The Plan will not provide benefits for any of the items listed in this section, regardless of *medical necessity* or recommendation of a *health care provider*. This list is intended to give you a general description of expenses for services and supplies not covered by the Plan. The Plan only covers those expenses for services and supplies specifically described as covered in the preceding section. There may be expenses in addition to those listed below which are not covered by the Plan.

General Exclusions

1. Expenses exceeding the *allowed amount*.

2. Expenses unnecessary for diagnosis of an *illness* or *injury*, except as specifically mentioned in Covered Medical Expenses.

3. Treatment not prescribed or recommended by a *health care provider*.

4. Services, supplies, or treatment not *medically necessary*.

5. *Experimental* equipment, services, or supplies which have not been approved by the United States Department of Health and Human Services, the American Medical Association (AMA), or the appropriate government agency.

6. Services furnished by or for the United States Government or any other government, unless payment is legally required.

7. Any condition or disability sustained as a result of being engaged in an activity primarily for wage, profit or gain, and for which the covered person benefits are provided under Worker's Compensation Laws or similar legislation.

8. Any condition, disability, or expense sustained as a result of being engaged in: an illegal occupation; commission or attempted commission of an assault or other illegal act; participating in a civil revolution or riot; duty as a member of the armed forces of any state or country; or a war or act of war which is declared or undeclared.

9. Educational, vocational, or training services and supplies, except as specifically mentioned in Covered Medical Expenses.

10. Expenses for failure to keep a scheduled appointment, or charges for completion of medical reports, itemized bills, or claim forms.

11. Mailing and/or shipping and handling expenses.

12. Services or supplies rendered by a facility operated by the Veteran's Health Administration for an *injury* or *illness* determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of uniformed service.

13. Communication, transportation expense, or travel time of *physicians* or *nurses*.

14. Charges resulting from penalties, exclusions, or charges in excess of allowable limits imposed by HMO, non-HMO, or PPO providers resulting from failure to follow the required procedures for obtaining services or treatment.

15. Services or supplies for which there is no legal obligation to pay, or expenses which would not be made except for the availability of benefits under this Plan.

16. Professional services performed by a person who ordinarily resides in your household or is related to the covered person, such as a spouse, parent, child, brother, sister, or in-law.

17. Intentionally self-inflicted *injury* or *illness* while sane or insane and suicide or any attempt to commit suicide while sane or insane, except a self-inflicted *injury* or *illness* that is the result of a physical or mental medical condition. This exclusion does not apply (a) if the *injury* resulted from being the victim of an act of domestic violence, or (b) if the *injury* or *illness* resulted from a documented medical condition (including both physical and mental health conditions).

18. Expenses used to satisfy Plan deductibles, co-pays, or applied as penalties.

19. Expenses eligible for consideration under any *other plan* of the *employer.*

20. Expenses incurred as the result of an auto accident up to the amount of any state required automobile insurance with respect to those expenses.

21. Expenses incurred for services rendered prior to the effective date of coverage under this Plan or expenses for services performed after the date coverage terminates.

Additional Exclusions

The following exclusions are in alphabetical order to assist you in finding information quickly; however, you should review the entire list of exclusions when trying to determine whether a particular treatment or service is covered as the wording of the exclusion may place it in a different location than you might otherwise expect.

1. Adoption expenses.

2. Behavioral health treatment used for the purposes of providing respite, day care, or educational services, or to reimburse a parent for participation in the treatment.

3. Breast prosthetic implant removals whether inserted for cosmetic reasons or due to a mastectomy are not covered, unless the removal is *medically necessary*.

4. Complications arising from any non-covered *surgery* or treatment.

5. *Cosmetic surgery* or reconstructive *surgery* unless specifically mentioned in Covered Medical Expenses.

6. Dental services, dental appliances, or treatment including hospitalization for dental services, except as specifically mentioned in Covered Medical Expenses.

7. Donor expenses unless specifically mentioned in Covered Medical Expenses.

8. Drugs, medicine, or supplies that do not require a *physician's* prescription. Some over-the-counter drugs are covered under the Preventive Care benefit if prescribed by a *physician*.

9. Education, counseling, or job training for learning disorders or behavioral problems whether or not services are rendered in a facility that also provides medical and/or mental health treatment, except as specifically mentioned in Covered Medical Expenses.

10. Equipment such as air conditioners, air purifiers, dehumidifiers, heating pads, hot water bottles, water beds, swimming pools, hot tubs, and any other clothing or equipment which could be used in the absence of an *illness* or *injury*.

11. Eyeglasses or lenses, orthoptics, vision therapy, or supplies unless specifically mentioned in Covered Medical Expenses.

12. Family counseling.

13. Foot treatment, palliative or cosmetic, including flat foot conditions, supportive devices for the foot, orthotics, orthopedic or corrective shoes, the treatment of subluxations of the foot, care of corns, bunions (except by capsular or bone *surgery*), calluses, toe nails (except *surgery* for ingrown nails), fallen arches, weak feet, chronic foot strain, and symptomatic complaints of the feet.

14. Gender reassignment *surgery*, except as specified in Covered Medical Expenses.

15. Genetic testing and counseling unless specifically mentioned in Covered Medical Expenses.

16. *Habilitation services* unless specifically mentioned in Covered Medical Expenses.

17. Hearing examinations unless specifically mentioned in Covered Medical Expenses or is a required preventive care under the Patient Protection and Affordable Care Act.

18. *Hospital* confinement for physiotherapy, hydrotherapy, convalescent care, or rest care.

19. Hypnosis.

20. Impotence medications.

21. *Infertility* services except as specifically mentioned in Covered Medical Expenses.

22. Insertion or removal of any contraceptive that is not a covered expense under this medical or prescription drug plan.

23. Kerato-refractive eye *surgery* (to improve nearsightedness, farsightedness, and/or astigmatism by changing the shape of the cornea including, but not limited to, radial keratotomy and keratomileusis *surgery*).

24. Massage therapy or rolfing.

25. Marital counseling.

26. Non-routine services rendered in connection with an *approved clinical trial*, including:

- The *experimental* treatment, procedure, device or drug itself.
- Items or services provided solely to satisfy data collection and analysis.
- Items or services customarily provided by the research sponsors free of charge.
- Items or services provided solely to determine trial eligibility.

27. Orthodontics for cleft palate.

28. Personal comfort or service items while confined in a *hospital* including, but not limited to, radio, television, telephone, and guest meals.

29. Prescription drugs or medicines other than specifically mentioned in any Covered Medical Expenses section.

30. Preventive care unless specifically mentioned in Covered Medical Expenses.

31. Reversal of any elective surgical procedure.

32. Sales tax.

33. Sanitarium, rest, or *custodial care*.

34. Sex counseling.

35. Smoking cessation programs or *physician's* office visits for smoking cessation treatment, except to the extent required under the preventive care mandate of the Patient Protection and Affordable Care Act.

36. Surrogate expenses, including use of a surrogate by a covered individual or services as a surrogate by a covered individual.

37. Temporomandibular joint dysfunction (TMJ): surgical treatment, non-surgical treatment or treatment for prevention of TMJ, craniomandibular disorder, and other conditions of the joint linking the jawbone and skull, the muscles, nerves and other related tissues to that joint.

38. Vitamins and nutritional supplements, regardless of whether or not a *physician's* prescription is required, except to the extent required under the preventive care mandate of the Patient Protection and Affordable Care Act.

39. Weight reduction or control, including treatments, instructions, activities, or drugs and diet pills, whether or not prescribed by a *physician*, except as specifically mentioned in Covered Medical Expenses, except to the extent required under the preventive care mandate of the Patient Protection and Affordable Care Act.

40. Wigs and artificial hair pieces.

ARTICLE V -- PRESCRIPTION DRUG PLAN

A. About Your Prescription Drug Benefits

The prescription drug program is an independent program, separate from the medical plan, and administered by Express Scripts, Inc.

The prescription drug program covers prescription drug costs incurred by you and your covered dependents. You will receive an identification card when you become covered under the Plan. In order to access your benefits, simply present your identification card at any participating pharmacy.

If you choose to use a non-participating pharmacy, you must pay the pharmacy the full amount for the prescription. The pharmacy should complete the section of the direct reimbursement form which may be obtained from your *employer*. You complete your section of the form and send the completed form to Express Scripts with your receipt. You will be reimbursed the amount that would have been paid to the participating pharmacy, less the applicable co-pay.

Keenan Pharmacy Care Management (KPCM) provides an independent, unbiased layer of clinical management by engaging Physicians and Program Participants directly to ensure that the best possible drug therapies are chosen, based on their clinical effectiveness and overall cost to Program Participants and the Program. KPCM may recommend modifications to a Prescription Drug order and, if approved by the prescribing Physician and Program Participant, a new Prescription Drug order is issued.

All specialty prescriptions require prior authorization review through the Keenan Pharmacy Care Management Program. Physicians should contact US-Rx Care at 844.744.4410.

B. Mail Service Prescription Drug Program

The mail service prescription drug program is offered when there is an ongoing need for medication. By using this service, you can obtain prescribed medication required on a non-emergency, extended-use basis.

If you need medication immediately, but will be taking it on an ongoing basis, ask your *physician* for two (2) prescriptions. The first should be for up to a thirty-four (34) day supply that you can have filled at a local pharmacy. The second prescription should be for the balance, up to a ninety (90) day supply. Send the larger prescription through the mail service prescription drug program.

If you need medication immediately, but will be taking it on an ongoing basis, ask your *physician* for two (2) prescriptions. The first should be for up to a thirty-four (34) day supply that you can have filled at a local pharmacy. The second prescription should be for the balance, up to

a ninety (90) day supply. Send the larger prescription through the mail service prescription drug program.

C. Co-pays

The co-pay amounts for generic and brand name prescriptions or refills are shown on the Schedule of Prescription Drug Benefits. The Prescription Drug Plan will pay 100% of the actual expense incurred for a prescription drug that is in excess of the prescription drug co-pay.

D. Out-of-Pocket Limit

An out-of-pocket limit is the maximum amount of covered expenses you must pay during a *benefit year*. When you reach the annual out-of-pocket limit applicable to you, the Plan will pay one hundred percent (100%) of additional covered expenses during the remainder of that *benefit year.*

The annual individual and family out-of-pocket limits are shown on the Schedule of Prescription Drug Benefits.

E. Dispensing Limitations

When purchasing prescription drugs at a retail pharmacy, prescriptions are covered for up to a thirty-four (34) day supply or the equivalent for drugs that are supplied in individual, unit packaging such as aerosols and eye drops.

The quantity of a prescribed drug ordered through the mail service program can be anything up to a ninety (90) day supply or the equivalent for drugs that are supplied in individual, unit packaging such as aerosols and eye drops.

NOTE: Certain controlled substances and several other prescribed medications may be subject to other dispensing limitations and to the professional judgment of the pharmacist.

F. Covered Prescription Drugs

Prescriptions covered under your Plan include all drugs bearing the legend "Caution: Federal law prohibits dispensing without a prescription" except as identified in Prescription Drugs Not Covered.

The following are specifically covered by this Plan when accompanied by a *physician's* prescription.

1. Contraceptives: oral, extended-cycle oral, *emergency*, injectable, implantable, transdermal and barrier forms.

2. *Infertility* agents and medications.

3. Impotence medications

4. Diabetic medications, including insulin, anti-hyperglycemic injectables and glucose elevating agents.

5. Diabetic supplies, including disposable needles, syringes, testing agents, test strips, lancets, lancet devices, alcohol swabs, non-continuous blood glucose monitors and calibration solution for monitors, and insulin pump supplies.

6. Prenatal and pediatric vitamins.

7. Fluoride supplements.

8. Acne agents and medications.

9 Anti-obesity medications.

10. Smoking deterrents.

11. A.D.D./Narcolepsy medications.

12. Brand immunological agents prescribed for prevention of vaccine-preventable diseases. Includes routine vaccines recommended by ACIP and their administration.

13. Growth hormones.

14. Androgenic steroids.

15. Preventive medications as mandated under the Patient Protection and Affordable Care Act (PPACA).

16. Injectable legend drugs, except those specifically mentioned in Prescription Drugs Not Covered.

17. Compounded medication of which at least one (1) ingredient is a legend drug.

18. Any other drug which under the applicable state law may only be dispensed upon the written prescription of a *physician* or other lawful prescriber.

G. Prescription Drugs Not Covered

1. Contraceptives, except as specifically mentioned under Covered Prescription Drugs or as required under the Patient Protection and Affordable Care Act.

2. Nutritional supplements, except as specifically mentioned under Covered Prescription Drugs.

3. Cosmetic agents and medications, including but not limited to, anti-wrinkle agents, hair growth stimulants, hair removal products and pigmenting/depigmenting agents.

4. Anabolic steroids.

5. Immunization agents, except as specifically mentioned under Covered Prescription Drugs.

6. Blood or blood plasma.

7. Respiratory therapies.

8. Non-legend drugs except those specifically mentioned in Covered Prescription Drugs.

9. Therapeutic devices or appliances, including support garments and other non-medicinal substances, regardless of intended use, except those specifically mentioned in Covered Prescription Drugs.

10. Charges for the administration or injection of any drug.

11. Drugs labeled "Caution: Limited by Federal law to investigational use," or *experimental* drugs even though a charge is made to the individual.

12. Medication which is to be taken by or administered to an individual, in whole or in part, while he or she is a patient in a licensed *hospital*, rest home, sanitarium, *skilled nursing facility*, convalescent *hospital*, nursing home or similar institution which operates on its premises or allows to be operated on its premises a facility for dispensing pharmaceuticals.

13. Any prescription refilled in excess of the number specified by the *physician*, or any refill dispensed more than one (1) year from the *physician's* original order.

ARTICLE VI -- COORDINATION OF BENEFITS (COB)

A. General Provisions

When you and/or your dependents are covered under more than one (1) health plan, the combined benefits payable by this Plan and all *other plan*s will not exceed one hundred percent (100%) of the eligible expense incurred by the individual. The plan assuming primary payor status will determine benefits first without regard to benefits provided under any other health plan. Any health plan which does not contain a coordination of benefits provision will be considered primary.

When this Plan is the secondary payor, it will reimburse, subject to all Plan provisions, the balance of remaining expenses, not to exceed normal Plan liability.

B. Excess Insurance

If at the time of *injury*, sickness, disease or disability there is available, or potentially available any coverage (including but not limited to coverage resulting from a judgment at law or settlements), the benefits under this Plan shall apply only as an excess over such other sources of coverage.

The Plan's benefits will be excess to, whenever possible:

1. Any primary payer besides the Plan;
2. Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage;
3. Any policy of insurance from any insurance company or guarantor of a third party;
4. Workers' compensation or other liability insurance company; or
5. Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

C. Vehicle Limitation

Benefits payable under this Plan will be coordinated with benefits provided or required by any no-fault automobile coverage statute, whether or not a no-fault policy is in effect, and/or any other vehicle insurance coverage. This Plan will be secondary to any state mandated automobile coverage for services and supplies eligible for consideration under this Plan.

Certain states permit vehicle insurance policyholders to choose personal injury protection (PIP) as a secondary coverage. In states where PIP coverage is available, this Plan will always be considered secondary regardless of the policyholder's election under PIP coverage with the vehicle insurance carrier. Insurance coverages under the names PIP, Med-Pay, First Party Medical and No-Fault are all used interchangeably and refer to a type of first party automobile coverage offering assistance with or direct payment of accident related claims.

Uninsured or underinsured motorist coverage, whether under your policy or not, is subject to recovery by the Plan as a third-party recovery.

D. Federal Programs

The term "group health plan" includes the Federal programs *Medicare* and Medicaid. The regulations governing these programs take precedence over the order of determination of this Plan. For more information, see the Medicare and Medicaid sections under Other Important Plan Provisions.

E. Application to Benefit Determinations

The plan that pays first according to the rules in the section entitled "Order of Benefit Determination" will pay as if there were no *other plan* involved. The secondary and subsequent plans will pay the balance due up to one hundred percent (100%) of the total Allowable Expenses.

F. Order of Benefit Determination

For the purposes of the section entitled "Application to Benefit Determinations," the rules establishing the order of benefit determination are:

1. A plan without a coordinating provision will always be the primary plan;

2. The benefits of a plan which covers the person on whose expenses claim is based, other than as a dependent, shall be determined before the benefits of a plan which covers such person as a dependent;

3. If the person for whom claim is made is a dependent child covered under both parents' plans, the plan covering the parent whose birthday (month and day of birth, not year) falls earlier in the year will be primary, except:

    a. When the parents are separated or divorced, and the parent with the custody of the child has not remarried, the benefits of a plan which covers the child as a dependent of the parent with custody will be determined before the benefits of a plan which covers the child as a dependent of the parent without custody; or

    b. When the parents are divorced and the parent with custody of the child has remarried, the benefits of a plan which covers the child as a dependent of the parent with custody shall be determined before the benefits of a plan which covers that child as a dependent of the stepparent, and the benefits of a plan which covers that child as a dependent of the stepparent will be determined before the benefits of a plan which covers that child as a dependent of the parent without custody.

        Notwithstanding the above, if there is a court decree which would otherwise establish financial responsibility for the child's health care expenses, the benefits of the plan

which covers the child as a dependent of the parent with such financial responsibility shall be determined before the benefits of any *other plan* which covers the child as a dependent child; and

4. When the rules above do not establish an order of benefit determination, the benefits of a plan which has covered the person on whose expenses claim is based for the longer period of time shall be determined before the benefits of a plan which has covered such person the shorter period of time.

G. Right to Make Payments to Other Organizations

Whenever payments which should have been made by this Plan have been made by any *other plan(s)*, this Plan has the right to pay the *other plan(s)* any amount necessary to satisfy the terms of this coordination of benefits provision.

Amounts paid will be considered benefits paid under this Plan and, to the extent of such payments, the Plan will be fully released from any liability regarding the person for whom payment was made.

ARTICLE VII -- THIRD PARTY RECOVERY, SUBROGATION AND REIMBURSEMENT

The Plan, in its sole discretion, may elect to conditionally advance payment of benefits in those situations where an *injury, illness* or disability is caused in whole or in part by, or results from the acts or omissions of participants, and/or their dependents, beneficiaries, estate, heirs, guardian, personal representative, or assigns (collectively referred to hereinafter in this section as "Participant(s)") or a third party, where any party besides the Plan may be responsible for expenses arising from an incident, and/or other funds are available, including but not limited to no-fault, uninsured motorist, underinsured motorist, medical payment provisions, third party assets, third party insurance, and/or guarantor(s) of a third party (collectively "Coverage").

Participant(s), his or her attorney, and/or legal guardian of a minor or incapacitated individual agrees that acceptance of the Plan's conditional payment of medical benefits is constructive notice of these provisions in their entirety and agrees to maintain 100% of the Plan's conditional payment of benefits or the full extent of payment from any one or combination of first and third party sources in trust, without disruption except for reimbursement to the Plan or the Plan's assignee. The Plan shall have an equitable lien on any funds received by the Participant(s) and/or their attorney from any source and said funds shall be held in trust until such time as the obligations under this provision are fully satisfied. The Participant(s) agrees to include the Plan's name as a co-payee on any and all settlement drafts. Further, by accepting benefits the Participant(s) understands that any recovery obtained pursuant to this section is an asset of the Plan to the extent of the amount of benefits paid by the Plan and that the Participant shall be a trustee over those Plan assets.

In the event a Participant(s) settles, recovers, or is reimbursed by any Coverage, the Participant(s) agrees to reimburse the Plan for all benefits paid or that will be paid by the Plan on behalf of the Participant(s). When such a recovery does not include payment for future treatment, the Plan's right to reimbursement extends to all benefits paid or that will be paid by the Plan on behalf of the Participant(s) for charges incurred up to the date such Coverage or third party is fully released from liability, including any such charges not yet submitted to the Plan. If the Participant(s) fails to reimburse the Plan out of any judgment or settlement received, the Participant(s) will be responsible for any and all expenses (fees and costs) associated with the Plan's attempt to recover such money. Nothing herein shall be construed as prohibiting the Plan from claiming reimbursement for charges incurred after the date of settlement if such recovery provides for consideration of future medical expenses.

If there is more than one party responsible for charges paid by the Plan, or may be responsible for charges paid by the Plan, the Plan will not be required to select a particular party from whom reimbursement is due. Furthermore, unallocated settlement funds meant to compensate multiple injured parties of which the Participant(s) is/are only one or a few, that unallocated settlement fund is considered designated as an "identifiable" fund from which the plan may seek reimbursement.

A. Subrogation

As a condition to participating in and receiving benefits under this Plan, the Participant(s) agrees to assign to the Plan the right to subrogate and pursue any and all claims, causes of action or rights that may arise against any person, corporation and/or entity and to any Coverage to which the Participant(s) is entitled, regardless of how classified or characterized, at the Plan's discretion, if the Participant(s) fails to so pursue said rights and/or action.

If a Participant(s) receives or becomes entitled to receive benefits, an automatic equitable lien attaches in favor of the Plan to any claim, which any Participant(s) may have against any Coverage and/or party causing the *illness* or *injury* to the extent of such conditional payment by the Plan plus reasonable costs of collection. The Participant is obligated to notify the Plan or its authorized representative of any settlement prior to finalization of the settlement, execution of a release, or receipt of applicable funds. The Participant is also obligated to hold any and all funds so received in trust on the Plan's behalf and function as a trustee as it applies to those funds until the Plan's rights described herein are honored and the Plan is reimbursed.

The Plan may, at its discretion, in its own name or in the name of the Participant(s) commence a proceeding or pursue a claim against any party or Coverage for the recovery of all damages to the full extent of the value of any such benefits or conditional payments advanced by the Plan.

If the Participant(s) fails to file a claim or pursue damages against:

1. The responsible party, its insurer, or any other source on behalf of that party.
2. Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage, including any similar coverage under a different name in a particular state.
3. Any policy of insurance from any insurance company or guarantor of a third party.
4. Workers' compensation or other liability insurance company.
5. Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

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

B. Right of Reimbursement

The Plan shall be entitled to recover 100% of the benefits paid or payable benefits incurred, that have been paid and/or will be paid by the Plan, or were otherwise incurred by the Participant(s) prior to and until the release from liability of the liable entity, as applicable, without deduction for attorneys' fees and costs or application of the common fund doctrine, made whole doctrine, or any other similar legal or equitable theory, and without regard to whether the Participant(s) is fully compensated by his or her recovery from all sources. The Plan shall have an equitable lien which supersedes all common law or statutory rules, doctrines, and laws of any State prohibiting assignment of rights which interferes with or compromises in any way the Plan's equitable lien and right to reimbursement. The obligation to reimburse the Plan in full exists regardless of how the judgment or settlement is classified and whether or not the judgment or settlement specifically designates the recovery or a portion of it as including medical, disability, or other expenses and extends until the date upon which the liable party is released from liability. If the Participant's/Participants' recovery is less than the benefits paid, then the Plan is entitled to be paid all of the recovery achieved. Any funds received by the Participant are deemed held in constructive trust and should not be dissipated or disbursed until such time as the Participant's obligation to reimburse the Plan has been satisfied in accordance with these provisions. The Participant is also obligated to hold any and all funds so received in trust on the Plan's behalf and function as a trustee as it applies to those funds until the Plan's rights described herein are honored and the Plan is reimbursed.

No court costs, experts' fees, attorneys' fees, filing fees, or other costs or expenses of litigation may be deducted from the Plan's recovery without the prior, express written consent of the Plan.

The Plan's right of subrogation and reimbursement will not be reduced or affected as a result of any fault or claim on the part of the Participant(s), whether under the doctrines of causation, comparative fault or contributory negligence, or other similar doctrine in law. Accordingly, any lien reduction statutes, which attempt to apply such laws and reduce a subrogating Plan's recovery will not be applicable to the Plan and will not reduce the Plan's reimbursement rights.

These rights of subrogation and reimbursement shall apply without regard to whether any separate written acknowledgment of these rights is required by the Plan and signed by the Participant(s).

This provision shall not limit any other remedies of the Plan provided by law. These rights of subrogation and reimbursement shall apply without regard to the location of the event that led to or caused the applicable *illness*, *injury*, or disability.

C. Participant is a Trustee Over Plan Assets

Any Participant who receives benefits and is therefore subject to the terms of this section is hereby deemed a recipient and holder of Plan assets and is therefore deemed a trustee of the Plan solely as it relates to possession of any funds which may be owed to the Plan as a result of any settlement, judgment or recovery through any other means arising from any *injury* or accident. By virtue of this status, the Participant understands that he or she is required to:

1. Notify the Plan or its authorized representative of any settlement prior to finalization of the settlement, execution of a release, or receipt of applicable funds.
2. Instruct his or her attorney to ensure that the Plan and/or its authorized representative is included as a payee on all settlement drafts.
3. In circumstances where the Participant is not represented by an attorney, instruct the insurance company or any third party from whom the Participant obtains a settlement, judgment or other source of Coverage to include the Plan or its authorized representative as a payee on the settlement draft.
4. Hold any and all funds so received in trust, on the Plan's behalf, and function as a trustee as it applies to those funds, until the Plan's rights described herein are honored and the Plan is reimbursed.

To the extent the Participant disputes this obligation to the Plan under this section, the Participant or any of its agents or representatives is also required to hold any/all settlement funds, including the entire settlement if the settlement is less than the Plan's interests, and without reduction in consideration of attorneys' fees, for which he or she exercises control, in an account segregated from their general accounts or general assets until such time as the dispute is resolved.

No Participant, beneficiary, or the agents or representatives thereof, exercising control over plan assets and incurring trustee responsibility in accordance with this section will have any authority to accept any reduction of the Plan's interest on the Plan's behalf.

D. Release of Liability

The Plan's right to reimbursement extends to any incident related care that is received by the Participant(s) (Incurred) prior to the liable party being released from liability. The Participant's/Participants' obligation to reimburse the Plan is therefore tethered to the date upon which the claims were Incurred, not the date upon which the payment is made by the Plan. In the case of a settlement, the Participant has an obligation to review the "lien" provided by the Plan and reflecting claims paid by the Plan for which it seeks reimbursement, prior to settlement and/or executing a release of any liable or potentially liable third party, and is also obligated to advise the Plan of any incident related care incurred prior to the proposed date of settlement and/or release, which is not listed but has been or will be incurred, and for which the Plan will be asked to pay.

E. Separation of Funds

Benefits paid by the Plan, funds recovered by the Participant(s), and funds held in trust over which the Plan has an equitable lien exist separately from the property and estate of the Participant(s), such that the death of the Participant(s), or filing of bankruptcy by the Participant(s), will not affect the Plan's equitable lien, the funds over which the Plan has a lien, or the Plan's right to subrogation and reimbursement.

F. Wrongful Death

In the event that the Participant(s) dies as a result of his or her injuries and a wrongful death or survivor claim is asserted against a third party or any Coverage, the Plan's subrogation and reimbursement rights shall still apply, and the entity pursuing said claim shall honor and enforce these Plan rights and terms by which benefits are paid on behalf of the Participant(s) and all others that benefit from such payment.

G. Obligations

It is the Participant's/Participants' obligation at all times, both prior to and after payment of medical benefits by the Plan:

1. To cooperate with the Plan, or any representatives of the Plan, in protecting its rights, including discovery, attending depositions, and/or cooperating in trial to preserve the Plan's rights.
2. To provide the Plan with pertinent information regarding the *illness*, disability, or *injury*, including accident reports, settlement information and any other requested additional information.
3. To take such action and execute such documents as the Plan may require to facilitate enforcement of its subrogation and reimbursement rights.
4. To do nothing to prejudice the Plan's rights of subrogation and reimbursement.
5. To promptly reimburse the Plan when a recovery through settlement, judgment, award or other payment is received.
6. To notify the Plan or its authorized representative of any incident related claims or care which may be not identified within the lien (but has been Incurred) and/or reimbursement request submitted by or on behalf of the Plan.
7. To notify the Plan or its authorized representative of any settlement prior to finalization of the settlement.
8. To not settle or release, without the prior consent of the Plan, any claim to the extent that the Participant may have against any responsible party or Coverage.
9. To instruct his or her attorney to ensure that the Plan and/or its authorized representative is included as a payee on any settlement draft.
10. In circumstances where the Participant is not represented by an attorney, instruct the insurance company or any third party from whom the Participant obtains a settlement to include the Plan or its authorized representative as a payee on the settlement draft.
11. To make good faith efforts to prevent disbursement of settlement funds until such time as any dispute between the Plan and Participant over settlement funds is resolved.

If the Participant(s) and/or his or her attorney fails to reimburse the Plan for all benefits paid, to be paid, incurred, or that will be incurred, prior to the date of the release of liability from the relevant entity, as a result of said i*njury* or condition, out of any proceeds, judgment or settlement received, the Participant(s) will be responsible for any and all expenses (whether fees or costs) associated with the Plan's attempt to recover such money from the Participant(s).

The Plan's rights to reimbursement and/or subrogation are in no way dependent upon the Participant's/Participants' cooperation or adherence to these terms.

H. Offset

If timely repayment is not made, or the Participant and/or his or her attorney fails to comply with any of the requirements of the Plan, the Plan has the right, in addition to any other lawful means of recovery, to deduct the value of the Participant's amount owed to the Plan. To do this, the Plan may refuse payment of any future medical benefits and any funds or payments due under this Plan on behalf of the Participant(s) in an amount equivalent to any outstanding amounts owed by the Participant to the Plan. This provision applies even if the Participant has disbursed settlement funds.

I. Minor Status

In the event the Participant(s) is a minor as that term is defined by applicable law, the minor's parents or court-appointed guardian shall cooperate in any and all actions by the Plan to seek and obtain requisite court approval to bind the minor and his or her estate insofar as these subrogation and reimbursement provisions are concerned.

If the minor's parents or court-appointed guardian fail to take such action, the Plan shall have no obligation to advance payment of medical benefits on behalf of the minor. Any court costs or legal fees associated with obtaining such approval shall be paid by the minor's parents or court-appointed guardian.

J. Language Interpretation

The *plan administrator* retains sole, full and final discretionary authority to construe and interpret the language of this provision, to determine all questions of fact and law arising under this provision, and to administer the Plan's subrogation and reimbursement rights with respect to this provision. The *plan administrator* may amend the Plan at any time without notice.

ARTICLE VIII -- OTHER IMPORTANT PLAN PROVISIONS

A. Assignment of Benefits

All benefits payable by the Plan may be assigned to the provider of services or supplies at your option. Payments made in accordance with an assignment are made in good faith and release the Plan's obligation to the extent of the payment.

B. Medicare

Applicable to Active Employees and Their Spouses Ages 65 and Over:

If you remain actively at work after reaching age sixty-five (65), you or your spouse may choose to elect or reject coverage under this Plan. If you or your spouse elects coverage under this Plan, the benefits of this Plan shall be determined before any benefits provided by *Medicare*. If you reject coverage under this Plan, benefits listed herein will not be payable even as secondary coverage to *Medicare*.

Applicable to All Other Participants Eligible for Medicare Benefits:

You are required to enroll in *Medicare* Parts A and B. To the extent required by Federal regulations, this Plan will pay before any *Medicare* benefits. There are some circumstances under which *Medicare* would be required to pay its benefits first. In these cases, benefits under this Plan would be calculated as secondary payor (as described in the Article entitled Coordination of Benefits).

If you are entitled to *Medicare* for any reason but chose not to enroll under *Medicare* Parts A and B when entitled, this Plan will process your claims as though *Medicare* Parts A and B had been elected. If the Plan determines that *Medicare* would have been the primary payor, if enrolled, this plan will calculate the amount that Traditional *Medicare* Parts A and B would have paid and coordinate benefits accordingly.

Applicable to Medicare Services Furnished to End Stage Renal Disease (ESRD) Participants Who Are Covered Under This Plan:

If any Plan participant is eligible for *Medicare* benefits because of ESRD, the benefits of this Plan will be determined before *Medicare* benefits for the first eighteen (18) months of *Medicare* entitlement (with respect to charges incurred on or after February 1, 1991 and before August 5, 1997), and for the first thirty (30) months of *Medicare* entitlement (with respect to charges incurred on or after August 5, 1997), unless applicable Federal law provides to the contrary, in which event the benefits of the Plan will be determined in accordance with such law.

Applicable to Participants enrolled in a Medicare Part D Plan:

This Plan will not coordinate benefits for prescription drugs for an individual enrolled in a *Medicare* D plan. If you or your dependent enrolls in a *Medicare* D plan, benefits available under this Prescription Drug Plan will be terminated–such termination may result in termination of all Plan coverage.

C. Medicaid-Eligible Employees and Dependents

If you or your dependents are Medicaid-eligible, you will be entitled to the same coverage under the Plan as all other employees and dependents. The benefits of this Plan will be primary to those payable through Medicaid.

D. Recovery of Excess Payments

Whenever payments have been made in excess of the amount necessary to satisfy the provisions of this Plan, the Plan has the right to recover excess payments from any individual (including yourself), insurance company, or other organization to whom the excess payments were made or to withhold payment on future benefits until the overpayment is recovered.

If excess payments were made for services rendered to your dependent(s), the Plan has the right to withhold payment on your future benefits until the overpayment is recovered.

Further, whenever payments have been made based on fraudulent information provided by you, the Plan will exercise the right to withhold payment on future benefits until the overpayment is recovered.

E. Right to Receive and Release Necessary Information

The *plan administrator* may, without notice to or consent of any person, release to or obtain any information from any insurance company or other organization or person any information regarding coverage, expenses, and benefits which the *plan administrator*, at its sole discretion, considers necessary to determine and apply the provisions and benefits of this Plan. In so acting, the *plan administrator* shall be free from any liability that may arise with regard to such action. Any participant claiming benefits under this Plan shall furnish to the *plan administrator* such information as requested and as may be necessary to implement this provision.

F. Alternate Payee Provision

Under normal conditions, benefits are payable to you and can only be paid directly to another party upon signed authorization from you. If conditions exist under which a valid release or assignment cannot be obtained, the Plan may make payment to any individual or organization that has assumed the care or principal support for you and is equitably entitled to payment.

The Plan may also honor benefit assignments made prior to your death in relation to remaining benefits payable by the Plan.

Any payment made by the Plan in accordance with this provision will fully release the Plan of its liability to you.

G. Severability

The provisions of this Plan will be considered severable; therefore, if a provision is deemed invalid or unenforceable, that decision will not affect the validity and enforceability of the other provisions of the Plan.

H. Fraud

Under this Plan, coverage may be retroactively canceled or terminated (rescinded) if a participant acts fraudulently or intentionally makes material misrepresentations of fact. It is a participant's responsibility to provide accurate information and to make accurate and truthful statements, including information and statements regarding family status, age, relationships, etc. It is also a participant's responsibility to update previously provided information and statements. Failure to do so may result in coverage of participants being canceled, and such cancellation may be retroactive.

A determination by the Plan that a rescission is warranted will be considered an *adverse benefit determination* for purposes of review and appeal. A participant whose coverage is being rescinded will be provided a 30-day notice period as described under The Patient Protection and Affordable Care Act (PPACA) and regulatory guidance. Claims incurred after the retroactive date of termination shall not be further processed and/or paid under the Plan. Claims incurred after the retroactive date of termination that were paid under the Plan will be treated as erroneously paid claims under this Plan.

If a participant, or any other entity, submits or attempts to submit a claim for or on behalf of a person who is not a participant of the Plan; submits a claim for services or supplies not rendered; provides false or misleading information in connection with enrollment in the Plan; or provides any false or misleading information to the Plan as it relates to any element of its administration; that shall be deemed to be fraud. If a participant is aware of any instance of fraud, and fails to bring that fraud to the *plan administrator's* attention, that shall also be deemed to be fraud. Fraud will result in immediate termination of all coverage under this Plan for the participant and their entire family unit of which the participant is a member.

I. Headings

The headings used in this Plan Document are used for convenience of reference only. Participants are advised not to rely on any provision because of the heading.

J. No Waiver or Estoppel

All parts, portions, provisions, conditions, and/or other items addressed by this Plan shall be deemed to be in full force and effect, and not waived, absent an explicit written instrument expressing otherwise, executed by the *plan administrator*. Absent such explicit waiver, there shall be no estoppel against the enforcement of any provision of this Plan. Failure by any applicable entity to enforce any part of the Plan shall not constitute a waiver, either as it specifically applies to a particular circumstance, or as it applies to the Plan's general

administration. If an explicit written waiver is executed, that waiver shall only apply to the matter addressed therein, and shall be interpreted in the most narrow fashion possible.

K. Blue Shield Disclosure Statement

Blue Shield of California, an independent member of the Blue Shield Association, provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.

L. Out of Area Services

Blue Shield of California has a variety of relationships with other Blue Cross and/or Blue Shield Plans Licensees. Generally these relationships are called Inter-Plan Arrangements and they work based on rules and procedures issued by the Blue Cross Blue Shield Association. Whenever you receive services outside of California, the claims for these services may be processed through one of these Inter-Plan Arrangements described below.

When you access Covered Services outside of California, but within the United States, the Commonwealth of Puerto Rico, or the U. S. Virgin Islands (BlueCard® Service Area), you will receive the care from one of two kinds of providers. Participating providers contract with the local Blue Cross and/or Blue Shield Licensee in that other geographic area (Host Blue). Non-participating providers don't contract with the Host Blue. The Administrator's payment practices for both kinds of providers are described below.

Inter-Plan Arrangements

Emergency Services

Members who experience an *emergency* medical condition while traveling outside of California should seek immediate care from the nearest *hospital*. The benefits of this Plan will be provided anywhere in the world for treatment of an *emergency* medical condition.

BlueCard Program

Under the BlueCard® Program, benefits will be provided for covered services received outside of California, but within the BlueCard Service Area (the United States, Puerto Rico, and U.S. Virgin Islands). When you receive covered services within the geographic area served by a Host Blue, Riverside Community College District will remain responsible for doing what we agreed to in the contract. However, the Host Blue is responsible for contracting with and generally handling all interactions with its participating healthcare providers, including direct payment to the provider.

The BlueCard Program enables you to obtain covered services outside of California, as defined, from a healthcare provider participating with a Host Blue, where available. The participating healthcare provider will automatically file a claim for the Covered Services provided to you, so there are no claim forms for you to fill out. You will be responsible for the member copayment, coinsurance and deductible amounts, if any, as stated in this Plan.

The *claims processor* calculates the member's share of cost either as a percentage of the *allowed amount* or a dollar copayment, as defined in this Plan. Whenever you receive covered services outside of California, within the BlueCard Service Area, and the claim is processed through the BlueCard Program, the amount you pay for covered services, if not a flat dollar copayment, is calculated based on the lower of:

1. The billed charges for covered services; or

2. The negotiated price that the Host Blue makes available to the Riverside Community College District.

Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to your healthcare provider. Sometimes, it is an estimated price that takes into account special arrangements with your healthcare provider or provider group that may include types of settlements, incentive payments, and/or other credits or charges. Occasionally, it may be an average price, based on a discount that results in expected average savings for similar types of healthcare providers after taking into account the same types of transactions as with an estimated price.

Estimated pricing and average pricing, going forward, also take into account adjustments to correct for over- or underestimation of modifications of past pricing of claims as noted above. However, such adjustments will not affect the price the *claims processor* used for your claim because these adjustments will not be applied retroactively to claims already paid.

Laws in a small number of states may require the Host Blue to add a surcharge to your calculation. If any state laws mandate other liability calculation methods, including a surcharge, we would then calculate your liability for any covered services according to applicable law.

To find participating BlueCard providers you can call BlueCard Access® at 1-800-810-BLUE (2583) or go online at www.bcbs.com and select "Find a Doctor".

Prior authorization may be required for non-*emergency services*. To receive prior authorization from the Plan, the out-of-area provider should call the customer service number noted on the back of your identification card.

Non-participating Providers Outside of California

When covered services are provided outside of California and within the BlueCard Service Area by non-participating providers, the amount you pay for such services will normally be based on either the Host Blue's non-participating provider local payment, the Allowable Amount that Riverside Community College District pays a Non-Participating Provider in California if the Host Blue has no non-participating provider allowance, or the pricing arrangements required by applicable state law. In these situations, you will be responsible for any difference between the amount that the non-participating provider bills and the payment that Riverside Community College District will make for Covered Services as set forth in this paragraph.

If you do not see a participating provider through the BlueCard Program, you will have to pay the entire bill for your medical care and submit a claim to the local Blue Cross and/or Blue Shield plan, or to the *claims processor* for reimbursement. The *claims processor* will review your claim and notify you of its coverage determination within 30 days after receipt of the claim; you will be reimbursed as described in the preceding paragraph. Remember, your share of cost is higher when you see a non-participating provider.

Federal or state law, as applicable, will govern payments for out-of-network *emergency services*. Riverside Community College District pays claims for covered *emergency* services based on the *allowed amount* as defined in this Plan.

Prior authorization is not required for *emergency* services. In an *emergency*, go directly to the nearest *hospital*. Please notify the Plan of your *emergency* admission within 24 hours or as soon as it is reasonably possible following medical stabilization.

Blue Shield Global® Core

Care for Covered Urgent and Emergency Services Outside the BlueCard Service Area

If you are outside of the BlueCard® Service Area, you may be able to take advantage of Blue Shield Global Core when accessing Out-of-Area Covered Health Care Services. Blue Shield Global Core is unlike the BlueCard Program available within the BlueCard Service Area in certain ways. For instance, although Blue Shield Global Core assists you with accessing a network of *inpatient*, *outpatient*, and professional providers, the network is not served by a Host Blue. As such, when you receive care from providers outside the BlueCard Service Area, you will typically have to pay the provider and submit the claim yourself to obtain reimbursement for these services.

If you need assistance locating a doctor or *hospital* outside the BlueCard Service Area you should call the service center at 1-800-810-BLUE (2583) or call collect at 1-804-673-1177, 24 hours a day, seven days a week. Provider information is also available online at www.bcbs.com: select "Find a Doctor" and then "Blue Shield Global Core".

Submitting a Blue Shield Global Core Claim

When you pay directly for services outside the BlueCard Service Area, you must submit a claim to obtain reimbursement. You should complete a Blue Shield Global Core claim form and send the claim form along with the provider's itemized bill to the service center at the address provided on the form to initiate claims processing. Following the instructions on the claim form will help ensure timely processing of your claim. The claim form is available from Customer Service, the service center or online at www.bcbsglobalcore.com. If you need assistance with your claim submission, you should call the service center at 1-800-810-BLUE (2583) or call collect at 1-804-673-1177, 24 hours a day, seven days a week.

Special Cases: Value-Based Programs

Claims Administrator Value-Based Programs

You may have access to covered services from providers that participate in a Value-Based Program. Claims administrator Value-Based Programs include, but are not limited to, Accountable Care Organizations, Episode Based Payments, Patient Centered Medical Homes and Shared Savings arrangements.

BlueCard® Program

If you receive covered services under a Value-Based Program inside a Host Blue's service area, you will not be responsible for paying any of the Provider Incentives, risk-sharing, and/or Care Coordinator Fees that are a part of such an arrangement, except when a Host Blue passes these fees to Blue Shield through average pricing or fee schedule adjustments.

ARTICLE IX -- CLAIM SUBMISSION PROCESS

A. What Is a Claim for Benefits

Pre-Service Claims:

Pre-service claims are claims for which advance approval is required. Pre-service claims may be submitted by telephone or in writing.

Refer to your medical ID card for contact information.

Post-Service Claims:

A post-service claim is defined as any request for Plan benefits that complies with the Plan's procedure for making a claim for benefits. A participating *health care provider* will submit a claim directly to the Plan on your behalf. If you desire Plan benefits, you must submit a claim when services are rendered by a *health care provider* that does not participate in the network.

A claim for benefits includes:

1. Employee information: name, address, plan name, group number.

2. Patient information: patient name, address, birth date.

3. Treatment information: date(s) of service, procedure code, description of each supply or service, diagnosis code, charge for each supply or service.

4. *Health care provider* information: name, address, telephone number, federal tax identification number.

Send the complete claim for benefits to the address indicated on your ID card.

The *plan administrator* will determine if enough information has been submitted to enable proper consideration of the claim for benefits. If not, more information may be requested from the claimant.

The *plan administrator* reserves the right to have a Plan participant seek a second medical opinion.

B. When a Claim for Benefits Should Be Filed

Pre-Service Claim:

When precertification of a claim is required, you should follow the procedures outlined in the Health Care Management Program article of this Plan.

If you desire a predetermination of Plan benefits, you should notify the *claims processor* at least 15 calendar days prior to receiving services.

Post-Service Claims:

A claim for benefits must be filed within 12 months of the date of service. A claim for benefits filed after that date may be declined or reduced unless:

1. It is not reasonably possible to submit the claim within 12 months of the date of service; or

2. The claimant is not legally capable of submitting the claim within 12 months of the date of service.

C. Claim for Benefits Procedure

There are different kinds of claim for benefits and each one has a specific timetable for approval, payment, request for further information, or denial. The period of time begins on the date the claim is filed. The following is a summary of the maximum response times allowed for each type of claim.

Pre-Service Urgent Care Claims

Notice to claimant of:	
Insufficient information on the claim for benefits	24 hours
Extension for claimant to provide required information	48 hours
Benefit determination	72 hours

Pre-Service Non-Urgent Care Claims

Notice to claimant of:	
Insufficient information on the claim for benefits	5 calendar days
Extension for claimant to provide required information	45 calendar days
Benefit determination	15 calendar days

Post-Service Claims

Notice to claimant of:	
Benefit determination (all required information received)	30 calendar days
Extension for claimant to provide required information	45 calendar days

Benefit determination (requested information provided) 15 calendar days

D. Notice to Claimant of Adverse Benefit Determination

The *plan administrator* shall provide written or electronic notice of any *adverse benefit determination*. The notice will state the following:

1. The specific reason(s) for the adverse determination.

2. Reference to the specific Plan provisions on which the determination was based.

3. A description of any additional information necessary for the claimant to perfect the claim for benefits, and an explanation of why such material or information is necessary.

4. A description of the Plan's appeal procedures, including, if applicable, a statement of the claimant's right to bring a civil action under section 502 of *ERISA*.

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

6. A statement that other voluntary dispute resolution options are available, such as mediation.

If the *adverse benefit determination* was based on an internal guideline, protocol, or other similar criterion, the specific guideline, protocol, or criterion will be provided. If this is not practical, a statement will be included that such a guideline, protocol, or criterion was relied upon in making the *adverse benefit determination*, and a copy will be provided free of charge to the claimant upon request.

If the *adverse benefit determination* is based on the *medical necessity*, *experimental*, or *investigational* exclusions of the Plan, an explanation of the clinical judgment for the determination will be provided. If this is not practical, a statement will be included that such explanation will be provided free of charge, upon request.

E. First Level Internal Appeal

You or your authorized representative may appeal an *adverse benefit determination*. Upon request, the *claims processor* will complete a full and fair review. When a claimant receives an *adverse benefit determination* for a claim, the claimant has 180 days following receipt of the notification to appeal the decision. Otherwise, the initial *adverse benefit determination* shall be the final decision of the Plan.

When a claimant receives an *adverse benefit determination* for a pre-service claim, a grievance can be filed with the *claims processor* orally or in writing. A grievance for a post-service claim must be submitted in writing.

This Plan provides for two levels of internal appeals. If the *adverse benefit determination* is partially or fully upheld, a claimant may appeal the initial appeal decision. The request for a second appeal must be filed no later than four months following the date you receive a notice that the benefit determination was partially or fully upheld. If the benefit determination is partially or fully upheld upon second appeal, a claimant may appeal under the external review provisions of this Plan. The following is a summary of the maximum response times allowed for each type of claim appeal.

Pre-Service Urgent Care Claims

Initial internal appeal	24 hours for phone response (written response within 3 business days of phone response)
Second internal appeal	24 hours for phone response (written response within 3 business days of phone response)

Pre-Service Non-Urgent Care Claims

Initial internal appeal	15 calendar days
Second internal appeal	15 calendar days

Post-Service Claims

Initial internal appeal	30 calendar days
Second internal appeal	30 calendar days

The period of time within which the Plan must make a benefit determination for an appeal begins at the time an appeal is filed in accordance with the procedures of the Plan. During voluntary dispute resolution, any statute of limitations or other defense based on timeliness is tolled during the time any appeal is pending.

For any appeal, a claimant may submit written comments, documents, records, and other information related to the claim for benefits. If the claimant requests, he or she will be provided, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits.

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

1. Was relied upon in making the benefit determination;

2. Was submitted, considered, or generated in the course of making the benefit determination;

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

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

Any review shall take into account all information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination. The review will not afford deference to the initial *adverse benefit determination*, and will be conducted by a Plan representative who is neither the individual who made the adverse determination nor a subordinate of that individual. The *claims processor* may hold a hearing of all parties involved, if the *claims processor* deems such hearing to be necessary.

If the determination was based on a medical judgment, including determinations with regard to whether a particular service or supply is *experimental*, *investigational*, or not *medically necessary* or appropriate, the representative of the Plan will consult with a health care professional who was not involved in the original benefit determination. This health care professional will have appropriate training and experience in the applicable field of medicine. Additionally, the Plan will identify medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the initial determination.

A written explanation of a claim appeal determination will include the following information:

1. The specific reason or reasons for the decision, including a response to any information and comments submitted by you or your duly authorized representative;

2. Reference to Plan provisions and records on which the decision is based;

3. A statement that you and your duly authorized representative are entitled to receive, upon request and free of charge, access to and copies of all documents, records and other information relevant to the benefit claim; and

4. If applicable, a statement regarding the Participant's right to bring a civil action under *ERISA* section 502(a) following an *adverse benefit determination* on appeal.

No action at law or in equity can be brought to recover under this Plan after the expiration of three years after the claim has been filed with the *plan administrator*.

F. Second Level External Review

The Federal external review process does not apply to a denial, reduction, termination, or a failure to provide payment for a benefit based on a determination that a claimant or beneficiary fails to meet the requirements for eligibility under the terms of a group health plan.

The Federal external review process, in accordance with the current Affordable Care Act regulations and other applicable law, applies only to:

1. Any eligible *adverse benefit determination* (including a final internal *adverse benefit determination*) by a plan or issuer that involves medical judgment (including, but not limited to, those based on the plan's or issuer's requirements for *medical necessity*, appropriateness, health care setting, level of care, or effectiveness of a covered benefit; its determination that a treatment is *experimental* or *investigational*; its determination whether a claimant or beneficiary is entitled to a reasonable alternative standard for a reward under a wellness program; its determination whether a plan or issuer is complying with the nonquantitative treatment limitation provisions of Code section 9812 and § 54.9812-1, which generally require, among other things, parity in the application of medical management techniques), as determined by the external reviewer.

2. An *adverse benefit determination* that involves consideration of whether the Plan is complying with the surprise billing and cost-sharing protections set forth in the No Surprises Act.

3. A rescission of coverage (whether or not the rescission has any effect on any particular benefit at that time).

You may file a request for an external review by an independent review organization (IRO) no later than four months following the date you receive a notice of an *adverse benefit determination* or final internal *adverse benefit determination*.

Within five business days following receipt of your external review request, the *claims processor* must complete a preliminary review of your request. If the appeal is granted, the *claims processor* must assign an IRO to conduct the external review and will submit all information to the IRO.

Within one business day following the preliminary review, the *claims processor* must issue a written notification to you indicating the status of your request. If additional information is required, the written notification will include a description of the material or information necessary for you to perfect your external review request within the four-month filing period.

Upon receipt of the material or information requested, the *claims processor* will review the information and forward it to the IRO within one business day. If, upon receipt of this information, the *claims processor* reverses the internal *adverse benefit determination*, the *claims processor* must send written notification to the IRO and to you within one business day after making such a decision. The assigned IRO must terminate the external review upon receipt of the notice from the *claims processor.*

For any other appeal not reversed by the *claims processor*, the IRO must provide written notice of the final external review decision within 45 days after receipt of the request for external review. The IRO must deliver this final notice to you and the *claims processor.* The decision of the IRO shall be the final decision of the Plan.

The IRO will conduct their review and will not be bound by any decisions or conclusions previously reached by the *claims processor.*

G. Second Level Expedited External Review

The external review process will be expedited if:

1. You have a medical condition where the timeframe for completion of a standard external review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function; or

2. The internal *adverse benefit determination* concerns an admission, availability of care, continued stay, or health care item or service which you received on an *emergency* basis, but have not yet been discharged from a facility.

Upon receipt of your request for expedited external review, the *claims processor* must immediately verify eligibility for external review, issue a notification in writing to you, and assign an IRO. The IRO is required to provide notice of the final external review decision as expeditiously as your medical condition or circumstances require, but no more than 72 hours after the IRO receives the request for an expedited external review. If the notice is not in writing, the assigned IRO must provide written confirmation of the decision within 48 hours after the date of providing that notice to you and the *claims processor*.

ARTICLE X -- COBRA CONTINUATION OF BENEFITS
(Consolidated Omnibus Budget Reconciliation Act)

A. Definitions

For purposes of this section, the terms listed below shall be defined as follows:

1. **COBRA**. The Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

2. **Code**. The Internal Revenue Code of 1986, as amended.

3. **Continuation Coverage.** The Plan coverage elected by a qualified beneficiary under *COBRA*.

4. **Covered Employee.** Covered *employee* has the same meaning as that term is defined in *COBRA* and the regulations thereunder.

5. **Qualified Beneficiary.**

   a. A covered *employee* whose employment terminates (other than for gross misconduct) or whose hours are reduced, rendering him ineligible for coverage under the Plan;

   b. A covered spouse or dependent who becomes eligible for coverage under the Plan due to a qualifying event, as defined below; or

   c. A newborn or newly adopted child of a covered *employee* who is continuing coverage under *COBRA*.

6. **Qualifying Event.** The following events which, but for continuation coverage, would result in the loss of coverage of a qualified beneficiary:

   a. termination of a covered *employee's* employment (other than for gross misconduct) or reduction in his hours of employment;

   b. the death of the covered *employee*;

   c. the divorce or legal separation of the covered *employee* from his spouse;

   d. A child ceasing to be eligible as a dependent child under the terms of the group health plan; or

   e. your *employer* filing a Chapter 11 bankruptcy petition. Coverage may continue for covered retirees and or their dependents if coverage ends or is substantially reduced within one year before or after the initial filing for bankruptcy.

B. Right to Elect Continuation Coverage

If a qualified beneficiary loses coverage under the Plan due to a qualifying event, he may elect to continue coverage under the Plan in accordance with *COBRA* upon payment of the monthly contribution specified by the *company*. A qualified beneficiary must elect the coverage within the 60-day period beginning on the later of:

1. The date of the qualifying event; or

2. The date he was notified of his right to continue coverage.

If you are considered an eligible worker, in accordance with the Trade Adjustment Assistance Reform Act (TAA), you may be entitled to elect COBRA Continuation Coverage during the 60-day period beginning on the first day of the month in which you begin receiving Trade Adjustment Assistance provided that the election is made within the six (6) month period immediately following the date of the TAA-related loss of coverage.

C. Notification of Qualifying Event

If the qualifying event is divorce, legal separation, or a dependent child's loss of eligibility, the qualified beneficiary must notify the *company* of the qualifying event within sixty (60) days of the event in order for coverage to continue. You must report the qualifying event to the *plan administrator* in writing. The statement must include:

1. Your name;

2. Your identification number;

3. The dependent's name;

4. The dependent's last known address;

5. The date of the qualifying event; and

6. A description of the event.

In the case of a request for extension of the *COBRA* period as a result of a finding of disability by the Social Security Administration, you must also submit the disability determination. In addition, a totally disabled qualified beneficiary must notify the *company* in accordance with the section below entitled Total Disability in order for coverage to continue.

Failure to provide such notice(s) will result in a loss of *COBRA* entitlement hereunder.

D. Length of Continuation Coverage

1. A qualified beneficiary who loses coverage due to the reduction in hours or termination of employment (other than for gross misconduct) of a covered *employee* may continue coverage under the Plan for up to eighteen (18) months from the date of the qualifying event.

2. A qualified beneficiary who loses coverage due to the covered *employee's* death, divorce, or legal separation, or dependent children who have become ineligible for coverage may continue coverage under the Plan for up to thirty-six (36) months from the date of the qualifying event.

E. Total Disability

1. A qualified beneficiary who is determined under Title II or XVI of the Social Security Act (hereinafter the "Act") to have been totally disabled within sixty (60) days of a qualifying event (if the qualifying event is termination of employment or reduction in hours) may continue coverage (including coverage for dependents who were covered under the continuation coverage). Coverage may continue for a total of twenty-nine (29) months as long as the qualified beneficiary notifies the *employer* that he was disabled as of the date of the qualifying event:

   a. Prior to the end of eighteen (18) months of continuation coverage; and

   b. Within sixty (60) days of the determination of *total disability* under the Act.

2. The *employer* will charge the qualified beneficiary an increased premium for continuation coverage extended beyond eighteen (18) months pursuant to this section.

3. If, during the period of extended coverage for *total disability* (continuation coverage months 19-29), a qualified beneficiary is determined to be no longer totally disabled under the Act, the qualified beneficiary shall notify the *employer* of this determination within thirty (30) days. Continuation coverage shall terminate the last day of the month following thirty (30) days from the date of the final determination under the Act that the qualified beneficiary is no longer totally disabled.

F. Coordination of Benefits

Benefits will be coordinated with any federal program, automobile coverage or group health plan in accordance with the provisions described in the Article entitled - Coordination of Benefits.

G. Medicare and COBRA

In general, if an individual does not enroll in Medicare Part A or B when first eligible because they are still employed, after the initial enrollment period for Medicare Part A or B, the individual has an 8-month special enrollment period to sign up, beginning on the earlier of:

- The month after their employment ends; or

- The month after group health plan coverage based on current employment ends.

If a qualified beneficiary does not enroll in Medicare Part B and elects COBRA continuation coverage instead, the qualified beneficiary may have to pay a Part B late enrollment penalty and may have a gap in coverage if they decide to enroll in Part B later. If the qualified beneficiary elects COBRA continuation coverage and then enrolls in Medicare Part A or B before the COBRA ends, the Plan may terminate the COBRA continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA may not be discontinued on account of Medicare entitlement, even if the qualified beneficiary enrolls in the other part of Medicare after the date of the election of continuation coverage.

If enrolled in both COBRA and Medicare, Medicare will generally pay first and COBRA Continuation Coverage will pay second. Certain continuation coverage plans may pay as if secondary to Medicare, even if the qualified beneficiary is not enrolled in Medicare.

H. Termination of Continuation Coverage

Continuation coverage will automatically end earlier than the applicable 18-, 29-, or 36-month period for a qualified beneficiary if:

1. The required monthly contribution for coverage is not received by the *company* within thirty (30) days following the date it is due;

2. The qualified beneficiary becomes covered under any other group health plan as an employee or otherwise.

3. For totally disabled qualified beneficiaries continuing coverage for up to twenty-nine (29) months, the last day of the month coincident with or following thirty (30) days from the date of a final determination by the Social Security Administration that such beneficiary is no longer totally disabled;

4. The qualified beneficiary becomes entitled to *Medicare* benefits; or

5. The *company* ceases to offer any group health plans.

I. Multiple Qualifying Events

If a qualified beneficiary is continuing coverage due to a qualifying event for which the maximum continuation coverage is eighteen (18) or twenty-nine (29) months, and a second qualifying event occurs during the 18- or 29- month period, the qualified beneficiary may elect, in accordance with the section entitled Right To Elect Continuation Coverage, to continue coverage under the group health plan for up to thirty-six (36) months from the date of the first qualifying event.

J. Continuation Coverage

The continuation coverage elected by a qualified beneficiary is subject to all of the terms, conditions, limitations and exclusions which are applicable to the Plan offered to similarly situated covered *employees* and their dependents. The continuation coverage is also subject to the rules and regulations under *COBRA*. If *COBRA* permits qualified beneficiaries to add dependents for continuation coverage, such dependents must meet the definition of dependent under the Plan.

K. Carryover of Deductibles and Plan Maximums

If continuation coverage under the group health plan is elected by a qualified beneficiary under *COBRA*, expenses already credited to the Plan's applicable deductible and co-pay features for the year will be carried forward into the continuation coverage elected for that year.

Similarly, if continuation coverage under the Plan is elected by a qualified beneficiary under *COBRA*, expenses already credited to the Plan's applicable maximum for the year will be carried forward into the continuation coverage elected for that year.

L. Payment of Premium

1. The Group Health Plan will determine the amount of premium to be charged for Continuation Coverage for any period, which will be a reasonable estimate of the cost of providing coverage for such period for similarly situated individuals, determined on an actuarial basis and considering such factors as the Secretary of Labor may prescribe.

    a. The Group Health Plan may require a Qualified Beneficiary to pay a contribution for coverage that does not exceed 102 percent of the applicable premium for that period.

    b. For Qualified Beneficiaries whose coverage is continued pursuant to the section entitled "Total Disability" of this provision, the Group Health Plan may require the Qualified Beneficiary to pay a contribution for coverage that does not exceed 150 percent of the applicable premium for Continuation Coverage months 19-29.

    c. Contributions for coverage may, at the election of the Qualified Beneficiary, be paid in monthly installments.

2. If Continuation Coverage is elected, the monthly contribution for coverage for those months up to and including the month in which election is made must be made within forty-five (45) days of the date of election.

3. Without further notice from the Company, the Qualified Beneficiary must pay each following monthly contribution for coverage by the first day of the month for which coverage is to be effective. If payment is not received by the Company within thirty (30) days of the payment's due date, Continuation Coverage will terminate in accordance with the

section entitled "Termination of Continuation Coverage", Subsection A. This 30-day grace period does not apply to the first contribution required under Subsection B.

4. No claim will be payable under this provision for any period for which the contribution for coverage is not received from or on behalf of the Qualified Beneficiary.

M. Options Other Than COBRA

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), Medicare, Medicaid, Children's Health Insurance Program (CHIP), even if that plan generally doesn't accept late enrollees.

N. Assistance from the Federal Government

Questions concerning the Plan or COBRA continuation coverage can be addressed by the COBRA claims administrator. For more information about the rights of the participant and other covered persons under COBRA, HIPAA and other laws affecting group health plans, all affected parties can contact the U.S. Department of Health and Human Services (HHS), through the Centers for Medicare & Medicaid Services (CMS) which has jurisdiction with respect to COBRA continuation coverage requirements of the Public Health Service Act that apply to State and local government employers, including counties, municipalities, public school districts and the group health plans that they sponsor ("Public Sector COBRA").

COBRA can be a daunting and complex area of federal law. If you have any questions or issues regarding Public Sector COBRA, you may contact the Administrator or email HHS at phig@cms.hhs

Keep your Plan informed of address changes

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

ARTICLE XI -- PROTECTED HEALTH INFORMATION

The Plan provides you with a separate Notice of Privacy Practices. This Notice describes how the Plan uses and discloses your personal health information. It also describes certain rights you have regarding this information. Additional copies of our Notice of Privacy Practices are available by contacting your Human Resources Department.

A. Protected Health Information

This Plan collects and maintains a great deal of personal health information about you and your dependents. Federal *HIPAA* regulations on privacy and confidentiality limit how a plan and its *plan administrator* may use and disclose this information. This article describes provisions that protect the privacy and confidentiality of your personal health information and complies with applicable federal law.

B. Permitted and Required Uses and Disclosure of Protected Health Information

Subject to obtaining written certification this Plan may disclose *protected health information* to the *plan sponsor*, provided the *plan sponsor* does not use or disclose such *protected health information* except for the following purposes:

1. performing administrative functions which the *plan sponsor* performs for the Plan;

2. obtaining bids for providing employee coverage under this Plan; or

3. modifying, amending, or terminating the Plan.

Notwithstanding the provisions of this Plan to the contrary, in no event shall the *plan sponsor* be permitted to use or disclose *protected health information* in a manner that is inconsistent with the regulation.

C. Conditions of Disclosure

The Plan or any *employee* coverage with respect to the Plan, shall not disclose *protected health information* to the *plan sponsor* unless the *plan sponsor* agrees to:

1. Not use or further disclose the *protected health information* other than as permitted or required by the Plan or as required by law.

2. Ensure that any agents, including a subcontractor, to whom it provides *protected health information* received from the Plan, agree to the same restrictions and conditions that apply to the *plan sponsor* with respect to *protected health information*.

3. Not use or disclose the *protected health information* for employment-related actions and decisions or in connection with any other benefit or benefit plan of the *plan sponsor*.

4. Report to the Plan any use or disclosure of the information that is inconsistent with the uses or disclosures provided for of which it becomes aware.

5. Make available to a *participant* who requests access the *participant's protected health information* in accordance with the regulation.

6. Make available to a *participant* who requests an amendment to the *participant's protected health information* and incorporate any amendments to the *participant's protected health information* in accordance with the regulation.

7. Make available to a *participant* who requests an accounting of disclosures of the *participant's protected health information* the information required to provide an accounting of disclosures in accordance with the regulation.

8. Make its internal practices, books, and records relating to the use and disclosure of *protected health information* received from the Plan available to the Secretary of Health and Human Services for purposes of determining compliance by the Plan with the regulation.

9. If feasible, return or destroy all *protected health information* received from the Plan that the *plan sponsor* still maintains in any form and retain no copies of such information when no longer needed for the purpose for which the disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information feasible.

10. Ensure that the adequate separation between the Plan and the *plan sponsor* required in the regulation is satisfied.

D. Certification of Plan Sponsor

The Plan shall disclose *protected health information* to the *plan sponsor* only upon the receipt of a certification by the *plan sponsor* that the Plan has been amended to incorporate the provisions of the regulation, and that the *plan sponsor* agrees to the conditions of disclosure set forth in the section Conditions of Disclosure.

E. Permitted Uses and Disclosure of Summary Health Information

The Plan may disclose *summary health information* to the *plan sponsor*, provided such *summary health information* is only used by the *plan sponsor* for the purpose of:

1. obtaining bids for providing *employee* coverage under this Plan; or

2. modifying, amending, or terminating the Plan.

F. Permitted Uses and Disclosure of Enrollment and Disenrollment Information

The Plan or a health insurance issuer or HMO with respect to the Plan, may disclose enrollment and disenrollment information and information on whether individuals are participating in the Plan to the *plan sponsor*, provided such enrollment and disenrollment information is only used by the *plan sponsor* for the purpose of performing administrative functions that the *plan sponsor* performs for the Plan.

G. Adequate Separation between the Plan and the Plan Sponsor

The *plan sponsor* shall limit access to *protected health information* to only those employees authorized by the *plan sponsor*. Such employees shall only have access to and use such *protected health information* to the extent necessary to perform the administration functions that the *plan sponsor* performs for the Plan. In the event that any such employees do not comply with the provisions of this section, the employee shall be subject to disciplinary action by the *plan sponsor* for non-compliance pursuant to the *plan sponsor's* employee discipline and termination procedures.

H. Security Standards for Electronic Protected Health Information

HIPAA and other applicable law shall override the following wherever there is a conflict, or a term or terms is/are not hereby defined. The Security Rule imposes regulations for maintaining the integrity, confidentiality, and availability of *protected health information* that it creates, receives, maintains, or maintains electronically that is kept in electronic format as required under *HIPAA*.

Where *electronic protected health information* will be created, received, maintained, or transmitted to or by the *plan sponsor* on behalf of the Plan, the *plan sponsor* shall reasonably safeguard the *electronic protected health information* as follows:

1. The *plan sponsor* shall implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the *electronic protected health information* that the *plan sponsor* creates, receives, maintains, or transmits on behalf of the Plan;

2. The *plan sponsor* shall ensure that the adequate separation that is required by the regulation is supported by reasonable and appropriate security measures;

3. The *plan sponsor* shall ensure that any agent, including a subcontractor, to whom it provides *electronic protected health information*, agrees to implement reasonable and appropriate security measures to protect such information; and

4. The *plan sponsor* shall report to the Plan any *security incidents* of which it becomes aware as described below:

    a. The *plan sponsor* shall report to the Plan within a reasonable time after *plan sponsor*

becomes aware, any *security incident* that results in unauthorized access, use, disclosure, modification, or destruction of the Plan's *electronic protected health information*; and

b. The *plan sponsor* shall report to the Plan any other *security incident* on an aggregate basis every month, or more frequently upon the Plan's request.

This Plan will comply with the requirement of 45 C.F.R. / 164.314 (b)(1) and (2) of the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations, 45 C.F.R. Parts 160, 162, and 164.

I. Notification Requirements in the Event of a Breach of Unsecured Protected Health Information

The required breach notifications are triggered upon the discovery of a breach of unsecured *protected health information*. A breach is discovered as of the first day the breach is known, or reasonably should have been known.

When a breach of unsecured *protected health information* is discovered, the Plan will:

1. Notify the member whose *protected health information* has been, or is reasonably believed to have been, assessed, acquired, used, or disclosed as a result of the breach, in writing, without unreasonable delay and in no case later than sixty (60) calendar days after discovery of the breach. Breach notification must be provided to individual by:

    a. Written notice by first-class mail to the member (or next of kin) at last known address or, if specified by participant, e-mail;

    b. If Plan has insufficient or out-of-date contact information for the member, the member must be notified by a substitute form;

    c. If an urgent notice is required, the Plan may contact the member by telephone.

2. The breach notification will have the following content:

    a. Brief description of what happened, including date of breach and date discovered;

    b. Types of unsecured *protected health information* involved (e.g., name, Social Security number, date of birth, home address, account number);

    c. Steps the member should take to protect from potential harm;

    d. What the Plan is doing to investigate the breach, mitigate losses, and protect against further breaches;

3. Notify the media if the breach affected more than five hundred (500) residents of a state or jurisdiction. Notice must be provided to prominent media outlets serving the state or

jurisdiction without unreasonable delay and in no case later than sixty (60) calendar days after the date the breach was discovered;

4. Notify the HHS Secretary if the breach involves five hundred (500) or more individuals, contemporaneously with the notice to the affected individual and in the manner specified by HHS. If the breach involves less than five hundred (500) individuals, an internal log or other documentation of such breaches must be maintained and annually submitted to HHS within sixty (60) days after the end of each calendar year; and

5. When a Business Associate, which provides services for the Plan and comes in contact with *protected health information* in connection with those services discovers a breach has occurred, that Business Associate will notify the Plan without unreasonable delay and in no case later than sixty (60) calendar days after discovery of a breach so that the affected members may be notified. To the extent possible, the Business Associate should identify each individual whose unsecured *protected health information* has been, or is reasonably believed to have been, breached.

ARTICLE XII -- GENERAL INFORMATION

Name and Address of the Plan Sponsor

Riverside Community College District
3801 Market Street
Riverside, CA 92501

Name and Address of the Plan Administrator

Riverside Community College District
3801 Market Street
Riverside, CA 92501

Name and Address of the Agent for Service of Legal Process

Riverside Community College District
3801 Market Street
Riverside, CA 92501

Claims Processor

HealthNow Administrative Services
P.O. Box 211034
Eagan MN 55121

Internal Revenue Service and Plan Identification Number

The corporate tax identification number assigned by the Internal Revenue Service is 95-6000929.

Plan Year

The twelve (12) month period for Riverside Community College District, beginning October 1 and ending September 30.

Plan Type

This Plan is a welfare benefit plan, providing medical and prescription drug benefits.

Plan Administration Type

The type of plan administration is contract administration. The processing of claims for benefits under the terms of the Plan is provided through one or more companies contracted by the *employer*.

Method of Funding Benefits

The funding for the benefits is derived from the funds of the *employer* and contributions made by covered employees. The Plan is not insured.

Plan Status

Non-Grandfathered

Plan Modification and Termination

The *plan administrator* intends to continue the Plan indefinitely. Nevertheless, Riverside Community College District reserves the right to amend, modify, or terminate the Plan at any time, which may result in the termination or modification of your coverage. The *plan administrator* will notify all covered persons as soon as possible, but in no event later than sixty (60) days after the effective date the Plan change was adopted. Expenses incurred prior to the Plan termination, modification or amendment will be paid as provided under the terms of the Plan prior to its termination, modification or amendment.

Discretion of Plan Administrator

The *plan administrator* shall be the sole determiner of all matters concerning medical benefits and coverage under this Plan. The *plan administrator* shall have broad discretion in interpreting the provisions of this Plan, which discretion shall be exercised in good faith. The *plan administrator's* discretionary authority includes, but is not limited to, resolving questions of coverage and benefits, determining matters relating to eligibility, deciding questions of administration, and deciding other questions under the Plan.

Not a Contract

This Plan Document and any amendments constitute the provisions of coverage under this Plan. The Plan Document is not to be construed as a contract between the Company and any participant or to be consideration for, or an inducement or condition of, the employment of any employee. Nothing in this Plan Document shall be deemed to give any employee the right to be retained in the company's service or to interfere with the company's right to discharge an employee at any time; provided, however, that the foregoing shall not be deemed to modify the provisions of any collective bargaining agreements which may be entered into by the Company and bargaining representatives of any employees.

HealthNow Administrative Services – Notice of Nondiscrimination

Brokerage Concepts, LLC d/b/a/ HealthNow Administrative Services complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. HealthNow Administrative Services does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

HealthNow Administrative Services:

Provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)

Provides free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

If you need these services, please call the customer service number on the back of your ID card or contact the Vice President, Chief Compliance Officer.

If you believe that HealthNow Administrative Services has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Vice President, Chief Compliance Officer, 257 West Genesee Street, Buffalo, NY 14202, 1-800-798-1453, (716) 887-6056 (fax), complaint.compliance@hnas.com. You can file a grievance in person or by mail, fax, or email. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at U.S. Department of Health and Human Services, 200 Independence Avenue SW, Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 1-800-537-7697 (TDD).

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

For assistance in English, call customer service at the number listed on your ID card.

Para obtener asistencia en español, llame al servicio de atención al cliente al número que aparece en su tarjeta de identificación.

如需中文的協助，請致電客戶服務部，電話號碼列於您的 ID 卡上面。

Для получения помощи на русском языке позвоните в службу поддержки клиентов по номеру, указанному на Вашей идентификационной карте.

Pou jwenn èd nan lang Kreyòl Ayisyen, rele sèvis kliyan nan nimewo ki endike sou kat Idantifikasyon ou an.

한국어로 도움이 필요하시면 ID 카드에 나와있는 번호로 고객 서비스에 문의하십시오

للحصول على المساعدة باللغة العربية، اتصل بخدمة العملاء على الرقم المُدوَّن في بطاقة الهوية الخاصة بك.

Per assistenza in italiano chiamate il numero del servizio clienti riportato nella vostra scheda identificativa.

Aby uzyskać pomoc w języku polskim, skontaktuj się z działem obsługi klienta pod numerem podanym na Twojej karcie identyfikacyjnej.

برای دریافت کمک به زبان فارسی، با شماره خدمات مشتریان لیست شده در کارت شناسایی خودتان تماس بگیرید.

Për ndihmë në gjuhën shqipe, merrni në telefon shërbimin klientor në numrin e renditur në kartën tuaj të identitetit.

Para assistência em português, ligue para o número do apoio a clientes, listado no seu cartão de identificação.

Để được hỗ trợ bằng Tiếng Việt, hãy gọi bộ phận dịch vụ khách hàng theo số ghi trên thẻ Định danh của quý vị.

Para sa tulong sa Tagalog, tumawag sa numero ng serbisyo sa customer na nasa inyong ID card.

日本語でのお問い合わせは、IDカードに記載されているカスタマーサービスの電話番号にお問合せください。

Pour une assistance en français, composez le numéro de téléphone du service à la clientèle figurant sur votre carte d'identification.

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