PLAN SPONSOR ACCEPTANCE OF RESPONSIBILITY

PLEASE SIGN BELOW TO ACKNOWLEDGE YOUR ACCEPTANCE OF RESPONSIBILITY FOR THE CONTENTS OF THIS DOCUMENT AND RETURN THIS SIGNED FORM TO:

Orange County Foundation for Medical Care
P. O. Box 11066
Orange, CA 92856

We, the Plan Sponsor, recognize that we have full responsibility for the contents of the Benefit Document and that, while the Contract Administrator, its employees and/or subcontractors, may have assisted in the preparation of the document, we are responsible for the final text and meaning. We further certify that the document has been fully read, understood, and describes our intent with regard to our employee welfare plan.

Plan Sponsor/Plan Administrator: Riverside Community College District

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Signed (authorized representative of Plan Sponsor) Date

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THIS DOCUMENT WAS NOT PREPARED OR REVIEWED BY AN ATTORNEY AND IS NOT INTENDED AS LEGAL ADVICE.

RIVERSIDE COMMUNITY COLLEGE DISTRICT

BENEFIT DOCUMENT & SUMMARY PLAN DESCRIPTION

OF THE

MEDICAL BENEFITS

RESTATED EFFECTIVE: OCTOBER 1, 2010

Contract Administrator:

Orange County Foundation for Medical Care
P. O. Box 11066
Orange, CA 92856
(714) 978-5048 or (800) 345-8643

TABLE OF CONTENTS

	Page
IMPORTANT INFORMATION	1
UTILIZATION MANAGEMENT PROGRAM	2
MEDICAL BENEFIT SUMMARY	3
ELIGIBLE MEDICAL EXPENSES	6
MEDICAL LIMITATIONS AND EXCLUSIONS	12
GENERAL EXCLUSIONS	15
COORDINATION OF BENEFITS (COB)	17
SUBROGATION AND REIMBURSEMENT PROVISIONS	20
ELIGIBILITY AND EFFECTIVE DATES	23
TERMINATION OF COVERAGE	27
EXTENSIONS OF COVERAGE	28
EXTENSION OF BENEFITS DURING TOTAL DISABILITY	30
CLAIMS PROCEDURES	31
DEFINITIONS	34
GENERAL PLAN INFORMATION	39
COBRA CONTINUATION COVERAGE	45
DOMESTIC PARTNER ELIGIBILITY	51

DIRECTORY OF PLAN VENDORS

The following providers render services on behalf of the Plan. A Plan participant can contact the appropriate office when he has a question or needs help.

TYPE OF SERVICE	PROVIDER
Contract (Claims) Administrator	**Orange County Foundation for Medical Care** P. O. Box 11066 Orange, CA 92856 Phone: (800) 345-8643
Medical Provider Networks	**PRIMARY NETWORK** **First Health** Phone: (800) 226-5116 www.FirstHealth.com **SECONDARY NETWORK** **California Foundation for Medical Care** Phone: (800) 458-5710 www.cfmcnet.org
Utilization Management Organization	**Orange County Foundation for Medical Care** Phone: (800) 345-8643 www.ocfmc.com
Prescription Drug Vendor	**CareMark** Phone: (800) 727-5574 www.CareMark.com

IMPORTANT INFORMATION

WHO TO CONTACT FOR ADDITIONAL INFORMATION

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

THE NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean delivery. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

THE WOMEN'S HEALTH AND CANCER RIGHTS ACT

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

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

DEFINITIONS

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

NOTICE OF RIGHT TO RECEIVE A CERTIFICATE OF CREDITABLE COVERAGE

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

UTILIZATION MANAGEMENT PROGRAM

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

HOSPITAL PRE-SERVICE REVIEW & AUTHORIZATION

The Orange County Foundation for Medical Care is contracted to provide pre-service review of Hospital admissions. The contact phone number is shown on the Employee's coverage identification card.

Except as noted, prior to any Hospital admission that is not a Medical Emergency, the Covered Person or someone acting on his behalf should contact the Utilization Management Organization for pre-service review and authorization. For an emergency admission, the Utilization Management Organization should be contacted as soon as possible after admission.

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

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

MORE INFORMATION ABOUT PRE-SERVICE REVIEW

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

Also, **prior authorization is not a guarantee of coverage**. The Utilization Management Program is designed ONLY to determine whether or not a proposed course of treatment is Medically Necessary and appropriate. Benefits under the Plan will depend upon the person's eligibility for coverage and the Plan's limitations and exclusions.

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

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

MEDICAL BENEFIT SUMMARY

CHOICE OF PROVIDERS

The Plan Sponsor has contracted with an organization or "Network" of health care providers. When obtaining health care services, a Covered Person has a choice of using providers who are participating in that Network or any other Covered Providers of his choice (Non-Network providers).

Network providers have agreed to provide services to Covered Persons at negotiated rates. When a Covered Person uses a Network provider his out-of-pocket costs may be reduced because he will not be billed for expenses in excess of those rates.

THE PLAN SPONSOR WILL AUTOMATICALLY PROVIDE A PLAN PARTICIPANT WITH INFORMATION ABOUT HOW HE CAN ACCESS A DIRECTORY OF NETWORK PROVIDERS. THIS INFORMATION WILL BE AVAILABLE ONLINE AT WWW.FIRSTHEALTH.COM OR WWW.CFMCNET.ORG AND PROVIDED WITHOUT CHARGE. SINCE CERTAIN COVERED SERVICES AND SUPPLIES MAY NOT BE AVAILABLE THROUGH THE NETWORK, A COVERED PERSON SHOULD REFER TO THE NETWORK LIST OR DIRECTORY TO DETERMINE IF ANY PARTICULAR SPECIALTY IS INCLUDED

Although there may be circumstances when a Network provider cannot be used, Non-Network provider services will be covered at the Non-Network benefit levels, except in the following limited circumstances:

Emergency Care - In an emergency situation and where the Covered Person is not able to choose a Network provider and travel to a Network provider is not feasible, then emergency services will be covered at the Reasonable and Customary level of benefits until the patient is stabilized and can be moved to a Network facility. All charges in excess of the Reasonable and Customary fee schedule becomes the responsibility of the patient. All follow up care must be provided by a Network provider in order to be paid at the Network level of benefits.

No Choice of Provider - When a Covered Person is under the treatment of a Network provider at a Network facility and receives services or supplies from a Non-Network provider in a situation in which the Covered Person has no control over provider selection (such as in the selection of an anesthesiologist, assistant surgeon, emergency room physician or a provider for diagnostic services), such Non-Network services and supplies will be covered at the Network benefit levels.

SCHEDULE OF BASIC & MAJOR MEDICAL BENEFITS

Benefits for Eligible Expenses are divided into two (2) types:

1) **Basic Benefits:** Basic Benefits are normally paid at 100%. Basic Benefits are available only for certain types of expenses as shown in the center column of the schedule below.

2) **Major Medical Benefits:** Major Medical Benefits are subject to the Calendar Year Deductible requirement, are paid at a benefit percentage less than 100% until the Covered Person's out-of-pocket maximum has been met,.. Major Medical benefits are available where Basic Benefits are not available ("N/A") or on the balance of Eligible Expenses after applicable Basic Benefits have been exhausted.

The percentages shown in this schedule apply to "charges". For Network providers, this means that the percentages apply to the negotiated rates. See " Reasonable and Customary " in the **Definitions** section for more information.

MAXIMUM LIFETIME BENEFIT	1,000,000.00
Medical benefits for each Covered Person will not exceed the Maximum Lifetime Benefit. The Maximum Lifetime Benefit applies to all periods a person is covered under the Plan. Lesser limits may apply to all or certain periods of Plan coverage, or to certain conditions or types or levels of care. Such limits are also included in this summary. At the beginning of each Calendar Year, up to $1,000 of benefits a Covered Person has used in the prior year will automatically be restored.	
CALENDAR YEAR DEDUCTIBLE	
Individual Deductible	$100
Family Maximum Deductible	$300.00 Combined

Individual Deductible - The Individual Deductible is an amount a Covered Person must contribute each year toward payment of eligible medical expenses before the Plan begins to provide benefits.

Family Maximum Deductible - If eligible medical expenses equal to the Family Maximum Deductible are incurred collectively by family members during a Calendar Year and are applied toward Individual Deductibles, the Family Maximum Deductible is satisfied. A "family" includes a covered Employee and his covered Dependents.

Deductible Carry-Over - Eligible Expenses incurred in the last 3 months of a Calendar Year and applied toward that year's Deductible can be carried forward and applied toward the person's Deductible for the next Calendar Year.

Common Accident Provision - If two or more Covered Persons who are members of the same family are injured in the same accident, only 1 Individual Deductible will be taken from the total eligible medical expenses incurred as the result of such accident during the Calendar Year in which the accident occurred.

INDIVIDUAL OUT-OF-POCKET MAXIMUM	$400 (applies to Major Medical Benefits ONLY)

Except as noted, a Covered Person will not be required to pay more than $400 (20% of $2,000) in any Calendar Year toward his share of eligible Major Medical In-Network expenses that are not paid by the Plan. Once he has paid his out-of-pocket maximum, his eligible Major Medical expenses will be paid at 100% for the balance of the Calendar Year.

NOTE: The out-of-pocket maximum does not include the deductible, co-pays or any expense over Reasonable & Customary when utilizing a Non-Network provider.

ELIGIBLE MEDICAL EXPENSES	**Basic Benefits**	**Major Medical Benefits**
Ambulance		
Ground Service, per admission	100% to $50	80%
Air Service, per admission	100% to $200	80%
Diagnostic Lab & X-ray, Outpatient (non-Hospital)	100% to $300/Cal. Year	80%
Hospital Services		
Inpatient Care:		
first 365 days, per period of confinement	100%	N/A
thereafter	N/A	80%
Emergency Room Services	100%	N/A
Outpatient Surgery	100%	N/A
Other Outpatient Care	N/A	80%

Basic Benefits for Inpatient care are limited to 365 days per “period of confinement”. Repeat admissions shall be deemed a continuous period of confinement unless the dates of discharge and re-admission are separated by at least 28 days or the re-admission is due to a new Accidental Injury.

Basic Benefits for emergency room services are limited to care within 72 hours of a Medical Emergency (see **Definitions**).

Eligible Expenses for Inpatient room and board are limited: (1) at a Network Hospital, to the Network negotiated rates and, (2) at a Non-Network Hospital, to the Reasonable and Customary Intensive Care Unit charge or the Semi-Private Room Charge (see **Definitions**)

Mental Health & Substance Abuse Care		
Inpatient Hospital Care	(see Hospital Services)	(see Hospital Services)
Outpatient Visits	N/A	80%
.		
Physician Services		
Inpatient Visits & Inpatient Consultations-limited to one visit per day	100% - see NOTE 1	80%
Emergency Room Care - see NOTE 2	100% True emergencies only	80% -all other conditions
		N/A
Surgeon, Assistant Surgeon, Anesthesiologist	100%	N/A
Outpatient, Office and Urgent Care Visits, per Calendar Year – **For Employee Only**	100% to $600	80%
Outpatient, Office and Urgent Care Visits, per Calendar Year-**All covered dependants**	N/A	80%
Physical Therapy	N/A	80%

Chiropractic Care	N/A	80%
Home Health Care-limit one visit per day per specialty	N/A	80%
Physical Therapy	N/A	80%
Accupuncture	N/A	80%

NOTE 1: Basic Benefits for Inpatient visits and consults are limited to 1 per day.

NOTE 2: Basic Benefits for emergency room Physician services are limited to care within 72 hours of a Medical Emergency (see **Definitions**). Also, the Calendar Year Deductible is waived for such conditions.

NOTE 3: Basic Benefits for Outpatient visits (Home, Office, Hospital, Urgent Care) are limited to 1 visit per day for both the employee and dependants. An **Employee's** first non-accident-related outpatient, office or urgent care visit in a Calendar Year is subject to a yearly $30 Deductible.

ELIGIBLE MEDICAL EXPENSES	**Basic Benefits**	**Major Medical Benefits**
Preventive Care		
Colonoscopy & Mammograms	100%	N/A
Well Baby Care (to age 12 months)	100% to $50.00 Max	N/A

Preventive care includes:

a routine Pap smear with an office visit each year;

a routine colonoscopy every 5 years for Covered Persons age 50 and over; (unless previous history indicates medical necessity)

routine mammograms at the following ages and frequencies:

- a baseline mammogram for women between the ages of 35 and 39
- a mammogram every 2 years for women age 40 to 49, if based on a Physician's recommendation
- an annual mammogram for women age 50 and over

Well baby check-ups for a covered Dependent child to age 12 months can be an office visit, routine laboratory work or immunizations.

Skilled Nursing Facility / Rehabilitation Center		
First 365 Days, per confinement	100%	N/A
Thereafter	N/A	80%

Eligible Expenses for room and board are limited to the facility's Semi-Private Room Charge.

Supplemental Benefit for Accident-Related Expense	100% to $500	N/A

The $500 Accident Expense benefit is available for: (1) medical or surgical treatment or supplies performed or recommended by a Physician, (2) Hospital care, or (3) services of a registered nurse (R.N.). Any such expenses must be incurred within 90 days of the Accidental Injury. Once the $500.00 maximum benefit has been exhausted, the claims will be subject to the Plans normal benefit.

Accident Expense benefits are not available for eye refractions, eyeglasses, hearing aids, prosthetic device or their fitting, or dental services of any kind except for treatment of injury to sound, natural teeth.

All Other Eligible Medical Expenses (See eligible expenses for covered services not listed above)	N/A	80%

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

ELIGIBLE MEDICAL EXPENSES

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

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

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

the date a purchase is contracted; or

the actual date a service is rendered.

Abortion – An elective or non-elective abortion procedure and treatment of any complications arising out of an abortion.

Acupuncture – Acupuncture treatment for a Sickness or Accidental Injury when provided by a Physician or licensed acupuncturist.

Alcoholism - see "Mental Health & Substance Abuse Care"

Ambulance - Professional ground or air ambulance service when used to transport a Covered Person to or returning from an institution for covered Inpatient treatment. Air ambulance service is limited to emergency transportation to the nearest facility equipped to provide the necessary care and treatment.

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

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

Biofeedback – Biofeedback treatment when prescribed by a Physician (MD) for the treatment of a documented medical condition.

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

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

Chemical Dependency - see "Mental Health & Substance Abuse Care"

Chemotherapy & Radiation Therapy - Services and supplies related to the administration of chemical agents in the treatment or control of a Sickness.

Radium and radioactive isotope therapy when provided for treatment or control of a Sickness.

Chiropractic Care - Musculoskeletal manipulation and modalities (e.g., hot & cold packs) provided by a chiropractor (DC) to correct vertebral disorders such as incomplete dislocation, off-centering, misalignment, misplacement, fixation, abnormal spacing, sprain or strain. **Message Therapy by a Chiropractor is not covered**

Diabetic Supplies – Diabetic supplies that are not available through the Plan's prescription drug program. Such supplies may include, but are not limited to:

syringes and needles;

insulin injection devices;

pump supplies;

swabs;

blood monitors and kits, blood test strips, blood glucose calibration solutions;

urine tests; and

lancets, and lancet devices.

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

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

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

NOTE: Coverage is limited to the least expensive item that is adequate for the patient's needs. Duplicate equipment and excess charges for deluxe equipment or devices are not covered.

Foot Care – Services are limited to Medically Necessary treatment of the feet (e.g., the removal of nail roots, other podiatry surgeries, or foot care services necessary due to a metabolic or peripheral-vascular disease). See Foot Care under Medical Limitations and Exclusions.

Home Health Care - Services and supplies that are furnished to a Covered Person in accordance with a written home health care plan. The home health care plan must be established by the Covered Person's attending Physician and must be monitored by the Physician during the period of home health care. Also, the attending Physician must certify that the condition would require Inpatient confinement in a Hospital or Skilled Nursing Facility in the absence of home health care.

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

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

services of physical, occupational and speech therapists;

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

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

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

Hospice Care - Care of a Covered Person with a terminal prognosis (i.e., a life expectancy of six months or less) who has been admitted to a formal program of Hospice care. Eligible Expenses include Hospice program charges for:

Inpatient Hospice facility services and supplies;

professional and other services and supplies including, but not limited to: (1) nursing care by a registered nurse, a licensed practical nurse, a vocational nurse or a public health nurse who is under the direct supervision of a registered nurse, (2) physical therapy and speech therapy when rendered by licensed therapists, (3) medical supplies, including drugs and biologicals and the use of medical appliances, (4) Physician services, and (5) services, supplies and treatments deemed Medically Necessary and ordered by a Physician.

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

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

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

Mental Health & Substance Abuse Care - Inpatient and Outpatient treatment of mental health conditions and substance abuse.

For Plan purposes, "mental health conditions" include schizophrenic disorders, paranoid disorders, affective disorders (depression, mania, manic-depressive illness), anxiety disorders, somatoform disorders, personality disorders, and disorders of infancy, childhood and adolescence. A mental health condition or covered mental health care will not include:

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

hypnotherapy;

marriage and family counseling;

sex counseling or sex therapy;

vocational testing or training.

For Plan purposes, "substance abuse" is abuse of and physical and/or psychological dependence on drugs, narcotics, alcohol, toxic inhalants, or other addictive substances to a debilitating degree. It does not include tobacco dependence or dependence on ordinary drinks containing caffeine. It also does not include an acute medical condition caused by alcoholism, chemical addiction or abuse. Such acute medical conditions shall be treated as any other Sickness.

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

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

Newborn circumcision.

Physician services for routine care provided during a covered newborn's birth confinement. See "Pregnancy Care" for newborn Hospital expenses.

Nursing Services - Nursing services, whether provided on an Inpatient or Outpatient basis, by a registered nurse (RN), licensed vocational nurse (LVN) or licensed practical nurse (LPN). Nursing services must be Medically Necessary and prescribed in writing by the attending Physician or surgeon specifically as to duration and type.

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

Orthotics – Orthopedic (non-dental) braces, casts, splints, trusses and other orthotics that are prescribed by a Physician and that are required for support of a body part due to a congenital condition, or an Accidental Injury or Sickness.

NOTE: Foot orthotics are <u>not</u> covered.

Oral Care – Care or treatment is limited to the necessary professional services for:

treatment of a fractured jaw, facial bones or other Accidental Injury to sound natural teeth. However, coverage is limited to services rendered within six (6) months of the accident;

surgical correction of harelip, cleft palate, or protruding mandible;

removal of stones from salivary ducts;

removal of bony cysts of the jaw, torus palatinus, leukoplakia or malignant tissues;

freeing of muscle attachments.

See page 12 under Medical Limitations and Exclusions

Oxygen - see "Durable Medical Equipment"

Physical Therapy - Professional services of a licensed physical therapist.

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

PKU & Amino-Acid Related Formulas & Special Food Products – Formulas, medications and special food products that are Medically Necessary for persons suffering from the following amino acids disorders: phenylketonuria, maple syrup urine disease, hemocystinuria, tyrosinosis, histidinemia or Crohn's disease, but only to the extent such products are not available through the Plan's prescription drug program.

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

pre-natal visits and routine pre-natal and post-partum care;

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

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

newborn Hospital services provided during the mother's confinement for delivery, but not to exceed the minimum requirements of the Newborns' and Mothers' Health Protection Act (see below). This will not apply, however, if the newborn is a Covered Person, is ill or injured, and the charges are covered as the newborn's own claim.

In accordance with the Newborns' and Mothers' Health Protection Act, the Plan will not restrict benefits for a Pregnancy Hospital stay for a mother and her newborn to less than forty-eight (48) hours following a normal vaginal delivery or ninety-six (96) hours following a cesarean section.

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

Prescription Drugs - Medicines that are dispensed and administered to a Covered Person during an Inpatient

confinement, during a Physician's office visit, or as part of a home health care or hospice care program.

NOTE: Outpatient drugs (i.e., drugs purchased at a pharmacy) are not covered hereunder. However, the Plan Sponsor provides a separate program of drug coverage through an independent vendor.

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

Prosthetics - An initial artificial limb, eye or other prosthetic appliance required to replace a natural limb, eye or other body part. Post-mastectomy breast prostheses as required by the Women's Health and Cancer Rights Act as well as two (2) brassieres.

Radiation Therapy – see "Chemotherapy & Radiation Therapy"

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

Respiratory / Inhalation Therapy - Professional services of a licensed respiratory or inhalation therapist, when specifically prescribed by a Physician or surgeon as to type and duration, but only to the extent that the therapy is for improvement of respiratory function.

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

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

Skilled Nursing Facility or Rehabilitation Center - Inpatient care in Skilled Nursing Facility or Rehabilitation Center, but only when the admission to the facility or center is Medically Necessary and:

is preceded by confinement of at least three (3) days in a Hospital, is for the same condition causing the preceding Hospital confinement and occurs within fourteen (14) days of discharge from such prior confinement; or

occurs within fourteen (14) days of discharge from a prior Skilled Nursing Facility or Rehabilitation Center confinement for the same condition; or

is ordered by a Physician in lieu of Hospital confinement.

Speech Therapy - Services of a qualified speech therapist when used to restore or rehabilitate a speech loss or impairment caused by Accidental Injury or Sickness but not a mental, emotional or nervous disorder. In the case of a congenital defect that can be corrected or improved with surgery, speech therapy is covered only if provided after surgery for the defect.

NOTE: Speech therapy provided to a child solely due to developmental delay is not covered.

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

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

Substance Abuse Care – see "Mental Health & Substance Abuse Care"

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

Expenses of an organ donor are covered only if both the donor and the transplant recipient are Covered Persons under the Plan and benefits will be provided for each in accordance with his respective Eligible Expense.

The Plan Sponsor has contracted with a utilization management (UM) firm that offers a Covered Person the

availability of special transplant facilities (designated "Centers of Excellence") and a coordinated program of transplant care to give the patient the opportunity for the best possible outcome.

When the utilization management (UM) program is used for a covered transplant, the Plan will provide benefits for travel and lodging expenses for the patient and a companion to the nearest Center of Excellence facility designated for that type of procedure if the facility is more than thirty (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.

Urgent Care Facility – Eligible Medical Expenses, as listed within this section, that are incurred by a Covered Person at an Urgent Care Facility.

Weight Control – "Bariatric Surgery" any such treatment must be necessitated as the direct result of a specifically identifiable and diagnosed condition of disease etiology and deemed to be medically indicated following the standard Medical Necessity guidelines. See Weight Control under "Medical Limitations and Exclusions"

MEDICAL LIMITATIONS AND EXCLUSIONS

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

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

Complications of Non-Covered Treatment - Care, services or treatments that are required to treat complications resulting from a treatment or surgery that is not or would not be covered under the terms of the Plan, unless expressly stated otherwise.

Contraceptives - Medications, injections, implants, devices or the fitting of devices or any other services or supplies provided for birth control purposes.

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

services necessitated by an Accidental Injury;

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

treatment necessary to correct a congenital abnormality (birth defect) in a covered newborn.

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

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

Any type of maintenance care that is not reasonably expected to improve the patient's condition within a reasonable period of time, except as may be included as part of a formal Hospice care program.

Dental & Oral Care - Care or treatment on or to the teeth, alveolar processes, gingival tissue, or for malocclusion. This exclusion will not apply to necessary professional services for:

treatment of a fractured jaw, facial bones or other Accidental Injury to sound natural teeth. However, coverage is limited to services rendered within six (6) months of the accident;

surgical correction of harelip, cleft palate, or protruding mandible;

removal of stones from salivary ducts;

removal of bony cysts of the jaw, torus palatinus, leukoplakia or malignant tissues;

freeing of muscle attachments.

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

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

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

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

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

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

trimming or treatment of toenails;

foot massage;

treatment of corns, calluses, metatarsalgia or bunions;

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

orthopedic shoes or other appliances for support of the feet.

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

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

Hair Restoration - Any surgeries, treatments, drugs, services or supplies relating to baldness or hair loss, whether or not prescribed by a Physician.

Hearing Exams & Hearing Aids - Hearing exams, hearing aids or the fitting of hearing aids.

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

Hypnotherapy - Treatment by hypnotism.

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

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

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

Maintenance Care – see “Custodial & Maintenance Care”

Marriage & Family Counseling - Counseling for marital or family problems.

Massage Therapy – Massage therapy, except when performed by a Physician.

Nicotine Addiction – see “Smoking Cessation”

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

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

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

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

Personal Comfort or Convenience Items - Services or supplies that are primarily and customarily used for nonmedical purposes or are used for environmental control or enhancement (whether or not prescribed by a Physician) including but not limited to: (1) air conditioners, air purifiers, or vacuum cleaners, (2) motorized transportation equipment, escalators, elevators, ramps, (3) waterbeds or non-hospital adjustable beds, (4)

hypoallergenic mattresses, pillows, blankets or mattress covers, (5) cervical pillows, (6) swimming pools, spas, whirlpools, exercise equipment, or gravity lumbar reduction chairs, (7) home blood pressure kits, (8) personal computers and related equipment, televisions, telephones, or other similar items or equipment, (9) food liquidizers, or (10) structural changes to homes or autos.

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

Reversal Surgeries – Reversal or takedown surgery or reconstruction of a prior surgical sterilization.

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

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

Smoking Cessation - Smoking cessation programs or any other services or supplies intended to assist an individual to quit smoking.

TMJ / Jaw Joint Treatment – Treatment, by any method, of jaw joint problems, including temporomandibular joint syndrome, craniomandibular disorders or other conditions of the joint linking the jawbone and skull and the complex of muscles, nerves and other tissues related to that joint.

Vaccinations – Immunizations or vaccinations other than: (1) those included within the “Preventive Care” coverages (see the **Medical Benefit Summary**), and (2) tetanus or rabies vaccinations administered in connection with an Accidental Injury.

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

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

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

NOTE: This exclusion will not apply to: (1) services necessitated by a Sickness or Accidental Injury, or (2) the initial purchase of glasses or contact lenses following cataract surgery, or (3) aphakic patients and soft lenses or sclera shells intended to use as corneal bandages.

Vitamins or Dietary Supplements - Prescription or non-prescription organic substances used for nutritional purposes.

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

Weight Control – Routine treatment of obesity or services primarily for weight loss or control, including gastric bypass or gastric stapling procedures - unless any such treatment is necessitated as the direct result of a specifically identifiable and diagnosed condition of disease etiology and deemed to be medically indicated following the standard Medical Necessity guidelines.

Wigs or Wig Maintenance - see "Hair Restoration"

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

GENERAL EXCLUSIONS

The following exclusions apply to all health benefits and no benefits will be payable for:

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

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

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

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

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

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

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

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

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

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

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

Late-Filed Claims - Claims that are not filed with the Contract Administrator for handling within the required time periods as included in the **Claims Procedures** section.

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

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

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

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

Nuclear Energy Release - Any injury or illness resulting from the non-therapeutic release of nuclear energy.

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

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

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

Postage, Shipping, Handling Charges, Etc. - Any postage, shipping or handling charges that may occur in the transmittal of information to the Contract Administrator. Interest or financing charges.

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

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

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

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

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

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

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

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

Work-Related Conditions - Any condition that arises from or is sustained in the course of any occupation or employment for compensation, profit or gain, including self-employment. This exclusion applies whether or not the Covered Person has or had a right to compensation under any Workers' Compensation or occupational disease law or any other legislation of similar purpose. If the Plan elects to provide benefits for any such condition, the Plan will be entitled to establish a lien upon such other benefits up to the amount paid.

COORDINATION OF BENEFITS (COB)

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

DEFINITIONS

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

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

group blanket or franchise insurance coverage;

service plan contracts, group practice, individual practice and other prepayment coverage;

any coverage under labor-management trusteed plans, union welfare plans, employer organization plans or employee benefit organization plans; or

any coverage under governmental programs, and any coverage required or provided by any statute.

An "Other Plan" does not include: (1) individual or family insurance, (2) closed panel or other individual coverage - except for group-type coverage, (3) school accident type coverage, (4) benefits for nonmedical components of group long-term care policies, (5) Medicare supplement policies, or (6) Medicaid.

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

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

This Plan - The health benefits that are described in this Benefit Document.

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

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

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

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

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

If a person is covered by one plan that calculates its benefits or services on the basis of Reasonable and Customary and another plan that provides its benefits or services on the basis of negotiated fees, the negotiated fees shall be the Allowable Expense for this Plan.

NOTE: Any expense not payable by a primary plan due to the individual's failure to comply with any utilization review requirements (e.g., precertification of admissions, second surgical opinion requirements, etc.) will not be considered an Allowable Expense. (Please see page 2 for pre-service review, authorization and utilization services.)

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

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

EFFECT ON BENEFITS UNDER THIS PLAN

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

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

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

ORDER OF BENEFIT DETERMINATION RULES

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

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

Medicare as an "Other Plan" – Unless expressly stated otherwise, Medicare will be the primary, secondary or last payer in accordance with federal law, . When Medicare is the primary payer, This Plan will determine its benefits based on Medicare Part A benefits paid or payable and on Part B or Part D benefits paid or payable if the Claimant is enrolled for those Medicare benefits.

NOTE: Effective January 1, 2008, the Plan will assume a secondary status to Medicare for retired individuals and/or their eligible Dependents who are over the age of 65 and are eligible for Medicare. Where Medicare is primary by law, This Plan will be secondary.

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

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

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

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

the plan of the Custodial Parent;

the plan of the spouse of the Custodial Parent;

the plan of the noncustodial parent; and then

the plan of the spouse of the noncustodial parent.

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

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

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

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

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

OTHER INFORMATION ABOUT COORDINATION OF BENEFITS

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

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

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

SUBROGATION AND REIMBURSEMENT PROVISIONS

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

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

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

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

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

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

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

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

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

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

worker's compensation or other liability insurance company; or

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

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

Right of Reimbursement - The Plan shall be entitled to recover 100% of the benefits paid, without deduction for attorneys' fees and costs or application of the common fund doctrine, make whole doctrine, or any other similar legal theory, without regard to whether the Plan Beneficiary is fully compensated by his/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 subrogation lien. The obligation 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. If the Plan Beneficiary's recovery is less than the benefits paid, then the Plan is entitled to be paid all of the recovery achieved.

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, expressed 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 Plan Beneficiary, whether under the doctrines of causation, comparative fault or contributory negligence, or any 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 Plan Beneficiary.

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 sickness, injury, disease or disability.

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 shall be excess to:

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

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

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

worker's compensation or other liability insurance company; or

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

Wrongful Death Claims - In the event that the Plan Beneficiary 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.

Obligations - It is the Plan Beneficiary's obligation:

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;

to provide the Plan with pertinent information regarding the sickness, disease, disability, or injury, including accident reports, settlement information and any other requested additional information;

to take such action and execute such documents as the Plan may require to facilitate enforcement of its subrogation and reimbursement rights;

to do nothing to prejudice the Plan's rights of subrogation and reimbursement;

to promptly reimburse the Plan when a recovery through settlement, judgment, award or other payment is received; and

to not settle or release, without the prior consent of the Plan, any claim to the extent that the Plan Beneficiary may have against any responsible party or Coverage.

If the Plan Beneficiary and/or his or her attorney fails to reimburse the Plan for all benefits paid or to be paid, as a result of said injury or condition, out of any proceeds, judgment or settlement received, the Plan Beneficiary will be responsible for any and all expenses (whether fees or costs) associated with the Plan's attempt to recover such money from the Plan Beneficiary.

Offset – Failure by the Plan Beneficiary and/or his or her attorney to comply with any of these requirement may, at the Plan's discretion, result in a forfeiture of payment by the Plan of medical benefits and any funds or payments due under this Plan may be withheld until the Plan Beneficiary satisfies his or her obligation.

Minor Status - In the event the Plan Beneficiary 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.

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. The Plan Administrator may amend the Plan at anytime without notice.

Severability - In the event that any section of this provision is considered invalid or illegal for any reason, said invalidity or illegality shall not affect the remaining sections of this provision and Plan. The section shall be fully severable. The Plan shall be construed and enforced as if such invalid or illegal sections had never been inserted in the Plan.

ELIGIBILITY AND EFFECTIVE DATES

IMPORTANT: This section outlines the District's eligibility requirements for the Plan coverages that are described in this document. However, coverage availability and eligibility requirements etc. are as described in written District policies and collective bargaining agreements. Those policies and agreements are incorporated by reference herein. In the case of any discrepancy between the following information and the terms of District policies and collective bargaining agreements, the terms of the policies and agreements will govern.

Eligibility Requirements - Employees
To participate as an Employee in the Plan coverages described herein, an individual must be in regular full-time active employment for the Employer, performing all customary duties of his occupation at his usual place of employment (or at a location to which the business of the Employer requires him to travel) and averaging twenty (20) or more hours of work per week.

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

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

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

Effective Date - Employees
An Employee's coverage is effective as follows:

if an Employee is hired (or is first eligible) prior to the 15th day of a month, his coverage is effective on the first day of the following calendar month;

if an Employee is hired (or is first eligible) on or after the 15th day of a month, coverage is effective on the first day of the second following calendar month.

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

a legally married spouse. A "spouse" will mean a person of the opposite sex (i.e., not the same sex as the Employee). "Legally married" means a legal union (as defined by the Employee's state of residence) between one man and one woman as husband and wife;

a domestic partner where the partnership meets the District standards as outlined in the District's "Regulations for Policy 3030/4030, Group Benefits for Domestic Partners." See the section entitled **Addendum for Domestic Partner Eligibility** for further information;

a child under age 26 who is principally dependent upon his parent(s) for support and maintenance, and who is:

- a natural child;
- a stepchild;
- a foster child;
- a child who is under the court-appointed legal guardianship of the Employee;
- a child who is adopted by the Employee or placed with him for adoption prior to age 18. "Placed for adoption" means the assumption and retention by the Employee of a legal obligation for total or partial support of the child in anticipation of adoption of the child. The child must be available for adoption and the legal process must have begun. Placement ends when the legal support obligation ends; or

- notwithstanding any residency or main support and care requirements, a child for whom Plan coverage is required due to a Medical Child Support Order (MCSO) that the Plan Sponsor determines to be a Qualified Medical Child Support Order in accordance with its written procedures (that are incorporated herein by reference and that can be obtained without charge). A QMCSO will also include a judgment, decree or order issued by a court of competent jurisdiction or through an administrative process established under state law and that satisfies the QMCSO requirements.

NOTES: An eligible Dependent does not include:

a spouse following final decree of dissolution of marriage or divorce (unless court ordered);

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

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

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

Effective Date - Dependents
A Dependent who is eligible and enrolled when the Employee enrolls, will have coverage effective on the same date as the Employee. Dependents acquired later may be enrolled within thirty-one (31) days of their eligibility date. See the "Special Enrollment Rights" provision for additional details as well as instances when the loss of other coverage and other circumstances can allow a Dependent to be enrolled. Otherwise, a Dependent can be enrolled only in accordance with the "Open Enrollment" provision.

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

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

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

the Employee stated in writing at the time a prior enrollment was offered or available that other coverage was the reason for declining enrollment in the Plan. However, this only applies if the Plan Sponsor required such a written statement and provided the person with notice of the requirement and the consequences of failure to comply with the requirement;

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

- loss of eligibility as a result of legal separation, divorce, cessation of dependent status, death of an employee, termination of employment, reduction in the number of hours of employment;

- loss of eligibility when coverage is offered through an HMO or other arrangement in the individual market that does not provide benefits to individuals who no longer reside, live, or work in a service area (whether or not within the choice of the individual);

- loss of eligibility when coverage is offered through an HMO or other arrangement in the group market that does not provide benefits to individuals who no longer reside, live or work in a service area (whether or not within the choice of the individual), and no other benefit package is available to the individual;

- loss of eligibility when an individual incurs a claim that would meet or exceed a lifetime limit on all benefits. An individual has a special enrollment right when a claim that would exceed a lifetime limit on all benefits is incurred, and the right continues at least until thirty-one (31) days after the earliest date that a claim is denied due to the operation of the lifetime limit;

- loss of eligibility when a plan no longer offers any benefits to a class of similarly situated individuals. For example, if a plan terminates health coverage for all part-time workers, the part-time workers incur a loss of eligibility, even if the plan continues to provide coverage to other employees;

- loss of eligibility when employer contributions toward the employee's or dependent's coverage terminates. This is the case even if an individual continues the other coverage by paying the amount previously paid by the employer;

- loss of eligibility when COBRA continuation coverage is exhausted; and

the Employee requested Plan enrollment within thirty-one (31) days of termination of the other coverage.

If the above conditions are met, Plan coverage will be effective on the date of the event.

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

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

Entitlement Due to Acquiring New Dependent(s) - If an Employee acquires one (1) or more new eligible Dependents through marriage, domestic partnership, birth, adoption, or placement for adoption, application for their coverage may be made within sixty (60) days of the date the new Dependent or Dependents are acquired (the "triggering event") and Plan coverage will be effective as follows - see NOTE:

where Employee's marriage or domestic partnership is the "triggering event" - the spouse's or partner's coverage (and the coverage of any newly eligible children) will be effective on the first day of the month following the date of event;

where acquisition of a child is the "triggering event" - the child's coverage will be effective on the date of the event (i.e., concurrent with the child's date of birth, date of placement or date of adoption). The "triggering event" date for a newborn adoptive child is the child's date of birth if the child is placed with the Employee within thirty-one (31) days of birth.

NOTES: For a newly-acquired Dependent to be enrolled under the terms of this provision, the Employee must be enrolled or must be eligible to enroll (i.e., must have satisfied any waiting period requirement) and must enroll concurrently. If the newly-acquired Dependent is a child, the spouse is also eligible to enroll. However, other Dependent children who were not enrolled when first eligible are not considered to be newly acquired and can only be enrolled in accordance with other enrollment allowances of the Plan.

Court or Agency Ordered Coverage - If an Employee or an Employee's spouse is required to provide coverage for a child under a Medical Child Support Order, coverage for the child shall be effective as of the date specified in such order provided that such order is qualified according to the Plan Sponsor's written procedures and provided that a request for coverage is made on a form acceptable to the Plan Sponsor within 31 days from the date such order is determined to be qualified (QMCSO). A request to enroll the child may be made by the Employee, the Employee's spouse, the child's other parent, or by a State Agency on the child's behalf.

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

Open Enrollment
If an individual does not enroll when he is first eligible to do so or if he allows coverage to lapse, he may later enroll during an Open Enrollment period that will be held annually. Plan coverage will generally be effective on the first day of October following the end of the Open Enrollment period.

Reinstatement / Rehire
If an Employee or Dependent returns to an eligible status after having experienced a "Qualifying Event" and having continued Plan coverage, without interruption, as a "Qualified Beneficiary" under the terms of the **COBRA Continuation Coverage**, such person will be reinstated to active status and will have uninterrupted coverage under the Plan. That is, a new waiting period requirement will not be applied.

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

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

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

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

TERMINATION OF COVERAGE

Employee Coverage Termination
Except as noted, an Employee's coverage will terminate upon the earliest of the following:

termination of the Plan or Plan benefits as described herein;

termination of participation in the Plan by the Employee;

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

at midnight on the last day of the month in which eligibility ceases, if the Employee leaves or is dismissed from the employment of the Employer prior to the 15th day of the month, – or at midnight of the last day of the month following the month in which eligibility ceases, if eligibility ceases on or after the 15th of the month - except when coverage is extended under the **Extensions of Coverage** section. However, in the case of a Certificated Employee who terminates after June 30th of a year, eligibility will extend through September 30th of that year;

the date the Employee dies.

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

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

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

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

termination of the coverage of the Employee;

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

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

*- (See **COBRA Continuation Coverage**) -*

EXTENSIONS OF COVERAGE

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

Extension of Coverage for Handicapped Dependent Children
If an already covered Dependent child is incapable of self-sustaining employment by reason of mental retardation, cerebral palsy, epilepsy, other neurological disorder or physical handicap, and:

such condition commenced on or before the child attained the age that would otherwise terminate his eligibility;

the child's condition has been diagnosed by a Physician as a permanent or long-term dysfunction or condition; and

such child is primarily dependent upon the Employee for support and maintenance;

then such child's status as a "Dependent" will not terminate solely by reason of his having attained the limiting age and he will continue to be considered a covered Dependent under the Plan so long as he remains in such condition, and otherwise conforms to the definition of "Dependent."

The Employee must submit proof of the child's incapacity to the Plan Administrator within thirty-one (31) days of the child's attainment of the limiting age, and thereafter as may reasonably be required, but not more frequently than once a year after the two-year period following the child's attainment of such age.

The Plan reserves the right to have such Dependent examined by a Physician of the Plan's choice to determine the existence of such incapacity.

Extensions of Coverage During Absence From Work
If an Employee fails to continue in eligible active status but is not terminated from employment (e.g., he is absent due to an approved leave or a temporary layoff), he may be permitted to continue health care coverages for himself and his Dependents though he could be required to pay the full cost of coverage during such absence. Any such extended coverage allowances will be provided on a non-discriminatory basis.

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

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

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

the date of termination of the Plan.

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

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

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

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

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

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

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

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

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

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

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

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

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

Maximum Period of Coverage – The maximum period of USERRA continuation coverage following Employee's cessation of active employment is the lesser of:

18 months (or 24 months for elections made on or after December 10, 2004); or
the duration of Employee's active military service.

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

The Employee must return to employment:

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

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

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

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

Extension of Coverage for Retirees
If a certificated Employee whose coverage has or would otherwise have terminated due to his retirement under any public retirement system, such Employee and his spouse (or his surviving spouse in the event of the death of such Employee), may continue coverage under the Plan in the same manner as an active certificated Employee and/or spouse, provided the Employee or spouse makes all required contributions when due.

Further, the Employer shall allow an annual, one-month Open enrollment period for such individuals. During the open enrollment period, such qualified individuals who are not enrolled under the Plan may elect to do so and such qualified individuals, whether currently enrolled or not, may elect to enroll or change their enrollment to any other health and welfare plan or dental benefit offered by the Employer at that time to active certificated Employees.

HIPAA's special enrollment rights will extend to retirees who acquire new Dependents.

Effective January 1, 2008, the Plan will assume a secondary status to Medicare for retired individuals and their eligible Dependents who are over the age of 65 and are eligible for Medicare. Where Medicare is primary by law, this Plan will be secondary.

*- (See **COBRA Continuation Coverage**) -*

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EXTENSION OF BENEFITS DURING TOTAL DISABILITY

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

upon termination of the Total Disability;

twelve (12) months following the date coverage terminated;

upon the individual's eligibility for coverage in any other group plan, self-insured plan, prepayment plan, HMO or government plan that does not limit coverage for the disabling condition;

upon termination of the Plan.

For an Employee, "Total Disability" or "Totally Disabled" means a disability resulting solely from a non-occupational sickness, non-occupational injury or pregnancy that prevents the Employee from engaging in his regular or customary occupation and he is performing no work of any kind for compensation or profit. For a Dependent, it is disability that prevents Dependent from engaging in substantially all the normal activities of a person in good health of like age and sex.

A Physician (MD or DO) must certify an Employee or Dependent as Totally Disabled.

*- (See **COBRA Continuation Coverage**) -*

CLAIMS PROCEDURES

SUBMITTING A CLAIM

A claim is a written request for benefit determination after a service has been rendered and expense has been incurred. A claim must name the Plan, a specific Claimant, a specific health condition or symptom or diagnostic code, and a specific treatment, service or supply for which a benefit or benefit determination is requested, the date of service, the amount of charges, the address (location) where services are received, and provider name, address, phone number and tax identification number.

The Plan Administrator has contracted with a separate entity to handle claims communications and benefit determinations. A claim must be submitted to the claims office within twelve (12) months of the date the charges were incurred. A claim should be submitted to:

Orange County Foundation for Medical Care
P. O. Box 11066
Orange, CA 92856

ASSIGNMENTS TO PROVIDERS

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

Benefits due to any Network provider will be considered "assigned" to such provider and will be paid directly to such provider, whether or not a written assignment of benefits was executed. Notwithstanding any assignment or non-assignment of benefits to the contrary, upon payment of the benefits due under the Plan, the Plan is deemed to have fulfilled its obligations with respect to such benefits, whether or not payment is made in accordance with any assignment or request.

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

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

CLAIMS TIME LIMITS AND ALLOWANCES

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

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

CLAIM ACTIVITY	TIME LIMIT OR ALLOWANCE
Claimant Makes Initial Incomplete Claim Request	Within 30 days (and sooner if reasonably possible), Plan advises Claimant of information needed to complete the claim request.

Plan Receives Completing Information	Within 30 days, Plan approves or denies claim. 15 additional days may be allowed with full notice to Claimant - see definition of "full notice" below.
Claimant Makes Initial Complete Claim Request	Within 30 days of receiving the claim, Plan approves or denies claim. 15 additional days may be allowed with full notice to Claimant - see definition of "full notice" below.
Claimant Appeals	See "Appeals Procedures" subsection.
Plan Responds to Appeal	Within 60 days after receipt of appeal (or within 30 days for each appeal if Plan provides for two appeal levels).

"Full notice" means that notice is provided to the Claimant describing the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. Such extension must be necessary due to matters beyond the control of the Plan and notification to Claimant must occur prior to the expiration of the initial 30-day or 60-day period.

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

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

CLAIMS DENIALS

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

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

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

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

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

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

APPEAL PROCEDURES

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

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

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

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

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

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

the specific reason(s) for the decision;

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

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

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

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

DEFINITIONS

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

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

Ambulatory Surgical Center - Any public or private establishment that:

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

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

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

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

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

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

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

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

has organized facilities for birth services on its premises;

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

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

maintains daily clinical records.

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

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

Contract Administrator - An external professional firm that performs functions reasonably related to the administration of one or more benefits of a self-funded health plan (e.g., processing of claims for payment) in accordance with the terms and conditions of the Benefit Document and an administration agreement between the Contract Administrator and the Plan Sponsor.

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

Convalescent Hospital - see "Skilled Nursing Facility"

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

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

Covered Provider - An individual who is:

licensed to perform certain health care services that are covered under the Plan and who is acting within the scope of his license; or

in the absence of licensing requirements, is certified by the appropriate regulatory agency or professional association;

and who is a/an:

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

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

any practitioner of the healing arts who is licensed and regulated by a state or federal agency and is acting within the scope of his license;

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

licensed Outpatient mental health facilities;

freestanding public health facilities;

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

enuresis control centers;

home infusion therapy providers;

durable medical equipment providers;

prosthetists and prosthetist-orthotists;

portable X-ray companies;

independent laboratories and lab technicians;

diagnostic imaging facilities;

blood banks;
speech and hearing centers;

ambulance companies.

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

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

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

Emergency - see "Medical Emergency"

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

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

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

Home Health Care Agency - An agency or organization that:

is primarily engaged in and duly licensed, if such licensing is required by the appropriate licensing authority, to provide skilled nursing services and other therapeutic services;

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

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

maintains a complete medical record on each patient;

has a full-time administrator.

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

Hospice or **Hospice Agency** - An entity providing a coordinated set of services rendered at home, in Outpatient settings or in institutional settings for Covered Persons suffering from a condition that has a terminal prognosis. A Hospice must have an interdisciplinary group of personnel that includes at least one Physician and one registered nurse, and must maintain central clinical records on all patients. A Hospice must meet the standards of the National Hospice Organization (NHO) and applicable state licensing requirements.

Hospital - An institution for care of the sick or injured which is properly licensed or permitted legally to operate as such, and which as registered nurses on duty 24-hours-a-day, a Physician on call at all times and facilities for diagnosis of illness and for major surgery.

The definition of “Hospital shall be expanded for purposes of Inpatient psychiatric benefits, to include any facilities operating legally as a psychiatric hospital and licensed as such by the state in which the facility operates.

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

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

Lifetime - All periods an individual is covered under the Plan, including any prior statements of the Plan. It does not

mean a Covered Person's entire lifetime.

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

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

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

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

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

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

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

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

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

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

Participating Employer - An Employer who is participating in the coverages of the Plan. See **General Plan Information** section for the identity of the Participating Employer(s).

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

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

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

Plan Administrator - see "Plan Sponsor"

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

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

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

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

With regard to charges made by a provider of service participating in the Plan's Network program, Reasonable and

Customary will mean the provider's negotiated rate - but not to exceed the actual charge or the non-Network Reasonable and Customary allowance unless such lesser amount is not permitted under the terms of the Network agreement.

When multiple surgeries are performed through separate incisions during the same operative session, the allowable expense shall be calculated at full value for the primary procedure and at 50% of full value for the lesser procedure.

If an assistant surgeon is required for a covered surgery, the assistant surgeon's R&C allowance will not exceed 20% of the surgeon's R&C allowance.

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

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

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

is approved for its stated purpose by Medicare.

Semi-Private Room Charge - The standard charge by a facility for a semi-private room and board accommodation (2 or more beds), or the average of such charges where the facility has more than one established level of such charges, or 90% of the lowest charge by the facility for a single bed room and board accommodation where the facility does not provide any semi-private accommodations.

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

Skilled Nursing Facility - An institution that:

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

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

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

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

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

has an effective utilization review plan;

is approved and licensed by Medicare;

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

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

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

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

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

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

GENERAL PLAN INFORMATION

Name of Plan:	**Riverside Community College District Health Plan**
Plan Sponsor / Plan Administrator: Address: Business Phone Number:	**Riverside Community College District** 3845 Market St. Riverside, CA 92501 (951) 328-3873
Participating Employer:	**Riverside Community College District**
Plan Sponsor ID Number (EIN):	**95-6000929W**
Plan Year:	**October 1 through September 30**
Named Fiduciary: Address: (See also definition of "Fiduciary")	**Riverside Community College District** 3845 Market St. Riverside, CA 92501
Agent for Service of Legal Process: Address:	**Riverside Community College District** 3845 Market St. Riverside, CA 92501

(Legal process may be served upon the Plan Administrator or a Fiduciary)

Plan Benefits Described Herein:	**Self-Funded Medical Benefits**
Contract Administrator: Address: Phone:	**Orange County Foundation for Medical Care** P. O. Box 11066 Orange, CA 92856 (800) 345-8643

FUNDING - SOURCES AND USES

Contributions are made to the Plan by the Employer and Employees. Benefits are provided through the Contract Administrator and directly from the Riverside Community College Health Plan Trust.

ADMINISTRATIVE PROVISIONS

Administration (type of)
The Plan benefits described herein are administered by a Contract Administrator under the terms and conditions of administration agreement(s) between the Plan Sponsor and Contract Administrator. The Contract Administrator is not an insurance company.

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

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

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

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

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

alter or postpone the method of payment of any benefit;

amend any provision of these administrative provisions;

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

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

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

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

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

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

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

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

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

discharge of any liability therefor under the Plan.

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

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

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

Fiduciaries may employ such agents, attorneys, accountants, investment advisors or other persons (who also may be employed by the Employer) or third parties (such as, but not limited to provider networks or utilization management organizations) as in their opinion may be desirable for the administration of the Plan, and may pay any such person or third party reasonable compensation. The Fiduciaries may delegate to any agent, attorney, accountant or other person or third party selected by them, any power or duty vested in, imposed upon, or granted to them by the Plan. However, Fiduciaries will not be liable for acts or omissions of any agent, attorney, accountant or other person or third party except to the extent that the appointing Fiduciaries violated their own general fiduciary duties in: (1) establishing or implementing the Plan procedures for allocation or delegation, (2) allocating or delegating the responsibility, or (3) continuing the allocation or delegation.

Force Majeure
Should the performance of any act required by the Plan be prevented or delayed by reason of any act of nature, strike, lock-out, labor troubles, restrictive governmental laws or regulations, or any other cause beyond a party's control, the time for the performance of the act will be extended for a period equivalent to the period of delay, and non-performance of the act during the period of delay will be excused. In such an event, however, all parties will use reasonable efforts to perform their respective obligations under the Plan.

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

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

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

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

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

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

an employee's cessation of active service for the employer;

a Plan participant's failure to pay his share of the cost of coverage, if any, in a timely manner;

a dependent ceases to meet the Plan's eligibility requirements (e.g., a child reaches a maximum age limit or a spouse divorces);

a Plan participant is injured and expenses for treatment may be paid by or recovered from a third party;

a claim for benefits is not filed within the time limits of the Plan.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

an individual has submitted a claim that, in good faith judgment and investigation, he knew or should have

known, contained false or fraudulent elements under state or federal law.

Type of Plan
This Plan is not a plan of insurance. This Plan is a self-funded nonfederal governmental group health plan that, for the most part, is exempt from the requirements of the Employee Retirement Income Security Act (ERISA). However, governmental plans are not automatically excluded from the following amendments to ERISA: The Health Insurance Portability and Accountability Act (HIPAA), the Mental Health Parity Act (MHPA), the Newborns and Mothers Health Protection Act (NMHPA), and the Womens Health and Cancer Rights Act (WHCRA). To be exempt from certain requirements of these laws, the Plan must make an affirmative written election to be excluded. Such election must be filed with the Centers for Medicare and Medicaid Services (CMS) prior to the beginning of each Plan Year, with notice provided to each Plan participant. Unless such written election is filed and participant notices are made, this Plan intends to fully comply with the above-stated federal laws.

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

COBRA CONTINUATION COVERAGE

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

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

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

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

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

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

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

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

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

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

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

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

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

for an Employee's child, the child's loss of Dependent status (e.g., a Dependent child reaching the maximum age limit);

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The cost of COBRA continuation coverage can only increase if:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Temporary Extension of COBRA Election Period

Definitions:

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

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

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

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

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

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

HIPAA Creditable Coverage Credit
With respect to any TAA-Eligible Individual who elects COBRA continuation of coverage as a Nonelecting TAA Individual, the period beginning on the date the TAA-Related Loss of Coverage, and ending on the first day of the

TAA-Related Election Period shall be disregarded for purposes of determining the 63-day break-in-coverage period pursuant to HIPAA rules regarding determination of prior creditable coverage for application to the Plan's preexisting condition exclusion provision.

Applicable Cost of Coverage Payments

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

GROUP BENEFITS FOR DOMESTIC PARTNERS
(AP 7515)

In accordance with current laws, group benefits are available for the domestic partners of employees if the domestic partnership is registered with the State of California.

References: Family Code Sections 297, 295.5, 298, 298.5, 299, 299.2, and 299.3

Domestic Partner Group Benefits are available to the bona fide domestic partner of a District employee. Such benefits are available only to domestic partner relationships that meet the State of California standards for registered domestic partners.

Employees wishing to have their domestic partner covered under the District's group benefits plan will be required to provide the Benefit Specialist of the Diversity and Human Resources Department with a certified copy of a State of California Certificate of Registered Domestic Partnership. Once received, the employee's domestic partner is entitled to all of the same rights, protections and benefits, and shall be subject to the same responsibilities, obligations and duties under the law, as are granted to and imposed upon spouses. All necessary enrollment paperwork will be provided to the employee by the Benefit Specialist. Therefore, the domestic partner is entitled to:

A. Medical and dental insurance benefits.
B. Medical insurance which may be available to spouses of eligible retired employees and any other benefits available to spouses, including survivor benefits within the limits of state and federal law.
C. The same rights regarding non-discrimination as those provided to spouses.

The employee must acknowledge that he or she understands that under applicable federal and state tax law, District-provided benefits coverage of the domestic partner could result in imputed taxable income to the employee, subject to income tax withholding and applicable payroll taxes.

Benefits for a domestic partner of an employee whose domestic partnership is NOT registered with the State of California, but was enrolled in the District benefits program that was in effect prior to adoption of this procedure, November 2008, which replaces the former benefits program, will have unchanged access to that former benefits program.

Definitions

Domestic Partnership - "Domestic partners" are two (2) persons, each age 18 or older, who have chosen to live together in a committed relationship and who have agreed to be jointly responsible for living expenses incurred during the domestic partnership and registered as such in the State of California.

Live Together – "Live together" means that two (2) people share the same living quarters. Each partner must have the legal right, documented in writing, to possess the living quarters.

Living Expenses – "Responsible for living expenses" means that the partners are jointly responsible for the common welfare and financial obligations of each other which are incurred during the domestic partnership.

ADOPTION OF THE DOCUMENT

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

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

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

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

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

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

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

Acceptance of the Document
IN WITNESS WHEREOF, the Plan Sponsor has caused this instrument to be executed, effective as of October 1, 2007.

Riverside Community College District

By: _____

Title: _____

WITNESS:

By: _____

Title: _____