Value Choice Program
For Employees Of
Marin General Hospital

Summary Plan Description

Effective January 1, 2006
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VALUE CHOICE PROGRAM

INTRODUCTION

This summary plan description (SPD) provides a brief description of the Value Choice Program portion of the Marin General Hospital Employee Group Health Plan (Plan) sponsored by Marin General Hospital (Employer), and administered by Sutter Health Partners. The benefits described in this SPD have been designed to pay a large portion of the usual, customary and reasonable fees for a broad range of necessary medical services, treatments, and supplies and will give you substantial protection against the cost of serious sickness and injuries.

Please read this SPD thoroughly and become familiar with its provisions. After you have read this SPD, keep it with your other valuable papers for future reference.

Note that this SPD is just a summary and general description of this portion of the Plan – it does not fully describe or summarize the provisions and operation of all of the benefits that may be provided through the Plan. The Employer has a copy of the official plan document for the Plan, as it may be modified from time to time, that is readily available for your inspection. If you have questions or need a copy of the Plan, please contact the Plan Administrator.

If there is ever any conflict between the plan document and any statements made in this SPD, the plan document will control. If there is ever any conflict between either an insurance policy providing benefits under the Plan or any contracts for medical and prescription drug review services and either the plan document or this SPD, the insurance policy or contract will control. Please remember that no employee of the Employer – not even your supervisor – has any authority to bind the Employer to any benefit or procedure that conflicts with the official plan document, this SPD, or any such insurance policy or contract.

Although the Employer currently intends to continue all of the benefits described in this SPD, the Employer has reserved the right to amend, reduce or terminate any of these benefits at any time and for any reason. If any of the benefits provided under the Plan is amended or terminated, you may not receive benefits as described in other sections of this SPD. Although you may become entitled to receive different benefits, or benefits under different conditions, it is also possible that you will lose all benefits coverage. Loss of coverage may happen at any time, even after you retire, if the Employer decides to terminate a benefit under the Plan or your coverage under the Plan. In no event will you become entitled to any vested rights under any of the benefits provided under the Plan.

There are terms in this SPD that have a special meaning under the Plan and are listed in the “Definitions” section of this SPD. When reading the provisions of this SPD, it may be helpful to refer to this section. Becoming familiar with the terms defined in this section will give you a better understanding of the procedures and benefits described.

In addition to this booklet describing your benefits, you will receive a wallet-sized card that identifies you and your enrolled dependents as eligible for benefits. This card contains your name, personal identification number, group number, applicable co-payment amounts, and the name of the Employer. The reverse of your card contains instructions for filing claims. Always carry this card with you when you or your dependents visit the hospital, doctor, or pharmacy. The card contains information that must be on every claim form submitted for consideration of payment. The information on the reverse of the card is necessary for proper submission of claims and provides telephone numbers for inquiries. If you lose your card, contact the customer service number on the back of the ID card.
TYPES OF PROVIDERS

PARTICIPATING PROVIDERS
The Plan has contracted with an established network of various types of “participating providers” to provide hospital, physician and other health care services for you and your dependents. These “Participating Providers” have agreed to provide our members with health care a special reimbursement. All care must be provided, or coordinated by a “participating” provider physician. A directory is available that lists all participating providers in your area, including health care facilities such as hospitals, physicians, laboratories, radiology and imaging providers. You may obtain a copy of this directory through your Human Resources department or the customer service number on your identification card. You may also search on our website at www.sutterhealthpartners.com.

The final choice of a health care provider is yours. However, if you receive care from a non-network provider, services may not be covered by the plan.

NON-PARTICIPATING PROVIDERS EXCEPTIONS
It is the responsibility of the covered person to assure services to be rendered are performed by participating providers in order to receive coverage. Non-participating providers are providers that have not agreed to the negotiated rates and other provisions of a contract. Coverage is paid only if you have received an authorization or for emergency or urgent care. The following listing of exceptions represents services, supplies or treatments rendered by a non-network provider where covered expenses shall be payable at the participating provider level.

The member will not be responsible for the difference between the billed and allowed amounts in the following circumstances:

1. Non-network emergency treatment that meets the definition of “Emergency Services.” If the covered person is admitted to the hospital after such emergency treatment, covered expenses shall be payable at the participating provider level;
2. Non-network anesthesiologist if the hospital/facility is a participating provider;
3. Hospital based radiologist or pathologist services for interpretation of x-rays and laboratory tests rendered in a Participating Hospital/Facility.
4. Medically necessary services, supplies and treatments not available through a participating provider within 30 miles.
5. Ambulance transportation by a licensed ambulance service by land, sea, or air when medically appropriate.

BILLS FROM PARTICIPATING PROVIDERS
The best way to determine your expense is to review your Explanation of Benefits (EOB) and verify your expense. If you are billed (other than co-payments) for a Covered Service provided by a participating provider or if you receive a bill for Emergency or Urgently Needed Services you should do the following:

1. Call the Provider, and then let them know you have received a bill in error and that you believe this should be covered under your health plan.
2. Give the Provider your Plan information, including your name, your subscriber number, the provider service number (on the back of your id card and the claims address (on the back of your ID card). Ask them to rebill this charge to the Plan.
3. If you continue to receive bills from the provider, please call the customer service number on the back of your ID card for assistance.

Please Note: Your Provider may bill you for services that are not covered by the Plan or haven't been properly authorized. You may also receive a bill if you've exceeded the Plan's coverage limit for a benefit.

BILLS FROM NON-PARTICIPATING PROVIDERS
If you receive a bill for a Covered Service from a Physician who is not one of our participating providers, and the service was Preauthorized and you haven’t exceeded any applicable benefit limits, the Plan will pay for the service, less the applicable Co-payment. (Preauthorization isn't required for Emergency Services and Urgently Needed Services). You may also submit a bill to the Plan if a non-participating
The provider has refused payment directly from the Plan. You should file a claim within 120 days of receiving any services and related supplies. Claim forms are available in your Human Resources Department as well as on our website at www.sutterhealthpartners.com. Attach a copy of the bill with proof of payment the claim form and submit it to:

BRMS
Attention: Sutter Health Partners
PO Box 2650
Rancho Cordova, CA  95741

The Plan will make a determination within 45 working days from the date the Plan receives a claim containing all information reasonably necessary to decide the claim. The Plan will not pay any claim that is received more than 120 days calendar days from the date the services or supplies were provided. The Plan also will not pay for excluded services or supplies. If you’ve reached or exceeded any applicable benefit limit, these bills will be your responsibility.

**HOW TO AVOID UNNECESSARY BILLS**

*Always obtain your care from participating providers.* By doing this, you only will be responsible for paying any related Co-payments and for charges in excess of your benefit limitations. Except for Emergency or Urgently Needed Services, if you receive services not authorized by the Plan or from a non-participating provider, you may be responsible for payment. This is also true if you receive any services not covered by the Plan.

**ELIGIBILITY, EFFECTIVE DATE AND TERMINATION OF COVERAGE**

**Employees Eligible for Coverage are as follows:**

1. **Regular Full-Time and Regular Part-Time Employees**
   Regular full-time and regular part-time Employees who have fully completed the waiting period of 60 days of continuous employment in a benefit eligible status; and who are at least 18 years of age, classified as a “Benefited Employee” at .50 or greater full-time equivalent (FTE). This does not include individuals performing work for the Employer in the capacity of independent contractor, contract worker, temporary or casual employee, or leased employee as interpreted by the Employer. Coverage will commence on the first of the calendar month coincident with, or following the completion of the 60-day eligibility period.

2. **Per Diem Employees**
   In general, employees classified as per diem, on-call, or short-notice are not eligible for coverage under the Plan, unless specified as part of a collective bargaining agreement in effect during the term covered by the Plan.

3. **Per Diem Employees Who Transfer to Benefited Status**
   Employees classified as per diem who transfer to a benefited position shall become eligible for coverage under the plan the first of the calendar month coincident with or following the change of status to Benefited, so long as at least 60 days of continuous employment has been completed at the time of the change of status. In the event that 60 days of continuous employment has not been completed at the time of the change of status, then eligibility for coverage shall commence the first of the calendar month coincident with or following completion of 60 days continuous employment.

4. **Inter-Affiliate Employment Program**
   Employees coming from another Sutter Health facility and who are eligible under the Inter-Affiliate Employment Program will be given full credit toward satisfaction of the eligibility requirements under the Plan.

5. **Retirees of Marin General Hospital**
   For the purposes of the Plan, "retirees" are defined as individuals who have been participants in the Plan and who have retired under the retirement provisions of the company which is age 55 and have worked for the company for a period of 5 years in a full-time capacity. This benefit is available only to Employees who are members of the California Nurses Association, the MH Radiology Associates, Teamsters Clerical Team Members and non-contractual employees.
These eligible Employees may continue participation in the Plan provided there has not been an interruption in coverage between active full-time employment and retirement. Eligibility under this provision expires when the retiree reaches age 65. The Employee will pay for continuation of coverage under the Plan at the Employer’s cost plus 2% (COBRA rate) following retirement between the ages of 55 and 65 during the term of coverage. California Nurses Association Employees who shall continue coverage under the Plan retiring between the ages of 55 and 65 shall be covered under the terms of the collective bargaining agreement in effect during the period covered by this SPD.

**DEPENDENTS ELIGIBLE FOR COVERAGE ARE AS FOLLOWS:**

1. **Spouse and Domestic Partners:**
   The spouse is the Employee’s lawful wife or husband. Domestic partners are eligible for medical benefits as long as they qualify under the following definition. “Domestic partner” is defined as a person of the same or opposite sex who:
   a. Shares your permanent residence;
   b. Has resided with you continuously for no less than twelve consecutive months;
   c. Is not less than 18 years of age;
   d. Is financially interdependent with you and has proven such interdependence by providing documentation of at least two of the following arrangements:
      i. Common ownership of real property or a common leasehold interest in such property;
      ii. Common ownership of a motor vehicle;
      iii. A joint bank account or a joint credit account;
      iv. Designation as a beneficiary for life insurance or retirement benefits;
      v. Designation as a devisee under a partner’s will;
      vi. Execution of a durable power of attorney naming you as attorney-in-fact; or
      vii. Such other proof as is considered by the Company to be sufficient to establish financial interdependency under the circumstances of your particular case.
   e. Is not a blood relative any closer than would prohibit legal marriage; and
   f. Has signed jointly with you, a notarized affidavit in form and content satisfactory to the Company affirming the domestic partner relationship.

   A domestic partner and his dependents, as otherwise defined herein, qualify as dependents as long as the domestic partner:
   a. Has not signed a domestic partner affidavit or declaration with any other person within 12 months prior to designating each other as domestic partner thereunder; or
   b. Is not currently legally married to another person; and marriage means two individuals in a lawful marriage contractually recognized by the State where the marriage was performed, or
   c. Does not have any other domestic partner, spouse, or spouse equivalent of the same or opposite sex; and,
   d. As long as you have registered as domestic partners if you reside or resided in a county or State that provides for such registration.

2. **Child (Children)**
   A child is the subscriber’s or the spouse’s unmarried natural child, stepchild, or legally adopted child of the Employee, covered spouse, or covered domestic partner of the Employee. An eligible child is also one whose medical care an Employee, covered spouse, or covered domestic partner of an Employee is legally responsible through a divorce decree or other court order. A child is subject to the following:
   a. Has not reached the end of the month in which they reach age 19 and qualifies as a dependent according to the Internal Revenue Service definition.
   b. Has not reached the end of the month in which they reach age 25 and is going to school full-time at an accredited institution of higher learning, and qualifies as a dependent according to the Internal Revenue Service definition.
   c. The Plan must receive verification in writing of age and full-time student status.
   d. Semester breaks (including summer break) do not jeopardize a child’s full-time student status. However, if a child is not attending as a full-time student during the semester following the break, that child will no longer be considered a dependent under the Plan, and coverage will terminate on
the first day coincident with or following the first of the calendar month coincident with or following the beginning of the first semester of non-attendance or attendance at less than full-time status. A previously ineligible dependent child may be enrolled under the Plan as a new dependent within 31 days of the date of attendance as a full-time student by meeting the criteria below:

i. Proof of full-time student attendance from the registrar of the educational institution must be provided to the Employer within this 31-day period. Coverage will be effective on the first of the month coincident with or following the date classes begin.

ii. If the child is enrolled before age 19 or 25 as applicable, and upon reaching the applicable age limit depends on the Employee for financial support and is unable to work due to a mental or physical disability. A physician must certify such disability in writing to the Company and must be received by the Plan within 31 days of the child’s 19th or 25th birthday as applicable. When a period of two years has passed, the Plan may request proof of continuing dependency and disability, and may do so annually thereafter. This exception will continue until the child is no longer disabled or dependent on the Employee for financial support. A child is considered financially dependent if he or she qualifies as a dependent for federal income tax purposes.

The term “child” does not include:

a. Any child who is not the Employee’s natural, step, or adopted child;
b. Any child residing full or part-time with the Employee who is not the natural, step, or adopted child of the Employee and for whom the Employee does not have legal guardianship;
c. Any person who is covered under the Plan as an Employee of the Company, or, who is eligible for health insurance coverage as the Employee of another company;
d. Any child who is married; or
e. Any person who is in active service in the armed forces of any country.

The Plan may require proof (such as a copy of the Employee’s income tax return, court order, legal adoption or legal guardianship papers) that the spouse or child qualifies as a dependent under the Employee’s coverage.

If both husband and wife or domestic partners are eligible as Employees, either or both may carry dependent coverage. The reimbursement and/or payment of claims filed on behalf of one individual, even though filed separately by each husband, wife or domestic partner covered under the Plan, shall not exceed 100% of the cost of the claim on a combined basis.

3. Adopted Child

Coverage for adopted children before the age of 19, who are enrolled within 31 days of the placement, begins on the date of placement for the purpose of adoption and is continued unless the placement is disrupted or discontinued prior to the legal adoption of the child. If disruption or discontinuation occurs, coverage will cease on the date the child is no longer in the custody of the Employee.

4. Qualified Medical Child Support Order

Any eligible child covered by a Qualified Medical Child Support Order (QMCSO) is required to be covered under the Plan as of the date of the QMCSO or coinciding with the Employee’s effective date of coverage, whichever is later. If the Employee is not enrolled for dependent coverage, the Employee must enroll the dependent under the Enrollment provisions stated in this SPD and plan document.

5. Developmentally or Physically Disabled Child

A developmentally or physically disabled child’s coverage may be extended beyond age 19 if the child is incapable of self-sustaining employment and is dependent upon the Employee for primary financial support and maintenance. A letter of proof of incapacity and dependency from the parents and the attending physician is required within 31 days of the dependent’s attainment of age 19, or 25 in the case of a full-time student. The Plan may require that a physician examine the child before granting a continuation of coverage. The Plan Administrator will elect a physician and pay all costs in connection with such an examination. This provision stops on the earliest of the following dates:

a. The date the child is no longer disabled according to the Plan; or
b. The date the Plan is not furnished with proof of the child’s disability when requested.

**EXCLUSIONS FROM THE DEFINITION OF DEPENDENT**

Those situations specifically excluded from the definition of dependent are:

1. A spouse who is legally separated or divorced from the Employee. Such spouse must have met all requirements of a valid separation or divorce contract in the State granting such separation or divorce.
2. If both husband and wife or domestic partners are eligible as Employees, either, but not both may carry dependent coverage.
3. Any person eligible under the Plan may be covered as an Employee or as a dependent.
4. An individual who ceases to qualify as a domestic partner for the purposes of the Plan.

**ENROLLMENT REQUIREMENTS**

Each eligible Employee is required to complete either an application or a declination of coverage form during his or her enrollment period in order to considered a timely entrant. To enroll as an Employee, or to enroll dependents, the Employee must properly file an application at the time he or she is eligible as follows:

1. Application and/or declination form must be completed by the Employee to enroll or decline enrollment for him/herself and/or dependents and filed within 31 calendar days after the Employee’s eligibility date.
2. Application and/or declination form must be completed by the Employee to enroll a new spouse or domestic partner within a time period ending 31 calendar days after the marriage or qualification of the domestic partner relationship as defined above.
3. Application and/or declination form must be completed by the Employee to enroll a newborn or newly adopted child, or child newly acquired through marriage, qualification of a domestic partnership, or legal guardianship (stepchild, foster, legal guardianship) within a time period ending 31 calendar days after the date of birth or date acquiring of the child.

Any Employee or dependent who does not complete an application or declination form within the time limits stated above or who has declined coverage for any other reason than having other group coverage will be considered late entrants. See separate Late Entrant provision.

**EMPLOYEE’S EFFECTIVE DATE OF COVERAGE**

1. **Active Employee**
   - An eligible Employee’s coverage becomes effective, on the first day of the month coincident with or following 60 continuous days of employment in a benefit eligible status. This is called the “waiting period”. If the Employee has completed the Waiting Period and has been covered under the Plan, and subsequently ceases to be eligible due to a change in employment status into non-benefit eligible status and then later regains benefit eligibility, the Employee will become eligible on the first day of the month coincident with or following the return to benefit-eligible status as long as there is no break in employment.

2. **Rehired Employees**
   - A former covered Employee who terminates employment and is rehired by the company must meet the same eligibility requirements as that of a newly hired Employee, unless the period between termination and re-employment is six months or less.

3. **Inter-Affiliate Employment**
   - If an Employee in a benefit eligible status comes into the Plan from another Sutter Health facility and has otherwise satisfied the Waiting Period, the Employee and eligible dependents will be covered as of the first of the calendar month coincident with or following the date of employment with the Employers covered by the Plan. If the Employee has not satisfied the Waiting Period at the prior Sutter Health affiliate, full credit will be given for prior service as a benefit eligible Employee and coverage will be effective as of the first calendar day of the month coincident with or following satisfaction of the Waiting Period in a benefit eligible status.
DEPENDENT’S EFFECTIVE DATE OF COVERAGE
Dependent coverage will not take effect unless the Employee’s coverage is in effect. Eligible dependents become covered as follows:

1. If the dependent is enrolled as a dependent on the Employee’s effective date, the dependent becomes covered under the Plan on the date of the Employee’s effective date.

2. If the dependent becomes an eligible dependent after the Employee’s effective date, the dependent becomes eligible to be enrolled under the Plan as specified in the special enrollment periods provision or the next annual open enrollment period whichever is applicable to the situation.

3. If a dependent is enrolled due to a court order, including a Qualified Medical Child Support Order, coverage will become effective on the date of the court order or coinciding with the effective date of the Employee’s coverage, whichever is later.

When a dependent has met one of the eligibility requirements above, the Employee must complete and submit an enrollment form and any additional forms required by the Employer within 31 calendar days of the initial date of the dependent’s eligibility. If the Employee fails to enroll the dependent within 31 calendar days of the initial date of the dependent’s eligibility, the dependent will be considered a late entrant, and will not be covered until the dependent either meets the criteria for late entry rules, or enrolls during annual Open Enrollment.

NEWBORN CHILDREN
A newborn child will be covered automatically from the date of birth for a period of 31 calendar days. The Employee must complete and submit all necessary forms adding the newborn child within the first 31 calendar days of the child’s date of birth.

If the Employee fails to enroll the newborn within 31 days of the date of birth, the newborn will be considered a late entrant unless the newborn becomes eligible under the special enrollment periods provision. Important Note: Newborn “well-baby” care is considered as part of the mother's expenses, subject to the mother’s deductible and out-of-pocket maximum until the baby’s initial discharge from the hospital provided the mother is covered for maternity benefits. If the mother is not covered under the Plan, benefits for the newborn’s “well-baby” care will be subject to the newborn’s own deductible and out-of-pocket maximum.

CHANGE IN STATUS
It is the covered Employee’s responsibility to advise the Employer in writing of any change in dependent status, including marriage, divorce, legal separation, domestic partner status, the addition of newborns, adopted children, or other qualified dependents as outlined above, and the deletion of coverage for covered children. Failure to provide this information could result in loss of eligibility and/or coverage under the Plan. If a person covered under the Plan changes from Employee to dependent or dependent to Employee, and the person is covered continuously under the Plan before, during and after the change in status, credit will be applied to all Plan provisions including deductibles and all amounts applied to maximums. If a spouse or domestic partner are both covered under the Plan as Employees, having both elected single coverage, either Employee or Employee’s spouse or domestic partner may change to family coverage within 31 days if:

1. The covered Employee is adding a newborn, adopted child, child placed for adoption, or a child covered under a court order; or

2. The covered Employee or Employee’s spouse or domestic partner terminates employment or ceases to be in a class of Employees eligible for coverage with the Employer.

If the covered Employee or the covered Employee’s spouse or domestic partner are covered under the Plan and the Employee who is covering the dependent children terminates coverage, dependent coverage may be transferred to the other covered Employee as long as coverage has been continuous.
DELETING DEPENDENT COVERAGE
To remove a dependent from your coverage, you must complete a change form and submit it to the Employer within 31 days of such change. If you fail to remove an ineligible dependent in a timely manner, the Employer reserves the right to recover any benefit payments made on behalf of such dependent back to the date such dependent should have been deleted.

SPECIAL ENROLLMENT PERIODS
If an eligible Employee or dependent declined coverage under the Plan when initially eligible, they may enroll when loss of other group coverage or a change in family status occurs.

The special enrollment rights may apply with respect to an Employee, dependent or both. The request for coverage must be made within 31 days of the following:

1. A loss of eligibility of an Employee and/or affected dependents under another group health plan or through a health insurance issuer offering group health insurance coverage due to:
   a. Legal separation or divorce
   b. Death
   c. Involuntary loss of other coverage
   d. Reduction in work hours
   e. Employer contributions for the coverage were terminated; or
   f. COBRA continuation coverage under the other plan has been exhausted.
   Note: An individual does not have to elect COBRA continuation coverage or exercise similar continuation rights in order to preserve the right to special enrollment. However, an individual does not have a special enrollment right if the individual loses the other coverage as a result of the individual's failure to pay premiums/contributions or for termination of coverage for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the Plan).

2. Loss of eligibility of an Employee and/or affected dependents under Medicare, Medicaid, or CHAMPUS coverage.

3. A change in family status due to:
   a. Marriage;
   b. Filing of a Declaration of Domestic Partnership with the California Secretary of State;
   c. Birth of a child;
   d. Adoption or placement for adoption of a child; or
   e. Court order.

The special enrollment rules allow an eligible Employee to enroll when he or she marries or has a new child (as a result of marriage, birth, adoption, placement for adoption, or court order). A spouse of a participant can be enrolled separately at the time of marriage or when a child is born, adopted, placed for adoption, or court ordered. The spouse can be enrolled together with the Employee when they marry or when a child is born, adopted, placed for adoption or court ordered. A child who becomes a dependent of a participant as a result of marriage, birth, adoption, placement for adoption, or court order can be enrolled when the child becomes a dependent. Similarly, a child who becomes a dependent of an eligible Employee as a result of marriage, birth, adoption, placement for adoption, or court order can be enrolled if the Employee enrolls at the same time. Individuals who enroll under these special enrollment conditions are not considered late entrants. The effective date of coverage for those individuals enrolled during a special enrollment is:

1. The date of the loss of eligibility under the group health plan, another group health insurance issuer offering group health insurance coverage, Medicare, Medicaid, or CHAMPUS coverage;
2. For a marriage the effective date is the date of the marriage;
3. For a birth the effective date is the date of birth;
4. For an adoption or placement for adoption the effective date is the date of the adoption or placement; or
5. For a court order the effective date is the date of the court order.
If written request is not made within 31 days of the status change, the Employee and/or affected dependent will be considered a late entrant.

ANNUAL OPEN ENROLLMENT PERIOD FOR LATE ENTRANTS
The Group has an open enrollment period once each year. If an eligible member files an enrollment application or membership change form with the group more than 31 days after the enrollment date and did not complete a declination form stating he/she had other group insurance within the 31 days period, or does not meet the late entrance requirements then the member must wait until the next open enrollment period.

EMPLOYEE TERMINATION OF COVERAGE
Subject to the requirements of continuation of coverage under COBRA, the Family and Medical Leave Act (FMLA), and certain leaves of absence, the coverage of any Employee will automatically terminate at midnight on the earliest date indicated below:
1. On the last day of the month in which employment ends;
2. On the date required contributions for coverage, if any, are not made;
3. On the last day of the month in which coverage is discontinued with respect to the entire class of Employees to which such Employee belongs;
4. On the date the Plan is terminated with respect to all Employees;
5. On the last day of the month in which an Employee retires;
6. On the date the Employee becomes an active full-time member of the armed forces of any county, or government service which involves employment outside the United States;
7. On the date of the covered Employee’s death;
8. On the date coverage terminates under COBRA.

DEPENDENT TERMINATION OF COVERAGE
Subject to COBRA, the FMLA, and certain leaves of absence, the coverage of a dependent will automatically terminate at midnight on the earliest date indicated below:
1. On the date the Employee coverage terminates, except in the event of death;
2. On the last day of the month in which the Employee ceases to be in a class eligible for dependent coverage;
3. On the date required contributions for dependent coverage, if any, are not made;
4. On the date the Plan is terminated with respect to all dependents;
5. On the last day of the month in which such dependent ceases to be a dependent of the Employee as defined herein;
6. On the date the dependent becomes an active full-time member of the armed forces of any county;
7. On the last day of the month following the Employee’s death;
8. On the last day of the pay period in which the Employee elects to terminate the dependent’s coverage;
9. On the date the dependent becomes effective as an Employee under the Plan; or
10. On the date coverage terminates under COBRA.

FAMILY AND MEDICAL LEAVE ACT (FMLA)
If a covered Employee ceases to work due to an Employer approved FMLA, coverage will be continued for a period not to exceed 12 weeks under the same terms and conditions which would have been provided had the covered Employee continued work, and provided the Employee continues to pay any required contributions. Contributions will remain at the same Employer/Employee percentage level as on the date immediately prior to the leave (unless contributions change for other covered Employees in the same classification).

If the covered Employee does not return to work during the approved family medical leave, or if the covered Employee has given the Employer notice of intent not to return to service during the leave, coverage may be continued under the COBRA provision of the Plan effective with the date notification is given to the Employer and provided the covered Employee elects to continue coverage under the COBRA provision. The covered Employee will be fully responsible for the contributions during COBRA.
continuation if elected. Coverage continued during a family or medical leave will not be counted toward the maximum COBRA continuation period. If the Employee’s coverage is continued under COBRA, the Employee must pay for self, spouse, and dependents, or only the Employee will be reinstated once he/she returns to work. Once the Employee returns from a leave of absence and has elected COBRA during the leave, a new application will be completed and submitted.

Coverage will be reinstated (for those Employees and their dependents who were covered when the leave began) on the date the Employee returns to work without re-satisfying any waiting period. The Employee must make any necessary contributions within 31 days of the return to work for coverage to be reinstated.

It is the intent of the Plan to comply with all existing FMLA regulations. If for some reason the information presented in the Plan differs from actual FMLA regulations, the Plan reserves the right to administer FMLA in accordance with such actual regulations.

NON-FAMILY AND MEDICAL LEAVE (FMLA) DESIGNATED LEAVES

ACTIVE MILITARY DUTY AND MILITARY RESERVISTS

If coverage terminates due to an Employee or covered dependent being called to active military duty, there is no extension of benefits except what is chosen through COBRA.

Employees and/or eligible dependents returning to work within 90 days from active duty in the armed forces may have reinstatement of immediate coverage provided such person was covered under the Plan as of the date he or she was called to active duty in the armed forces. The coverage provided will be the benefits currently provided by the Plan. The waiting period will not apply. If he/she returns within the same calendar year, credit will be given for eligible charges accumulated toward the satisfaction of provisions such as the out-of-pocket and deductible or calendar year maximums when determining benefits available for the remainder of the calendar year.

It is the intent of the Plan to comply with all existing regulations of the Uniformed Services Employment and Reemployment Rights Act (USERRA) of 1993. If for some reason the information presented in the Plan differs from actual regulations of the USERRA, the Plan reserves the right to administer the USERRA in accordance with such actual regulations.

LAYOFF

In the event of a company layoff, there is no continuation of coverage except what is designated under COBRA.

EXTENSION OF BENEFITS DUE TO DISABILITY

If coverage terminates due to total disability, there is no continuation of coverage except what is designated under COBRA.

REINSTATEMENT OF COVERAGE

If Employee, spouse, domestic partner and covered dependents qualify and elect COBRA continuation and subsequently again become eligible for coverage under the Plan during the designated COBRA continuation period (with no break in coverage), the Employee, spouse. Domestic partner and dependent are not required to re-qualify as a new Plan participant. All Plan provisions will continue as though there were no lapses of coverage status.

CONTINUATION OF BENEFITS FOLLOWING TERMINATION OF COVERAGE (COBRA)

COBRA requires that many Employers sponsoring group health plans offer the covered employees and their family members the opportunity for a temporary extension of health coverage (continuation coverage) at group rates in instances where coverage under the Plan would otherwise end (that is, upon
a qualifying event as described below). This portion of the SPD is intended to inform you, in a summary fashion, of your rights and obligations under COBRA. If you are married, both you and your spouse should take the time to read this information carefully. You (and your spouse if you are married) will also receive a separate general notice regarding COBRA that you should read carefully.

COBRA CONTINUATION COVERAGE IN GENERAL
COBRA continuation coverage is a continuation of group health plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed below. After a qualifying event, COBRA continuation coverage must be offered to each Person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage. Continuation coverage is generally the same as the coverage that you had at the time of the qualifying event with the following exceptions:

1. If the coverage provided to similarly situated active employees is changed or eliminated, but the Employer continues to maintain one or more group health plans, the Employer must permit you to elect to be covered under any of the Employer's remaining group health plans for similarly situated active employees.
2. If the coverage provided under the group health plan in which you are participating is limited geographically (e.g., a region-specific HMO) and you relocate to an area in which the plan will not service your health needs, the Employer must permit you to elect to be covered under alternative coverage that the Employer makes available to active employees as follows:
   a. If the Employer makes group health plan coverage available to similarly situated active employees that can be extended in the area to which you relocate, then that coverage is the alternative coverage; or
   b. If no such coverage is available, but the Employer makes group health plan coverage available to other employees that can be extended in the area to which you relocate, then that coverage is the alternate coverage; provided, however, that if no such coverage is available, then no alternative coverage will be available to you.
3. If the Employer makes an open enrollment period available to similarly situated active employees with respect to whom a qualifying event has not occurred, the same open enrollment period rights must be available to each qualified beneficiary receiving COBRA continuation coverage (e.g., elect coverage under another group health plan or under another benefit package within the same plan, or add or eliminate coverage of family members).

COBRA continuation coverage is not conditioned upon the insurability of you or any of your family members.

If you elect to continue coverage under COBRA, you may change coverage status (for example, from individual to family coverage) upon the birth or adoption of a child. Such a child may be enrolled without any preexisting condition limitations if the child is enrolled within 30 days of the date of birth or placement for adoption. A child who is born to or placed for adoption with the covered employee during the period of COBRA continuation coverage has his or her own separate COBRA rights as a qualified beneficiary even though the child was not covered by the plan at the time of the qualifying event.

QUALIFYING EVENTS
If you are an Employee covered by the Plan, you have a right to choose this continuation coverage if you lose your group health benefits for any of the following reasons:

1. A reduction in your hours of employment from benefited to non benefited position;
2. Termination of your employment (for reasons other than gross misconduct on your part); or
3. The Employer has filed for bankruptcy under Title 11 of the United States Code, but only with respect to coverage for a covered retiree and his dependents.

If you are the spouse of an Employee covered by the Plan, you have the right to choose continuation coverage for yourself if you lose group health benefits for any of the following reasons:

1. The death of your spouse;
2. A termination of your spouse’s employment (for reasons other than gross misconduct) or reduction in your spouse’s hours of employment;
3. Divorce or legal separation from your spouse (also if an Employee drops his spouse from coverage in anticipation of a divorce or legal separation, and the divorce or legal separation later occurs, then the later divorce or legal separation will be considered a qualified event even though the ex-spouse lost coverage earlier. If the ex-spouse notifies the Employer within 60 days of the divorce or legal separation and can establish that the coverage was dropped earlier in anticipation of divorce or legal separation, then COBRA coverage may be available for the period after the divorce or legal separation);
4. Your spouse becomes covered by Medicare; or
5. Your spouse’s Employer files for bankruptcy under Title 11 of the United States Code, but only with respect to coverage for a covered retiree and his dependents.

In the case of a dependent child of an Employee covered by the Plan, he has the right to continue coverage if group health benefits under the Plan are lost for any of the following reasons:
1. The death of the Employee parent;
2. The termination of the Employee parent’s employment (for reasons other than gross misconduct) or reduction in the Employee parent’s hours of employment;
3. Employee parent’s divorce or legal separation;
4. The Employee parent becomes covered by Medicare;
5. The dependent ceases to be a “dependent child” under the Plan; or
6. The Employee parent’s Employer files for bankruptcy under Title 11 of the United States Code, but only with respect to coverage for a covered retiree and his dependents.

Important Note: COBRA is not offered to Domestic Partners.

CHILDREN BORN TO, OR PLACED FOR ADOPTION WITH THE COVERED EMPLOYEE AFTER THE QUALIFYING EVENT
If, during the period of continuation coverage, a child is born to, adopted by or placed for adoption with the covered Employee and the covered Employee has elected continuation coverage for himself, the child is considered a qualified beneficiary. The covered Employee or other guardian has the right to elect continuation coverage for the child, provided the child satisfies the otherwise applicable Plan eligibility requirements (for example, age).

The covered Employee or a family member must notify the Employer with 31 days of the birth, adoption or placement to enroll the child on COBRA, and COBRA coverage will last as long as it lasts for other family members of the Employee. (The 31 day period is the Plan’s normal enrollment window for newborn children, adopted children or children placed for adoption.).

If the covered Employee or family member fails to notify the Employer in a timely fashion, the covered Employee will NOT be offered the option to elect COBRA coverage for the child.

THE EMPLOYER’S OBLIGATION TO PROVIDE NOTICE
When the qualifying event is the termination of employment, a reduction of hours of employment, the death of the employee, the employee’s becoming entitled to Medicare benefits, or, if the Plan provides retiree health coverage, commencement of a proceeding in bankruptcy with respect to the Employer, the Employer must notify the Plan Administrator of the qualifying event.

YOUR OBLIGATION TO PROVIDE NOTICE
For the other qualifying events (i.e., divorce or legal separation of the employee and spouse or a dependent child’s losing eligibility for coverage as a dependent child), you must notify the Plan in writing, by delivering or mailing the written notice to the Employer’s address in this SPD or at the address contained in any COBRA notices received from the Employer, the Plan Administrator or their authorized representatives, within 60 days after the qualifying event occurs. Your failure to give such notice within the 60-day period will result in the loss of the right to elect to continue coverage under the Plan. For additional notice requirements, see the Disability Extension and the Second Qualifying Event Extension descriptions below.
ELECTING COBRA CONTINUATION COVERAGE

Once the Plan receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

An election to continue coverage must be made in writing, by delivering or mailing the written election to the address shown in the qualifying event notice or election form that accompanies the qualifying event notice, during the period beginning on the date coverage under the Plan terminates by reason of a qualifying event described above and ending 60 days after the later of (a) the date coverage under the Plan terminates, or (b) the date when notice is sent to the Person entitled to the election.

If you do not choose to continue coverage during this election period, your health plan coverage will end. If you elect not to continue coverage and then change your mind during the election period, you may still elect continuation coverage provided that you notify the Plan Administrator of your election to continue coverage within the election period. In this event, your coverage will commence as of the date of the notice of your election to continue coverage and you will not have coverage for the period of time beginning with the initial loss of coverage to the date of the notice of your election to continue coverage.

MAXIMUM PERIOD OF COBRA CONTINUATION COVERAGE

COBRA continuation coverage is a temporary continuation of coverage.

When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months.

When the qualifying event is the termination of employment or a reduction of the employee's hours of employment and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement.

Otherwise, when the qualifying event is the termination of employment or a reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended:

1. **Disability Extension**
   If you or anyone in your family covered under the Plan is determined by the Social Security Administration (SSA) to be disabled and you notify the Plan in writing in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage.

   You must make sure that the Plan is notified of the SSA's determination in writing, by delivering or mailing the written notice to the Employer's address in this SPD or at the address contained in any COBRA notices received from the Employer, the Plan Administrator or their authorized representatives, within 60 days of the date of the determination and before the end of the 18-month period of COBRA continuation coverage. Your failure to notify the Plan of this determination by this deadline will result in the loss of the right to elect to continue coverage under the Plan beyond the period of 18 months following the employee's termination of employment or reduction of hours of employment based upon such Social Security disability.

2. **Second Qualifying Event Extension**
   If your family experiences another qualifying event while receiving 18 months (or 29 months under a disability extension described above) of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months (or 7 additional months under a disability extension described above) of COBRA continuation coverage, for a
maximum of 36 months, if the notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits, or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

You must make sure that the Plan is notified of the second qualifying event in writing, by delivering or mailing the written notice to the Employer's address in this SPD or at the address contained in any COBRA notices received from the Employer, the Plan Administrator or their authorized representatives, within 60 days. Your failure to notify the Plan of a second qualifying event by this deadline will result in the loss of the right to elect to continue coverage under the Plan beyond the period of 18 months based upon the second qualifying event.

**COST OF CONTINUATION COVERAGE**
Ordinarily, you or your qualifying family member will be offered COBRA coverage that is the same coverage that you, or he had on the day before the qualifying event. Therefore, a Person (employee, spouse, or dependent child) who is not covered under the Plan on the day before the qualifying event is generally not entitled to COBRA coverage except, for example, where there is no coverage because it was eliminated in anticipation of a qualifying event like divorce. If the coverage for similarly situated employees or their family members is modified, COBRA coverage will be modified the same way. The cost of continuation coverage is determined by the Employer and paid by the qualifying individual. If the qualifying individual is not disabled, the applicable premium cannot exceed 102% of the Plan’s cost of providing coverage. The cost of coverage during a period of extended continuation coverage due to a disability cannot exceed 150% of the Plan’s cost of coverage. The qualified individual must make the first payment within 45 days of notifying the Plan of selection of continuation coverage. Future payments must be made in monthly installments within 31 days of the due date. Rates and payment schedules are established by the Employer and may change when necessary due to Plan modifications. The cost of continuation coverage is computed from the date coverage would normally end due to the qualifying event. Failure to make the first payment within 45 days or any subsequent payment within 31 days of the established due date will result in the permanent cancellation of continuation coverage.

**WHEN COBRA CONTINUATION COVERAGE ENDS**
Continuation of coverage ends on the earliest of:

1. The date the maximum continuation coverage period expires;
2. The date the Employer no longer provides group health benefits to any of its Employees;
3. The date your contribution for your continuation coverage is not paid in a timely fashion (within 31 days of the due date);
4. The date, after electing COBRA, you become entitled to (i.e., covered by) Medicare. This will apply only to the person who becomes entitled to Medicare;
5. After electing COBRA, you become covered by another group health plan that has no exclusion or limitation with respect to any pre-existing condition that you have;
6. If the other plan has applicable exclusions or limitations, your COBRA coverage will terminate after the exclusion or limitation no longer applies (for example, after a 12 month pre-existing condition waiting period expires) (this rule applies only to the qualified beneficiary who becomes covered by another group health plan);
7. If you became entitled to a 29-month maximum coverage period due to disability of a qualified beneficiary, but then there is a final determination under Title II or XVI of the Social Security Act that the qualified beneficiary is no longer disabled. However, continuation coverage will not end until the month that begins more than 30 days after the determination; or
8. Occurrence of any event that permits termination of coverage for cause (e.g. submission of fraudulent benefit claims) with respect to covered Employees or their spouses or dependent
children who have coverage under the Plan for a reason other than the COBRA coverage requirements of federal law.

**Important Note:** COBRA is not offered to domestic partners.

**CONVERSION PRIVILEGE**
There is no conversion coverage available when your COBRA participation ends.

**BENEFITS MANAGEMENT PROGRAM**

The Plan has established the Benefits Management Program to assist you, your Dependents, or provider in determining whether the services are medically necessary, whether the Plan considers the proposed treatment medically necessary, if Plan Benefits will be provided for the proposed treatment, and if the proposed setting, and the course of treatment are the most appropriate. However, you, your Dependents and your provider make the final decision concerning treatment.

The Benefits Management Program includes precertification, medical necessity review, concurrent review; emergency admission notification (for emergency admissions), discharge planning; and care management. The Benefits Management Program also includes a 24-hour nurse advice line.

Please read the following sections thoroughly so you understand your responsibilities in reference to the Benefits Management Program. **Remember that all Provisions of the Benefits Management Program also apply to your Dependents.**

**PRECERTIFICATION**
The Plan requires prior notification on the following services:
- All hospital inpatient services including medical/surgical and rehabilitation
- Chiropractic Services
- DME
- Electrophysiological Studies
- Home Health Services
- Home Infusion
- Hospice
- Infertility Services; (limited benefit – call customer service)
- Obesity Surgery
- Occupational Therapy
- Orthotics
- Outpatient Infusion
- PET Scans
- Physical Therapy
- Procedures that are cosmetic in nature
- Prosthetics
- Self Injectables (approval obtain through injectable program 1-800-562-6223)
- Skilled Nursing Services
- Sleep Studies
- Speech Therapy
- Transplants
- Vein Stripping
Call the customer service phone number listed on your id card to report any of the above services. Notification of decision on precertification requests will be rendered within 10 business days from receipt of the request.

For urgent services in situations in which the routine decision making process might seriously jeopardize the life or health of a Person or when the Person is experiencing severe pain, the Plan will respond within 72 hours from receipt of the request.

**MEDICAL NECESSITY REVIEW**
Certain procedures may warrant a medical necessity review. These are usually procedures that may not be covered under the Plan. Some examples of these services are ongoing chiropractic services; cosmetic procedures, and gastric bypasses.

**CONCURRENT REVIEW**
The Plan monitors Inpatient stays. The stay may be extended or reduced as warranted by your condition, except in situations of maternity admissions for which the length of stay is 48 hours or less for a normal vaginal delivery or 96 hours or less for a Cesarean section unless the attending Physician, in consultation with the mother, determines a shorter Hospital length of stay is adequate. Also, for mastectomies or mastectomies with lymph node dissections, the length of Hospital stays will be determined solely by your Physician in consultation with you. When a determination is made that the Person no longer requires the level of care available only in an Acute Care Hospital, written notification is given to you and your Doctor of Medicine. You will be responsible for any Hospital charges Incurred beyond 24 hours of receipt of notification.

**EMERGENCY ADMISSION NOTIFICATION**
If you are admitted for emergency services, the Plan (through Sutter Health Partners) should receive emergency admission notification within 48 hours.

**DISCHARGE PLANNING**
If further care at home or in another facility is appropriate following discharge from the Hospital, the Plan will work with the Physician and Hospital discharge planners to ensure that his orders are being implemented.

**CASE MANAGEMENT**
This program offers individualized case management beginning when the patient is admitted to the hospital and continuing on after discharge. This process is designed to try to reduce barriers to improve patient’s health.

**FUTUREFOOTSTEPS® MATERNITY MANAGEMENT**
Notify the precert team during your first trimester or as soon as you know and work with a maternity nurse case manager who will complete a prenatal risk assessment and offer information and educational material, as well as advice and guidance, throughout your pregnancy.

**NURSE ADVICE LINE**
The Plan provides participants with no charge, confidential, unlimited telephone support for healthcare advice. Participants may obtain these services by calling 1-800-858-8769, 24-hours a day, 7 days a week.

**AUDIO LIBRARY**
This audio library has hundreds of general health education topics in may separate categories and it can be accessed 24 hours a day, 365 days a year. This may be accessed through the nurse advice line at 1-800-858-8769.

**HEALTH EDUCATION AND HEALTH PROMOTION**
Health education and health promotion services provided by Sutter Health Partners Wellness Program offer a variety of wellness resources including, but not limited to:
1. Health Risk Assessment Questionnaires and Reports;
2. Wellness coaching;
3. Member newsletters; and
4. Periodic health seminars/discussions.

SUTTER HEALTH PARTNERS ONLINE
Sutter Health Partners Internet site is located at http://www.sutterhealthpartners.com. Members with Internet access and a Web browser may view and download healthcare information and forms.

SCHEDULE OF BENEFITS TABLE

CO-PAYMENTS
You may be required to pay a charge when you receive covered services. This charge is called a co-payment and is outlined in the Schedule of Medical Benefits Table above. The co-payment depends on the provision and service.

MEDICAL LIFETIME MAXIMUM
The lifetime maximum applies to all eligible charges paid during the lifetime each person is covered under the Plan, either as an Employee, dependent, or while under COBRA, whether or not coverage is continuous. Lifetime is not interpreted to mean the lifetime of the individual.

The lifetime maximum of $5,000,000 for Medical Benefits under the Plan includes services provided by the PPO Network.

The Schedule of Benefits contains separate maximum benefit limitations for specific conditions. Any separate maximum benefit will include all such benefits paid by the Plan for the covered person during any and all periods of coverage under the Plan. All separate maximum benefits are part of, and not in addition to, the lifetime maximum benefit. No more than the lifetime maximum benefit will be paid for any covered person while covered by the Plan.

ANNUAL OUT-OF-POCKET MAXIMUM
For certain covered services, a limit is placed on the total amount you pay for co-payments during a calendar year. This limit is called your annual out-of-pocket maximum and when you reach it, for the remainder of the calendar year, you will not pay any additional payments for these covered services. if you've surpassed your maximum, submit all your health care receipts and a letter of explanation to: BRMS, Attn: Sutter Health Partners, P.O. Box 2650, Rancho Cordova, CA 95741. Remember, it's important to send the Plan all Co-payment receipts along with your letter. Please send receipts to the Plan within 120 days from date of service. You will be reimbursed by the Plan for payments you make beyond your individual or family maximum.

SERVICES NOT INCLUDED IN OUT-OF-POCKET MAXIMUMS
Co-payments paid for certain covered services are not applicable to a member's out-of-pocket maximum and include the following:
1. Durable medical equipment;
2. Chiropractic co-payments;
3. Mental Health co-payments;
4. Severe Mental Illness co-payments; and
5. Chemical Dependency co-payments.

The Schedule of Benefits Table (see next pages) is a summary of the important terms of your health coverage. The complete plan document must be consulted to determine the exact terms and conditions of coverage. Call 1-888-326-2555 regarding any questions on benefits, authorizations or co-payments. It is your responsibility to see that your physician starts the utilization review process before scheduling you for any services subject to review. If you fail to receive precertification, you may not receive benefits or your benefits will be reduced. Services with an “*” require precertification.
<table>
<thead>
<tr>
<th>BENEFIT TYPE</th>
<th>participating provider of</th>
</tr>
</thead>
<tbody>
<tr>
<td>ALLERGY TESTING/TREATMENT</td>
<td>$5 Co-pay</td>
</tr>
<tr>
<td>(Serum is included)</td>
<td></td>
</tr>
<tr>
<td>AMBULANCE SERVICES</td>
<td>No Co-pay</td>
</tr>
<tr>
<td>(Ground or air transportation)</td>
<td></td>
</tr>
<tr>
<td>ANNUAL CO-PAY MAXIMUM</td>
<td>$750/Individual</td>
</tr>
<tr>
<td>(2 individual maximum per family; does not include co-pays for DME,</td>
<td></td>
</tr>
<tr>
<td>chiropractic, mental health, chemical dependency or severe mental illness</td>
<td></td>
</tr>
<tr>
<td>benefits)</td>
<td></td>
</tr>
<tr>
<td>BLOOD &amp; BLOOD PRODUCTS</td>
<td>No Co-pay</td>
</tr>
<tr>
<td>CHIROPRACTIC</td>
<td>$10 Co-pay</td>
</tr>
<tr>
<td>(20 Visits Maximum per calendar year)</td>
<td></td>
</tr>
<tr>
<td>DETOXIFICATION</td>
<td>No Co-pay</td>
</tr>
<tr>
<td>(Inpatient or Outpatient)</td>
<td></td>
</tr>
<tr>
<td>DURABLE MEDICAL EQUIPMENT, CORRECTIVE APPLIANCES &amp; PROSTHETICS (ITEMS</td>
<td>No Co-pay</td>
</tr>
<tr>
<td>OVER $1000 REQUIRE PRECERTIFICATION)</td>
<td></td>
</tr>
<tr>
<td>EMERGENCY/URGENT SERVICES</td>
<td>$30 Co-pay</td>
</tr>
<tr>
<td>(Co-pay is waived if admitted to hospital)</td>
<td></td>
</tr>
<tr>
<td>FAMILY PLANNING SERVICES</td>
<td>No Co-pay</td>
</tr>
<tr>
<td>✥ IUD contraceptive</td>
<td>$5 Co-pay for first visit, then No Co-pay</td>
</tr>
<tr>
<td>✥ Pregnancy and Maternity Care</td>
<td>No Co-pay</td>
</tr>
<tr>
<td>(Including office visits, test, labs, procedures)</td>
<td>$50 Co-pay</td>
</tr>
<tr>
<td>✥ Delivery</td>
<td>$150 Co-pay</td>
</tr>
<tr>
<td>✥ Vasectomy</td>
<td>$5 Co-pay</td>
</tr>
<tr>
<td>✥ Tubal Ligation</td>
<td>$5 Co-pay</td>
</tr>
<tr>
<td>✥ Insertion/Removal of IUD</td>
<td>$35 Co-pay</td>
</tr>
<tr>
<td>✥ Removal of Norplant</td>
<td>$150 Co-pay</td>
</tr>
<tr>
<td>✥ Depo-Provera Injection</td>
<td></td>
</tr>
<tr>
<td>✥ Depo-Provera medication (limited to one injection every 90 days)</td>
<td></td>
</tr>
<tr>
<td>✥ Voluntary interruption of pregnancy</td>
<td></td>
</tr>
<tr>
<td>FOOT ORTHOTICS</td>
<td>No Co-pay</td>
</tr>
<tr>
<td>(Covered for Diabetic foot disease only)</td>
<td></td>
</tr>
<tr>
<td>HOME HEALTH CARE</td>
<td>No Co-pay</td>
</tr>
<tr>
<td>HOSPICE</td>
<td>No Co-pay</td>
</tr>
<tr>
<td>HOSPITAL SERVICES (Inpatient services)</td>
<td>No Co-pay</td>
</tr>
<tr>
<td>LABORATORY SERVICES</td>
<td>No Co-pay</td>
</tr>
<tr>
<td>MATERNITY CARE</td>
<td>No Co-pay</td>
</tr>
<tr>
<td>✥ Delivery</td>
<td>$5 Co-pay for first visit, then No Co-pay</td>
</tr>
<tr>
<td>✥ Office Visits, tests, procedures</td>
<td></td>
</tr>
<tr>
<td>MENTAL HEALTH &amp; CHEMICAL DEPENDENCY COMBINED BENEFIT</td>
<td>No Co-pay</td>
</tr>
<tr>
<td>✥ Inpatient (up to 30 days per calendar year)</td>
<td>$5 Co-pay</td>
</tr>
<tr>
<td>✥ Outpatient treatment (up to 20 visits per calendar year)</td>
<td></td>
</tr>
</tbody>
</table>
## Outpatient Surgery
- No Co-pay

## Physician Services
- Office Visits and office consultations: $5 Co-pay
- Inpatient Visits: No Co-pay

## Preventive Care Services
- Well-Baby & Well-Child Visits: $5 Co-pay
  (For children under 2; including immunizations)
- Routine Physical Exams: $5 Co-pay
  (Children two years and older)
- Routine Immunizations for children 2 through age 18: $5 Co-pay
- Routine Immunizations for adults (Advised by CDC, travel and work immunizations are not covered): $5 Co-pay
- Routine radiology and laboratory services in connection with routine physical exam: $5 Co-pay
- Well-Woman Exam, including pap smear: $5 Co-pay
- Mammography: No Co-pay
- Routine Hearing Screenings (up to age 19): $5 Co-pay
- Prostate Screening: $5 Co-pay

## Radiology Services
(MRI and CT Scans)
- No Co-pay

## Rehabilitation Therapy
(Physical, Occupational, Speech)
(Inpatient or Outpatient)
- No Co-pay

## Severe Mental Illness Benefit
(Unlimited days and unlimited maximum)
- Inpatient: No Co-pay
- Outpatient: No Co-pay

## Skilled Nursing Care
(Up to 100 consecutive calendar days from the first treatment per disability)
- No Co-pay

## Prescription Services
- Retail Pharmacy (30 day supply): $5 Co-pay for Generic; $10 Co-pay for Brand
- Mail Order (90 day supply): $10 Co-pay for Generic; $20 Co-pay for Brand

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**Prior Authorization Summary**

**MGH Value Choice Program**

**Effective January 1, 2006**

- All hospital inpatient services including; medical/surgical, rehabilitation
- Chiropractic Services
- DME
- Electrophysiological Studies
- Home Health Services
- Home Infusion
- Hospice
- Infertility Services; (limited benefit – call customer service)
- Obesity Surgery
- Occupational Therapy
- Orthotics
- Outpatient Infusion
PET Scans  
Physical Therapy  
Procedures that are cosmetic in nature  
Prosthetics  
Self Injectables (approval obtain through injectable program 1-800-562-6223)  
Skilled Nursing Services  
Sleep Studies  
Speech Therapy  
Transplants  
Vein Stripping

This is not an inclusive list so please verify with customer service at 1-888-326-2555.

COVERED MEDICAL EXPENSES

INPATIENT BENEFITS:
With the exception of Emergency Services or Urgently Needed Services, the benefits are covered when receiving prior authorization as Medically Necessary (as defined in the Plan) are listed below.

1. **Alcohol, Drug or Other Substance Abuse Detoxification** – Treatment in an acute care setting is covered for the acute stage of alcohol, drug or other substance abuse withdrawal when medical complications occur or are highly probable. Detoxification is initially covered up to 48 hours and extended when medically necessary. Methadone treatment for detoxification is not covered. See separate coverage under Chemical Dependency benefit.

2. **Blood and Blood Products** – Autologous (self-donated), donor-directed and donor-designated blood processing costs are limited to blood collected for a scheduled procedure.

3. **Bloodless Surgery** - Surgical procedures performed without blood transfusions or blood products, including Rho(D) Immune Globulin for members who object to such transfusion on religious grounds.

4. **Bone Marrow and Stem Cell Transplants** – Non-Experimental/Non-Investigational autologous and allogeneic bone marrow and stem cell transplants. The testing of immediate blood relatives to determine the compatibility of bone marrow and stem cells is limited to the immediate blood relatives who are sisters, brothers, parents and natural children. The testing for compatible unrelated donors, and costs of computerized national and international searches for unrelated allogeneic bone marrow or stem cell donors conducted through a registry are covered when the member is the intended recipient. Costs for such searches are covered up to a maximum of $15,000. A Center of Excellence approved by the Plan must conduct the computerized searches. There is no dollar limitation for medically necessary donor-related clinical transplant services once a donor is identified.

5. **Cancer Clinical Trials** - All routine patient care costs related to an approved therapeutic clinical trial for cancer (Phase I, II, III and IV) are covered for a member who is diagnosed with cancer and whose participating treating physician recommends that the clinical trial has a meaningful potential to benefit the member. Routine patient care costs associated with the provision of health care services, including drugs, items, devices and services that would otherwise be covered if those drugs, items, devices and services were not provided in connection with an approved clinical trial program, including;
   a. Health care services typically provided absent a clinical trial
   b. Health care services required solely for the provision of the investigational drug, item, device or service;
   c. Health care services required for the clinically appropriate monitoring of the investigational item or service; and
   d. Health care services needed for the reasonable and necessary care arising from the provision of the investigational drug, item, device or service, including the diagnosis or treatment of the complication.

For purposes of this benefit, routine patient care costs do not include the costs associated with provision of any of the following, which are not covered;
a. Drugs or devices that have not been approved by the Food and Drug Administration (FDA) and that are associated with the clinical trial;
b. Services other than health care services, such as travel, transportation, housing, companion expenses and other nonclinical expenses that the member may require as a result of the treatment being provided for purposes of the clinical trial;
c. Any item or service that is provided solely to satisfy data collection and analysis needs that is not used in the clinical management of the member’s care;
d. Health care services that, except for the fact that they are being provided in a clinical trial, are otherwise specifically excluded form coverage; and
e. Health care services customarily provided by the research sponsor free of charge.

An approved clinical trial for cancer is one where the treatment either involves a drug that is exempt under federal regulations from a new drug application or is approved by one of the following:

a. One of the National Institutes of Health,
b. The FDA, in the form of an investigational new drug application;
c. The United States Department of Defense; or
d. The United States Veteran’s Administration.

A clinical trial with endpoints defined exclusively to test toxicity is not approved clinical trial. All services must be Prior authorized. Additionally, services must be provided by a participating provider.

6. Chemical Dependency - Prior authorized and medically necessary Inpatient Treatment is covered up to 30 days per calendar year. Day Treatment is 50% of 1 inpatient day. This benefit is combined with Mental Health benefit.

7. Hospice Services – Hospice services are covered for members with a terminal illness, defined as a medical condition resulting in a prognosis of life expectancy of one year or less, if the disease follows its natural course. Hospice services are provided pursuant to the plan of care developed by the Member’s interdisciplinary team, which includes, but is not limited to, the Member, the Member’s treating physician, a registered nurse, a social worker and a spiritual caregiver. Hospice services are provided in an appropriately licensed Hospice Facility when the Member’s interdisciplinary team has determined that the Member’s care cannot be managed at home because of acute complications or the temporary absence of a capable primary caregiver. Hospice services include skilled nursing services, certified home health aide services and homemaker services under the supervision of a qualified registered nurse; bereavement services; social services/counseling services; medical direction; volunteer services; pharmaceuticals, medical equipment and supplies that are reasonable and necessary for the palliation and management of the Terminal Illness and related conditions; and physical and occupational therapy and speech-language pathology services for purposes of symptom control, or to enable the Member to maintain activities of daily living and basic functional skills. Inpatient Hospice services are provided in an appropriately licensed Hospice Facility when the Member’s interdisciplinary team has determined that the Member’s care cannot be managed at home because of acute complications or when it is necessary to relieve the Family Members or other persons caring for the Member (respite care). Respite care is limited to an occasional basis and to no more than 5 consecutive days at a time.

8. Inpatient Hospital Benefits/Acute Care – Prior authorized and medically necessary inpatient Hospital Services are covered, including, but not limited to: semi-private room, nursing and other licensed health professionals, intensive care, operating room, recovery room, laboratory and professional charges by the hospital pathologist or radiologist and other miscellaneous hospital charges for medically necessary care and treatment.

9. Inpatient Professional Care – Services from Physicians, including other licensed health professionals are covered while the Member is hospitalized as an inpatient.

10. Inpatient Rehabilitation Care – Rehabilitation Services that must be provided in an inpatient rehabilitation Facility are covered. Inpatient rehabilitation consists of the combined and coordinated use of medical, social, educational and vocational measures for training or retraining individuals disabled by disease or injury. The goal of these services is for the disabled Member to obtain his or her highest level of functional ability. Rehabilitation Services include, but are not limited to, physical, occupational and speech therapy. This benefit does not include drug, alcohol or other substance abuse rehabilitation.
11. **Mastectomy, Breast Reconstruction After Mastectomy and Complications From Mastectomy** - Medically necessary mastectomy and lymph node dissection are covered, including prosthetic devices and/or reconstructive surgery to restore and achieve symmetry for the Member incident to the mastectomy. The length of a hospital stay is determined by the attending Physician and surgeon in consultation with the Member, consistent with sound clinical principles and processes. Coverage includes any initial and subsequent reconstructive surgeries or prosthetic devices for the diseased breast on which the mastectomy was performed. Coverage is provided for surgery and reconstruction of the other breast if, in the opinion of the attending surgeon, this surgery is necessary to achieve symmetrical appearance. Medical treatment for any complications from a mastectomy; including lymphedema, is covered.

12. **Maternity Care** – Prenatal and maternity care services are covered, including labor, delivery and recovery room charges, delivery by cesarean section treatment of miscarriage and complications of pregnancy or childbirth. Educational courses on lactation; childcare and/or prepared childbirth classes are not covered. Alternative birthing center services are covered when provided or arranged by a Participating Hospital affiliated with the participating provider. Nurse midwife services are covered. Home deliveries are not covered. A minimum 48-hour inpatient stay for normal vaginal delivery and a minimum 96-hour inpatient stay following delivery by cesarean section are covered. Coverage for inpatient hospital care may be for a time period less than the minimum hours if the decision for an earlier discharge of the mother and newborn is made by the treating Physician in consultation with the mother. In addition, if the mother and newborn are discharged prior to the 48- or 96-hour minimum time periods, a post-discharge follow-up visit for the mother and newborn will be provided within 48 hours of discharge, when prescribed by the treating Physician.

13. **Mental Health** - Medically necessary and prior authorized Inpatient Treatment up to 30 days per calendar year are covered. Day Treatment counts as 50% of 1 inpatient day. This is a combined benefit with Chemical Dependency. If diagnosis is Severe Mental Illness (SMI), see separate SMI Benefits.

14. **Morbid Obesity (Surgical Treatment)** – The Plan covers Roux-en-Y gastric bypass or vertical banded gastroplasty surgical procedures when medically necessary and Priorauthorized; the Plan utilized the National Institutes of Health (NIH) Consensus Report criteria as a factor for determining the Medical Necessity of requests for surgical treatment for morbid obesity.

15. **Newborn Care** – Postnatal Hospital Services are covered, including circumcision (if desired and performed in the Hospital) and special care nursery.

16. **Organ Transplant and Transplant Services** – Non-Experimental and Non-Investigational organ transplants and transplant services are covered when the recipient is a Member and the transplant is performed at a National Preferred Transplant Network Facility. Listing of the Member at a second National Preferred Transplant Network Center is excluded, unless the Regional Organ Procurement Agencies are different for the two Facilities and the Member is accepted for listing by both Facilities. In these cases, organ transplant listing is limited to two National Preferred Transplant Network Facilities. If the Member is dual listed, his or her coverage is limited to the actual transplant at the second Facility. The Member will be responsible for any duplicated diagnostic costs incurred at the second Facility. Covered Services for living donors are limited to medically necessary clinical services once a donor is identified. Transportation and other non-clinical expenses of the living donor are excluded, and are the responsibility of the Member who is the recipient of the transplant. (See the definition for “National Preferred Transplant Network.”)

17. **Reconstructive Surgery** – Reconstructive surgery is covered to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors or disease. The purpose of reconstructive surgery is to correct abnormal structures of the body to improve function or create a normal appearance to the extent possible. Reconstructive procedures require Preauthorization in accordance with standards of care as practiced by Physicians specializing in reconstructive surgery.

18. **Skilled Nursing/Subacute and transitional Care** – Medically necessary skilled nursing care and skilled rehabilitation care are covered limited up to 100 consecutive calendar days from the first treatment per disability. skilled nursing facility services will be provided when authorized in place of a hospital stay; when medically necessary. Days spent out of a skilled nursing facility when transferred to an acute hospital setting are not counted toward the 100 consecutive day limits when the member is transferred back to a skilled nursing facility. Such days spent in an acute hospital setting do not count
toward renewing the limits. In order to renew the room and board coverage in a Skilled Nursing Facility, the Member must either be out of all Skilled Nursing Facilities for 60 consecutive days, or if the Member remains in a Skilled Nursing Facility, then the Member must not have received Skilled Nursing Services or Skilled Rehabilitation Care for 60 consecutive days. Custodial care and services or supplies not included in the written treatment plan are not covered. Prescription drugs are covered when furnished by the Skilled Nursing Facility and used by the Member during a period of covered Skilled Nursing Facility care.

19. **Severe Mental Illness (See Definitions section for included conditions)** - Prior authorized hospitalization and day treatment are covered; unlimited days for definitions that apply under this definition.

20. **Voluntary Termination of Pregnancy** – Services are covered up to 2nd trimester or 20 weeks. After 20 weeks not covered unless mother’s life is in jeopardy or fetus not viable.

**OUTPATIENT BENEFITS:**

These services are covered; subject to precertification and medical necessity.

1. **Alcohol, Drug or Other Substance Abuse Detoxification** - Detoxification is the medical treatment of withdrawal from alcohol, drug or other substance addiction. Medically necessary detoxification is covered. Methadone treatment for detoxification is not covered. In most cases of alcohol, drug or other substance abuse or toxicity, outpatient treatment is appropriate unless another medical condition requires close inpatient monitoring.

2. **Allergy Testing** - Services and supplies are covered for the determination of the appropriate course of allergy treatment.

3. **Allergy Treatment** - Services for the treatment of allergies are covered according to an established treatment plan, with allergy serum.

4. **Ambulance** - The use of an ambulance (land or air) is covered without Preauthorization, when the Member, as a Prudent Layperson, reasonably believes that the medical or psychiatric condition requires Emergency Services, and an ambulance transport is necessary to receive these services. Such coverage includes, but is not limited to, ambulance or ambulance transport services provided through the 911 emergency response system. Ambulance transportation is limited to the nearest available emergency Facility having the expertise to stabilize the Member's Emergency Medical Condition. Use of an ambulance for a non-Emergency Services is covered only when specifically authorized.

5. **Attention Deficit/Hyperactivity Disorder** - The medical management of Attention Deficit/Hyperactivity Disorder (ADHD) is covered, including the diagnostic evaluation and laboratory monitoring of prescribed drugs. This benefit does not include non-crisis Mental Health counseling, or behavior modification programs.

6. **Blood and Blood Products** - Blood and blood products are covered. Autologous (self-donated), donor-directed and donor-designated blood processing costs are limited to blood collected for a scheduled procedure.

7. **Bloodless Surgery** - Please refer to the benefit described above under "Inpatient Benefits for Bloodless Surgery." Outpatient services Co-payments and/or deductibles apply for any services received on an outpatient basis.

8. **Cancer Clinical Trials** - Please refer to the benefit described above under Inpatient Cancer Clinical Trials. Outpatient services Co-payments and/or deductibles apply for any Cancer Clinical Trials services received on an outpatient basis according to the Co-payments for that specific outpatient service. Plan is required to pay for the services covered under this benefit at the rate agreed upon by the Plan and a participating provider, minus an applicable Co-payment, Coinsurance or deductibles. In the event the Member participates in a clinical trial provided by a non-participating provider that does not agree to perform these services at the rate the Plan negotiates with participating providers, the Member will be responsible for payment of the difference between the non-participating provider's billed charges and the rate negotiated by the Plan with participating providers, in addition to any applicable Co-payment, Coinsurance or deductibles. Any additional expenses the Member may have to pay the negotiated rate as a result of using a non-participating provider do not apply to the Member's Annual Out-of-Pocket Maximum.

9. **Chemical Dependency** - Prior authorized and medically necessary outpatient treatment is covered up to twenty visits per calendar year.
10. **Chiropractic**—an initial examination, subsequent visits; including manipulations, adjustments, therapy, X-ray procedures and laboratory tests in various combinations. Conjointive therapy involving therapies such as ultrasound, hot packs, cold packs, Electrical Muscle Stimulation and other therapies. Chiropractic Appliances are payable up to maximum of $50 per year when prescribed by Participating chiropractic. 20 visits annual maximum benefit.

11. **Cochlear Implant Device**—An implantable cochlear device for bilateral, profoundly hearing-impaired individuals who are not benefited from conventional amplification (hearing aids) is covered. Coverage is for Members at least 18 months of age who have profound bilateral sensory hearing loss or for prelingual Members with minimal speech perception under the best hearing aided condition. Please also refer to "Cochlear Implant Medical and Surgical Services." below.

12. **Cochlear Implant Medical and Surgical Services**—The implantation of a cochlear device for bilateral, profoundly hearing impaired or prelingual individuals who are not benefited from conventional amplification (hearing aids) is covered. This benefit includes services needed to support the mapping and functional assessment of the cochlear device at the authorized participating provider. (For an explanation of speech therapy benefits, please refer to "Outpatient Medical Rehabilitation Therapy: ")

13. **Dental Treatment Anesthesia**—See "Oral Surgery and Dental Services; Dental Treatment Anesthesia."

14. **Diabetic Management and Treatment**—Coverage includes outpatient self-management training, education and medical nutrition therapy services. The diabetes outpatient self-management training, education and medical nutrition therapy services covered under this benefit will be provided by appropriately licensed or registered health care professionals. These services must be provided under the direction of and prescribed by a participating provider.

15. **Diabetic Self-Management Items**—Equipment and supplies for the management and treatment of Type 1, Type 2 and gestational diabetes are covered, based upon the medical needs of the Member, including, but not necessarily limited to: blood glucose monitors; blood glucose monitors designed to assist the visually impaired; strips; lancets and lancet puncture devices; pen delivery systems (for the administration of insulin); insulin pumps and all related necessary supplies; ketone urine testing strips; insulin syringes; podiatry services; and devices to prevent or treat diabetes related complications. Members must have coverage under the Outpatient Prescription Drug Benefit for insulin, glucagon and other diabetic medications to be covered. Visual aids are covered for Members who have a visual impairment that would prohibit the proper dosing of insulin. Visual aids do not include eyeglasses (frames and lenses) or contact lenses.

16. **Dialysis**—Acute and chronic hemodialysis services and supplies are covered. For chronic hemodialysis, application for Medicare Part A and Part B coverage must be made. Chronic dialysis (peritoneal or hemodialysis) must be authorized.

17. **Durable Medical Equipment**—Durable medical equipment is covered when it is designed to assist in the treatment of an injury or illness of the Member, and the equipment is primarily for use in the home. Durable medical equipment is medical equipment that can exist for a reasonable period of time without significant deterioration. Examples of covered durable medical equipment include wheelchairs, hospital beds, and standard oxygen delivery systems. Replacements, repairs and adjustments to durable medical equipment are limited to normal wear and tear or because of a significant change in the Member's physical condition. The Plan has the option to repair or replace durable medical equipment items. No benefits are provided for rental charges in excess of the purchase cost. Replacement of lost or stolen durable medical equipment is not covered. The following equipment and accessories are not covered: Non-medically necessary optional attachments and modifications to durable medical equipment for the comfort or convenience of the Member, accessories for portability or travel, a second piece of equipment with or without additional accessories that is for the same or similar medical purpose as existing equipment and home and car remodeling.

18. **Family Planning**—The following services are covered: vasectomy, tubal ligation, insertion and removal of Intra-Uterine Device (IUD); Intra-Uterine Device (IUD); Removal of Norplant; Depo-Provera injections; Depo Provera medication limited to injection every 90 days; Voluntary interruption of pregnancy up to 20 week or 2nd month. After 20 weeks is not covered unless mother's life is in jeopardy or fetus not viable Refer to the Schedule of Benefits for the specific co-payments. Note: Injectables may also be administered through the Employer's prescription drug program.
19. **Footwear** - Specialized footwear, including foot orthotics, custom-made or standard orthopedic shoes are covered for a Member with diabetic foot disease or when an orthopedic shoe is permanently attached to a medically necessary orthopedic brace.

20. **Home Health Care** - Part-time or intermittent services, consisting of Skilled Nursing Care and Skilled Rehabilitation Care, are covered in the home Part-time intermittent skilled nursing services are services provided by:
   a. A registered nurse or licensed vocational nurse;
   b. Part-time or intermittent home health aide services which provide supportive services in the home under the supervision of a registered nurse or a physical, speech or occupational therapist;
   c. Physical, occupational or speech therapy; and
   d. Drugs and medications and related pharmaceutical services, medical supplies, and medical equipment infusion therapy drugs and lab services prescribed by a Physician to the extent such charges or costs would have been covered under the plan if the covered person had remained in the hospital. Drugs and medications and related pharmaceutical services are covered only if the Plan provides the Outpatient Prescription Drug Benefit. If needs are more extensive than part-time or intermittent Services, the Member will be transferred to a Skilled Nursing Facility to obtain coverage for this benefit.

21. **Hospice Services** - Hospice services are covered for Members with a Terminal Illness, defined as a medical condition resulting in a prognosis of life expectancy of one year or less, if the disease follows its natural course. Hospice services are provided pursuant to the plan of care developed by the Member's interdisciplinary team, which includes, but is not limited to, the Member, the Member's Physician, a registered nurse, a social worker and a spiritual caregiver. Hospice services include skilled nursing services, certified home health aide services and homemaker services under the supervision of a qualified registered nurse; bereavement services; social services/counseling services; medical direction; volunteer services; pharmaceuticals, medical equipment and supplies that are reasonable and necessary for the palliation and management of the Terminal Illness and related conditions; physical and occupational therapy and speech-language pathology services for purposes of symptom control, or to enable the Member to maintain activities of daily living and basic functional skills. Covered Hospice services are available in the home on a 24-hour basis when medically necessary; during periods of crisis, when a Member requires continuous care to achieve palliation or management of acute medical symptoms. Inpatient Hospice services are provided in an appropriately licensed Hospice Facility when the Member's interdisciplinary team has determined that the Member's care cannot be managed at home because of acute complications or when it is necessary to relieve the Family Members or other persons caring for the Member (respite care). Respite care is limited to an occasional basis and to no more than five (5) consecutive days at a time.

22. **Immunizations** - Immunizations for children (through age 18 years) are covered consistent with the most current version of the Recommended Childhood Immunization Schedule/United States. An exception is made if: within 45 days of the published date of the schedule, the State Department of Health Services determines that the schedule is not consistent with State law; Immunizations for adults are covered consistent with the most current recommendations of the Center for Disease Control (CDC) for routine adult immunizations as advised by the Advisory Committee on Immunization Practices. For children under two years of age, refer to "Periodic Health Evaluations -Well-Baby." Routine boosters and immunizations must be obtained through. Travel and/or required work immunizations are not covered.

23. **Infertility Services** – To be covered, infertility services must be medically necessary and consistent with accepted standards of care for the diagnosis and treatment of infertility. Must be prior authorized. Diagnosis of Infertility including:
   a. Complete medical history;
   b. Female General medical exams, including but not limited to pelvic exam; labs (FSH, LH, prolactin), laparoscopy, and hysterosalpingogram;
   c. Male general medical examination, including semen analysis up to 3 times following 5 days of abstinence, labs (FSH, prolactin, and serum testosterone), testicular biopsy and scrotal ultrasound;
   d. EARS;
e. HIV, Hepatitis B surface antibody, Hep C antibody, HTLV-1 and syphilis testing. Treatment of infertility includes:
   i. Insemination Procedures limited to 6 per lifetime unless Member conceives, in which case benefit renews;
   ii. Clomid used during covered periods of infertility;
   iii. Injectable medications and syringes for treatment such as the following:
      iv. Pergonal;
      v. Profasi;
      vi. Metrodin; and
      vii. Urofollitophin

All benefits, including physician services, procedures, diagnostic services, and injectable medications are covered at 50% of cost. Certain exclusions apply. Services are applied to lifetime maximum.

24. Infusion Therapy - Infusion therapy means the therapeutic use of drugs or other substances, prepared or compounded, and administered by a participating provider and given to a Member through a needle or catheter. Services must be provided in the Member's home or an institution that is not a hospital or is not primarily engaged in providing skilled nursing or Rehabilitation Services. (For example, board and care, Custodial Care Facility and assisted living Facility.) Infusion therapy is only covered as part of a treatment plan authorized.

25. Injectable Drugs (Outpatient Injectable Medications) - Outpatient injectable medications administered in the Physician's office (except insulin) are covered when a part of the medical office visit. Self-injectable medications (except insulin) are covered through the Employer's prescription drug program. Outpatient injectable medications must be obtained through a participating provider and may require Preauthorization. Insulin is covered as a prescription group benefit.

26. Laboratory Services - Medically necessary diagnostic and therapeutic laboratory services are covered.

27. Maternity Care, Tests and Procedures - Physician visits, laboratory services (including the California Department of Health Services' expanded alpha fetoprotein (AFP) program), and radiology services are covered for prenatal and postpartum maternity care. Nurse midwife services are covered when available. Genetic testing and counseling are covered when authorized by the Plan as part of an amniocentesis or chorionic villus sampling procedure.

28. Medical Supplies and Materials - Medical supplies and materials necessary to treat an illness or injury are covered when used or furnished while the Member is treated in the participating provider's office, during the course of an illness or injury; or stabilization of an injury or illness, under the direct supervision of the participating provider. Examples of items commonly furnished in the participating provider's office to treat the Member's illness or injury are gauzes, ointments, bandages, slings and casts.

29. Mental Health Services - Only services to treat Severe Mental Illness for adults and children, and Serious Emotional Disturbances of a Child are covered.

30. OB/GYN Physician Care - See "Physician OB/GYN Care."

31. Oral Surgery and Dental Services - Emergency Services for stabilizing an acute injury to sound natural teeth, the jawbone or the surrounding structures and tissues are covered. Coverage is limited to treatment provided within 48 hours of injury or as soon as the Member is medically stable. Other covered oral surgery and dental services include: Oral surgery or dental services, rendered by a Physician or dental professional, for treatment of primary medical conditions. Examples include, but are not limited to:
   a. Biopsy and excision of cysts or tumors of the jaw; treatment of malignant neoplastic disease(s) and treatment of temporomandibular joint syndrome (TMJ);
   b. Biopsy of gums or soft palate;
   c. Oral or dental examinations performed on an inpatient or outpatient basis as part of a comprehensive workup prior to transplantation surgery;
   d. Preventive fluoride treatment prior to an aggressive chemotherapeutic or radiation therapy protocol. Fluoride trays and/or bite guards used to protect the teeth from caries and possible infection during radiation therapy;
   e. Reconstruction of a ridge that is performed as a result of and at the same time as the surgical removal of a tumor (for other than dental purposes);
f. Reconstruction of the jaw when medically necessary (e.g., radical neck or removal of mandibular bone for cancer or tumor);
g. Ridge augmentation or alveoplasty are covered when determined to be medically necessary based on State cosmetic reconstructive surgery law and jawbone surgery law;
h. Setting of the jaw or facial bones;
i. Tooth extraction prior to a major organ transplant or radiation therapy of neoplastic disease to the head or neck;
j. Treatment of maxilofacial cysts, including extraction and biopsy.

32. **Dental Services** beyond emergency treatment to stabilize an acute injury—including, but not limited to, crowns, fillings, dental implants, caps, dentures, braces, dental appliances and orthodontic procedures are not covered. Charges for the dental procedure(s) beyond emergency treatment to stabilize an acute injury including, but not limited to, professional fees of the dentist or oral surgeon, X-ray and laboratory fees or related dental supplies provided in connection with the care, treatment, filling, removal or replacement of teeth or structures directly supporting the teeth, dental services include those for crowns, root canals, replacement of teeth, complete dentures, gold inlays, fillings, and other dental services specific to the replacement of teeth or structures directly supporting the teeth and other dental services specific to the treatment of the teeth are not covered except for services outlined under the outpatient benefit, "Oral Surgery and Dental Services."

33. **Oral Surgery and Dental Services**: Dental Treatment Anesthesia -Anesthesia and associated charges for dental procedures provided in a hospital or outpatient surgery center are covered when:

a. The Member's clinical status or underlying medical condition requires use of an outpatient surgery center or inpatient setting for the provision of the anesthesia for a dental procedure(s) that ordinarily would not require anesthesia in a hospital or outpatient surgery center setting; and

b. One of the following criteria is met:
   i. The Member is under seven years of age;
   ii. The Member is developmentally disabled, regardless of age; or
   iii. The Member's health is compromised and general anesthesia is medically necessary; regardless of age.

The Member's dentist must obtain Preauthorization from the Plan before the dental procedure is provided. Dental anesthesia in a dental office or dental clinic is not covered. Charges for the dental procedure(s) itself, including, but not limited to, professional fees of the dentist or oral surgeon, X-ray and laboratory fees or related dental supplies provided in connection with the care, treatment, filling, removal or replacement of teeth or structures directly supporting the teeth are not covered except for services covered under the outpatient benefit, "Oral Surgery and Dental Services."

34. **Outpatient Medical Rehabilitation Therapy** - Services provided by a registered physical, speech or occupational therapist for the treatment of an illness, disease or injury are covered.

35. **Outpatient Surgery** - Short-stay; same-day or other similar outpatient surgery Facilities are covered when provided as a substitute for inpatient care.

36. **Periodic Health Evaluation** - Periodic health evaluations are covered as recommended in the Bay Health Partners’ Preventive Health Guidelines and performed by participating providers. This may include, but is not limited to, the following screenings:

a. **Breast Cancer Screening and Diagnosis** - Services are covered for the screening and diagnosis of breast cancer. Screening and diagnosis will be covered consistent with generally accepted medical practice and scientific evidence. Mammography for screening or diagnostic purposes is covered.

b. **Hearing Screening** -Routine hearing screening by a participating health professional is covered to determine the need for hearing correction. Hearing aids are not covered, nor are their testing, adjustments, or batteries. (Hearing screenings are limited to Dependents under age 19.)

c. **Prostate Screening** - Evaluations for the screening and diagnosis of prostate cancer is covered (including, but not limited to, prostate-specific antigen testing and digital rectal
examination). These evaluations are provided when consistent with good professional practice.

d. **Well-Baby Care** - Up to the age of two, preventive health services is covered (including immunizations). An office Co-payment applies when infants are ill at the time services are provided.

e. **Well-Woman Care** - medically necessary services, including a Pap smear (cytology), are covered.

37. **Phenylketonuria (PKU) Testing and Treatment** - Testing for Phenylketonuria (PKU) is covered to prevent the development of serious physical or mental disabilities or to promote normal development or function as a consequence of PKU enzyme deficiency. PKU includes those formulas and special food products that are part of a diet prescribed and managed by a health care professional in consultation with a Physician who specializes in the treatment of metabolic disease and who participates in or is prior authorized, provided that the diet is deemed medically necessary to avert the development of serious physical or mental disabilities or to promote normal development or function as a consequence of PKU. Special food products do not include food that is naturally low in protein, but may include a special low-protein formula specifically approved for PKU and special food products that are specially formulated to have less than one gram of protein per serving.

38. **Physician Care** - Diagnostic, consultation and treatment services provided by the participating providers.

39. **Prosthetics and Corrective Appliances** - Prosthetics (except for bionic or myoelectric as explained below) are covered when medically necessary and prior authorized. Prosthetics are durable, custom-made devices designed to replace all or part of a permanently inoperative or malfunctioning body part or organ. Examples of covered prosthetics include initial contact lens in an eye following a surgical cataract extraction and removable, non-dental prosthetic devices such as a limb that does not require surgical connection to nerves, muscles or other tissue. Custom-made or custom-fitted corrective appliances are covered when medically necessary and prior authorized. Corrective appliances are devices that are designed to support a weakened body part. These appliances are manufactured or custom-fitted to an individual Member. Bionic and myoelectric prosthetics are not covered. Bionic prosthetics are prosthetics that require surgical connection to nerves, muscles or other tissues. Myoelectric prosthetics are prosthetics which have electric motors to enhance motion. Replacements, repairs and adjustments to corrective appliances and prosthetics coverage are limited to normal wear and tear or because of a significant change in the Member's physical condition. The Plan must authorize repair or replacement. Refer to "Footwear" in "Benefits Available on an Outpatient Basis."

40. **Radiation Therapy** (Standard and Complex) - Standard photon beam radiation therapy is covered. Complex radiation therapy is covered. This therapy requires specialized equipment, as well as specially trained or certified personnel to perform the therapy. Examples include, but are not limited to: brachytherapy (radioactive implants) and conformal photon beam radiation and IMRT. (Gamma knife procedures and stereotactic procedures are covered as outpatient surgeries for the purpose of determining Co-payments.

41. **Radiology Services** - Including, but not limited to Standard X-ray films (with or without oral, rectal, injected or infused contrast medium) for the diagnosis of an illness or injury are covered. Standard X-ray services are X-ray(s) of an extremity) abdomen, head, chest, back, mammograms, nuclear studies and barium studies. Specialized scanning and imaging procedures, such as CT, SPECT, PET, MRA and MRI (with or without contrast media), are covered.

42. **Reconstructive Surgery** - Reconstructive surgery is covered to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors or disease. The purpose of reconstructive surgery is to improve function or create a normal appearance to the extent possible. Reconstructive procedures require Preauthorization by the Plan in accordance with standards of care as practiced by Physicians specializing in reconstructive surgery.

43. **Severe Mental Illness** – Outpatient treatment is covered; unlimited visits per definition of SMI.

44. **Vision** - **Routine vision services** are covered under separate benefit.
PRINCIPAL EXCLUSIONS, EXCEPTIONS & LIMITATIONS

All services and benefits described below are excluded from coverage or limited under the Plan. Additional exclusions and limitations may be included with the explanation of your benefits in additional materials.

GENERAL EXCLUSIONS
Services that are not medically necessary; as defined in the "Definitions" section of the plan document, are not covered. Services not specifically included in the plan document or any supplement purchased by the Plan are not covered.

1. Services that are rendered without authorization (except for Emergency Services or Urgently Needed Services) described in this document.
2. Services obtained from non-participating providers when such services were offered or authorized and the Member refused to obtain the services as offered by a participating provider, are not covered.
3. Services rendered prior to the Member’s effective date of enrollment or after the effective date of disenrollment are not covered.
4. The Plan does not cover the cost of services provided in preparation for a non-Covered Service where such services would not otherwise be medically necessary. Additionally, the Plan does not cover the cost of routine follow-up care for non-Covered Services. The Plan will cover medically necessary services directly related to non-Covered Services when complications exceed routine follow-up care such as life-threatening complications of cosmetic surgery.

OTHER EXCLUSIONS AND LIMITATIONS
1. Acupuncture and acupressure are not covered.
2. Air Conditioners, Air Purifiers and Other Environmental Equipment are not covered.
3. Behavior Modification and Non-Crisis Mental Health Counseling and Treatment are not covered. Examples include, but are not limited to, art therapy; music therapy and play therapy.
4. Biofeedback services are not covered except for bladder rehabilitation as part of an authorized treatment plan.
5. Bone Marrow and Stem Cell Transplants - Autologous or allogeneic bone marrow or stem cell transplants are not covered when they are Experimental or Investigational unless prior authorized. Unrelated donor computer searches for Members who require a bone marrow or stem cell transplant are limited to $15,000. Unrelated donor searches must be performed at a Plan-approved transplant center. (See "National Preferred Transplant Network" in "Definitions.")
6. Chiropractic services for examination and/or treatment of strictly non-neuromuscular skeletal disorders. Any manipulation under general anesthesia, hospitalization or any related services.
7. Communication Devices - Computers, personal digital assistants and any speech-generating devices are not covered.
8. Cosmetic Services and Surgery are not covered. Cosmetic surgery and cosmetic services are defined as surgery and services performed to alter or reshape normal structures of the body in order to improve appearance. Drugs, devices and procedures related to cosmetic surgery or cosmetic services are not covered. Cosmetic surgeries or cosmetic services are not considered as reconstructive surgery because of a Member’s psychological or psychiatric condition.
9. Custodial Care is not covered except for those services provided by an appropriately licensed Hospice agency or appropriately licensed Hospice Facility incident to a Member’s Terminal Illness as described in the explanation of Hospice services Section.
10. Dental Care, Dental Appliances and Orthodontics are not covered except as otherwise provided under the outpatient benefit captioned "Oral Surgery and Dental Services". Dental care means all services required for prevention and treatment of diseases and disorder of the teeth, including, but not limited to: oral exams, X-rays, routine fluoride treatment, plaque removal, tooth decay; routine tooth extraction, dental embryonal tissue disorders, periodontal disease, crowns, fillings, dental implants, caps, dentures, braces and orthodontic procedures.
11. Dental Treatment Anesthesia provided or administered in a dentist’s office is not covered. Charges for the dental procedure(s) itself, including, but not limited to, professional fees of the dentist or oral surgeon, X-ray and laboratory fees or related dental supplies provided in connection with the care, treatment, filling, removal or replacement of teeth or structures directly supporting the teeth are not covered except for services covered under the outpatient benefit, "Oral Surgery and Dental Services."

12. Disabilities Connected to Military Services - Treatment in a government Facility for a disability connected to military service that the Member is legally entitled to receive through a federal governmental agency; and to which Member has reasonable access, is not covered.

13. Drugs and Prescription Medication (Outpatient) - Outpatient drugs and prescription medications except as those listed under benefits, "Injectable Drugs" and "Infusion Therapy". See the separate description of the Employer's prescription drug program for coverage information.

14. Durable Medical Equipment - Replacements, repairs and adjustments to durable medical equipment are limited to normal wear and tear or because of a significant change in the Member's physical condition. No benefits are provided for rental charges in excess of the purchase cost.

15. Replacement of lost or stolen durable medical equipment is not covered. The following equipment and accessories are not covered: Non-medically necessary optional attachments and modifications to durable medical equipment for the comfort or convenience of the Member, accessories for portability or travel, a second piece of equipment with or without additional accessories that is for the same or similar medical purpose as existing equipment and home and car remodeling. Educational Services for Developmental Delays and Learning Disabilities - Educational services to treat developmental delays or learning disabilities are not covered. A learning disability is a condition where there is a meaningful difference between a child's current academic level of function and the level that would be expected for a child of that age. Educational services include, but are not limited to, language and speech training, reading and psychological and visual integration training as defined by the American Academy of Pediatrics.

16. Elective Enhancements - Procedures services and supplies for elective, non-medically necessary enhancements to normal body parts (items, devices or services to improve appearance or performance) are not covered. This includes, but is not limited to, elective enhancements related to hair growth, athletic performance, cosmetic changes and anti-aging. Please refer to "Reconstructive Surgery" for a description of reconstructive surgery services covered under the Plan.

17. Exercise Equipment and Services - Exercise equipment or any charges for activities, instructions or facilities normally intended or used for developing or maintaining physical fitness are not covered, except under the Plan's Wellness Program. This includes, but is not limited to, charges for physical fitness instructors, health clubs or gyms or home exercise equipment or swimming pools, even if ordered by a health care professional.

18. Experimental and/or Investigational Procedures, Items and Treatments are not covered unless prior authorized or as described under "Cancer Clinical Trials" in the "Inpatient Benefits" and "Outpatient Benefits" sections of this document. Unless otherwise required by federal or State law, decisions as to whether a particular treatment is Experimental or Investigational and therefore not a covered benefit are determined by a Plan Medical Director, or his or her designee. For the purposes of this document, procedures, studies, tests, drugs or equipment will be considered Experimental and/or Investigational if any of the following criteria/guidelines is met:
   a. It cannot lawfully be marketed without the approval of FDA and such approval has not been granted at the time of its use or proposed use;
   b. It is a subject of a current investigation of new drug or new device (IND) application on file with the FDA;
   c. It is the subject of an ongoing clinical trial (phase I, II or the research arm of Phase III) as defined in regulations and other official publications issued by the FDA and Department of Health and Human Services (DHHS);
   d. It is being provided pursuant to a written protocol that describes among its objectives the determination of safety, efficacy; toxicity, maximum tolerated dose or effectiveness in comparison to conventional treatments;
   e. It is being delivered or should be delivered subject to approval and supervision of an institutional review board (IRE) as required and defined by federal regulations or other official
actions (especially those of the FDA or DHHS). Other facilities studying substantially the same drug, device, medical treatment or procedures refer to it as experimental or as a research project, a study, an invention, a test, a trial or other words of similar effect;
f. The predominant opinion among experts as expressed in published, authoritative medical literature is that usage should be confined to research settings; and
g. It is not Experimental or Investigational itself pursuant to the above criteria, but would not be Medically Necessary except for its use in conjunction with a drug, device or treatment that is Experimental or Investigational (e.g., lab tests or imaging ordered to evaluate the effectiveness of an Experimental therapy).

The sources of information to be relied upon by the Plan in determining whether a particular treatment is Experimental or Investigational, and therefore not a covered benefit under the Plan, include but are not limited to the following:
a. The Member's medical records;
b. The protocol(s) pursuant to which the drug, device, treatment or procedure is to be delivered;
c. Any informed consent document the Member, or his or her representative, has executed or will be asked to execute, in order to receive the drug, device, treatment or procedure;
d. The published authoritative medical and scientific literature regarding the drug, device, treatment or procedure;
e. Expert medical opinion;
f. Opinions of other agencies or review organizations, e.g., ECRI Health Technology Assessment Information Services, HAYES New Technology Summaries or MCMC Medical Ombudsman; and
h. Regulations and other official actions and publications issued by agencies such as the FDA, the DHHS or the Agency for Health Care Policy and Research (AHCPR).

19. Eyewear and Corrective Refractive Procedures - Corrective lenses and frames, contact lenses and contact lens fitting and measurements are not covered (except for initial post-cataract extraction " or corneal bandages and for the treatment of keratoconus and aphakia. Surgical and laser, procedures to correct or improve refractive errors are not covered. Routine screenings for glaucoma are limited to Members who meet the medical criteria.

20. Family Planning - Family planning benefits, other than those specifically listed in the Schedule of Benefits are not covered.

21. Follow-up Care from non-participating providers after Emergency Services or Urgently Needed Services following discharge not covered without authorization.

22. Foot Care - Except as medically necessary, routine foot care, including, but not limited to, removal or reduction of corns and calluses and clipping of toenails, is not covered.

23. Foot Orthotics/Footwear - Specialized footwear, including foot orthotics and custom-made or standard orthopedic shoes is not covered, except for Members with diabetic foot disease or when an orthopedic shoe is permanently attached to a medically necessary orthopedic brace.

24. Genetic Testing and Counseling - Genetic testing of non-Members is not covered. Genetic testing solely to determine the gender of a fetus is not covered. Genetic testing and counseling are not covered when done for non-medical reasons or when a Member has no medical indication or family history of a genetic abnormality. General testing and counseling are not covered to screen newborns, children or adolescents to determine their carrier status for inheritable disorders when there would be no immediate medical benefit or when the test results would not be used to initiate medical interventions during childhood. Genetic testing and counseling are not covered except when determined to be medically necessary to treat the Member for an inheritable disease. Refer to "Maternity Care Test and Procedures" in the "Outpatient Benefits" section for coverage of amniocentesis and chorionic villus sampling.

25. Government Services and Treatment - Any services that the Member receives from a local, State or federal governmental agency are not covered, except when coverage under this Health Plan is expressly required by federal or State law.

26. Hearing Aids and Hearing Devices - Hearing aids and non-implantable hearing devices are not covered. Audiology services (other than screening for hearing acuity) are not covered. Hearing aid supplies are not covered. Implantable hearing devices are not covered except for cochlear
devices for bilaterally; profoundly hearing-impaired individuals or for prelingual Members who have not benefited from conventional amplification (hearing aids).

27. Hypnotherapy, behavior training and sleep therapy are not covered.

28. Immunizations and vaccines for international travel and/or required for work, insurance, school, marriage, adoption, immigration, camp, volunteer work, licensure, certification or registration, sports or recreational activities are not covered.

29. Infertility Reversal- Reversals of sterilization procedures are not covered.

30. Infertility Services after elective vasectomy of tubal ligation, treatment of female sterility in which a donor ovum would be necessary; Insemination with semen from a partner with an infectious disease (guidelines of Society of Artificial Reproductive Technology); microdissection of zona or sperm microinjection, In-Vitro Fertilization (IVF); Gamete Intrafallopian Transfer (GIFT) and Zygote Intrafallopian Transfer (ZIFT) and procedures performed in conjunction with above; intravenous Gamma Globin (IVIG); ovum transplants, ovum bank charges, sperm or sperm bank charges and the Medical or Hospital Services incurred by surrogate mothers who are not the Plan’s Members are not covered.

31. Institutional Services and Supplies –Except for skilled nursing services provided in a Skilled Nursing Facility, any services or supplies furnished by a Facility that is primarily a place of rest, a place for the aged, a nursing home or any similar institution, regardless of affiliation or denomination, are not covered. (Skilled nursing services are covered as described under the sections entitled "Inpatient Benefits" and "Outpatient Benefits.") Members residing in these Facilities are eligible for Covered Services that are determined to be medically necessary and are authorized.

32. Medicare Benefits for Medicare Eligible Members - The amount payable by Medicare for Medicare Covered Services is not covered by the Plan for Medicare Eligible Members, whether or not a Medicare Eligible Member has enrolled in Medicare Part A and Medicare Part B.

33. Mental Health or Nervous Disorder- outpatient visits are covered for crisis intervention, up to 20 visits per calendar year.

34. Nonphysician Health Care Practitioners - The Plan may not cover services of all Nonphysician Health Care Practitioners. Treatment by Nonphysician Health Care Practitioners, such as acupuncturists, psychologists, chiropractors, licensed clinical social workers, and marriage and family therapists, may be available if purchased as a supplemental benefit. (For coverage of Severe Mental Illnesses (SMI) of adults and children, and for children, the treatment of Serious Emotional Disturbances (SED), refer to "Outpatient Benefits Mental Health Services.")

35. Nurse Midwife Services are covered if services provided at participating facility. Deliveries at home (home deliveries) are not covered.

36. Nursing, Private Duty - Private-duty nursing is not covered.

37. Nutritional Supplements or Formulas - Formulas, food, vitamins, herbs and dietary supplements are not covered, except as described under the outpatient description of "Phenylketonuria (PKU) Testing and Treatment."

38. Off-Label Drug Use - Off-label drug use, which means the use of a drug for a purpose that is different from the use for which the drug has been approved for by the FDA, including off-label self-injectable drugs, is not covered except as follows:
   a. If the self-injectable drug is prescribed for off-label use, the drug and its administration is covered only when the following criteria are met:
      i. The drug is approved by the FDA;
      ii. The drug is prescribed by a participating provider for the treatment of a life-threatening condition or for a chronic and seriously debilitating condition;
      iii. The drug is medically necessary to treat the condition;
      iv. The drug has been recognized for treatment of the life-threatening or chronic and seriously debilitating condition by one of the following: i.e. American Medical Association Drug Evaluations, i.e. American Hospital Formulary Service Drug Information, i.e. United States Pharmacopoeia Dispensing Information, Volume 1, or in two articles from major peer-reviewed medical journals that present data supporting the proposed off-label drug use or uses as generally safe and effective;
      v. The drug is covered under the injectable drug benefit described in the outpatient benefits section of this Combined Evidence of Coverage and Disclosure Form.
Nothing in this section shall prohibit the Plan from use of a Formulary; Co-payment, technology assessment panel or similar mechanism as a means for appropriately managing the utilization of a drug that is prescribed for a use that is different from the use for which that drug has been approved for marketing by the FDA.

39. Oral Surgery and Dental Services - Dental services, including, but not limited to, crowns, rulings, dental implants, caps, dentures, braces and orthodontic procedures, are not covered.

40. Oral Surgery and Dental Services: Dental Treatment Anesthesia - Dental anesthesia in a dental office or dental clinic is not covered. Professional fees of the dentist are not covered. (Please see "Dental Care, Dental Appliances and Orthodontics" and "Dental Treatment Anesthesia.")

41. Organ Donor Services - Medical and Hospital Services, as well as other costs of a donor or prospective donor, are only covered when the recipient is a Member. The testing of blood relatives to determine compatibility for donating organs is limited to sisters, brothers, parents and natural children. Computer searches of unrelated donors for Members who require a bone marrow or stem cell transplant are limited to $15,000 per procedure. Organ donor searches are only covered when performed by a Provider included in the "National Preferred Transplant Network Facility."

42. Organ Transplants - All organ transplants must be Preauthorized by the Plan and performed in a Plan National Preferred Transplant Network Facility-
   a. Transportation is limited to the transportation of the Member and one escort to a National Preferred Transplant Network Facility greater than 60 miles from the Member's Primary Residence as Preauthorized by the Plan. Transportation and other non-clinical expenses of the living donor are excluded, and are the responsibility of the Member who is the recipient of the transplant. (See the definition for "National Preferred Transplant Network."
   b. Food and housing is not covered unless the National Preferred Transplant Network Center is located more than 60 miles from the Member's Primary Residence, in which case food and housing is limited to $125.00 a day to cover both the Member and escort, if any (excludes alcohol and tobacco) as Preauthorized by the Plan. Food and housing expenses are not covered for any day a Member is not receiving medically necessary transplant services.
   c. Listing of the Member at a second National Preferred Transplant Network Center is excluded, unless the Regional Organ Procurement Agencies are different for the two Facilities and the Member is accepted for listing by both Facilities. In these cases, organ transplant listing is limited to two National Preferred Transplant Network Facilities. If the Member is dual listed, his or her coverage is limited to the actual transplant at the second Facility. The Member is responsible for any duplicated diagnostic costs incurred at the second Facility. (See the definition for "Regional Organ Procurement Agency. ")

43. Phenylketonuria (PKU) Testing and Treatment - Food products naturally low in protein are not covered.

44. Physical or Psychological Examinations - Physical or psychological examinations for court hearings, travel, premarital, preadoption or other nonpreventive health reasons are not covered.

45. Private Rooms and Comfort Items – Personal or comfort items, and non-medically necessary private rooms during inpatient hospitalization are not covered.

46. Prosthetics and Corrective Appliances - Replacement of lost prosthetics or corrective appliances is not covered. Prosthetics that require surgical connection to nerves, muscles or other tissues (bionic) are not covered. Prosthetics that have electric motors to enhance motion (myoelectronic) are not covered.

47. Reconstructive Surgery - Reconstructive surgeries are not covered under the following circumstances:
   a. When there is another more appropriate surgical procedure that has been offered to the Member; or
   b. When only a minimal improvement in the Member's appearance is expected to be achieved.

48. Recreational, lifestyle, Educational or Hypnotic Therapy and any related diagnostic testing is not covered except for services under the Sutter health Partners Wellness Program.
49. Rehabilitation Services and Therapy are either limited or not covered as follows:
   a. Speech, occupational or physical therapy is not covered when medical documentation does
      not support the Medical Necessity because of the Member's inability to progress toward the
      treatment plan goals or when a Member has already met the treatment goals.
   b. Speech therapy is limited to medically necessary therapy to treat speech disorders caused by
      a defined illness, disease or surgery (for example, cleft palate repair).
   c. Exercise programs are only covered when they require the direct supervision of a licensed
      physical therapist and are part of an authorized treatment plan.
   d. Activities that are motivational in nature or that are primarily recreational, social or for general
      fitness are not covered.
   e. Aquatic/pool therapy is not covered unless conducted by a licensed physical therapist and
      part of an authorized treatment plan.
   f. Massage therapy is not covered.

50. Respite Care- Respite care is not covered, unless part of an authorized Hospice plan and is
    necessary to relieve the primary caregiver in a Member's residence. Respite care is covered only
    on an occasional basis, not to exceed five consecutive days at a time.

51. Third-Party Liability - Expenses incurred due to liable third parties are not covered, as described in
    the section "Sutter Health Partners' Right to the Repayment of a Debt as a Charge Against
    Recoveries From Third Parties Liable for a Member's Health Care Expenses."

52. Services in the Home- Services in the home provided by relatives or other household Members
    are not covered.

53. Services While Confined or Incarcerated - Services required for injuries or illnesses experienced
    while under arrest, detained, imprisoned, incarcerated or confined pursuant to federal, State or
    local law are not covered. However, the Plan will reimburse Members their out-of-pocket
    expenses for services received while confined/incarcerated, or, if a juvenile, while detained in any
    Facility, if the services were provided or authorized by a Participating Physician or in accordance
    with the terms of the Plan or were Emergency Services or Urgently Needed Services. This
    exclusion does not restrict the Plan's liability with respect to expenses for Covered Services
    solely because the expenses were incurred in a State or county hospital; however, the Plan's
    liability with respect to expenses for Covered Services provided in a State hospital is limited to the
    rate the Plan would pay for those Covered Services if provided by a Participating Hospital.

54. Sex Transformations - Procedures, services, medications and supplies related to sex
    transformations are not covered.

55. Sexual dysfunction; including erectile dysfunction, impotence, anorgasmic or hyporgasmic are not
    covered.

56. Surrogacy - Infertility and maternity services for non-Members are not covered. The Plan may
    seek recovery of actual costs incurred by the Plan from a Member who is receiving
    reimbursement for medical expenses for maternity services while acting as a surrogate.

57. Transportation - Transportation is not a covered benefit except for Ambulance transportation as
    defined in this document. Also see "Organ Transplants listed in "Exclusions and Limitations."

58. Veterans' Administration Services - Except for Emergency or Urgently Needed Services, services
    received by a Member in a Veterans' Administration Facility are not covered.

59. Vision Care - See "Routine Vision" listed in "Covered Services" for Exclusions and Limitations.

60. Vision Training - Vision therapy and ocular training programs (orthoptics) are not covered.

61. Weight Alteration Programs (Inpatient or Outpatient) - Weight loss or weight gain program are not
    covered except services provided under the Plan's Wellness Program. These programs include,
    but are not limited to, dietary evaluations, counseling, exercise, behavioral modification, food
    and food supplements, vitamins and other nutritional supplements. Weight loss or weight gain
    programs and services associated with these programs, except as described under inpatient
    benefits "Morbid Obesity (Surgical Treatment)" are not covered. For the treatment of anorexia
    nervosa and bulimia nervosa, please refer to the behavioral health supplement of this document.

REIMBURSEMENT FOR ACTS OF THIRD PARTIES

No payment will be made under the Plan for expenses incurred for or in connection with any illness,
injury, or condition for which a third party may be liable or legally responsible by reason of negligence, or
an intentional act or breach of any legal obligation. However, benefits under the Plan will be provided subject to the following:

1. The Plan will automatically have a lien, to the extent of benefits provided, upon any recovery, whether by settlement, judgment or otherwise, that the Plan participant receives from the third party, the third party’s insurer, or the third party’s guarantor. The lien will be in the amount of benefits paid by the Plan for the treatment of the illness, disease, injury, or condition for which the third party is liable but no more than the amount allowed by California Civil Code section 3040. The Plan also reserves the right to seek recovery on the Plan’s behalf if the Plan participant fails to seek recovery from the third party, the third party’s insurer, or the third party’s guarantor.

2. You must advise the Plan Administrator in writing within 60 days of filing a claim against the third party and take necessary action, furnish such information and assistance, and execute such papers as the Plan may require to facilitate enforcement of its rights. You must not take action that may prejudice the rights or interest of the Plan. Failure to give such notice to the Plan or cooperate with the Plan, or actions that prejudice the rights or interest of the Plan, will be a material breach of the terms of the Plan and will result in you personally responsible for reimbursing the Plan.

**SUBROGATION AND THIRD PARTY LIABILITY**

The Plan has a right to subrogation and reimbursement, as defined below:

**Right to Subrogation**

The right to subrogation means that the Plan has a right to pursue any legal claims that you may be entitled to pursue for Benefits that the Plan has paid. Subrogation applies when the Plan has paid benefits for a Sickness or Injury for which a third party is considered responsible – for example an insurance carrier if you are involved in an auto accident.

The Plan shall be subrogated to, and shall succeed to, all rights of recovery from any or all third parties, under any legal theory of any type, for 100% of any services and Benefits the Plan has paid on your behalf relating to any Sickness or Injury caused by any third party.

**Right to Reimbursement**

The right to reimbursement means that if a third party causes a Sickness or Injury for which you receive a settlement, judgment, or other recovery, you must use those proceeds to fully return to the Plan 100% of any Benefits you received for that Sickness or Injury.

**Third Parties**

The following persons and entities are considered third parties:

- A person or entity alleged to have caused you to suffer a Sickness, Injury or damages, or who is legally responsible for the Sickness, Injury or damages;
- Another company other than the Employer; or
- Any person or entity who is or may be obligated to provide you with benefits or payments under:
  - Underinsured or uninsured motorist insurance;
  - Medical provisions of no-fault or traditional insurance (auto, homeowners or otherwise);
  - Workers’ compensation coverage; or
  - Any other insurance carrier or third party administrator.

**Subrogation and Reimbursement Provisions**

As a Covered Person, you agree to the following:

- The Plan has a first priority right to receive payment on any claim against a third party before you receive payment from that third party.
The Plan’s subrogation and reimbursement rights apply to full and partial settlements, judgments, or other recoveries paid or payable to you or your representative, no matter how those proceeds are captioned or characterized. Payments include, but are not limited to, economic, non-economic, and punitive damages. The Plan is not required to help you to pursue your claim for damages or personal injuries, or pay any of your associated costs, including attorney’s fees. No so-called “Fund Doctrine” or “Common Fund Doctrine” or “Attorney’s Fund Doctrine” shall defeat this right.

The Plan may enforce its subrogation and reimbursement rights regardless of whether you have been “made whole” (fully compensated for your injuries and damages).

You will cooperate with the Plan and its agents in a timely manner to protect its legal and equitable right to subrogation and reimbursement, including, but not limited to:

- Complying with the terms of this section;
- Providing any relevant information requested;
- Signing and/or delivering documents at its request;
- Appearing at medical examinations and legal proceedings, such as depositions or hearings;
- Obtaining the Plan’s consent before releasing any party from liability or payment of medical expenses.

If you receive payment as part of a settlement or judgment from any third party as a result of a Sickness or Injury, and the Plan alleges some or all of those funds are due and owed to it, you agree to hold those settlement funds in trust, either in a separate bank account in your name or in your attorney’s trust account. You agree that you will serve as a trustee over those funds to the extent of the Benefits the Plan has paid.

If the Plan incurs attorney’s fees and costs in order to collect third party settlement funds held by you or your representative, the Plan has the right to recover those fees and costs from you.

You may not accept any settlement that does not fully reimburse the Plan, without its written approval.

You will assign to the Plan all rights of recovery against third parties to the extent of Benefits the Plan has provided for a Sickness or Injury caused by a third party.

The Plan’s rights will not be reduced due to your own negligence.

The Plan may file suit in your name and take appropriate action to assert its rights under this section. The Plan is not required to pay you part of any recovery it may obtain from a third party, even if it files suit in your name.

The provisions of this section apply to the parents, guardian, or other representative of a Dependent child who incurs a Sickness or Injury caused by a third party.

In case of your wrongful death, the provisions of this section apply to your estate, the personal representative of your estate, and your heirs.

Your failure to cooperate with the Plan or its agents is considered a breach of contract. As such, the Plan has the right to terminate your Benefits, deny future Benefits, take legal action against you, and/or set off from any future Benefits the value of Benefits the Plan has paid relating to any Sickness or Injury caused by any third party to the extent not recovered by the Plan due to you or your representative not cooperating with the Plan.

If a third party causes you to suffer a Sickness or Injury while you are covered under this Plan, the provisions of this section continue to apply, even after you are no longer a Covered Person.

Subrogation – Example:

Suppose you are injured in a car accident that is not your fault, and you receive Benefits under the Plan to treat your injuries. Under subrogation, the Plan has the right to take legal action in your name against the driver who caused the accident and that driver’s insurance carrier to recover the cost of those Benefits.

GENERAL PROVISIONS/INFORMATION

Providing of Care
The Plan is not responsible for providing any type of hospital, medical or similar care, nor is the Plan responsible for the quality of any such care received.
INDEPENDENT CONTRACTORS
Our relationship with providers is that of an independent contractor. Physicians and other health care professionals, hospitals, skilled nursing facilities and other community agencies are not our agents.

NON-REGULATION OF PROVIDERS
The benefits provided under the Plan do not regulate the amounts charged by providers of medical care, except to the extent that rates for covered services are regulated with participating providers.

TERMS OF COVERAGE
1. In order for you to be entitled to benefits under the agreement, both the agreement and your coverage under the agreement must be in effect on the date the expense giving rise to a claim for benefits is incurred.
2. The benefits to which you may be entitled will depend on the terms of coverage in effect on the date the expense giving rise to a claim for benefits is incurred. An expense is incurred on the date you receive the service or supply for which the charge is made.
3. The agreement is subject to amendment, modification or termination according to the provisions of the agreement without your consent or concurrence.

PROTECTION OF COVERAGE
The Plan does not have the right to cancel your coverage under the Plan while:
1. The Plan is in effect;
2. You are eligible; and
3. Your subscription charges are paid according to the terms of the agreement.

FREE CHOICE OF PROVIDER
The Plan in no way interferes with your right as a member entitled to hospital benefits to select a hospital. You may choose any physician who holds a valid physician and surgeon’s certificate and who is a member of, or acceptable to, the attending staff and board of directors of the hospital where services are received. You may also choose any other health care professional or facility, which provides care covered under the Plan and is properly licensed according to appropriate State and local laws. However, your choice may affect the benefits payable according to the Plan.

CONTINUITY OF CARE
If the Plan terminates its contractual relationship with a participating provider and you are undergoing a course of treatment from that provider at the time the contract is terminated, you may be able to continue to receive services from that provider (but only if such provider agrees to continue to comply with the same contractual requirements that applied prior to termination). To qualify, you must have an acute or a serious chronic condition, a high-risk pregnancy, or a pregnancy in the second or third trimester. You may request this continuity of care by calling our customer service telephone number listed on your ID card. If approved, services may be received for a limited period of time, but no longer than 90 days, unless you cannot be safely transferred to a participating provider. Coverage is provided according to the terms and conditions of the Plan applicable to participating providers.

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

EXPENSE IN EXCESS OF BENEFITS
Neither the Employer nor the Plan is liable for any expense you incur in excess of the benefits of the Plan.
**Benefits Not Transferable**  
Only the enrolled member is entitled to receive benefits under the Plan. The right to benefits cannot be transferred.

**Notice of Claim**  
You or the provider of service must send properly and fully completed claim forms to the Plan within 90 days of the date you receive the service or supply for which a claim is made. Services received and charges for the services must be itemized and clearly and accurately described.

**Payment to Providers**  
The Plan will pay the benefits of the Plan directly to contracting hospitals, participating providers, COE and medical transportation providers. Also, the Plan will pay non-contracting hospitals and other providers of service directly when you assign benefits in writing.

**Right of Recovery**  
When the amount the Plan paid exceeds its liability under the Plan, the Plan has the right to recover the excess amount. This amount may be recovered from you, the person to whom payment was made or any other plan.

**Renewal Provisions**  
The Employer may change the subscription charges or other terms of the Plan from time to time.

**Confidentiality and Release of Medical Information**  
The Plan will use reasonable efforts, and take the same care to preserve the confidentiality of the member’s medical information. The Plan may use data collected in research. If such data is ever released to a third party, it shall be released only in aggregate statistical form without identifying the member. Medical information may be released only with the written consent of the member or as required by law. It must be signed, dated and must specify the nature of the information and to which persons and organizations it may be disclosed. Members may access their own medical records.

The Plan may release your medical information to professional peer review organizations and to the group for purposes or reporting claims experience or conducting an audit of our operations, provided the information disclosed is reasonably necessary for the group to conduct a review or audit.

A statement describing our policies and procedures for preserving the confidentiality of medical records is available in each welcome package and will be furnished upon request.

**Foreign Claims:**  
In the event a covered person incurs a covered expense in a foreign country, the covered person shall be responsible for providing the following to the claims administrator before payment of any benefits due are payable:

1. The claim form, provider invoice and any other documentation required to process the claim must be submitted in the English language.
2. The charges for services must be converted into dollars.
3. A current conversion chart validating the conversion from the foreign country’s currency into dollars.

Send complete information to the claim address listed on your identification card.

**Appeals Procedure**  
All grievances received by the Plan will be acknowledged in writing, together with a description of how the Plan proposes to resolve the grievance. After the Plan has reviewed your grievance, the Plan will send you a written statement on its resolution within 30 days. If your case involves an imminent threat to your health, including but not limited to, the potential loss of life, limb, or major bodily function, review of your grievance will be expedited and resolved within three working days.
Under normal circumstances, claims are processed and payments are made within three weeks of receipt of the claim at the office of the claims administrator. If the claims administrator requests additional, clarified, or updated information regarding your claim, your timely response will facilitate the processing of your claim. If any part of the claim is denied, the notice will explain the specific reason(s) for the denial and will include a specific reference to the Plan provision(s) upon which the denial was based. If applicable, you will be given a description of any additional information necessary to process the claim in the form of a pending letter.

If you believe a claim was improperly processed, the following procedure is available:

1. Within 180 days of the date of the claim notice, you may request, in writing or verbally, that the Plan conduct a review of the processed claim. You may request within this 180-day period an extension if more time is needed to prepare an appeal. The Plan will review the processed claim and inform you whether or not an error was made. Any errors will be corrected promptly. Written requests should be sent to:
   
   BRMS  
   Attention: Sutter Health Partners: Appeals  
   PO Box 2650  
   Rancho Cordova, CA  95741

2. If you are not satisfied with the above review, a written request for a second review may be submitted to the Plan within 60 days following the first review. The request should state, in clear and concise terms, the reason for disagreement with the way the claim was processed. When the written request is received, the claim will be reviewed again and the results of this review furnished in writing to you within 60 days in most cases, but in no case more than 120 days.

3. All requests for a review of denied benefits should include a copy of the initial denial letter and any other pertinent information. Send all information to:

   Sutter Health Partners  
   Attention:  2nd Level Appeal  
   4000 Civic Center Drive  
   Suite #110  
   San Rafael, CA 94903

4. Requests for appeals that do not comply with this procedure will not be considered, except in extraordinary circumstances.

5. The decision upon review will be final. It shall be in writing and contain the specific reason(s) for the decision, contain references to the pertinent Plan language upon which the decision was based, and be written in a manner to be understood by the Employee.

**Reading Your Explanation of Benefits (EOB)**
After the processing of your claim is complete, you will receive an Explanation of Benefits (EOB) from the claims administrator. This is not a bill. This form will explain the following information to you:

1. The name of the provider;
2. The date(s) of service;
3. The submitted charges;
4. The amount of charges allowed;
5. The application of any deductibles, coinsurance or co-payments, reducing the reimbursable charges;
6. The amount of charges disallowed;
7. The reason(s) charges may have been disallowed (e.g., discount due from network provider);
8. The amount paid on the allowed charges; and
9. To whom payment was made.

Each of these considerations will be based on the plan document. You retain the opportunity to request a review of the decision denying any or your entire claim according to the provisions of the Plan (refer to “Appeals Procedures” in this section).
**ALLOCATION OF RESPONSIBILITY**
The Named Fiduciary and Plan Administrator, Marin General Hospital, hereinafter known as “Employer,” shall have the authority to control and manage the operation and administration of the Plan. The Plan Administrator may delegate responsibilities for the operation and administration of the Plan. The Plan Administrator will have the authority to amend the Plan, to determine its policies, to appoint and remove other supervisors, fix their compensation (if any), and exercise general administrative authority over them. The Plan Administrator has the sole authority and responsibility to review and make final decisions on all claims to benefits hereunder. Marin General Hospital shall perform its duties as the Plan Administrator and in its sole discretion shall determine appropriate courses of action in light of the reason and purpose for which the Plan is established and maintained. In particular, the Plan Administrator shall have full and sole discretionary authority to interpret all plan documents, and make all interpretive and factual determinations as to whether any individual is entitled to receive any benefit under the terms of the Plan. Any construction of the terms of any plan document and any determination of fact adopted by the Plan Administrator shall be final and legally binding on all parties. Any interpretation, determination or other action of the Plan Administrator shall be subject to review only if it is arbitrary or capricious or otherwise an abuse of discretion. Any review of a final decision or action of the Plan Administrator shall be based only on such evidence presented to or considered by the Plan Administrator at the time it made the decision that is the subject for review. Accepting any benefits or making any claim for benefits under the Plan constitutes agreement with and consent to any decisions that the Plan Administrator makes, in its sole discretion, and, further, constitutes agreement to the limited standard and scope of review described by this section.

**INDEMNIFICATION**
To the extent permitted by law, Employees of the Employer, the fiduciaries, and all agents and representatives of the fiduciaries shall be indemnified by the Plan Administrator and saved harmless against any claims and conduct related to the administration of the Plan, except claims arising from gross negligence, willful neglect, or willful misconduct. The Plan Administrator 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. The Employer may purchase insurance to cover the potential liability of Employees of the Employer, the fiduciaries, and all agents and representatives of the fiduciaries, serving in a fiduciary capacity with respect to the Plan, and the Plan itself, at its expense, may insure itself against loss by misdeeds or omissions of Plan fiduciaries, provided such insurance permits recourse by the insurer against such fiduciaries. The Employer may also purchase insurance to cover the exposure of its Employees, fiduciaries, and all agents and representatives of the fiduciaries by reason of such right of recourse.

**BASIS ON WHICH PAYMENTS ARE TO BE MADE FROM THE PLAN**
The amount of contributions to the Plan is to be made on the following basis:

1. The Employer shall, from time to time, evaluate the costs of the Plan and determine the amount to be contributed by the Employer and the amount to be contributed (if any) by each covered Employee or COBRA participant.
2. Participation in the Plan is entirely voluntary. The Employer reserves the right to modify the amount of any Employee contributions. If the fund resulting from Employee contributions is insufficient to pay benefits provided by the Plan, the Employer will make the necessary contribution to enable benefits to be paid.
3. Any participant contributions to the Plan will be initially applied to insurance premiums (if any) and then to administrative fees. Any participant contributions in excess of funds needed for premiums and fees will be used to pay claims.

**FUNDING POLICY**
Notwithstanding any other provision of the Plan, the Employer’s obligation to pay claims otherwise allowable under the terms of the Plan shall be limited to its obligation to make contributions to the Plan as set forth in the preceding paragraph entitled “Basis On Which Payments Are To Be Made From the Plan.” Payment of said claims in accordance with these procedures shall discharge completely the Employer obligation with respect to such payments.
In the event that the Plan Administrator terminates the Plan, then as of the effective date of termination, the Employer (and covered Employee and dependent participants and COBRA participants) shall have no further obligation to make additional contributions to the Plan. In addition, coverage for allowable claims filed after the Plan termination date shall be limited to those remaining assets of the fund (if any) not required to pay claims filed before the effective Plan termination date. If the fund’s assets are not sufficient to fund the benefits otherwise payable under the Plan, then benefits shall not be payable under the Plan and neither the Plan Sponsor, Named Fiduciary, or Plan Administrator shall be liable for such benefits. It is intended that the Plan shall be approved and qualified by the Internal Revenue Service as meeting the requirements of the federal Internal Revenue Code and Regulations issued thereunder with respect to employee plans (a) so as to the amounts of its contributions to the Plan; (b) so that contributions so made to the Plan shall be exempt from federal income tax. In the event the Commissioner of Internal Revenue or his delegate rules that the plan set forth in this agreement is not qualified, or a deduction for all or a part of the Employer’s contribution is not allowed, the Plan Sponsor reserves the right to recover that portion or all of its contribution for which no deduction is allowed.

**PROTECTION AGAINST CREDITORS**

No benefit payment under the Plan shall be subject in any way to alienation, sale, transfer, pledge, attachment, garnishment, execution or encumbrance of any kind, and any attempt to accomplish the same shall be void. If the Employer shall find that such an attempt has been made with respect to any payment due or to become due to any covered participant, the Employer in its sole discretion may terminate the interest of such covered participant or former covered participant in such payment. The Employer shall apply the amount of such payment to or for the benefit of such covered participant or former covered participant as the Employer may determine. Any such application shall be a complete discharge of all liability with respect to such benefit payment. The Employer is not responsible for any portion of a claim submitted by or on behalf of a covered Employee and dependent participants and COBRA participants:

1. Which is disallowed by the Plan; or
2. Which is not provided as a benefit under the Plan; or
3. Which is either not paid or delayed in payment because of financial inability of the Employer to make the payment; or
4. For any unpaid claims arising or incurred after a participating group Employer, or participant, terminated participation in the Plan.

**ASSIGNMENT OF BENEFITS**

All network benefits payable by the Plan are automatically assigned to the provider of services or supplies, unless evidence of previous payment is submitted with the claim. All other benefits payable by the Plan may be assigned to the provider of services or supplies at your option. Payments made in accordance with an assignment are made in good faith and release the Plan’s obligation to the extent of the payment. Payments will also be made to your separated/divorced spouse, State child support agencies or Medicaid agencies if required by a qualified medical child support order (QMCSO) or State Medicaid law. The Plan may also honor benefit assignments made prior to your death in relation to remaining benefits payable by the Plan.

**ALTERNATE PAYEE PROVISION/FACILITY OF PAYMENT**

Under normal conditions, all network benefits are payable to the provider of services or supplies. All other benefits are payable to you and can only be paid directly to another party upon signed authorization from you. If conditions exist under which a valid release or assignment cannot be obtained, the Plan may make payment to any individual or organization that has assumed the care or principal support for you and is equitably entitled to payment. The Plan must make payments to your separated/divorced spouse, State child support agencies or Medicaid agencies if required by a qualified medical child support order (QMCSO) or State Medicaid law. The Plan may also honor benefit assignments made prior to your death in relation to remaining benefits payable by the Plan. If any such benefit remains unpaid at the death of the participant or if the participant is a minor or is, in the opinion of the Employer, legally incapable of giving a valid receipt and discharge for any payment, the Employer may, at its option, pay such benefits to a duly appointed legal representative or to any one or more of the following relatives of the participant: wife, husband, mother, father, child or children, brother or brothers, sister or sisters. Any payment so
made will constitute a complete discharge of the Employer’s obligation to the extent of such payment and the Employer will not be required to see the application of the money so paid. If the claim is not paid in full, the Employer will furnish notice to the participant that will specify the reason or describe the additional information required to understand the claim. Any payment made by the Plan in accordance with this provision will fully release the Plan of its liability to you.

**Lost Distributees**
Any benefit payable hereunder shall be deemed forfeited if the Plan Administrator is unable to locate the covered person to whom payment is due, provided, however, that such benefits shall be reinstated if a claim is made by the covered person for the forfeited benefits with the time prescribed in “How to File a Claim” and “Claims Procedures Notice and Proof of Claim”.

**Replacement Provision**
This coverage is an immediate replacement of a prior Plan of coverage offered by this Employer. Any benefits paid with respect to covered person under this Employer’s prior Plan will be deemed to be paid under the Plan. Any continuous periods a covered person is covered under this Employer’s prior Plan will be deemed to be time covered under the Plan.

**Plan Amendments and Termination**
The Employer intends to continue the Plan indefinitely, but reserves the right to amend or terminate the Plan in whole or in part, at any time. Such action may include, but not be limited to the type of benefit, deductible, out-of-pocket maximums, maximum benefits, limitations and exclusions, and monthly contribution. Any such action will be communicated to participants in writing as soon as reasonably possible. Any oral statement or representation made by the Employer, its Employees or its representatives that alter, modify, amend or are inconsistent with the written terms of the Plan are invalid and unenforceable. The Employer intends to provide benefits under the Plan indefinitely. However, the Employer may, without prior notice:
1. Change the contributions you must make under the Plan; or
2. Amend or terminate the Plan in a written instrument that is signed by the Administrative Director of Human Resource Services or equivalent, as designated by the Employer.

**Allocation and Apportionment of Benefits**
The Employer reserves the right to allocate the deductible amount to any eligible charges and to apportion the benefits to the covered person and any assignees. The determination by the Plan as to which charges are used for the deductible and the distribution of the benefits is final and binding upon the covered person and all assignees.

**Maximum Amount**
The maximum payable for all covered expenses for each covered person shall not exceed in the aggregate the maximum amount shown in the Schedule of Benefits hereof.

**Physical Examination**
The Employer shall have the right and opportunity to have a covered person examined, whose injury or sickness is the basis of a claim hereunder, when and so often as it may reasonably require during pendency of claim hereunder.

**Records**
Each covered person authorizes and directs any provider that has attended, examined or treated them to furnish to the claims administrator, at any time upon its request, any and all information, records or copies of records relating to the attendance, examination or treatment rendered to the covered person; and the claims administrator agrees that such information and records will be considered confidential. Further, the covered person will absorb any charges imposed relative to the acquisition of such information.
**Change in Amount of Coverage for You**
Any change in the amount of your coverage resulting from a change of the factors on which these amounts are based (such as Employee classification) will take effect on the date of the change. Any change in the amount of your coverage resulting from an amendment, which revises the amounts or benefits provided under the Plan, will become effective on the date of the amendment.

**Change in Amount of Coverage for Your Dependents**
Any change in the amount of a dependent’s coverage as a result of the Employee’s coverage change, will take effect on the date of the change. Any change in the amount of a dependent’s coverage resulting from an amendment, which revises the amounts or benefits provided under the Plan, will become effective on the date of the amendment.

**Misstatement of Age or Classification**
If the age or classification of a covered person is misstated or omitted, the correct age or classification will decide whether and what amount of coverage is payable. The contribution will also be adjusted as required.

**Statements**
In the absence of making a fraudulent claim or an intentional misrepresentation of a material fact, all statements made by a covered person will be deemed representations and not warranties. No such representations will void the Plan benefits or be used in defense to a claim hereunder unless a copy of the instrument containing such representation is or has been furnished to such covered person.

**Clerical Error**
If a clerical error is made, it will not affect the coverage to which the covered person is entitled.

**Periodic Report**
Within one month following the date of any change in the group of Employees and dependents covered, the Employer shall furnish the claims administrator the names of all Employees who have become covered or cease to be covered since the date of the previous reports.

Failure on the part of the Employer to report the name of any Employees or dependents that are eligible for coverage shall not deprive such persons of their benefits under the Plan.

**Affiliated Companies**
Any of the Employer’s affiliates, subsidiaries or divisions may be deleted or added to the Plan upon written notice by the Employer on or before the date such deletion or addition is effective.

**Claims Procedures Notice and Proof of Claim**
Written notice of injury or of illness upon which a claim may be based must be given to the Employer within 120 days of the date of the commencement of the first loss of which benefits arising out of such injury or illness may be claimed. Notice given by or on behalf of the covered person to the claims administrator with particulars sufficient to identify the covered person, shall be deemed to be notice to the Employer. Failure to furnish notice within the time provided in the Plan shall not invalidate any claim if it shall be shown not to have been reasonably possible to furnish such notice and that such notice was furnished as soon as was reasonably possible. The claims administrator, upon receipt of the notice required by the Plan, will furnish to the covered person such forms as are usually furnished by it for filing proof of loss. If such forms are not so furnished within 15 days after the claims administrator receives such notice, the covered person shall be deemed to have complied with the requirements of the Plan as to proof of loss upon submitting, within the time fixed in the Plan for filing proofs of loss, written proof covering the occurrence, character and extent of the loss for which claim is made. Affirmative proof of any loss on which a claim is made must be furnished to the claims administrator within 120 days after the date of service. Failure to furnish proof within the time provided in the Plan shall not invalidate or reduce any claim if it shall be shown not to have been reasonably possible to furnish such proof and that such proof was furnished as soon as reasonably possible. Upon termination of the Plan, final claims must be
received within a period of time determined by the Employer and will be communicated to the Plan participants as soon as reasonably possible.

**NOTICE OF DENIAL OF CLAIM**
In accordance with section 503 of ERISA, the Employer shall provide adequate notice in writing to any covered participants or COBRA participants whose claim for benefits under the Plan has been denied, setting forth the specific reasons for such denial and written in a manner calculated to be understood by the participant or COBRA participant. Further, the Employer shall afford a reasonable opportunity to any participant or COBRA participant, whose claim for benefits has been denied, for a full and fair review of the decision denying the claim by the person designated by the Employer for that purpose. Details of the claim procedure that are in compliance with ERISA regulations are given to Plan participants or COBRA participants in their booklets. Refer to “Appeals Procedures” in prior section of this document.

**RETROSPECTIVE REVIEW**
The Plan Administrator will have the right to allow benefit payments under the Plan on a previously denied claim when there are extenuating circumstances.

**CLAIM PAYMENTS MADE IN ERROR (OVERPAYMENTS)**
If payments in excess of the correct amount due are made, the Plan may recover all excess amounts paid. Recovery will be made by reducing or suspending future Plan payments on that covered person, or by requiring the covered person or his legal representative to pay back the overpayment in full, or in installments, until the overpayment is recovered.

**INCONTESTABILITY**
All statements made by the Employer or by the Employee covered under the Plan shall be deemed representations and not warranties. Such statements shall not void or reduce the benefits under the Plan or be used in defense to a claim unless they are contained in writing and signed by the Employer or by the covered person, as the case may be. A statement made shall not be used in any legal contest unless a copy of the instrument containing the statement is or has been furnished to the other party to such a contest.

**LEGAL PROCEEDINGS**
No legal action to recover any benefits under the Plan may be brought before 60 days after the required written proof of loss has been filed in accordance with the requirements of the Plan, nor shall such legal action be brought more than 2 years after written proof of loss is required by the Plan.

**TIME LIMITATION**
If any time limitation of the Plan with respect to giving notice of claim or furnishing proof of loss, or the bringing of an action at law or in equity, is less than that permitted by ERISA, such limitation is hereby extended to agree with the minimum period permitted by such law.

**WORKERS’ COMPENSATION not Affected**
The Plan is not in lieu of and does not affect any requirement for coverage by workers’ compensation insurance laws or similar legislation.

**CONFORMITY WITH LAW**
If any provision of the Plan is contrary to any law to which it is subject, such provision is hereby amended to conform thereto.

**NO IMPLIED WAIVER**
Failure by the Plan Administrator to avail itself of a right conferred in this SPD and the plan document shall in no event be construed as a waiver of its rights to enforce said right in the future.

**FORCE MAJEURE**
Should the performance of any act required by the Plan be prevented or delayed by reason of any act of God, 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 shall use reasonable efforts to perform their respective obligations under the Plan.

**MISCELLANEOUS**

Section titles are for conveniences of reference only, and are not to be considered in interpreting the Plan. Failure to enforce any provision of the Plan shall not affect the right thereafter to enforce such provision, nor shall such failure affect its right to enforce any other provision of the Plan.

**REASONABLE CASH VALUE**

If any other plan provides benefits in the form of services rather than cash payment, the reasonable cash value of services provided will be considered Allowable Expense. The reasonable cash value of such service will be considered a benefit paid and the plan’s liability reduced accordingly.

**PLAN IS NOT A CONTRACT OF EMPLOYMENT**

The Plan will not be deemed to constitute a contract of employment or to give any participant the right to be retained in the service of the Employer or to interfere with the right of the Employer to discharge or otherwise terminate the employment of any participant.

**MASCULINE GENDER**

The masculine gender, where it appears in this booklet, shall be deemed to include the feminine gender, not to be documentary, but to avoid “he/she” type wording, unless the context clearly indicates to the contrary.

**COORDINATION OF BENEFITS (COB)**

If a covered person is eligible for medical or prescription drug benefits under any other group or student Plan (including Health Maintenance Organizations or HMOs) or any property/casualty coverage (including individual automobile insurance coverage), the benefits of the Plan may be reduced so that not more than 100% of eligible expenses will be paid by all plans combined. When Employees and spouses are both covered under the Plan, benefits will be coordinated within the Plan (but not more than the full amount of a Covered Expense).

**ORDER OF BENEFIT DETERMINATION**

The Plan will coordinate benefits with the spouse’s employer’s coverage, whether or not the spouse elects that coverage, as if the spouse had elected such coverage from his/her employer. Any group health plan that does not contain a coordination of benefits provision will be considered primary.

When all plans covering you and/or your dependents contain a coordination of benefits provision, order of payment will be as follows:

1. The plan covering a person as an active employee will be primary over a plan covering the same person as a dependent, a retiree or a laid-off individual.
2. When a person is an active employee under more than one plan, the plan covering the individual for the longer period of time will be considered primary.
3. The plan covering a person as an employee or a dependent will be primary over the plan providing continuation coverage under COBRA.
4. A plan covering a person as a dependent child of non-divorced or non-separated parents will be primary according to which parent has the earlier birth date (month and day) in the year. If both parents have the same birth date, the plan covering the child for the longer period of time will be primary.
ORDER OF BENEFIT DETERMINATION FOR CHILDREN OF DIVORCED OR SEPARATED PARENTS

When all plans covering a person as a dependent child of divorced or separated parents contain a coordination of benefits provision, the order of payment will be:

1. The plan covering the dependent child of the natural parent designated by court order to be responsible for the child’s health care expenses will be considered primary.
2. In the absence of a court order specifying otherwise, the plan covering the dependent child of the natural parent having legal custody of the child will be considered primary.
3. In the absence of a court order specifying otherwise, the plan covering the dependent child of a stepparent who is the spouse of the natural parent having legal custody of the child will be considered primary.
4. If none of the above rules determine the order of benefits, the benefits of the plan that covered a person longer are determined before those of the plan that covered a person for the shorter term.
   a. To determine the length of time a person has been covered under a plan, 2 plans shall be treated as one if the claimant was eligible under the second within 24 hours after the first ended.
   b. The start of a new plan does not include: (1) a change in the amount or scope of a plan’s benefits; (2) a change in the entity which pays, provides or administers the plan’s benefits; and (3) a change from one type of plan to another (such as, from a single Employer plan to that of a multiple Employer plan).
   c. The person’s length of time covered under a plan is measured from the person’s first date of coverage under that plan. If that date is not readily available, the date the covered person first became a member of the group shall be used as the date from which to determine the length of time the covered person’s coverage under the present plan has been in force.

COORDINATION OF BENEFITS WITH MEDICARE

1. The Plan will pay its benefits before Medicare for:
   a. An active full-time Employee who is age 65 or older; and
   b. An active full-time Employee’s spouse who is age 65 or older.
   You have the option of rejecting the Plan thereby retaining Medicare as your primary coverage. If you choose Medicare as primary, you will have no coverage under the Plan. If you reject coverage under the Plan, that choice must be made in writing to the Employer.
2. The Plan will pay benefits only after Medicare has paid its benefits:
   a. For an individual covered under a retiree medical plan;
   b. For an individual receiving benefits through COBRA continuation;
   c. For employers with fewer than 20 employees for individuals receiving Medicare benefits as a result of being age 65 or older.
3. Federal law mandates, which Plan is primary in the case of certain persons who are totally disabled or have, end stage renal disease.
   a. Medicare must be secondary for 30 months for End Stage Renal Disease (ESRD) patients regardless of whether their coverage is under an active Employee or retiree medical plan. An individual who was entitled to Medicare (on the basis of age or disability) on a primary basis at the time he becomes eligible on the basis of ESRD may continue to receive Medicare benefits on a primary basis.
   b. Medicare will pay first for Employers with fewer than 100 Employees for individuals receiving Medicare benefits as a result of being disabled.
4. Medicare Private Contracts with a Health Care Practitioner:
   a. Under the law, you are entitled to enter into a Medicare private contract with certain health care practitioners under which you agree that no claim will be submitted to or paid by Medicare for health care services and/or supplies furnished by this health care practitioner.
   b. If you enter into such a contract, the Plan will not pay any benefits for any health care services and/or supplies you receive pursuant to the contract.

It is the intent of the Plan to comply with all existing Medicare regulations. If for some reason the information presented in the Plan differs from actual Medicare regulations, the Plan reserves the right to administer Medicare in accordance with such actual regulations.
**SPECIAL ELECTION FOR EMPLOYEES AND SPOUSES AGE 65 AND OVER**

If you remain actively employed after reaching age 65, you or your spouse may choose to remain covered under the Plan without reduction for Medicare benefits or designate Medicare as the primary payer of benefits.

If you choose to remain covered under the Plan, the Plan will be the primary payer of benefits and Medicare will be secondary. If you choose Medicare as primary, coverage under the Plan will end for both you and your dependent(s). If you do not specifically choose one of the options, the Plan will continue to be primary.

If you are under age 65 and your spouse is over age 65, he or she can make his or her own choice.

**COORDINATION OF BENEFITS WITH HEALTH MAINTENANCE ORGANIZATION (HMO)**

If an eligible dependent elects membership in a Health Maintenance Organization (HMO) as an Employee of another Employer, benefits under the Plan are limited to co-payment and/or deductibles not covered under the HMO and eligible expenses that are specifically excluded under the HMO. There will be no coverage under the Plan for any item not covered by the HMO because the dependent chose not to avail himself or herself to the HMO participating provider.

**COORDINATION OF BENEFITS WITH OTHER GOVERNMENT PROGRAMS**

The term group health plan includes, but is not limited to the government programs of Medicaid, CHAMPUS, and Indian Health Programs. The regulations governing these programs take precedence over the determination of the Plan. For example, in determining the benefits payable under the Plan, the Plan will not take into account the fact that you or any eligible dependent(s) are eligible for or receive benefits under a Medicaid plan.

**COORDINATION OF BENEFITS WITH NO-FAULT AUTOMOBILE INSURANCE**

Benefits of the Plan will be coordinated with the minimum no-fault automobile coverage required under State law. Whenever injury is sustained by a covered individual in an automobile accident, the automobile insurer is primarily responsible to provide benefits for medical expenses. The Plan’s benefits are coordinated with the complying automobile insurer for covered services. The Plan will pay up to the deductible under the covered individual's automobile insurance, if any, for covered medical expenses.

When the complying automobile insurer has provided its maximum benefits, the Plan shall become liable for covered medical expenses not payable by the complying automobile insurer. If more than one complying automobile insurer is responsible for providing benefits, the Plan shall become liable only after all complying automobile insurers have provided their maximum benefits.

To the extent coverage is required by State law, the Plan will not pay benefits for injuries received by the covered individual while he or she is riding in or operating a motor vehicle which he or she owns if it is not covered by an automobile “No-Fault” complying policy as required by law. However, the Plan will pay benefits as described in the Plan for injuries sustained by a non-owner operator, non-owner passenger or pedestrian in a motor vehicle accident if that individual is not covered by a complying policy. This Auto ("No-Fault") Act shall apply only where allowed under State law.

**PAYMENTS**

Whenever payments, which should have been made under the Plan in accordance with this COB provision, have been made under any other plan or plans, the Employer will have the right, exercisable alone and in its sole discretion, to pay to any insurance company or other organization or person making such other payments any amounts it will determine in order to satisfy the intent of this COB provision, and amounts so paid will be deemed to be benefits paid under the Plan and to the extent of such payments, the Employer will be fully discharged from liability under the Plan. The benefits that are payable will be charged against any applicable maximum payment or benefit of the Plan rather than the amount payable in the absence of this COB provision.
**RIGHTS OF RECOVERY**
Whenever payments have been made by the Employer, with respect to allowable expenses, in a total amount, at any time, in excess of the maximum amount of payment necessary at this time to satisfy the intent of this COB provision, the Employer shall have the right, exercisable alone and at its sole discretion, to recover such payments to the extent of such excess from among one or more of the following, as the Employer shall determine: any persons, companies or other organizations to, or for, or with respect to whom payments have been made.

**RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION**
For the purpose of determining the applicability of and implementing the terms of this COB provision of the Plan or any provision of similar purpose of any other plan, the Plan may, without the consent of or notice to any person, release to or obtain from any insurance company or other organization or person any information with respect to any person, which the Plan deems to be necessary for such purposes. Any person claiming benefits under the Plan shall furnish to the Plan such information as may be necessary to implement this provision.

**DEFINITIONS**

1. "Annual Out-of-Pocket" means the maximum amount of co-payments a Member is required to pay for certain Covered Services in a calendar year.
2. "Case Management" means collaborative process that assesses, plans, implements, coordinates, monitors and evaluates options to meet an individual's health care needs based on the health care benefits and available resources in order to promote a quality outcome for the individual Member.
3. "Chronic Condition" means a medical condition that is continuous or persistent over an extended period of time and requires ongoing treatment for its management.
4. "Completion of Covered Services" means covered services for the continuity of care condition under treatment by the terminated provider or non-participating provider will be considered complete, when:
   a. The Member's continuity of care condition under treatment is medically/clinically stable; and
   b. There are no clinical contraindications that would prevent a medically/clinically safe transfer to a participating provider.
5. "Continuity of Care Condition(s)" means the completion of covered services will be provided by:
   a. A terminated provider to a member who, at the time of the participating provider's contract termination, was receiving covered services from that participating provider; or
   b. A non-participating provider for newly enrolled Member who, at the time of his or her coverage became effective with the Plan, was receiving covered services from the non-participating provider, for one of the continuity of care conditions, as limited and described below:
      i. "Acute Condition" means a medical condition, including medical and mental health that involves a sudden onset of symptoms due to an illness, injury; or other medical problem that requires prompt medical attention and that has a limited duration. Completion of covered services will be provided for duration of the acute condition.
      ii. "Serious Chronic Condition" means a medical condition due to disease, illness, or other medical or mental health problem or medical or mental health disorder that is serious in nature, and that persists without full cure or worsens over an extended period of time, or requires ongoing treatment to maintain remission or prevent deterioration. Completion of covered services will be provided for the period of time necessary to complete the active course of treatment and to arrange for a clinically safe transfer to a participating provider. Completion of covered services for this condition will not exceed 12 months from the agreement's termination date or 12 months from the effective date of coverage for a newly enrolled Member. A pregnancy diagnosed and documented by (a) the terminated provider prior to termination of the agreement, or (b) by the non-participating provider prior to the newly enrolled Member's effective date of coverage with the Plan. Completion
of covered services will be provided for the duration of the pregnancy and the immediate postpartum period.

iii. "Terminal Illness" means an incurable or irreversible condition that has a high probability of causing death within 1 year or less. Completion of covered services will be provided for the duration of the terminal illness, not to exceed 12 months, provided that the prognosis of death was made by the: (a) terminated provider prior to the agreement termination date, or (b) non-participating provider prior to the newly enrolled Member's effective date of coverage with the Plan.

iv. "The Care of a Newborn" means services provided to a child between birth and age 36 months. Completion of covered services will not exceed 12 months from the: (a) provider agreement termination date, or (b) the newly enrolled Member's effective date of coverage with the Plan, or (c) extend beyond the child's 3rd birthday.

v. "Surgery or Other Procedure" means performance of a surgery or other procedure that has been authorized by previous carrier's documented course of treatment and has been recommended and documented by the: (a) terminating provider to occur within 180 calendar days of the agreement's termination date, or (b) non-participating provider to occur within 180 calendar days of the newly enrolled Member's effective date of coverage with the Plan.

6. "Co-Payment" means the fee that a Member is obligated to pay, if any, at the time he or she receives a covered service. Co-payments may be a specific dollar amount or a percentage of the cost of the covered services. Co-payments are fees paid by the Member in addition to the premium paid by the Employer and any payroll contributions required from the Member.

7. "Covered Services" or "Medically Necessary Services" means services or supplies provided under the terms of the plan document, the Schedule of Benefits and supplemental benefit materials.

8. "Custodial Care" means the care and services that assist an individual in the activities of daily living. Examples include: assistance in walking; getting in or out of bed; bathing; dressing; feeding; and using the toilet; preparation of special diets; and supervision of medication that usually can be self-administered. Custodial Care includes all homemaker services, respite care, convalescent care or extended care not requiring skilled nursing. Custodial Care does not require the continuing attention of trained medical or paramedical personnel.

9. "Dependent" means a member of a Subscriber's family who is enrolled with the Plan after meeting all of the eligibility requirements of the Plan and for whom applicable Health Plan Premiums have been received by the Plan.

10. "Emergency Medical Condition" means a medical condition manifesting itself by acute symptoms of sufficient severity, (including severe pain, such that the absence of immediate medical attention could reasonably be expected by a prudent layperson (member) to result in any of the following; placing the Member's health in serious jeopardy; serious impairment to bodily functions; serious dysfunction of any bodily organ or part; active labor, meaning labor at a time that either of the following would occur:
   a. There is inadequate time to effect safe transfer to another hospital prior to delivery or
   b. A transfer poses a threat to the health and safety of the Member or unborn child.

11. "Emergency Services Medical Screening" means examination and evaluation by a Physician or other personnel - to the extent provided by law to determine if an Emergency Medical Condition or psychiatric Emergency Medical Condition exists. If this condition exists, Emergency Services include the care, treatment and/or surgery by a Physician necessary to relieve or eliminate the Emergency Medical Condition or psychiatric Emergency Medical Condition within the capabilities of the Facility. (For a detailed explanation of Emergency Services, see “Emergency and Urgently Needed Services” provision.

12. "Experimental or Investigational " means the same as the definition of that term under the "Exclusions and Limitations of Benefits" section of the plan document.

13. "Family Member" means the Subscriber's Spouse, domestic partner, and any person related to the Subscriber or Spouse by blood, marriage, adoption or guardianship. An enrolled Family Member is a Family Member who meets all the eligibility requirements of the Plan and is enrolled with the Plan. An eligible Family Member is a Family Member who meets all the eligibility requirements of the Plan.
14. "Grievance" or "Complaint" means a written or oral expression of dissatisfaction regarding the plan and/or Provider, including quality of care concerns, and shall include a Complaint, dispute, request for "reconsideration or appeal made by a Member or the Member's representative.

15. "Health Plan" means your group benefit program as described in this Document, Schedule of Benefits and supplemental benefit materials.

16. "Hospice" means the specialized team of interdisciplinary healthcare for a Member with a life expectancy of a year or less due to a Terminal Illness. Hospice programs or services are designed to provide palliative care; alleviate the physical, emotional, social and spiritual discomforts of a Member who is experiencing the last phase of life due to the existence of a terminal disease; and provide supportive care to the primary caregiver and family of the Member receiving Hospice services.

17. "Infertility" means either: (a) the inability to conceive a pregnancy or to carry a pregnancy to a live birth after a year or more of regular sexual relations without contraception; or (b) the presence of a demonstrated condition recognized by a licensed Physician who is a participating provider as a cause of Infertility.

18. "Late Enrollee" means an Employee who declined enrollment in the Plan when offered and who subsequently requests enrollment outside the designated Open Enrollment Period.

19. "Limiting Age" means the age established by the employer group when a Dependent is no longer eligible to be an enrolled Family Member under the Subscriber's coverage.

20. "Medically Necessary" or "Medical Necessity" means an intervention, if, as recommended by the treating Physician and determined by the Chief Medical Officer of Sutter Health Partners is all of the following:
   a. A health intervention for the purpose of treating a medical condition;
   b. The most appropriate supply or level of service, considering potential benefits and harms to the Member;
   c. Known to be effective in improving health outcomes. For existing interventions, effectiveness is determined first by scientific evidence, then by professional standards, then by expert opinion. For new interventions, effectiveness is determined by scientific evidence; and
   d. If more than one health intervention meets the requirements of (a) through (c) above, furnished in the most cost-effective manner that may be provided safely and effectively to the Member. "Cost-effective" does not necessarily mean lowest price. A service or item will be covered under the Plan if it is an intervention that is an otherwise covered category of service or item, not specifically excluded, and Medically Necessary; An intervention may be medically indicated yet not be a covered benefit or meet the definition of Medical Necessity. In applying the above definition of Medical Necessity, the following terms shall have the following meanings:
      i. "Treating Physician" means a Physician who has personally evaluated the patient.
      ii. "Health intervention" is an item or service delivered or undertaken primarily to treat (that is, prevent, diagnose, detect, treat or palliate) a medical condition or to maintain or restore functional ability. A medical condition is a disease, illness, injury; genetic or congenital defect, pregnancy or a biological or psychological condition that lies outside the range of normal, age-appropriate human variation. A health intervention is defined not only by the intervention itself, but also by the medical condition and the patient indications for which it is being applied.
      iii. "Effective" means that the intervention can reasonably be expected to produce the intended results and to have expected benefits that outweigh potential harmful effects.
      iv. "Health Outcomes" means outcomes that affect health status as measured by the length or quality (primarily as perceived by the patient) of a person's life.
      v. "Scientific Evidence" means, primarily, controlled clinical trials that either directly or indirectly demonstrate the effect of the intervention on health outcomes. If controlled clinical trials are not available, observational studies that suggest a causal relationship between the intervention and health outcomes can be used. Partially controlled observational studies and uncontrolled clinical series may be suggestive but do not by themselves demonstrate a causal relationship unless the magnitude of the effect observed exceeds anything that could be explained either by the natural history of the medical condition or potential Experimental biases. For existing interventions, the
scientific evidence should be considered first and, to the greatest extent possible, should be the basis for determinations of medical necessity. If no scientific evidence is available, professional standards of care should be considered. If professional standards of care do not exist, or are outdated or contradictory, decisions about existing interventions should be based on expert opinion. Giving priority to scientific evidence does not mean that coverage of existing interventions should be denied in the absence of conclusive scientific evidence. Existing interventions can meet the definition of medical necessity in the absence of scientific evidence if there is a strong conviction of effectiveness and benefit expressed through up-to-date and consistent professional standards of care or, in the absence of such standards, convincing expert opinion.

vi. "New Intervention" means a new invention that is not yet in widespread use for the medical condition and patient indications being considered. New interventions for which clinical trials have not been conducted because of epidemiological reasons (i.e., rare or new diseases or orphan populations) shall be evaluated on the basis of professional standards of care. If professional standards of care do not exist, or are outdated or contradictory, decisions about such new interventions should be based on convincing expert opinion. An intervention is considered cost-effective if the benefits and harms relative to costs represent an economically efficient use of resources for patient with this condition. In the application of this criterion to an individual case, the characteristics of the individual patient shall be determinative.

21. "Medicare" means the Hospital Insurance Plan (Part A) and the supplementary Medical Insurance Plan (Part B) provided under Title XVIII of the Social Security Act, as amended.
22. "Medicare Eligible" means those Members who meet eligibility requirements under Title XVIII of the Social Security Act, as amended.
23. "Member" means the Subscriber or any Dependent who is eligible, enrolled and covered by the Plan.
24. "National Preferred Transplant Network" means a network of transplant facilities that are:
   a. Licensed in the In State of California;
   b. Certified by Medicare as a transplant facility for a specific organ transplant;
   c. Designated by the Plan as a transplant facility for a specific organ program;
   d. Able to meet the reasonable access standards for organ transplantation based on the Regional Organ Procurement Agency statistics within the transplant Facility's geographic location. A Regional Organ Procurement Agency is a geographic area designated by a State-licensed organ procurement organization for transplants in the State of California.
25. "Non-Participating Provider" means a hospital or other health care entity, a physician or other health care professional, or a health care vendor that has not entered into a written agreement to provide Covered Services to the Plan's Members.
26. "Nonphysician Health Care Practitioners" - includes but is not limited to: psychologists, acupuncturists, optometrists, podiatrists, chiropractors, licensed clinical social workers, marriage and family therapists and nurse midwives.
27. "Open Enrollment Period" means the time period determined by the Plan when all eligible Employees and their eligible family members may enroll in the Plan.
28. "Participating Hospital" means any general acute care hospital licensed by the State of California that has entered into a written agreement with the Plan to provide Hospital Services to the Plan's Members.
29. "Participating Provider" means a hospital or other health care entity, a physician or other health care professional, or a health care vendor who has entered into a written agreement with the network of providers from whom the Member is entitled to receive Covered Services.
30. "Physician" means any licensed allopathic or osteopathic physician.
31. "Prevailing Rates" means the usual, customary and reasonable rates for a particular health care service in the service area, as determined by the Plan.
32. "Primary Residence" means the home or address where the Member actually lives most of the time. A residence will no longer be considered a Primary Residence if: (a) the Member moves without intent to return; (b) the Member is absent from the residence for 90 consecutive days, or (c) the Member is absent from the residence for more than 100 days in any six-month period.
33. “Primary Workplace” means the facility or location where the Member works most of the time and to which the Member regularly commutes. If the Member does not regularly commute to one location, then the Member does not have a Primary Workplace.

34. "Provider" means a person, group, facility or other entity that is licensed or otherwise qualified to deliver any of the health care services described in this Combined Evidence of Coverage and Disclosure Form and supplemental benefit materials.

35. "Prudent Layperson" means a person without medical training whom reasonably draws on practical experience when making a decision regarding whether Emergency Services are needed.

36. "Rehabilitation Services" means the combined and coordinated use of medical, social, educational and vocational measures for training or retraining individuals disabled by disease or injury.

37. "Schedule of Benefits" means an important part of your Combined Evidence of Coverage and Disclosure Form that provides benefit information specific to your Health Plan, including Co-payment information.

38. "Serious Emotional Disturbances of a Child" means a Serious Emotional Disturbance (SED) of a Child is defined as a child who:
   a. Has one or more mental disorders as defined by the Diagnostic and Statistical Manual (DSM-IV), other than a primary substance use disorder or developmental disorder, that results in behavior inappropriate to the child's age according to expected developmental norms;
   b. Is under the age of 18 years old; and
   c. Meets one or more of the following criteria:
      i. The child is at risk of removal from home or has already been removed from the home;
      ii. The mental disorder and impairments have been present for more than six months or are likely to continue for more than one year without treatment; or
      iii. The child displays one of the following: psychotic features, risk of suicide or risk or violence due to a mental disorder; or
      iv. The child meets special education eligibility requirement under Chapter 26.5 commencing with section 7570 of Division 7 of Title 1 of the California Government Code.

39. "Severe Mental Illness" (SMI) - includes the diagnosis and medically necessary treatment of the following conditions: anorexia nervosa; bipolar disorder; bulimia nervosa; Major depressive disorder; obsessive-compulsive disorder; panic disorder; pervasive developmental disorder or autism; schizoaffective disorder; schizophrenia.

40. "Skilled Nursing Care" means the care provided directly by or under the direct supervision of licensed nursing personnel, including the supportive care of a home health aide.

41. "Skilled Nursing Facility" means a comprehensive free-standing rehabilitation facility or a specially designed unit within a hospital licensed by the State of California to provide skilled nursing care.

42. "Skilled Rehabilitation Care" means the care provided directly by or under the direct supervision of licensed nursing personnel or a licensed physical, occupational or speech therapist.

43. "Spouse" means the Subscriber's husband or wife who is legally recognized as a husband or wife under the laws of the State of California.

44. "Subacute and Transitional Care" means levels of care needed by a Member who does not require hospital acute care but who requires more intensive licensed skill nursing care than is provided to the majority of the patients in a skilled nursing facility.

45. "Subscriber" means the individual enrolled in the Plan for whom the appropriate Plan premiums have been received by the Plan and whose employment or other status, except for family dependency; is the basis for enrollment eligibility.

46. "Totally Disabled" or "Total Disability" means, for subscribers, the persistent inability to reliably engage in any substantially gainful activity by reason of any medically determinable physical or mental impairment resulting from an injury or illness. For Dependents, "Totally Disabled" means the persistent inability to perform activities essential to the daily living of a person of the same age and sex by reason of any medically determinable physical or mental impairment resulting from an
injury or illness. Determination of total disability will be made by a physician on the basis of a medical examination of the Member.

47. "Transitional Care" means the same as "Subacute Care."

STATEMENT OF ERISA RIGHTS

YOUR RIGHTS
As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all participants are entitled to:

1. Examine, without charge, at the Plan Administrator’s office and at other specified locations, such as work sites, all documents governing the Plan, including insurance contracts, and a copy of the latest summary annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor.

2. Obtain upon written request to the Plan Administrator copies of documents governing the operation of the Plan, including insurance contracts and copies of the latest summary annual report (Form 5500 Series) and an updated SPD. The Plan Administrator may make a reasonable charge for the copies.

3. Receive a summary of the Plan’s annual financial report, if any. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

4. COBRA Rights.
   Continue coverage for yourself, spouse, domestic partner, or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You and/or your dependents may have to pay for such coverage. Review this SPD and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

5. HIPAA Rights.
   Reduction or elimination of exclusionary periods of coverage for pre-existing conditions under your group plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group plan or insurance issuer when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request one before losing coverage, or if you request one up to 24 months after losing coverage.

FIDUCIARY OBLIGATIONS
In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the Plan. These people, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. Fiduciaries who violate ERISA may be removed and required to make good any losses they have caused the Plan.

NO DISCRIMINATION
No one, including the Employer or any other person, may fire you or discriminate against you in any way to prevent you from obtaining welfare benefits or exercising your rights under ERISA.

RIGHTS TO REVIEW
If your claim for a welfare benefit is denied in whole or in part you will receive a written explanation of the reason(s) for the denial. You have a right to have the Plan review and reconsider your claim.

FILING SUIT
Under ERISA, there are steps you can take to enforce these rights. For instance, if you request materials from the Plan Administrator and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a State or federal court. However, see the subsection in this section “Appeals Procedures” that must be followed before you file suit. In addition, if you disagree with the Plan’s decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in federal
court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

QUESTIONS

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

ERISA INFORMATION

- **Plan Name And Number:** Marin General Hospital Employee Group Health Plan; Plan Number 526
- **Employer Whose Employees Are Covered By The Plan:** Marin General Hospital
  250 Bon Air Road
  Greenbrae, CA 94904
- **Employer Identification Number:** 94-2823538
- **Type of Plan:** The Plan is an employee welfare benefit plan providing medical benefits on a self-insured basis.
- **Contributions To The Plan:** Marin General Hospital contributes to the cost of the Plan and may require contributions from participants.
- **Method Of Funding Benefits:** Plan contributions are made by the Employer and, if designated by the Employer, participating employees. All benefits under the Plan are paid from the Employer's general assets. Any required employee contributions are used to partially reimburse the Employer for benefits or contributions under the Plan. Employee required contributions are the employee's share of costs as determined by the Employer. From time to time, the Employer will determine the required employee contributions and will notify employees in writing. The total level of funding will be determined by the reinsurance aggregate stop-loss policy taking into consideration the number of employees covered each month. Contribution rates will also be determined in this manner. Payments out of the Plan to providers on behalf of the covered person will be based on the provisions of the Plan.
- **Loss Of Benefits:** An employee or his or her dependent may lose benefits that the employee, or his or her dependent, might otherwise have received under the Plan if:
  1. The employee fails to meet the eligibility requirements at any time;
  2. The employee ceases to be an eligible employee after commencing participation in the Plan;
  3. The employee or his or her dependent fails to submit a written claim for benefits in a timely manner as required by the Plan;
  4. The employee or his or her dependent fails to follow any third party provider's procedures for obtaining benefits;
  5. The employee's or his or her dependent's claims are for expenses not covered under the Plan;
  6. The employee's or his or her dependent's claims that are incurred during a plan year exceed the limitations in effect for the benefit for the plan year;
  7. The employee's or his or her dependent's claims are for benefits that are subject to a preexisting condition exclusion that is permitted by HIPAA (or the claimant has failed to...
provide a certificate of prior health coverage that demonstrates the satisfaction of the maximum preexisting condition limitation period);

8. The employee goes on a leave of absence that includes a period of time during which no benefits are paid by the Employer, and the employee, or his or her dependent, does not elect continuation coverage if applicable; or

9. The employee terminates employment, and the employee, or his or her dependent, does not elect continuation coverage if applicable.

• **Type Of Administration:**
  The Plan Administrator has appointed one or more Third Party Administrators (TPAs) to handle the day-to-day operation of the Plan. A TPA does not serve as an insurer, but just as a claims processor/administrator. A TPA processes claims, then requests and receives funds from the Plan Administrator to pay the claims, and makes payment on the claims to hospitals and other providers. Remember that the Employer is ultimately responsible for providing Plan benefits, not any TPA or any reinsurance carrier. The TPAs and other third parties who are providing services to the Plan are:

• **Enrollment/Eligibility Management:**
  BRMS
  PO Box 2650
  Rancho Cordova, CA 95741
  Telephone: 888-326-2555

• **Benefit Manager:**
  Prescription Solutions
  3515 Harbor Blvd.
  Costa Mesa, CA 92626
  Telephone: 800-797-9791
  [www.rxsolutions.com](http://www.rxsolutions.com)

• **Program Manager:**
  Sutter Health Partners
  4000 Civic Center Drive, Suite 110
  San Rafael, CA 94903
  Telephone: 866-307-6600
  [www.sutterhealthpartners.com](http://www.sutterhealthpartners.com)

• **Plan Administrator:**
  Marin General Hospital is the Plan Administrator. The Plan Administrator is responsible for the overall operation of the Plan. The Plan Administrator has the right to make rules and decisions concerning the operation of the Plan and the eligibility for benefits. In particular, the Plan Administrator has full and sole discretionary authority to interpret all plan documents and make all interpretive and factual determinations as to whether any individual is entitled to receive any benefit under the terms of this Plan. Any construction of terms of any plan documents and any determination of fact adopted by the Plan Administrator shall be final and legally binding on all parties. Any interpretation, determination or other action of the Plan Administrator shall be subject to review only if it is arbitrary or capricious or otherwise an abuse of discretion. Any review of a final decision or action of the Plan Administrator shall be based only on such evidence presented to or considered by the Plan Administrator at the time it made the decision that is the subject of review. Accepting any benefits or making any claim for benefits under this Plan constitutes agreement with and consent to any decisions that the Plan Administrator makes, in its sole discretion, and, further, constitutes agreement to the limited standard and scope of review described by this provision.

• **Agent For Service Of Legal Process:**
  Administrative Director - Human Resource Services
  Marin General Hospital
  250 Bon Air Road
  Greenbrae, CA 94904
• **Plan Year:**  
  Each plan year begins January 1 and ends on the following December 31. Financial records of the Plan are kept on a plan year basis.

• **Effective Date:**  
  The Plan was effective January 1, 2002. It was most recently amended effective as of January 1, 2006.