GOLD COAST JOINT BENEFITS TRUST

Indemnity Medical PPO Plan 4

Plan Description Booklet

Restated: July 1, 2018

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Dear Plan Participant:

The Board of Directors of the Gold Coast Joint Benefits Trust is pleased to present you with this Plan Description Booklet describing the Trust's Indemnity Medical PPO Plan 4 (the "Plan") as of July 1, 2018. This booklet replaces all previous benefit booklets and amendments/inserts.

This Plan Description Booklet describes the Trust's Indemnity Medical PPO Plan 4, which includes medical, prescription drug, mental-health, substance abuse and chiropractic benefits. The Trust also provides indemnity dental and vision benefits, which are described in separate benefit booklets, and can be requested from the Trust Administrator or school district employer.

The Trust also offers medical coverage through a health maintenance organization (HMO). The HMO medical plan is described in a separate booklet available to participants by Kaiser Permanente or your school district employer.

This Plan Description Booklet also includes applicable benefit and dependent eligibility provisions required under Health Care Reform, as signed into Federal law on March 23, 2010, under the Patient Protection and Affordable Care Act (PPACA), and as amended by the Health Care and Education Affordability Reconciliation Act of 2010 (Reconciliation Act) on March 30, 2010. These Acts required benefit modifications and eligibility changes for group health care plans such as the Gold Coast Joint Benefits Trust. These changes have been included in this restated Plan Description Booklet.

Note: This Plan is not considered a "grandfathered" plan, as defined under the PPACA, and is therefore subject to all rules and regulations of the Act. It is the Plan's intent to comply with the PPACA rules and regulations and the Plan will administer any changes in the Act in good faith, with guidance from its professional benefit consultants and legal counsel.

Please take time to read this booklet and become familiar with the Plan's benefits, its rules of eligibility, and the use of its programs. You will periodically receive updates to this booklet advising you of changes in benefit and eligibility rules. Please keep the updates with this booklet.

In order to receive the full benefits provided by the Plan, you must comply with *all* Plan provisions. If you do not, you may become responsible for some or all of the charges incurred.

Questions as to eligibility, benefits and other matters should be submitted in writing to the Trust Administrator at:

Delta Health Systems (DHS)
3244 Brookside Rd
P.O. Box 80
Stockton, CA 95201

Toll Free Customer Service:
1 (800) 556-5918

The office of the Trust Administrator is open from 7:30 a.m. to 5:00 p.m., Monday through Friday.

BOARD OF DIRECTORS

PLAN AMENDMENTS AND INTERPRETATION

The Plan Description Booklet is used to explain certain medical, prescription drug, mental health, substance abuse and chiropractic benefits for Eligible Members and their Eligible Dependents. This document should be considered a "living document"; that is, it will be periodically updated to include clarifications and modifications approved by the Board of Directors. The Board of Directors may amend the Plan as described in this booklet in writing. Only the Board of Directors is authorized to interpret the Plan described in this booklet. The Board has broad discretion to interpret the Plan, and its interpretation of the Plan described in this booklet is final and binding on all parties. All rights to benefits shall be determined in accordance with this Plan as interpreted by the Board of Directors. The Board of Directors also has the right, upon sixty days advanced written notice to the districts and the unions, to modify the benefits described herein, if the contributions to the Trust and the reserves of the Trust are insufficient to maintain the Plan as described herein.

AUTHORIZED SOURCES OF INFORMATION

If you have any questions about your benefits, you may only rely upon this booklet, any supplements or amendments, if any, the Trust Agreement, and the written statements of the Trust Administrator and his or her authorized agents. Oral statements or written representations made by individuals other than authorized personnel are not authoritative sources of information. School districts, employee organizations, or any representative of any school district or employee organization, are not authorized to interpret the Plan on behalf of the Board of Directors, nor can such person act as an agent of the Board of Directors.

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OVERVIEW OF THE HEALTH AND WELFARE PLAN

Benefits	▪ Medical ▪ Prescription Drug ▪ Mental Health ▪ Substance Abuse ▪ Employee Assistance Program ▪ Chiropractic
Effective Date	July 1, 1990
Restatement Date	July 1, 2018
Calendar Year (Benefit Year)	January 1 through December 31
Plan Year (Fiscal Year)	July 1 through June 30
Participation	Employees and Retirees of school districts participating in the Gold Coast Joint Benefits Trust.
Self-Funding	This Plan is established on a self-funded basis with Gold Coast Joint Benefits Trust assuming liability for payment of fees and claims. Your employer pays the cost of the plan as determined by the Trust. The participating school district and applicable Collective Bargaining Agreements determine the benefit plans for which you are eligible. Delta Health Systems administers the processing and payment of claims.
Benefit Booklet	This booklet has been prepared to furnish you with a description of your benefits provided through this Plan. We suggest that you review this booklet carefully so you will be familiar with the benefits available to you and your family.
Medical Claim Submission	Medical claims should be sent to: Anthem Blue Cross P.O. Box 60007 Los Angeles, CA 90060-0007 Note: For claims for services rendered by out-of-state providers, please refer to your ID card for claims submission address. If you have any questions regarding the status of a claim, your coverage or the benefits described in this booklet, please contact: Delta Health Systems 3244 Brookside Rd P.O. Box 80 Stockton, CA 95201-3080 1 (800) 556-5918 To be eligible for reimbursement, completed claim forms and itemized billings should be submitted: ▪ as soon as is reasonably possible, or ▪ except in the absence of legal capacity of the claimant, not later than one year after the services were rendered.

	You will be responsible for expenses not filed within these timeframes. In addition, certain medical expenses require Pre-Authorization. See the section entitled, "Hospital Utilization review and *Pre-Authorization (Pre-Certification)* for more details or contact the Trust Administrator directly (see *Important Numbers and Web Site Addresses*).
Dental Claim Submission	*If you are enrolled in the Delta Dental Plan:* Please refer to the combined Evidence of Coverage/Disclosure form for eligibility provisions and a description of your dental benefits. Delta Dental Plan of California P.O. Box 997330 Sacramento, CA 95899-7330 If you have questions about your dental benefits or need assistance, call Delta Dental at 1 (866) 499-3001. Claims should be submitted within 12 months of the date of service.
Vision Claim Submission	*If you are enrolled in the Vision Service Plan (VSP):* Please refer to the combined Evidence of Coverage/Disclosure form for eligibility provisions and a description of your vision benefits. If you use a VSP provider, you do not have to file a claim. If you use a non-VSP provider, submit your claim to: Vision Service Plan P.O. Box 997105 Sacramento, CA 95899-7105 1 (800) 877-7195 If you have questions about your dental benefits or need assistance, call VSP at 1 (800) 877-7195. Claims for non-VSP providers should be filed within 180 days of the date of service.

CHOICE OF PLANS

Once you become eligible, you may choose to be covered under either: (1) the Indemnity Medical PPO Plan 4 described in this booklet; or (2) one of the prepaid medical plans offered by a Health Maintenance Organization ("HMO"), that is also provided through the Gold Coast Joint Benefits Trust. Your eligible dependents must be covered under the same medical plan that you choose for yourself.

The HMO plan currently provided under the Gold Coast Joint Benefits Trust is Kaiser. The Trust Administrator and your school district employer will provide you with separate booklets that describe the HMO plans. Your eligible dependents must be covered by the same plan you choose for yourself.

If you and your spouse are both Employees, both of you may choose to be covered by the same medical plan, or you may each choose between the Trust prepaid HMO plan or the indemnity Plan available through your district. You, your spouse and your dependent children will be covered in accordance with the Trust's Coordination of Benefits rules. If you and your spouse choose separate plans, each of you must use the respective plan in which you have enrolled and may not use the other plan as a dependent, unless you each have first exhausted your benefits under your primary plan.

When you enroll, you will select your medical plan. You will be notified of your eligibility date by your school district. You will also be furnished with enrollment forms and asked to complete the enrollment forms for the plan which you have chosen. It is very important that you complete and return the forms as soon as possible. If you do not return the forms, your claims will be denied. If you do not complete the forms on time, or if you do not correctly fill in all of the required information, it may cause services and reimbursements to be delayed or denied. If you need help in completing the forms, the Trust Administrator will be pleased to help you. You can reach the Trust Administrator Monday through Friday, 8:00 a.m. to 5:00 p.m., at 1 (800) 556-5918.

If you decline enrollment when first eligible (or enroll but subsequently drop coverage), you and your eligible dependents can enroll during an annual open enrollment period (or earlier if you become eligible for special enrollment). More information can be found under the "Special Eligibility Rules" section of this booklet.

By participating in this Plan, you are agreeing to have any dispute with the GOLD COAST JOINT BENEFITS TRUST and its agents and their employees regarding any claims for benefits decided by neutral arbitration, giving up your right to a jury or court trial, and agreeing to a reduced period of limitations in which to initiate your claim.

If you are eligible for benefits under the self-pay provisions of this Plan, and you elect not to continue coverage, or you cease to make the required payments to the Plan, you cannot re-elect to participate in any medical, dental or vision plan unless a change in your employment status occurs which re-qualifies you as an eligible Employee.

YOUR BENEFITS AT-A-GLANCE

Important Definitions you should know to help you to understand your costs for medical services described on the following pages:

- Deductible (shown as a dollar amount): Refers to the amount you pay toward the cost of covered services prior to payment being made by the Plan.

- Copay (shown as a dollar amount): Refers to the fixed amount you pay, at the time covered care or services are received.

- Coinsurance (shown as a percentage): Refers to the percentage amount you pay after covered care or services are received *and* the claim has been processed.

- Contract/PPO Providers: Physicians or facilities that allow you to receive medical care and services at lower, negotiated rates. Your out-of-pocket expenses will be substantially lower if you use contract providers. *Note:* Contract Providers are also referred to herein as PPO Providers.

- Non-Contract/Non-PPO Providers: Any other providers that are not under a contract to provide lower negotiated rates. Benefits for non-contract/non-PPO providers will be paid based on the Usual, Customary and Reasonable (UCR) rate. A charge is considered usual, customary and reasonable if it falls within the range of fees usually charged by health care providers for the same service or supply in the same (or comparable) geographic area. Charges above UCR will not be paid; your out-of-pocket expenses will be higher if you use non-contract providers. Non-Contract Providers are also referred to herein as Non-PPO Providers.

- Benefits will be paid at the PPO percentage (based on usual, customary and reasonable allowances) for non-PPO providers only in the following situations:
  - For emergencies requiring immediate care;
  - When there is no opportunity to choose providers such as ambulance, emergency room physicians, anesthesiologists and hospital based pathologists;
  - If there is not a PPO provider within a thirty (30) mile radius of your residence or work; or
  - If medically necessary specialized services are only available by a non-PPO hospital (Pre-Authorization must be obtained).

For your convenience, a brief summary of your benefits is provided on the following few pages; more detailed information about covered and non-covered benefits can be found under the sections designated *Medical Benefit and Prescription Benefit.*

YOUR MAXIMUM COST WHEN USING PPO PROVIDERS

Indemnity Medical PPO Plan 4	Benefit
Annual Deductible (Calendar Year)	$400 per individual, per Calendar Year $1,200 per family, per Calendar Year The Calendar Year Deductible is waived for Covered Expenses incurred under the; Chiropractic and Prescription Drug Programs.
Medical Benefits Out-of-Pocket Maximum	$2,000 for an individual, per Calendar Year $4,000 for a family, per Calendar Year You and each of your dependents covered by the Plan are considered to be a "Covered Person". The maximum a Covered Person will pay out-of-pocket in any calendar year for medical benefits is $2,000 for an individual, and $4,000 for a family. Once an individual reaches $2,000 in out of pocket expenses, the plan will pay 100% of that person's covered medical expense (for PPO Providers Only) for the remainder of the calendar year. If the family maximum out-of-pocket maximum of $4,000 is met, the plan will pay 100% of the family's covered medical expenses (PPO Providers only) for the remainder of the calendar year. The participant's share of the cost for non-PPO providers, co-pays, charges in excess of plan maximums, prescription, vision or dental benefits do not apply toward the maximum out-of-pocket limit.
Prescription Benefits Out-of-Pocket Maximum	$4,600 for an individual, per Calendar Year $9,200 for a family, per Calendar Year Once an individual reaches $4,600 or a family reaches $9,200 in Calendar Year maximum Out-of-Pocket expenses, the Plan will pay 100% of Covered Charges for the remainder of the year. Only prescription drug copays paid in compliance with the Trust's prescription drug plan accumulate toward the out of pocket maximum. Participants' expenses for drugs that are excluded from the plan, prescriptions filled at non-network pharmacies or due to non-compliance with the prior authorization process, failure to participate in the mandatory mail-order, step therapy, drug quantity limitation, or any other utilization management programs established under the prescription benefits plan do not apply to the Prescription Out-of-Pocket Maximum.

The Medical and Prescription Out-of-Pocket maximums will not exceed the amounts established by the Department of Health and Human Services; these maximums are indexed by law and will be subject to change in subsequent years.

MEDICAL BENEFITS SUMMARY

Indemnity Medical PPO Plan 4	Benefit		Limitations When Applicable
	PPO Providers	Non-PPO Providers*	
Hospital Benefits			
▪ Hospitals	Plan pays 90%	Plan pays 50%	
▪ Emergency Room	Plan pays 90%	Plan pays 90%	Non-PPO provider payments are based on usual and customary rates (UCR). Amounts billed by Non-PPO providers above the UCR allowance are the responsibility of the patient.
▪ Mental Health and Substance Abuse	Plan pays 90%	Plan pays 50%	
▪ Skilled Nursing Facility	Plan pays 90%	Plan pays 50%	Maximum of 90 days/calendar year. Confinement must begin within 14 days of hospital stay consisting of 3 or more days.
Medical Benefits*			
▪ Preventive Benefits: Well Woman Care, Well Child Care, Immunizations, Routine Physical Exam, Health Screenings	** Plan pays 100%	Not Covered	
▪ Primary Care Doctor or ▪ Specialist Office Visits	Plan pays 90%	Plan pays 50%	Does not include Chiropractic or EAP services
▪ Allergy Testing	Plan pays 90%	Plan pays 50%	
▪ Ambulance	Plan pays 90%	Plan pays 90%	Non-PPO provider payments are based on usual and customary rates (UCR). Amounts billed by Non-PPO providers above the UCR allowance are the responsibility of the patient.
▪ Chiropractic	Plan pays 100% after $20 Copay	Not covered	Maximum of 30 visits/calendar year
▪ Durable Medical Equipment	90%	80%	
▪ Emergency Services : Physician, Lab/X-ray	Plan pays 90%	Plan pays 90%	Non-PPO provider payments are based on usual and customary rates (UCR). Amounts billed by Non-PPO providers above the UCR allowance are the responsibility of the patient.
• Home Health Care	Plan pays 90%	80%	Maximum of 60 visits per calendar year
• Hospice Care	Plan pays 100%	Plan pays 90%	The plan will pay Hospice Care benefits for home or inpatient care for up to six months. Following six

			months, medical necessity must be re-certified no less frequently than every 30 days. Lifetime Maximum of 12 months
▪ Nutritional Counseling for diabetes 15 visits/lifetime	Plan pays 90%	Plan pays 50%	
▪ Outpatient Mental Health and Substance Abuse	Plan pays 90%	Plan pays 50%	
▪ Organ Transplant	Plan pays 90%	Plan pays 50%	
▪ Surgeon and Related Services	Plan pays 90%	Plan pays 50%	
▪ X-rays / Lab	Plan pays 90%	Plan pays 50%	

** Non-PPO provider allowances are based on Usual, Customary and Reasonable (UCR); amounts that exceed UCR will not be considered for payment..*

*** Preventive services NOT subject to the deductible*

WHEN YOU MUST NOTIFY THE HOSPITAL UTILIZATION REVIEW PROGRAM

The following chart outlines when you must obtain Pre-Authorization (Pre-Certification) from the Hospital Utilization Review Program, administered by Anthem Blue Cross.

Care or Services	Timeframe
All Non-Emergency Inpatient Hospitalizations Note: Applies to any medical or surgical admission, including mental health and substance abuse admissions.	Prior to being admitted to the hospital
Most Outpatient Facility Services and Procedures Including mental health/substance abuse services	Prior to medical or surgical procedures
All Inpatient Emergency Admissions	Within 48 hours of the admission
Durable Medical Equipment (over $2,000)	Prior to ordering the equipment
Home Health Care	Prior to receiving care
Hospice Care (Inpatient)	Prior to being admitted to the hospice facility
Skilled Nursing Facility	Prior to being admitted to the skilled nursing facility

Benefits will be paid at 80% of usual plan benefits on any claim when Pre-Authorization has not been obtained within these time frames. See *Important Numbers and Website Addresses* for contact information.

Important: Although there are no prior notification requirements for benefits other than listed above, Delta Health Systems reserves the right to review all claims for their necessity of treatment and services. Delta Health Systems may use the services of a consultant to determine medical necessity and coverage under the plans.

PRESCRIPTION BENEFITS SUMMARY

Prescription Drug Plan	Benefits	
Must be obtained at In-Network Pharmacies. Generics mandatory when available Preferred Drug Step Therapy and Utilization Management Programs in effect. Maintenance medication must be obtained through Mail Order Program*	Retail Pharmacy Program Up to 30-day supply	▪ Generic: $15 ▪ Brand Formulary: $30 or 20%, whichever is greater ▪ Brand Non-Formulary: $50 or 35%, whichever is greater
	Mail Order Program Up to 90-day supply	▪ Generics: $30 ▪ Brand Formulary: $60 ▪ Brand Non-Formulary: $100

*After second fill of a maintenance medication at a retail pharmacy, future refills for that medication will only be filled through mail order program.

IMPORTANT NUMBERS AND WEBSITE ADDRESSES

Benefit Plan / Vendor	Address & Telephone Number	Website Address
Trust Administration and Customer Service ▪ Eligibility ▪ Benefits ▪ Claims ▪ Questions ▪ Appeals Send Medical Claims to:	Delta Health Systems 3244 Brookside Rd, 2nd Floor P.O. Box 80 Stockton, CA 95201-3080 1 (800) 556-5918 P.O. Box 1931 Stockton, CA 95201 Anthem Blue Cross P.O. Box 60007 Los Angeles, CA 90060-0007	www.deltahealthsystems.com
Indemnity Medical PPO Plan 4 ▪ PPO Provider Network ▪ Utilization Management	In CA: Anthem Blue Cross UM Only: 1 (800) 274-7767 Out of State: PHCS/Multiplan Call DHS at 1 (800) 556-5918	For PPO Provider list access: www.anthem.com/ca or www.multiplan.com
Employee Assistance Program (EAP)	Anthem EAP 1 (800) 999-7222	www.anthemeap.com (Access code: Gold Coast Joint Benefits Trust)
Chiropractic	Chiropractic Health Plan of California 1 (800) 995-2442 In CA 1 (800) 680-9997 Out of State	www.chpc.com
Prescription ▪ Retail Pharmacy ▪ Mail Order ▪ Prior Authorizations	Express Scripts 1 (800) 711-0917	www.express-scripts.com
Medical HMO – Kaiser Health Maintenance Organization	Kaiser Permanente 1 (800) 464-4000	www.kaiserpermanente.com
Dental Plan	Delta Dental 1 (866) 499-3001	www.deltadentalins.com
Vision Plan	Vision Service Plan 1 (800) 877-7195	www.VSP.com

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ELIGIBILITY & ENROLLMENT

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ELIGIBILITY & ENROLLMENT

Employee Eligibility

To be eligible for coverage under this Plan, you must be:

- an employee covered under the terms of a current Collective Bargaining Agreement (CBA) of a participating employer in the Gold Coast Joint Benefits Trust, or
- a non-collectively bargained employee for whom participation is permitted under the Trust's Participation Agreement.

If you qualify for benefits under two separate employers covered by Gold Coast Joint Benefits Trust, benefits will be coordinated up to the total allowed under one Plan.

Exception for HMO Membership

If you are enrolled in an HMO Plan provided through this Trust, you are not eligible for the medical or prescription drug benefits shown in this Plan Description Booklet. The Trust's HMO provider, Kaiser Permanente or your school district employer will provide you with a separate booklet that describes the HMO plan. Please refer to your HMO Plan Booklet for information regarding your medical and prescription benefits.

Employee Effective Date – Initial Enrollment

The effective date(s) of coverage for eligible Employees and their eligible dependents upon initial enrollment is pursuant to the collective bargaining agreement or memorandum of understanding.

Open Enrollment

Each school district that participates in the Trust holds annual open enrollment periods during which: (1) eligible Employees and their eligible dependents can enroll for coverage under the Trust; (2) covered Employees may add and/or drop their eligible dependents; (3) covered Employees can add or drop medical, dental and/or vision benefits, if otherwise permitted; and (4) covered Employees can change from one plan to another (e.g., switch from an HMO to the Indemnity Plan). Any changes made during open enrollment generally will become effective on the first day of the month following the last month of open enrollment.

Special Enrollment

For the effective date(s) of coverage for eligible Employees and/or eligible dependents enrolled under the special enrollment provisions, see section entitled Special Enrollment Rights under HIPAA.

Dependent Eligibility

Dependent means:

- the covered employee's spouse under a legally valid marriage,
- the covered employee's registered domestic partner (or similar legal union recognized in other states) as defined under Registered Domestic Partner Coverage section,
- the covered employee's children from birth to age 26, including:
    - step-children, including children of a registered domestic partner,
    - legally adopted children or children placed with the covered employee for adoption, and
    - children placed with you by virtue of a conservatorship or guardianship.

The term dependent shall not include:

- any person in full-time military service, except for children under the age of 26,
- foster children, or
- any individual other than as stated above.

Proof of dependent status may be requested periodically. Failure to provide proof will result in termination of coverage for the dependent(s) in question.

Adult children may be covered until they end of the month in which they reach age 26, even if the adult child no longer lives with his/her parent, is not a dependent on the parent's tax return, is no longer a student, or has their own employer-based health coverage.

The Trust will allow coverage of minor children to age 18 who are in the permanent legal guardianship of the covered employee by court order. Coverage will begin on the date the child is placed in the physical custody of the employee, provided a written application and copy of the court order is provided within sixty (60) days of the effective date of the legal guardianship.

Disabled Dependent Eligibility

Disabled Dependent means an unmarried mentally or physically disabled child beyond the maximum age of 26, provided the child is incapable of self-sustaining employment due to the disabling condition and is dependent upon the employee for support and maintenance, and further provided that the disabling condition existed prior to such child reaching age 26, and the child was covered under the Plan at the time he or she became disabled. Proof of mental or physical disability and financial dependency shall be required 31 days prior to such child's 26th birthday; subsequently, the Trust may periodically require additional proof.

Coverage for a disabled dependent will be continued until the earliest of the:

- date he or she ceases to be eligible for reasons other than age;
- date he or she ceases to be incapacitated;
- 31st day after the request for additional proof of his or her incapacity if such proof is not provided; or
- date when employee coverage ends.

If you and your spouse/Domestic Partner are both eligible as an Employee, each shall be eligible both as an Employee and as a dependent. If a person has such dual coverage, the total amount of benefits payable under this Plan shall in no event exceed the amount of expense actually incurred for which benefits are provided, less any applicable deductions for noncompliance with the Plan rules.

If both parents of an eligible dependent child are Employees, such child shall be eligible as a dependent of each. If a child has such dual coverage, the total amount of benefits payable under this Plan shall in no event exceed the amount of expense actually incurred for which benefits are provided, less any applicable deductions for noncompliance with Plan rules.

Dependent Effective Date

Coverage for your dependents will be in force under the same terms as your coverage.

- Coverage for a newly acquired spouse, Registered Domestic Partner or child through marriage/Domestic Partnership will become effective on the date of marriage, but only if a valid

marriage certificate or California's Secretary of State Declaration of Domestic Partnership, and an application to enroll the new spouse and stepchild has been filed within sixty (60) days of marriage.

- Newborn infants will be covered as of the date of birth provided a written application and a birth certificate is filed within sixty (60) days of the birth of the child and provided that, as of the date of application, all required contributions since the date of birth have been paid.
- A legally adopted child will be covered on the date the child is placed in the physical custody of the employee, provided a written application and copy of the court order is provided within sixty (60) days of the effective date of the adoption.
- If the forms to add a newly acquired dependent are not submitted to the Trust Administrator on time, or if all of the required information is not correctly filled in, the dependent will not be added to the Plan and the next opportunity to enroll the dependent will be at the next open enrollment period.

Domestic Partner Coverage

In addition to a lawful spouse and dependent children, a Domestic Partner is also eligible for coverage. A Domestic Partner must be either (1) of the same sex, or (2) of the opposite sex, provided that either you or your domestic partner is over the age 62, or (3) have a domestic partnership that meets the legal requirements of the place in which it was entered into. In addition, you and your Domestic Partner must:

- be each other's sole domestic partner and have filed with California's Secretary of State a Declaration of Domestic Partnership,
- not be currently married or legally separated,
- be at least 18 years old,
- be of sound mind (e.g. are legally competent to enter into a contract),
- not be related to such a degree that would prohibit you from marrying in the state of California,
- not be anyone else's domestic partners, and
- be jointly responsible for each other's basic living expenses.

For your domestic partner to be eligible for benefits, you must submit the following information to the Trust Administrator's Office:

- an application of enrollment,
- a copy of the Certificate of Domestic Partnership issued to you and your Domestic Partner by the Secretary of State, or certificates/documents used in other states to document similar legal unions

Coverage for a newly acquired domestic partner and any eligible children of your domestic partner, will become effective on the date of domestic partnership, but only if the above required information has been submitted within sixty (60) days after the date on the Certificate of Domestic Partnership issued to you by the state. In the event the domestic partner and any eligible children of your domestic partner are reported later than 60 days from their initial eligibility date, the next opportunity to enroll the domestic partner will be at the next open enrollment period.

WHEN BENEFITS END

Employee Termination of Benefits

Your coverage under this Plan will cease the last day of the calendar month in which any of the following events occur:

- you enter full-time military service (e.g Army, Navy or Air Force);

- the Plan terminates;
- you cease to be eligible;
- the required contributions were not received by the Trust; or
- your participating school district ceases to participate in the Trust under a Participation Agreement.

Rescission of Coverage

Coverage under the Plan can only be "rescinded," which means that the coverage can be cancelled retroactively, when a participant has committed fraud or has intentionally misrepresented a material fact (see the definition of "Rescission" referenced in the Definitions section of this booklet). When coverage is cancelled retroactively, it means that coverage will be cancelled back to the first day of enrollment in the Plan. Enrolling an individual in the Plan who you know is not an "eligible Dependent" under the Plan is an example of fraud and an intentional misrepresentation of a material fact. Coverage will be retroactively cancelled back to the first day the individual was fraudulently enrolled in the Plan, and you will be responsible for repaying the Plan for any health costs incurred on the individual's behalf. In addition, when coverage is cancelled retroactively because of fraud or intentional misrepresentation the individual will not have the right to COBRA continuation. If the Plan cancels coverage retroactively, it will provide 30 calendar days advance written notice explaining the reasons for the retroactive cancellation of coverage, information regarding appealing the retroactive cancellation of coverage, and the contact information of the individual available to answer your questions. You will have the right to appeal the rescission of coverage. The Plan can still cancel coverage prospectively, or cancel coverage retroactively if the cancellation is based on the individual's failure to timely pay required contributions (if you fail to pay COBRA contributions, for example). If coverage is cancelled prospectively, or for failure to timely pay required contributions, the Plan is not required to provide you with 30 calendar days advance written notice.

Termination of Domestic Partner Coverage

Your domestic partner's coverage, and the coverage of any dependent children of your domestic partner, terminates once the domestic partnership terminates, dissolves, or is nullified in accordance with California law.

Dependent Termination of Benefits

Coverage for all of your dependents will end when any of the below conditions exist or when they cease to be your dependent as outlined in the conditions described under Dependent Eligibility. You and your dependents are required to notify Delta Health Systems within 60 days following the date on which any dependent ceases to meet the eligibility criteria for dependent coverage. You will be responsible for the reimbursement of any claims paid for ineligible dependents.

Eligibility for your dependents will cease on the last day of the calendar month in which any of the following events occur:

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- The eligibility for the Employee ceases,
- With respect to a dependent spouse, the employee and spouse become legally divorced,
- With respect to a Registered Domestic Partner, when the employee and Registered Domestic Partner terminate, dissolve, or nullify their Domestic Partnership.
- The dependent ceases to be eligible as a dependent as set forth in the eligibility provisions for dependents

For more information regarding continuation of coverage after termination of eligibility under this Plan, please refer to the section entitled *COBRA.*

SPECIAL ELIGIBILITY RULES

Special Enrollment Rights under HIPAA

If you decline enrollment when first eligible (or enroll, but subsequently drop coverage), you and your eligible dependents can enroll or drop coverage during an annual open enrollment period, or earlier if you become eligible for special enrollment. Once you have enrolled in the plan of your choice, opt outs (cancellation of coverage) or transfers from one plan to another are permitted only during open enrollment, upon qualifying for special enrollment rights, or following an approved leave of absence.

After the initial enrollment period has expired, eligible Employees and/or their eligible dependents may enroll or drop coverage at times other than open enrollment, under the terms described in this section, in the following situations:

- Loss of coverage under a different group health plan or health insurance.
- Acquisition of a new dependent by marriage, birth, adoption or placement for adoption.
- Becoming eligible for state premium assistance subsidy.
- Becoming eligible for Medicare.
- Following an approved leave of absence.

This special enrollment right extends to any benefit package under the Trust (i.e. medical, dental and vision), and the Trust may not limit the employee's right to change from one benefit package to another upon special enrollment.

Important: Changes requested at times that are not during the annual open enrollment period are allowed only for the specific situations as outlined above. Becoming eligible for other coverage (other than Medicare), through a spouse's plan, for example, does not allow you the ability to opt out (cancel coverage under this plan) before the next annual open enrollment period.

Loss of Other Coverage under a Different Group Health Plan or Health Insurance

An Employee and/or a dependent may enroll upon the loss of other Group Health Coverage or Health Insurance Coverage, provided that all of the following requirements are satisfied:

- You declined to enroll yourself and/or your dependent(s) in the Trust when you initially became eligible or during a subsequent open enrollment period, or you terminated Trust coverage for yourself and/or your dependent(s), because of the existence of other Group Health Coverage or Health Insurance Coverage.
- You or your dependent loses the other coverage due to any of the following events:

    - Loss of eligibility for such other coverage as a result of an event, including, but not limited to:
        - Termination of employment, reduction in hours of employment, divorce, loss of dependent child status, or death of an employee.
        - For HMO coverage, no longer residing or working in the service area (and, if HMO coverage is offered through the group market, no other benefit package is available to the individual).
        - The plan no longer offers any benefits to the class of similarly situated individuals that include you and your dependent.
        - Termination of employer contributions toward the coverage.

- For COBRA coverage, exhaustion of COBRA coverage, which generally means exhaustion of the 18, 29 or 36 month COBRA coverage period.
- Loss of eligibility for Termination of No-Share-of-Cost Medi-Cal coverage or coverage under a state children's health insurance program.

Important: A loss of coverage does not occur if you (or your dependent) voluntarily drop the other coverage, benefits are reduced under the other coverage, or premiums are increased for the other coverage.

- You and any dependent requesting enrollment are otherwise eligible for Trust coverage.
- You request enrollment by contacting the Trust Administrator within sixty (60) days after the loss of eligibility, termination of employer contributions, or exhaustion of COBRA.

Individuals Eligible

- If it is the Employee who loses the other coverage, then the Employee and any or his or her dependents may enroll.
- If it is the Employee's dependent that loses coverage, then only that dependent (and the Employee, if necessary) may enroll. You may not enroll dependents under any circumstances if you are not enrolled or covered.

Effective Date

Coverage will begin on the first day of the first calendar month following the date the Trust Administrator receives the request for special enrollment.

Acquisition of a New Dependent by Marriage, Birth, Adoption, or Placement for Adoption

If you acquire a new dependent due to marriage, birth, adoption, or placement for adoption, you may be able to enroll or drop coverage for yourself, your spouse, and your new dependent(s), provided that:

- You and any dependent requesting enrollment are otherwise eligible for Trust coverage; and
- You request enrollment or cancellation by contacting the Trust Administrator within sixty (60) days after the marriage, birth, adoption, or placement for adoption.

Individuals Eligible

The following individuals may be able to enroll upon the acquisition of a new dependent:

- If the Employee is already enrolled: the Employee's spouse and his or her newly acquired dependent.
- If the Employee is not enrolled: the Employee, his or her spouse, and his or her newly acquired dependent.
- A retiree who is enrolled under the Voluntary Self-Pay Retiree Plan: the retiree's spouse and his or her newly acquired dependent. (Note: This is the only special enrollment right available to retirees, and the retiree must be enrolled at the time a new dependent is acquired to qualify for this right.)

Existing dependent children (such as siblings of a newborn child) cannot be added at this time. They can, however, be added during the next open enrollment period, but only if they are the existing dependent children of an Employee (a retiree's existing dependent children cannot be added during open enrollment).

Effective Date

- When a new dependent (including a spouse) is acquired by marriage, coverage will begin on the first day of the first calendar month following the date the Trust Administrator receives the request for special enrollment.
- When a new dependent is acquired through birth, adoption, or placement for adoption, coverage will begin retroactive to the date of birth, adoption, or placement for adoption.

Important Note: If a request for special enrollment is not received with 60 days of the date of marriage or birth, the dependent will not be allowed to be added to or dropped from the Plan until the next annual open enrollment period as determined by the participant's school district.

Eligibility for State Premium Assistance

If you or any of your dependents become eligible for premium assistance, with respect to Trust coverage, through either a Medicaid plan under Title XIX of the Social Security Act or a state children's health insurance program (CHIP) under Title XXI of the Social Security Act, you may be able to enroll or drop coverage for yourself and your dependents in this Trust, provided that: (i) you and your dependents are otherwise eligible for Trust coverage; and (ii) you request enrollment or cancelation of coverage by contacting the Trust Administrator within sixty (60) days after the date on the notice informing you of such eligibility.

Individuals Eligible

- If the Employee becomes eligible for the subsidy, then the Employee and any of his or her dependents may enroll or drop coverage.
- If the Employee's dependent becomes eligible for the subsidy, then that dependent (and the Employee, if necessary) may enroll.

Effective Date

Coverage will begin on the first day of the first calendar month following the date the Trust Administrator receives the request for special enrollment.

Becoming Eligible for Medicare

If you or any of your dependents become eligible for Medicare, you may be able to enroll or drop coverage for yourself and your dependents in this Trust, provided that: (i) you and your dependents are otherwise eligible for Trust coverage; and (ii) you request enrollment or cancelation by contacting the Trust Administrator within sixty (60) days after the date on the notice informing you of such eligibility.

Individuals Eligible

- If the Employee becomes eligible for Medicare, then the Employee and any of his or her dependents may enroll or drop coverage.
- If the Employee's dependent becomes eligible for Medicare, then that dependent (and the Employee, if necessary) may enroll or drop coverage.

Effective Date

Coverage will begin or end on the first day of the first calendar month following the date the Trust Administrator receives the request for special enrollment.

Following an approved leave of absence

Upon returning from an approved leave of absence, you may be able to enroll or drop coverage for yourself and your dependents in this Trust, provided that: (i) you and your dependents are otherwise eligible for Trust coverage; and (ii) you request enrollment or cancelation by contacting the Trust Administrator within sixty (60) days after the date on the notice informing you of such eligibility

Effective Date

Coverage will begin or end on the first day of the first calendar month following the date the Trust Administrator receives the request for special enrollment.

OTHER ELIGIBILITY PROVISIONS

Family and Medical Leave Act (FMLA)

Under the Family and Medical Leave Act of 1993 (FMLA), an active Employee may be entitled to family or medical leave. If an Employee is eligible to take and elects FMLA leave, coverage under this Plan will continue until the earlier of:

- The date the Employee notifies his or her district that he or she does not intend to return to work at the end of the FMLA leave; or
- The end of the FMLA Leave.
- Contributions will continue to be paid by the participating District on the Employee's behalf while he or she is on FMLA leave.
- The Employee must contact their District to determine his or her eligibility for FMLA leave.

Paid or Unpaid Leaves – Non-FMLA Leaves

Employees on an approved, paid or unpaid non-FMLA leave of absence can continue to receive health, dental and vision coverage, provided that the contributions are paid by you or by the participating District on your behalf. When you return to active work following your approved leave, the Trust's coverage and contributions will begin upon your return and no waiting or exclusion periods apply. If you do not return to work after your approved leave of absence, your coverage under the Trust ends and you will be given the opportunity to continue your coverage under COBRA. See COBRA section of this Plan Booklet for more information.

Veteran Benefits (USERRA)

The Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), increases the number of months from 18 to 24 during which someone serving active military duty may continue their employment-based health and welfare benefits. The rules for continuing your benefits as provided by USERRA are as follows:

- In Uniform 30 Days or Less: Your employer is required to contribute on your behalf and health care coverage must be provided to you as if you were still employed.

- In Uniform More Than 30 Days: If you enter uniformed service for more than 30 days you may elect to continue receiving health care coverage for up to 24 months and may then be required to pay up to 102% of the full contribution for health care coverage.

- USERRA Protections Don't Last More Than 5 Years: To be eligible for USERRA's protections the absence from employment generally must not exceed five years.

- Obligation to Timely Pay Contributions: When you are continuing your benefits while you are serving in the military by paying your monthly contribution as set forth in this section, you must pay the monthly contribution on time or your coverage will be terminated and you will not be permitted to reinstate it. Thus, your contribution for any given month is due the first day of that month, and you are allowed a grace period until the last day of that month to pay the contribution. However, if the Plan has not received your monthly contribution by the end of the applicable month, your coverage will be terminated without right to reinstate.

- Returning Vets and Their Eligible Dependents are Entitled to Reinstatement of Plan Coverage Immediately Upon Reemployment With the Vet's Pre-Service Employer: If you lost or dropped your coverage while serving in the military and you return to work with the same employer for whom you worked before leaving on military leave (i.e., the employer that paid contributions to the Plan for you previously), you are entitled to have that employer pay your contribution and start your coverage immediately upon your return to work.

- No Independent Right to USERRA Coverage For Spouses and Dependents: Your spouse and other dependents have no independent legal right to obtain continuation coverage pursuant to USERRA – they have only the right to be covered as your dependents under the eligibility rules of the Plan if you opt for continuation coverage pursuant to USERRA. However, your spouse and other dependents may have an independent right to continuation coverage under COBRA (see page 77).

- QMCSOs: If an employee does not elect continuation coverage at the time his or her qualified uniformed service begins his Qualified Medical Child Support Order is no longer enforceable against the Trust. However, the covered child may have the right to elect COBRA continuation coverage once coverage is lost.

Your rights under COBRA and USERRA are essentially the same, with the exception that COBRA provides benefits for up to 18 months of coverage for you and your dependents while USERRA provides up to 24 months of coverage for you and your dependents. Any election you make pursuant to COBRA will also be an election under USERRA, and COBRA and USERRA will both apply with respect to the continuation coverage elected.

COBRA and USERRA coverage are concurrent for up to the first 18 months of coverage. This means that COBRA coverage and USERRA coverage begin at the same time. As with COBRA, you are responsible for paying for USERRA coverage. The monthly premiums are the same. The cost of the USERRA premium is the same as it would be under COBRA.

Your USERRA coverage will terminate if one of the following events takes place before the end of the 24 months:

- You fail to make a premium payment within the required time;
- You fail to return to work within the time required under USERRA following the completion of your service in the uniformed services (the time for returning varies, please contact your employer for more details); or
- You lose your rights under USERRA as a result of a dishonorable discharge or other conduct specified in USERRA.

You may lose coverage under COBRA and USERRA for different reasons. You could, therefore, lose coverage under COBRA, but retain it under USERRA, or vice versa. For example, if you lose coverage

under USERRA due to a dishonorable discharge, your COBRA coverage would continue as long as you were within the 18-month time limit (plus any extensions, if applicable) for COBRA.

RETIREMENT ELIGIBILITY

Retirees are eligible for benefits under this Plan only if they are eligible under the rules of the participating district from which they retired. The Trust provides coverage for retirees and their dependents as follows:

District-Paid Coverage

You may be entitled to district-paid coverage, but only if provided for by the collective bargaining agreement covering you. You should contact your school district to determine under what circumstances and for how long you are entitled to such coverage.

Voluntary Self-Pay Retiree Plan

Upon retirement, or at the end of district-paid coverage, you have the option of continuing medical coverage for yourself and your dependents through the Voluntary Self-Pay Retiree Plan established by the Trust. To qualify for coverage under this plan:

- You must be retired per your participating district rules;
- You and your dependents must each enroll in Medicare Parts A and B upon turning 65 years old;
- You and your dependents must respectively enroll in Medicare Parts A and B, if either or both is under age 65 and is disabled or otherwise qualifies for Medicare coverage; and
- You must elect coverage under the Voluntary Self-Pay Retiree Plan within 30 days of your retirement date or the date your district-paid coverage ends.

When you enroll, you and your dependents may only elect to continue coverage in those benefit options (medical, vision and/or dental) in which you were enrolled as an Employee immediately prior to your retirement or end of district-paid coverage, and you and your dependents may not enroll in additional benefit options if not previously covered. For example, if you were enrolled in medical and dental, you may continue or decline coverage in either one or both, but you may not add vision. You may only add benefit options or change medical plans (e.g., Indemnity vs. HMO) at the next open enrollment period or upon special enrollment. In addition, at the time you enroll, you may not add dependents that were not previously covered. Once you decline coverage, you may not subsequently re-enroll.

Coverage is provided at your own expense at rates set annually by the Board of Directors. Coverage under the Voluntary Self-Pay Retiree Plan will end on the earliest of:

- The first of the month for which payment has not been received by its due date;
- The date the Voluntary Self-Pay Retiree Plan is terminated by the Trust; or
- The date your participating school district ceases to participate in the Trust.

Once your coverage under the Voluntary Self-Pay Retiree Plan is terminated for any reason, reinstatement will not be allowed in any other plan offered by the Trust. If you are eligible for benefits under the self-pay provisions of this Plan, and you elect not to continue coverage, or you cease to make the required payments to the Plan, you cannot re-elect to participate in any medical, dental or vision plan unless a change in your employment status occurs which re-qualifies you as an eligible Employee.

The Board of Directors of the Trust has full and exclusive authority to modify or terminate the Voluntary Self-Pay Retiree Plan, establish self-pay rates, and/or change carriers and health care providers at its discretion. The Trust is not required to provide benefits for retirees for life or any

other guaranteed period. The Trust's modification and/or termination of the Voluntary Self-Pay Retiree Plan is independent of any right or claim to health insurance that a retiree may have or assert against his or her former employer.

Contact your district office or the Trust Administrator for full details concerning the Voluntary Self-Pay Retiree Plan.

Surviving Spouse Benefit – For Retirees Only

In the event of your death, coverage for your spouse and eligible dependents may be continued, provided your surviving spouse first elects COBRA coverage and then elects, without any interruption in coverage, to pay for the surviving spouse coverage provided by the Trust. Surviving spouse coverage will be provided after COBRA coverage ends for any reason.

In addition, your spouse must enroll in Medicare Parts A and B upon turning 65 years old, or if he or she is under age 65 and disabled.

Coverage will cease on the last day of the month during which one of the following events first occurs:

- Failure to remit the required contribution payment on time and in full;
- Your spouse remarries;
- Your spouse becomes covered under another group policy; or
- The district ceases to provide any group health coverage through the Trust.

Coverage is provided under many of the same rules governing the Voluntary Self-Pay Retiree Plan. Your surviving spouse and any dependents may only elect to continue coverage in those benefit options (medical, vision, and/or dental) in which they were enrolled immediately prior to your death. Your surviving spouse may not add dependents that were not previously covered, and your surviving spouse and dependents may not enroll in additional benefit options if not previously covered. Once your surviving spouse declines coverage, he or she may not subsequently re-enroll. You may only change medical plans at the next open enrollment period (e.g., Indemnity Medical Plan vs. Kaiser).

The Board of Directors of the Trust has full and exclusive authority to modify or terminate the surviving spouse coverage, establish rates and/or change carriers and health care providers at its discretion. The Trust is not required to provide benefits for your surviving spouse for life or any other guaranteed period.

Certificated Retiree Continuation of Coverage Under State (Ed. Code 7000/AB 528)

Upon retirement, an Employee and eligible spouse or Domestic Partner will have the option of continuing medical coverage provided under this Plan if the Employee was a certificated Employee of a participating school district prior to retirement and the Employee:

- Retired under any public employee retirement system;
- Gained permanent status while in the employment of the district;
- Would currently be eligible for health and welfare benefits in the district if they were employed under the current conditions and in the same capacity as when permanency was gained;
- Otherwise meet the requirements of Education Code Section 7000; and
- Enrolls in the Trust's Ed. Code Section 7000 plan within 30 days after losing active Employee or other Trust coverage.
- If an individual is the surviving spouse or Domestic Partner of a retired certificated Employee, he/she is also eligible to continue coverage.

Coverage will be provided at the individual's own expense, and premiums as set by the Trust must be paid by the individual for a minimum of three months coverage. A retiree or spouse (or Domestic Partner) who has elected coverage under Education Code Section 7000, and who subsequently voluntarily terminates that coverage for any reason, will be excluded from re-obtaining coverage at any later date.

Enrollment in Medicare

The Trust requires that you and your covered dependents enroll in Medicare Part A as soon as you or your dependent first become eligible, at age 65 or for disability.

If you are a Retiree: You and your dependent must enroll in and pay for Medicare Part B when you retire on or after January 1, 1999, and you or your dependent become eligible for Medicare.

For Retirees: failure to enroll in both Medicare Parts A and B when you first become eligible will result in the following:

- Members of the Voluntary Self-Pay Retiree Plan — coverage will be terminated.
- Retirees whose benefits are paid for by their district — HMO members: coverage will be terminated.
- Retirees whose benefits are paid for by their district — Medical Indemnity PPO Plan 4 members: the Plan will process claims as if Medicare is the primary payer and the Trust's Plan is the secondary payer.

If you are a Retiree, you and/or a dependent are enrolled in the Indemnity Medical PPO Plan 4, and you/your dependent do not enroll in Medicare Parts A and B when first eligible, the Plan will pay claims as if Medicare is the primary payer and the Trust's Plan is the secondary payer, which will mean significant out of pocket expenses for you. The only exception to this rule is for those employees who were hired prior to March 31, 1986 and do not qualify for premium free Medicare Part A. You must still, however, enroll and pay premiums for Medicare Part B. Note that this exception does not apply to the HMO Medical plan option.

The Trust will continue to provide prescription drug benefits after you and/or your dependent are Medicare eligible, so enrollment in Medicare Part D is not required. Do not enroll in a Medicare Part D Plan. If you and/or your dependents enroll in Medicare Part D, you may permanently lose prescription drug coverage under the Trust, and the Trust will not reimburse any premiums paid for Medicare part D coverage.

If you are an active employee, and you or a dependent is Medicare eligible, the Trust will be your primary coverage. Please see the *"Important: Information About How Your Plan Works"* section of this booklet, under "*Coordination of Benefits (COB), Coordination with Medicare."*

MEDICAL BENEFITS

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MEDICAL BENEFITS

Under the Medical Indemnity PPO Plan 4, although you and your dependent(s) may receive care from any provider you choose, most covered care and/or services may be provided by PPO providers/facilities. The difference is as follows:

PPO Providers

These physicians or facilities have agreed to provide medical care and services at lower, negotiated rates. When you use PPO Providers, also referred to as Contracted Providers, your out-of-pocket expenses will be lower.

The Medical Indemnity PPO Plan 4 pays a percentage of charges for medically necessary services and supplies until you reach the out-of-pocket maximum. Once you reach the out-of-pocket maximum, the plan pays 100% of allowed charges for covered medical expenses provided by PPO Providers for the rest of that year.

Non-PPO Providers

These are any other providers ***not*** under contract. Benefits for non-PPO providers are paid based on the Usual, Customary and Reasonable (UCR) rate. A charge is considered usual, customary and reasonable if it falls within the range of fees usually charged by health care providers for the same service or supply in the same (or comparable) geographic areas. If you use a non-PPO provider, your out-of-pocket share of cost and charges above UCR will not be paid, and will not be applied to our out-of-pocket maximum. Your out-of-pocket expenses will be higher if you use non-PPO providers.

The Medical Benefit will pay 50% of the UCR rate for covered expenses at a non-PPO provider when the patient has access to a PPO provider, but chooses not to use a PPO provider. Covered services rendered by non-PPO providers do not apply to the out-of-pocket maximum. The Medical Plan will not pay for preventive care services rendered by a non-PPO provider.

Exceptions

Benefits will be paid at the PPO percentage of UCR for Non-PPO providers in the following situations.

- For emergencies requiring immediate care;
- When there is no opportunity to choose providers such as ambulance, emergency room physicians, anesthesiologists and hospital based pathologists;
- If there is not a PPO provider within a thirty (30) mile radius of your residence; or
- If medically necessary services are only available from a non-PPO provider.

Medical Necessity

Medical Benefits are provided only for services that are medically necessary, except for those specific preventive services outlined in the Preventive Services section of this booklet. Medically necessary services include only those which have been established as safe and effective and are furnished in accordance with generally accepted professional standards to treat an illness or injury, and which are determined to be: consistent with the symptoms or diagnosis in treatment of the illness or injury; not furnished primarily for the convenience of the patient, the attending physician, or other provider; and are furnished at the most appropriate level which can be provided safely and effectively to the patient.

Note: Delta Health Systems reserves the right to review all claims for medical necessity and may use the services of a Physician or Dental Consultant or other health care professional with appropriate expertise in the field.

Deductible

The Deductible that you must pay before the Plan pays is $400 per individual / $1,200 per family. The Calendar Year Deductible is waived for Covered Expenses incurred under the Chiropractic and Prescription Drug Program.

Coinsurance

Coinsurance is the percentage share of cost that the Plan participant must pay the provider after the Plan has reimbursed for services at the appropriate percentage payable. For example, if the benefit pays at 90%, the Plan participant's coinsurance will be 10%.

Out-of-Pocket Maximum

The out-of-pocket maximum means that if, during one calendar year, your copays and deductibles, if any, plus covered charges rendered by PPO Providers under the Medical Indemnity PPO Plan 4 exceeds $2,000 on a participant, the Plan will pay 100% of any additional covered charges incurred for the remainder of that calendar year for that participant and provided by PPO Providers. The medical maximum you will pay in a calendar year for Plan 4 is $2,000 per individual / $4,000 per family. There is a separate out-of-pocket maximum for prescription drug coverage. Please see the Prescription Drug Coverage section of this booklet for details.

The Medical and Prescription Out-of-Pocket maximums will not exceed the amounts established by the Department of Health and Human Services; these maximums are indexed by law and will be subject to change in subsequent years.

The Out-of-Pocket Maximum applies only to covered expenses you incur at PPO Providers. The Medical PPO Providers include Hospital-Medical-Surgical, Mental Health or Substance Abuse providers under the Anthem Blue Cross Network, CHPC chiropractic network, and the PHCS/Multiplan out-of-state network and Mental Health and Substance Abuse providers.

Exceptions to the Medical Out-of-Pocket Maximum

The following costs will not be applied toward the Medical Indemnity PPO Plan 4 out-of-pocket maximum:

- services rendered by Non-PPO providers for non-emergency services
- charges in excess of the usual, customary and reasonable (UCR) rate
- any payment reduction imposed for not complying with the hospital Pre-Authorization (Pre-Certification) requirement
- services or care not covered by the Plan
- any expense in excess of a specific benefit maximum
- prescription drug benefits
- dental services, except for services required as a direct result of injury to natural teeth while insured by this plan
- services for vision correction

Right of Recovery

If payments are made in error, the Plan may recover all amounts in excess of the correct amount paid. Recovery can be made by reducing or suspending future plan payments or by requiring the Plan Participant

or the provider/facility to pay back the overpayment in full, or in installments, until the overpayment is recovered.

HOSPITAL COVERAGE

PPO Hospitals

As an additional cost-containment measure, your Plan offers you the opportunity to utilize hospitals with negotiated contracts to help assure more stable rates for your health coverage. PPO Hospital Benefits pay at 90% of a contracted fee for all covered services, compared to non-PPO Hospital Benefits that pay at 50% of Usual, Customary and Reasonable (UCR).

As an example, if your hospital bill totaled $10,000 at a non-PPO Hospital, the claim would pay at 50% of UCR for covered services and your share of the cost (50% coinsurance) would be a minimum of $5,000. If you had used a PPO Hospital, the Plan would pay 90% of the cost (after the deductible); your coinsurance would be $1,000 (unless non-covered services were received).

Emergency

An emergency medical condition is a medical condition that manifests itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in the health of the individual (or in the case of a pregnant woman, her unborn child) to be in serious jeopardy, cause serious impairment of bodily functions, or cause a serious dysfunction of any body part or organ.

Although the same cost sharing will be applied to treatment of qualified emergency medical conditions whether they are performed at a PPO Hospital or not, you are encouraged to utilize a PPO Hospital if feasible. However, if you obtain emergency treatment at a non-PPO Hospital, those services will be paid at a percentage of Usual, Customary, and Reasonable (UCR) rates. The Plan does not pay a percentage of actual charges. If the Provider's charge exceeds the Plan's UCR allowance, you will be responsible for the difference.

Additional rules applicable to Emergency Services coverage:

- Prior authorization does not need to be obtained before seeking emergency room treatment for an Emergency Medical Condition.
- In all cases of emergency hospital admission, the Plan's Utilization Review Provider (Anthem Blue Cross), must be notified within 48 hours of the emergency admission; otherwise, the following payment penalties will apply:
    - The Plan will pay 80% of the applicable Benefit Percentage Payable for Hospital and medical expenses, including Physician charges related to the Hospital confinement.
    - If Anthem Blue Cross determines that continued hospitalization is unnecessary, a penalty may apply to that portion of the hospitalization that exceeds the approval of the Continued Stay Review.
- The amount payable to a Non-Contract/Non-PPO Provider will not be less that what is required by law.

HOSPITAL UTILIZATION REVIEW AND PRE-AUTHORIZATION (PRE-CERTIFICATION)

When Pre-Authorization (Pre-Certification) is Required

Pre-Authorization (Pre-Certification), provided by the Hospital Utilization Review Program, administered by Anthem Blue Cross, assists in determining the appropriate length of stay for all medical conditions and/or surgeries that take place in a hospital, acute care or skilled nursing facility. The chart below outlines when Pre-Authorization (Pre-Certification), by the Utilization Review Program, is required.

In most circumstances, your physician and hospital are familiar with these procedures, and normally request certification for your inpatient surgical procedures and hospitalization on your behalf; however, it is ultimately your responsibility to ensure that the Pre-Authorization (Pre-Certification) is obtained. See *Important Numbers and Website Addresses* for contact information.

Care or Services	Timeframe
All non-emergency hospitalizations For any medical or surgical procedures, including admissions for mental health and substance abuse.	Prior to being admitted to the hospital
Most Outpatient facility procedures, including outpatient mental health and substance abuse treatment at an outpatient facility	Prior to medical or surgical procedures
All Inpatient Emergency Admissions	Within 48 hours of the admission
Durable Medical Equipment (over $2,000)	Prior to ordering the equipment
Home Health Care	Prior to receiving care
Hospice Care (Inpatient)	Prior to being admitted to the hospice facility
Skilled Nursing Facility	Prior to being admitted to the skilled nursing facility

Penalty

The plan will pay 80% of the covered expense on any claim when Pre-Authorization (Pre-Certification) has not been obtained:

- prior to admission to the hospital, or
- within 48 hours of an emergency admission.

Hospital claims will not be processed for payment without a certification from the Hospital Utilization Review Program indicating that review requirements have been satisfied.

IMPORTANT: Notifying the Hospital Utilization Review Program is not a guarantee of benefits. Actual availability of benefits is subject to eligibility, usual and customary allowances, medical necessity and other terms, conditions, limitations and exclusions of the Indemnity Medical PPO Plan 4.

Ongoing Review Program and the Hospital Utilization Review Program

After a hospital admission, Anthem Blue Cross assumes the responsibility for additional, ongoing review to monitor the level of care you require, including:

- medical necessity,
- appropriateness of treatment, and
- length of hospitalization to determine if you are receiving the level of care that you require.

Ongoing review does not require any patient involvement and helps to reduce medical expenses, as well as assuring the quality of your care.

Choice of Treatment

The decision regarding choice of treatment is made by the patient and his/her physician; it will be the participant's responsibility to pay for any services or days in the hospital that are not approved as medically necessary.

Case Management

In the unfortunate circumstances where there is a catastrophic illness or injury, selected cases may require case management to provide ongoing review and coordination of medical care to ensure that the Plan participant is receiving optimum utilization of his or her medical benefits in the most cost effective manner. With the acceptance and cooperation of the Plan participant, case management will assist in the coordination of medical care and expenses from the time of case identification until the patient has achieved his or her maximum functional potential.

Discharge Planning

At the time of discharge from the hospital, the Utilization Review Organization nursing staff and medical director will be evaluating, coordinating and expediting your transfer from an inpatient, acute-care hospital to an alternate, more efficient setting if medically required and/or assessing your need for home health care or other medically necessary services.

COVERED MEDICAL BENEFITS

The following table summarizes what portion of Covered Expenses will be paid under the Indemnity Medical PPO Plan 4.

BENEFITS	Amount Paid by the Plan, PPO	Amount Paid by Plan, Non-PPO (benefit is % of UCR)	COVERAGES
All Medical Care	Copays and Coinsurance amounts are listed for each benefit		All medical plan benefits must be: Medically Necessary, Provided by a physician or licensed certified practitioner (see definitions), Received at a licensed providers' office, patient's home, hospital or other licensed, carrier-approved facility; and Are subject to the following deductibles: $400 individual / $1200 family calendar year deductible
Acupuncture	90%	50%	Services must be provided by a licensed Acupuncturist (LAC) *Note: Maximum of 18 visits per calendar year.*
Allergy Testing	90%	50%	Includes testing, injections ad serum.
Ambulance Services	90%	90%	Medically necessary ambulance services to the nearest facility that can treat the condition, including the base charge, mileage and supplies to transport the patient. Air or ground transportation to a hospital specially equipped to furnish the medically necessary treatment. The ambulance must be licensed under state laws regulating the operation of ambulatory services.
Ambulatory Surgery Center (Facility fee)	90%	Not Covered	Services performed at an out of network ambulatory surgery center are not covered. Ambulatory surgery centers (ASC), also known as outpatient surgery centers, surgicenters, or same day surgery centers, are health care facilities not affiliated with a hospital, where surgical procedures and certain pain management and diagnostic (e.g., colonoscopy) services not requiring an overnight hospital stay are performed.
Bariatric Surgery	90%	50%	Charges for diagnostic x-ray and laboratory tests and for the non-surgical treatment of morbid obesity by a Physician, provided the Participant receiving the treatment has a Body Mass Index (BMI) of 40+ when treatment is started. Plan benefits will be paid for gastrointestinal bypass surgery for morbid obesity only after Pre-Authorization (Pre-Certification).
Blood Work	90%	50%	Blood transfusions, blood processing, autologous transfusions and the cost of un-replaced blood and blood products.
Chemotherapy and Radiation Therapy	90%	50%	All hospital based services require prior authorization.

BENEFITS	Amount Paid by the Plan, PPO	Amount Paid by Plan, Non-PPO (benefit is % of UCR)	COVERAGES
Chiropractic Therapy	100% after $20 copay Important: CHPC Providers only	Not covered	Services by a Chiropractor or Certified Message Therapist (CMT) through Chiropractic Health Plan of California (CHPC). *Notes: Contracted Provider must submit a treatment plan to CHPC and receive approval for benefits to be payable. Benefit maximum is 30 visits per calendar year.*
Cochlear Implants	90%	50%	Medically necessary cochlear implants. Pre-Authorization (Pre-Certification) is required.
Dental Injury and Illness Benefit	80%	50%	Dental treatment required by injury to natural teeth as a direct result of injury while insured. Benefits for hospitalization will be paid if hospitalization is demonstrated to be medically necessary for the performance of dental services. These benefits will be paid at an 80% reimbursement rate.
Dialysis	90%	50%	
Durable Medical Equipment (DME) Benefit	90% Important: Pre-Authorization is required when DME exceeds $2,000.	50% or 80%, depending on the service	Charges for the rental or purchase, whichever costs less, of durable medical equipment, including dialysis equipment, used in the patient's home. *Note: Equipment, Non-PPO – 80%; Misc. Supplies; Non-PPO – 50%; Orthotic/Foot, Non-PPO – 80%*
Emergency	90%	90%	*Includes emergency room facility charge and physician 's services.* *Note: If you or your covered dependent do not obtain Pre-Authorization (Pre-Certification) by contacting the Plan's utilization review provider within 48 hours of an Emergency admission), the Plan will pay only 80% of the applicable Benefit Percentage Payable.*
Employee Assistance Program (EAP)	100%	Not Covered	Benefits under the EAP are available to active employees and District Paid Retirees in Plan 4, whether they are enrolled in the Medical Indemnity PPO Plan 4 or in a Trust-sponsored HMO. Services provided through the Anthem Employee Assistance Program. For information on services, call 800-999-7222, or visit anthemeap.com and enter Company Code: Gold Coast Joint Benefits Trust. *Note: The EAP is not available to Voluntary Self-Pay Retirees.*
Family Planning Services	100%	50%	Benefit includes devices, injections, tubal ligation, and vasectomy. Prescriptions are covered under the Prescription Drug Benefit *Note: Sterilization reversals are not covered.*

BENEFITS	Amount Paid by the Plan, PPO	Amount Paid by Plan, Non-PPO (benefit is % of UCR)	COVERAGES
Home Health Care Benefit	90%* Important: Pre-Authorization from the URO is required	80%	Medically necessary services of an approved Home Health Care Agency when ordered by a physician; including, but not limited to, services of a Registered Nurse, Licensed Vocational Nurse, Licensed Physical Therapist, Occupational Therapist, Speech Therapist or Medical Social Service Worker. *Note: No more than 60 visits per calendar year, whether paid at 80% or 90%, combined for all Home Health Care services. Four (4) hours equals one (1) visit.*
Hospice Care Services	100% Important: Pre-Authorization from the URO is required for inpatient Hospice Care. Not subject to deductible	90% Subject to deductible	The Plan will cover medically necessary services of an approved Hospice Agency when ordered by a physician; including services of a Registered Nurse, Licensed Vocational Nurse, Licensed Physical Therapist, Occupational Therapist, Speech Therapist or Medical Social Service Worker. Eligible Hospice Care services are those provided by a hospice care program in the patient's home or a hospice facility, including nutrition services, special meals and counseling services by a licensed social worker or a licensed pastoral counselor for the patient. *Note: The plan will pay eligible Hospice Care benefits for home or inpatient care for up to six months. Following six months, medical necessity must be re-certified no less frequently than every 30 days. Hospice Care benefits are limited to a lifetime maximum of 12 months.*
Hospital - Inpatient	90% Important: Pre-Authorization from the URO is required.	50%	Hospital inpatient services for medically necessary treatment of injury, illness or mental health, including the hospital's charges for room and board up to the semi-private room rate; charges are covered for intensive care when such services are medically necessary. Covered Expenses for a private room will be the Hospital's average two-bed room rate for each day of confinement. All inpatient hospitalizations require Pre-Authorization through the Utilization Review Organization. Please refer to the section entitled *Hospital Utilization Review and Pre-Authorization (Pre-Certification)*. If Pre-Authorization (Pre-Certification) is not obtained, Plan payment is reduced to 80%.

BENEFITS	Amount Paid by the Plan, PPO	Amount Paid by Plan, Non-PPO (benefit is % of UCR)	COVERAGES
Hospital - Outpatient	90% Important: Pre-Authorization from the URO is required.	50%	Hospital outpatient services for medically necessary treatment of injury, illness or mental health conditions are covered when provided in the hospital outpatient facility. X-ray and laboratory services performed at a hospital, but not associated with an emergency room visit or outpatient surgery are covered under the outpatient x-ray and lab benefit and are payable at 90%. For services rendered at an Ambulatory Surgery center, outpatient surgery center not affiliated with a hospital, surgicenters and same day surgery centers, please see "Ambulatory Surgery Center."
Infertility Services - Diagnostic	90%	50%	Diagnostic services covered until a diagnosis is established.
Infertility Services - Treatment	50%	50%	All professional and facility charges. Benefits are for the treatment to correct the condition causing the infertility. Artificial insemination and in-vitro fertilization are not covered. *Note: Lifetime maximum of $20,000.*
Maternity Benefit Professional Services	90%	50%	Medically necessary treatment and services for pregnancy and complications of pregnancy are covered. Benefits payable for employee, employee's spouse/registered domestic partner and children. *Includes coverage for Birthing Centers. See **Hospital** for information about coverage for facility services.*
Mental Health Benefits – Inpatient	90% Important: Pre-Authorization through URO required.	50%	Medically necessary hospital services for mental health treatment are covered. All inpatient hospitalizations require Pre-Authorization. Please refer to the section entitled *Hospital Utilization Review and Pre-Authorization (Pre-Certification).* Licensed Eating Disorder Programs are only payable for the treatment of Anorexia Nervosa or Bulimia and will be considered a Mental Health Benefit. *Note: Voluntary Self-Pay Retirees are not eligible for this benefit.*

BENEFITS	Amount Paid by the Plan, PPO	Amount Paid by Plan, Non-PPO (benefit is % of UCR)	COVERAGES
Mental Health Benefits – Outpatient PPO	90% Pre-Authorization through the URO may be required.	50%	Medically necessary outpatient services for mental health treatment are covered. Pre-Authorization (Pre-Certification) through the Utilization Review Organization may be required for some outpatient services (such as intensive out-patient treatment, or partial hospitalization). See section entitled Utilization Review and Pre-Authorization (Pre-Certification). Services can be provided by a Psychiatrist, Psychologist, Licensed Clinical Social Worker (L.C.S.W.), or Licensed Marriage Family and Child Counselor (M.F.C.C.). Psychological testing is a covered benefit. Marital and family counseling not covered under Mental Health. Benefits. Please see Employee Assistance Program. Licensed outpatient Eating Disorder Programs are only payable for the treatment of Anorexia Nervosa or Bulimia and will be considered as a Mental Health Benefit. *Note: Voluntary Self-Pay Retirees are not eligible for this benefit.*
Nutritional Counseling	90%	50%	Nutritional Counseling services for diabetes limited to 15 visits per lifetime.
Occupational Therapy	90%	50%	A treatment plan must be certified by a Physician and services provided by a licensed therapist.
Outpatient Surgery	90%	50%	Services performed at an out of network ambulatory surgery center are not covered. Ambulatory surgery centers (ASC), also known as outpatient surgery centers, surgicenters, or same day surgery centers, are health care facilities not affiliated with a hospital, where surgical procedures and certain pain management and diagnostic (e.g., colonoscopy) services not requiring an overnight hospital stay are performed.
Physical Therapy	90%	50%	A treatment plan must be certified by a Physician and services provided by a licensed therapist.
Physician Services	90%	50%	Non-preventive and non-emergency visits at home, office or inpatient. Includes primary care visits for Family Practice, General Practice, Internal Medicine, OB/GYN and Pediatric office visits. *Note: Visits to a non-PPO Provider will be covered at 50% of UCR and subject to deductible.*

BENEFITS	Amount Paid by the Plan, PPO	Amount Paid by Plan, Non-PPO (benefit is % of UCR)	COVERAGES
Podiatry	90%	50%	
Preventive Services	100% Important: PPO Providers Only	Not Covered	Preventive screenings, tests and services will be covered at no cost to you if performed by a PPO provider and so long as the primary purpose of the visit is to obtain the applicable preventive screening, test or service. See Preventive Services section for a listing of the preventive screenings covered by the Plan.
Prostate Antigen Testing	100%	Not Covered	One (1) test per calendar year for men age 40 and over.
Prosthetic Benefit	90%	50%	Surgical implants, artificial limbs or eyes, other prosthetic devices and replacements. Orthotics must be medically necessary and custom molded. *Note: Pre-Authorization from Anthem Blue Cross required.*
Reconstructive Surgery Benefit	90% Important: Pre-Authorization from the URO is required	50%	Medically necessary treatment to repair or alleviate bodily damage caused by illness or injury is covered as any other illness or injury. Services require Pre-Authorization. Please refer to the section entitled *Pre-Authorization*. *Breast Reconstruction Following Mastectomy* If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the *Women's Health and Cancer Rights Act of 1998 (WHCRA)*. The following services are covered for you and your dependents if required as a result of a mastectomy: reconstruction of the breast on which the mastectomy has been performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, and prostheses and treatment of physical complications for all stages of a mastectomy, including lymphedemas (swelling associated with the removal of lymph nodes).
Skilled Nursing Facility Benefit	90% Important: Pre-Authorization from the URO is required.	50%	Inpatient services for necessary medical care for the treatment of illness or injury for a maximum of 90 days per calendar year. Services are covered only when the patient has been referred to the facility by a physician. Confinement must begin within 14 days of a hospital stay consisting of 3 or more days. The patient must remain under the active supervision of a physician treating the illness or injury for which the patient was confined in the Skilled Nursing Facility.
Sleep Disorders	90%	50%	Medically necessary services for sleep disorders.
Speech Therapy	90%	50%	Covered if following surgery or for non-congenital illness.

BENEFITS	Amount Paid by the Plan, PPO	Amount Paid by Plan, Non-PPO (benefit is % of UCR)	COVERAGES
Substance Abuse Benefit – Inpatient	90% Important: Pre-Authorization from URO is required.	50%	Medically necessary hospital services for substance abuse treatment. All inpatient hospitalizations require Pre-Authorization. Please refer to the section *entitled Hospital Utilization Review and Pre-Authorization (Pre-Certification).* *Note: Voluntary Self-Pay Retirees are not eligible for this benefit.*
Substance Abuse Benefit - Outpatient	90% Important: Pre-Authorization from the URO may be required	50%	Medically necessary outpatient services for substance abuse treatment. *Note: Voluntary Self-Pay Retirees are not eligible for this benefit.*
Surgical Benefit	90%	50%	Medically necessary services by a Surgeon, Assistant Surgeon, Anesthesiologist or Consulting Physician.
TMJ Disorders	90%	50%	Non-surgical treatment for Temporomandi-bular Jaw Disorder (TMJ). *Note: Lifetime maximum of $1500.*
Transgender Services	90%	50%	Medically necessary transgender services. Pre-Authorization (Pre-Certification) is required.
Transplant Benefit	90% Important: Pre-Authorization from the URO is required.	50%	Non-Experimental services provided in connection with surgery for cornea, liver, kidney, bone marrow, tissue, heart or heart-lung transplants. Coverage is provided for: a Plan participant who receives the organ or tissue; a Plan participant who donates the organ or tissue; or an organ or tissue donor who is not a Plan participant, if the organ or tissue recipient is a Plan participant. The above benefits are reduced by any amounts paid or payable by the non-participant's own insurance coverage. A second transplant of the same organ will not be covered if the original transplant was covered under this Plan.
Urgent Care Center	90%	50%	
X-ray & Lab Benefit	90%	50%	Diagnostic x-ray services and clinical laboratory services when provided to diagnose illness or injury.

PREVENTIVE SERVICES

The Plan will cover 100% of Covered Charges for Preventive Care Services when those services are provided by a PPO Provider. There is no deductible, copay, or coinsurance for these services when these services are provided by a PPO Provider. Preventive services provided by a Non-PPO Provider are not covered . The below screenings, tests, and services will be covered at no cost to you as long as they are performed by a Contract (PPO) Provider and as long as the primary purpose of the medical appointment is to obtain the applicable preventive screening, test or service. It is the intent of this Plan to comply with the provisions of the Affordable Care Act; therefore, the list of covered services may be subject to change. Please refer to government website https://www.healthcare.gov/coverage/preventive-care-benefits/, for most recent list of preventive services that health plans are required to cover pursuant to the Affordable Care Act.

Some things you should know about the Plan's payment for Preventive Care Services:

- If a Preventive Service is billed separately from an office visit, the plan may impose cost sharing on the office visit.
- If the Preventive Service is not billed separately from the office visit, and the office visit is primarily for the purpose of providing Preventive Service(s), then the Plan may not impose cost sharing on the office visit and will pay the office visit at 100% of Covered Charges if you use a PPO Provider.
- If the Preventive Service is not billed separately from the office visit, and the main purpose of the office visit is not for the purpose of providing Preventive Service(s), the Plan may impose cost sharing on the office visit. For example, if you go to a doctor because of an ear infection and the doctor takes your blood pressure, the Plan may impose cost sharing on the office visit.

Covered preventive screenings for adults (age 18 and older):

- Abdominal aortic aneurysm (one time screening), plus one-time screening for men ages 65-75
- Alcohol misuse and behavioral counseling interventions
- Aspirin recommended use for adults at higher risk of cardiovascular disease
- Blood pressure screening for all adults
- Cholesterol screening
- Colorectal cancer (Colonoscopy) screening for adults over 50; under age 50 if based on family history
- Depression screening for adults
- Diabetes screening for adults with high blood pressure
- Healthy diet/nutritional counseling
- Human Papillomavirus (HPV) DNA Testing
- Immunization vaccines for adults (doses, recommended ages, and recommended populations vary):
    - Hepatitis A and B
    - Herpes zoster
    - Human papillomavirus
    - Influenza
    - Measles, mumps, rubella
    - Meningococcal and Pneumococcal
    - Tetanus, diphtheria, pertussis
    - Varicella
- Obesity screening and counseling for all adults

- Physical exam (routine), once per calendar year
- Prostate specific antigen (PSA) testing
- Sexually transmitted infection prevention counseling
- Sexually transmitted infection screening, including:
    - Chlamydia
    - HIV
    - Syphilis, non-pregnant persons
- Tobacco use counseling and interventions, including smoking cessation medications
- Vitamin D supplements for adults age 65 and older

Covered preventive services for women, including pregnant women:

- Anemia screening
- Bacteriuria (urinary tract) or other infection screening for pregnant women
- BRCA (breast and/or ovarian cancer) counseling about genetic testing for women
- Breast cancer mammography screenings
    - One mammogram (baseline) for women 35 to 39
    - One mammogram every one to two years for women over 40
- Breast cancer preventive medication counseling
- Breastfeeding interventions to support and promote breastfeeding
- Breastfeeding support
    - Purchase or rental of breast pump and supplies
    - Lactation support and counseling
- Cervical cancer (PAP) screening for sexually active women
- Chlamydia infection screening
- Contraception method and procedures, counseling and education
- Contraceptive drugs (generic), FDA approved
- Contraceptive devices and sterilization services (generic), FDA approved
- Folic acid counseling and supplementation
- Gestational diabetes screening
- Gonorrhea screening
- Hepatitis B screening, once per pregnancy
- Interpersonal and domestic violence screening and counseling
- Osteoporosis screening
- Prenatal visits
- Rh incompatibility screening for pregnant women and follow-up testing for women at higher risk
- Sexually transmitted infection counseling, including HIV screening
- Syphilis screening, once per pregnancy
- Tobacco use counseling
- Well Woman exam

Covered preventive services for children (up to age 18):

- Alcohol and drug use assessments for adolescents
- Autism screening for children between 18 and 36 months
- Behavioral assessments for children of all ages
- Cervical dysplasia screening for female adolescents through age 17
- Depression screening for adolescents
- Dyslipidemia screening for children at higher risk of lipid disorders

- Fluoride chemoprevention for children without fluoride in their water source
- Fluoride Supplements, through age 6
- Folic acid counseling and supplementation
- Gonorrhea preventive medication for the eyes of all newborns
- HIV screening for adolescents at higher risk
- Immunization vaccines for children from birth to age 18 (doses, recommended ages, and recommended populations vary):
    - Diphtheria, tetanus, pertussis
    - Hemophilic influenza type b
    - Hepatitis A and Hepatitis B
    - Human papillomavirus
    - Inactivated poliovirus
    - Influenza
    - Measles, mumps, rubella
    - Meningococcal and Pneumococcal
    - Rotavirus
    - Varicella
- Iron recommended for children ages up to 12 months of age
- Lead screening for children at risk of exposure
- Medical history for all children throughout development
- Newborn Screenings, including:
    - Congenital hypothyroidism
    - Hypothyroidism
    - Hearing
    - Hemoglobinopathies or sickle cell
    - Metabolic/
    - PKU (Phenylketonuria)
- Obesity screening and counseling, through age 17
- Sexually transmitted infection screening and prevention counseling for adolescents, including:
    - HIV
    - Gonorrhea
    - Hepatitis B
    - Syphilis
    - Chlamydial infection
- Tuberculin testing
- Well Baby/Child Care; birth through age 17, which may include :
    - Blood pressure screening
    - Developmental assessments
    - Hematocrit or Hemoglobin screening
- Medical History
    - Measurement for height, weight, head circumference, body mass index
    - Visual Acuity Screening

Preventive Care services and other provisions mandated by the Affordable Care Act (ACA) may change occasionally. The Plan will remain in compliance with all applicable provisions of ACA. Please refer to government website https://www.healthcare.gov/coverage/preventive-care-benefits/, for most recent list of preventive services that health plans are required to cover pursuant to the Affordable Care Act.

OTHER MEDICAL BENEFIT PROVSIONS

Newborn's and Mothers' Health Protection Act of 1996

Under federal law, group health plans, generally, may not restrict benefits for any hospital length of state in connection with childbirth for the mother or newborn child to less than 48 hours following vaginal delivery, and 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). Health plans may not require that a provider obtain authorization from the plan or the issuer for prescribing length of stay no in excess of 48 hours (or 96 hours).

The Women's Health and Cancer Rights Act

The Women's Health and Cancer Rights Act (WHCRA) provides protections for individuals who elect breast reconstruction after a mastectomy. Under WHCRA, group health plans offering mastectomy coverage must also provide coverage for certain services relating to the mastectomy, in a manner determined in consultation with the attending physician and the patient. Required coverage includes all stages of reconstruction of the breast on which the mastectomy was performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, prostheses, and treatment of physical complications of the mastectomy, including lymphedema.

EXCLUSIONS AND LIMITATIONS – MEDICAL

Under the Indemnity Medical PPO Plan 4, the following items are not considered covered expenses:

1. Services and supplies that are not Medically Necessary.

2. Services, supplies or equipment for which a charge is not customarily made in the absence of insurance. This does not apply to charges incurred at a charitable research Hospital or covered by Medi-Cal.

3. Injury or Sickness arising out of or in the course of employment or self-employment.

4. Declared or undeclared war, or act of war. Conditions caused by the release of nuclear energy, whether or not the result of war.

5. Expenses which are not approved by a licensed health care provider.

6. Any amounts by a Non-PPO Provider in excess of the UCR allowance.

7. Cosmetic surgery, except for repair of damage caused by accidental bodily injury while eligible under this Plan. The term "cosmetic surgery" means surgery to change the shape or structure of, or otherwise alter a portion of the body, performed solely or primarily for the purpose of improving appearance and not as a result of a disease or condition which, in accordance with accepted medical practice, requires surgical intervention to cure, alleviate pain, or restore function. Restorative surgery performed during or following surgery, which was required as a result of illness or injury shall not be considered cosmetic. Reconstructive surgery performed to correct a congenital disease or defect shall not be considered cosmetic.

8. Eye examination for the purpose of prescribing corrective lenses, fitting glasses or correcting visual acuity via surgical procedures.

9. Glasses, hearing aids, or contact lenses, except the first pair of glasses or contact lenses when required because of surgery.

10. Radial keratotomy, Lasik or any other surgical procedure performed to correct visual acuity.

11. Charges made by a health care provider who is related to or living with the Participant requiring treatment.

12. Any period of custodial care confinement in a Hospital or Skilled Nursing Facility, except as specifically stated in the Skilled Nursing Facility definition.

13. Dental plates, bridges, crowns, caps or other dental prostheses, dental services, extraction of teeth or treatment to the teeth or gums, except for dental treatment required by injury to natural teeth as a direct result of injury while insured. Benefits for hospitalization will be paid if hospitalization is demonstrated to be Medically Necessary to the performance of dental services. These benefits will be paid on an 80% reimbursement rate.

14. Sterilization reversal, artificial insemination and in vitro fertilization.

15. Expenses incurred for Hospital, surgical and in-Hospital Physician services or supplies in excess of reduced Plan benefits resulting from noncompliance with the provisions of the Hospital Utilization Review and Pre-Authorization (Pre-Certification) Programs.

.16. Charges that are used to satisfy the Calendar Year Deductible.

17. Chiropractic services obtained from Non-PPO Providers or PPO Providers that have not been pre-authorized by Chiropractic Health Plan of California.

18. Prescription Drug benefits except as described in Prescription Drug Section or under the Coordination of Benefits provisions.

19. Outpatient speech therapy, except following surgery, injury or noncongenital Sickness.

20. For Voluntary Self-Pay Retirees in Plan 4, any expenses incurred for Mental Illness and Substance Abuse treatment, whether inpatient or outpatient.

21. Experimental treatment including genetic testing, except for the BCRA testing defined under the preventive benefits for women or the Cologuard-type (DNA) screening if determine to be a medically necessary screening based on Anthem Blue Cross guidelines.

22. Services, supplies or equipment covered under any plan, other than the Indemnity Medical Plan, offered by Gold Coast Joint Benefits Trust, if the plan is a primary plan for coordination of benefits purposes. If such services, supplies or equipment are not available as a covered item under the dependent's primary plan, and this Plan is the dependent's secondary Plan for Coordination of benefits purposes, then this plan will pay according to its rules upon receipt of a letter of declination of benefits payable from the primary plan.

23. The Employee Assistance Program does not provide benefits to voluntary self-pay retirees or their dependents.

24. Any illness or injury incurred in, or aggravated during, performances of services in uniformed services. In determining whether an illness or injury was incurred in or aggravated during military service, the Board will give deference to any determination by the Department of Veterans Affairs.

PRESCRIPTION BENEFITS

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PRESCRIPTION BENEFITS

This benefit covers medically necessary prescription drugs and medicines which can be lawfully purchased only with a written prescription from a physician, but not to exceed a 30-day (retail) or 90-day (mail order) supply per prescription. You and your Physician select whether a generic, preferred brand or non-preferred brand Drug is medically best for you. Your choice may result in higher copayments. The Trust's pharmacy benefit manager (and not the Trust's Board of Directors) determines which Drugs are placed on the formulary. In compiling the formulary, Express Scripts, in consultation with an outside group of Physicians and Pharmacists, selects Drugs from among virtually all therapeutic types — based upon such factors as effectiveness, cost, quality, safety and potential side effects. The list of preferred brand Drugs on the formulary is extensive and is updated frequently.

Prescription benefits are provided through the Pharmacy Benefit Manager (PBM),. There are two options for filling or refilling your prescriptions:

Retail Pharmacy: For immediate, short-term needs, up to a 30-day supply. Your PBM has a large national network of participating pharmacies. In most cases, you will not have to visit a non-participating pharmacy. However, if you choose to go to a non-participating pharmacy, you will pay 100% of the prescription price when you receive your prescription.

Mail Order: For maintenance medications that can be delivered directly to your home, up to a 90-day supply. This plan has a mandatory mail order program. To be covered under the Plan, you may only purchase maintenance medications at a retail pharmacy twice, and then the third fill must be purchased through Express Scripts mail order program.

Prior Authorization

Prior Authorization is generally utilized to promote quality, utilization practices of potentially high cost, limited use, or inappropriately utilized medications. If you fill or refill a prescription for any drug that requires prior authorization, your doctor must obtain authorization from the PBM before the prescription will be covered.

This Plan has the following prescription drug program requirements:

Utilization Review

In order to prevent the abuse of prescription drugs, particularly controlled substances such as narcotics, the Plan reserves the right to require utilization review by a medical consultant for the renewal of any prescription if it appears that it is not being utilized in accordance with safe and accepted medical practice (e.g. a narcotic drug taken over an excessively long period of time and/or in extremely high doses *may* be an indication of drug addiction rather than medically necessary treatment of episodic or chronic pain, in which case consultation with the prescribing doctor and review by the Plan's independent physician consultant may be required before the renewal is approved).

Step Therapy

Step therapy is a process to ensure you are receiving a cost effective therapy. Under this program, you will be required to first try a recognized first line medication (Step 1) before approval of a more costly and complex therapy is approved (Step 2). If the Step 1 therapy does not provide you with the therapeutic benefit desired, your physician may write a prescription for a Second Line medication. Generally, Second Line medications require the usage and failure of a First Line medication before coverage is authorized.

Specialty Drug Program

Specialty medications are used to treat and manage complex disease conditions that include, but are not limited to multiple sclerosis, hemophilia, and cancer. Depending on the condition and prescribed therapy, these medications may be taken orally (by mouth), intravenously (IV), or self-injected. Specialty medications often require special handling, such as refrigeration, and they can be expensive. Certain specialty medications require prior authorization and must be obtained through US Specialty Care Pharmacy after one fill at a participating retail pharmacy. US Specialty Care Pharmacy provides complete and comprehensive specialty pharmacy services for chronic conditions.

Quantity Limitations

The Quantity Limitations program sets quantity limits on certain medications. The Plan will provide coverage for medications up to the designated quantity limit. If the prescribing physician determines it is medically necessary to exceed the set limit, prior approval must be obtained before the higher quantity can be covered.

BENEFITS	COVERAGES
Annual/Calendar Year Deductible: None Annual/Calendar Year Out-of-Pocket Maximum: $4,600/person, $9,200/family	
Retail Pharmacy Benefits The plan allows for up to a 30-day supply, if prescribed by your physician and purchased at a contracted pharmacy.	This Plan: Covers the contract rate for most medicines, including contraceptives, which can be lawfully purchased only with a written prescription from a Physician, but excluding the following: most vitamins and dietary supplements; drugs or devices for infertility purposes; as well as most over-the-counter medications. Pharmacies that are part of the pharmacy benefit manager network will automatically substitute a generic equivalent drug for the brand name drug unless your physician indicates otherwise. Provides coverage of an annual flu shot obtained at a participating network pharmacy, payable at 100%.
Your Cost: Generics $15 copay Formulary $30 or 20% copay, whichever is greater Non-Formulary $50 or 35% copay, whichever is greater	
Mail Order Benefits The plan allows for up to a 90-day supply, if prescribed by your physician and purchased at a contracted pharmacy.	
Your Cost: Generics $30 copay Formulary $60 copay Non-Formulary $100 copay	

After you pay the required copay shown in the table above, the Plan pays the remainder of the retail price for the prescription or refill up to a 30-day supply for retail and 90-day supply for mail orders.

If the full retail price is less than minimum copayment shown per Plan, your copayment will be the retail price. You must pay your copayment to the pharmacy at the time you purchase the prescription or refill.

The FDA requires that generic drugs must be as high quality, strong, pure and stable as brand-name drugs. As a result, a generic drug is the same as a brand name drug in dosage, safety, strength and quality. A generic drug is also the same in the way it works, it is taken and the way it should be used. The main difference between Generic and Brand Name is that Brand Name Medications are usually under patent or have a trademarked name that appears on the package label.

Out-of-Pocket Maximum

The out-of-pocket maximum means that if, during one calendar year, if out-of-pocket expenses for covered prescriptions exceeds the maximum amount established, the Plan will pay 100% of any additional covered charges incurred for the remainder of that calendar year for that participant or family, provided that network pharmacies are used. The prescription maximum you will pay in a calendar year for prescription drugs is $4,600 per covered participant / $9,200 per family.

Your combined medical and prescription Out-of-Pocket maximums will not exceed the maximums established by the Department of Health and Human Services. These maximums are indexed by law and may be subject to change in subsequent years. Any covered expense which was incurred during the last three months (October, November or December) of the preceding calendar year for which there was a percentage share of cost will be carried forward and counted toward the out-of-pocket maximum for the next plan year.

Only prescription drug copays paid in compliance with the Trust's Prescription Drug Plan accumulate towards the Prescription Drug Out of Pocket Maximum. The following charges do not count towards the Prescription Out of Pocket Maximum and are not paid by the Trust at 100% in the event that you reach your individual or family prescription Out of Pocket Maximum:

- Charges for prescriptions filled at non-Network pharmacies;
- Charges for prescriptions obtained at a retail pharmacy for maintenance medications after the second refill, as it is required that they be obtained under the Pharmacy Benefit Manager's Mail Order Program;
- Charges for prescriptions requiring Prior Authorization that have not been approved under the Express Scripts Step-Therapy Program and Drug Quantity Management programs; and
- Prescription and non-prescription drug expenses excluded by the Prescription Drug Plan.

Prescription Drug Network providers are pharmacy (retail, mail order, and specialty) providers who have contracted with the Trust's pharmacy benefit manager.

EXCLUSIONS AND LIMITATIONS – PRESCRIPTION

The following list provides some of the medicines that are not covered by the Plan:

1. Non-legend Drugs, vitamins (except as listed above) and minerals;

2. Prescriptions which are covered by workers' compensation laws, or other county, state or federal programs;

3. Drugs labeled "Caution: Limited by Federal Law to Investigational Use" or Experimental Drugs, even though a charge is made to the Participant;

4. Drugs dispensed or administered in an outpatient setting, including but not limited to outpatient Hospital facilities and Doctors' offices;

5. Drugs administered while in an inpatient at a licensed Hospital, Skilled Nursing Facility, extended care facility, nursing home or similar facility;

6. Blood and blood-related products;

7. Oxygen;

8. Drugs obtained outside the United States;

9. Professional charges in connection with administering or injecting Drugs;

10. Weight loss control or management;

11. Devices, appliances and medical supplies;

12. Any prescription refilled in excess of the number of refills specified by the Physician, or any refill dispensed one year after the Physician's original order;

13. Contraceptive jellies, creams, foams or devices;

14. Smoking deterrents;

15. Topical fluoride products;

16. Methadone;

17. Drugs whose sole purpose is to promote or stimulate hair growth (e.g.. Rogaine, Propecia) or for cosmetic purposes only (e.g. Renova, Vanica); and

18. Allergy sera; and biologicals, immunization agents or vaccines.

IMPORTANT
INFORMATION ABOUT HOW YOUR PLAN WORKS

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SUBROGATION & REIMBURSEMENT PROVISION

If a Participant incurs a Sickness, injury, disease or other condition (hereinafter "injury") for which a third party may be liable or legally responsible, the Trust will be reimbursed from any proceeds received by way of judgment, settlement or otherwise in connection with, or arising out of, any claim for damages by such Participant or his heirs, parents or legal guardians, in an amount equal to the payments made or to be made by the Trust in connection with, or arising out of, such injury for which recovery is obtained from a third party.

The Trust will have a lien on all amounts paid or to be paid by or on behalf of any third party as a result of the exercise of any rights of recovery by the Participant against the third party for any injury sustained by the Participant for which the Trust has made payment. The Trust will be entitled to reimbursement and/or payment in satisfaction of its lien, even though the total amount of the Participant 's recovery is less than the actual loss suffered by the Participant. The proceeds of any recovery obtained by a Participant on account of the injury shall first be applied to satisfy the Trust' s lien or other rights under this provision.

The Trust does not recognize the Make Whole Doctrine. The Trust is entitled to obtain restitution of any amounts owed to it either from third-party funds received by the Participant or the Participant's eligible dependents, regardless of whether the Participant or the Participant's eligible dependents have been made whole for losses sustained at the hands of the third party.

The Trust expressly rejects the Common Fund Doctrine with respect to payment of attorney's fees. A Trust representative may commence or intervene in any proceeding or take any other necessary action to protect or exercise this Trust's equitable (or other) right to obtain full restitution.

In addition, the proceeds of any such recovery are not the Participant 's personal property unless and until the Trust's right to reimbursement and/or payment in satisfaction of its lien is resolved, may not be included or considered during and/or as part of any bankruptcy and must be held in trust by the Participant on the Trust's behalf while the Trust's right to reimbursement and/or payment in satisfaction of its lien is resolved.

The Participant will do whatever is necessary or appropriate to secure the above rights of the Trust, including: (I) the execution of any assignments, liens, Agreement to Reimburse, acknowledgements, or other documentation requested by the Trust; and (2) notifying Participant 's attorney of the Trust 's lien. The Participant will do nothing to prejudice such rights. A Participant' s failure to sign such an assignment or acknowledgement of lien will not defeat the Trust's right to reimbursement and/or any other of its rights as set forth in this provision.

The Participant will hold in trust for the benefit of the Trust all amounts received from or on account of a third party . If any action or proceeding is commenced or any claim is asserted against any third party for the injury or death of a Participant, or if any settlement agreement is made with the third party , the Participant or his or her representative or heir instituting an action or claim or participating in a settlement will promptly notify the Trust. The failure of the Participant to give such notice to the Trust, to cooperate with the Trust, or to sign the Agreement to Reimburse constitutes a material breach under the Plan and will result in the Participant being personally responsible to reimburse the Trust.

Notice of the rights of the Trust, including the above mentioned lien rights, may be filed by the Trust with any person having a material interest in the existence of such rights, including, but limited to, the court in which an action is filed, the attorney for the Participant, the third party responsible for the Participant's injury, and the third party's insurer.

The Trust's reimbursement, lien and trust rights will be limited to the recovery by the Trust of the amounts it has paid in connection with such injury.

Subject to the provisions set forth herein, the Trust's Administrator has the authority to reduce third-party liens in accordance with the following formula. The Trust will accept the lesser of:

Two-third s (2/3) of the Trust's gross lien (100% of the Trust's gross lien if the Participant obtains a recovery without incurring legal fees); or

Fifty percent (50%) of the first $25,000 of the individual's net recovery, plus eighty-five percent (85%) of any excess.

"Gross lien" means the total benefits paid or payable to or on behalf of the injured Participant ("injured party").

"Net recovery" means the total amount paid or payable to or on behalf of the injured party, less attorney's fees and litigation costs actually expended by or on behalf of the injured party.

The formula set forth above shall not apply to any case where the net recovery exceeds $100,000, but is less than the Trust's gross lien. Any such case shall be referred to the Board of Directors to determine the appropriate reduction.

In the event the injured party, or such party's attorney, requests a reduction beyond the formula set forth in (a) or (b) above, such request shall be forwarded to the Trust's Administrator who shall present the same to the Board of Directors. Factors such as loss of earnings, out-of-pocket expenses, anticipated unreimbursed future medical expenses, the permanence of the injuries and the impact of the same on future employment may be considered by the Board in determining the appropriateness of any further reduction.

The Trust's lien applies to all amounts received or to be received by the injured party regardless of the source of payment, except that no lien shall apply to any amount received from any uninsured motorist or underinsured motorist coverage in any policy of insurance, provided that the injured party is a named insured in the policy.

Notwithstanding the foregoing, no reduction of any lien will be made (whether or not the injured party or the party's attorney has been previously advised of a reduction) if:

- The Trust brings any suit or other legal proceeding, or becomes involved in any suit or proceedings, to enforce its lien or to recover any amount owing thereunder, or to defend against any claim arising out of the same; or

- In the opinion of the Board the injured party or the party's attorney has attempted to evade or avoid the Trust's lien. "Evade or avoid" includes, but is not limited to, the failure to advise the Trust that the injuries were caused by a third party, the failure to execute the written acknowledgment of the lien, or the failure to timely notify the Trust Administrator of any recovery.

COORDINATION OF BENEFITS (COB)

The intent of coordination of benefits (COB) is to provide that the sum of benefits paid under this Plan plus benefits paid under all other plans will not exceed the actual amount of covered expense for a treatment or service. Covered expense will be interpreted to be the Covered Expense or the usual, customary and reasonable amount for a service or treatment; therefore, a claim will not necessarily be paid to the full billed amount by receiving benefits through more than one health plan.

Covered Expenses shall not include out-of-pocket expenses incurred as the result of non-compliance with the Plan's Hospital Contracting and Hospital Utilization Review and Pre-Certification Programs (see section entitled Hospital Utilization Review and Pre-Authorization (Pre-Certification).

Effect on Benefits

The effect on benefits is that the amount of covered expense that would otherwise be payable under this Plan may be reduced if benefits are payable under any other plan for the same expenses.

Order of Benefit Determination

If a person is covered under this Plan and under one or more other plans, the rules set forth below apply. The plan that pays first does so without regard to coverage under other plans. The plan that pays as secondary does so with regard to, or in coordination with, the allowed amounts and inclusions of coverage in excess of the primary Plan.

1. A plan that does not provide for Coordination of Benefits will pay its benefits first.
2. A plan that covers a person as an employee will pay its benefits before the plan that covers the person as a dependent.
3. A plan that covers a person as a dependent is primary to one that covers a person as a retiree or laid off employee or dependent of such person. If either plan does not have a provision regarding laid off or retired employees and it results in each plan determining its benefits after the other, then this provision shall not apply.
4. A plan covering a person as an active employee or eligible dependent is primary to a COBRA plan. In cases where the plans do not agree on this order of benefit determination, the plan that has covered the person for the longer period of time will be designated as the primary payer.
5. A plan covering a person as a dependent is primary to Medicare and a plan covering a person as a retiree or disabled individual is secondary to Medicare.
6. When a child is covered by the plans of both parents, unless they are divorced or legally separated, the plan of the parent whose birthday occurs earlier in the calendar year will pay first. This rule applies to the month and day of birth, without regard to the year. However, if the other plan's Coordination of Benefits provisions do not use the parents' birthdays to determine which of the parents' plans pay first, the other plan's provisions will make the determination.
7. If a child's parents are divorced or legally separated, payment will be made by: (a) the plan of the parent with custody before the plan of a stepparent or of the parent without custody; or (b) the plan of a stepparent before the plan of the parent without custody. However, if, by court decree, one parent is held responsible for the child's health care expenses, payment will be made first by the plan of that parent.
8. When the rules above do not apply, the plan that has covered the person for the longer period of time will pay its benefits first. A new plan is not established when coverage under one health plan or carrier is replaced within one day by that of another.

Coordination with Medicare

Medicare is the secondary payer for:

(a) active employees over age 65;

(b) active employees' spouses who are age 65 or older;

(c) covered employees and their dependents who are eligible for Medicare due to disability regardless of age; and

(d) the first thirty (30) months of treatment for 'end stage renal disease' for employees and their dependents under age 65.

Charges are excluded for any services or supplies to the extent that the Plan participant is eligible for coverage under Parts A or B of Medicare, whether or not he or she has actually enrolled in Medicare or claimed Medicare benefits. The only exception to this rule is for those employees who were hired prior to March 31, 1986 and do not qualify for premium free Medicare Part A. You must still, however, enroll and pay premiums for Medicare Part B. Note that this exception does not apply to the HMO Medical plan option.

Coordination of Benefits with the PPO and HMO

- Preferred Provider Organizations (PPO): Where this Plan is coordinating benefits with another health plan which has entered into a Preferred Provider Agreement with a medical or hospital provider, in no event will this Plan's covered expenses exceed the lesser of this Plan's own PPO rate or UCR (whichever is applicable) or the other Plan's PPO rate.

- Health Maintenance Organizations (HMO): Where this Plan is coordinating benefits with a Health Maintenance Organization, this Plan will coordinate only on copayments, and will not assume primary status when services are obtained from out of network providers.

Exchange of Information

Any Plan participant who claims primary benefits under this Plan must provide all information that is needed to coordinate benefits. In addition, all information that is needed to coordinate benefits may be exchanged with other companies, organizations, or persons only for this express purpose.

Facility of Payment

The Plan may reimburse any other plan if benefits were paid by that other plan but should have been paid under this Plan in accordance with the detailed provisions of this section. In such instances, the reimbursement amounts will be considered benefits paid under this Plan and, to the extent of those amounts, will discharge this Plan from liability.

Explanation of Benefits Required

When it is clearly indicated that a Plan participant has primary coverage under Medicare or another health plan, the claim submitted to Delta Health Systems must also have an Explanation of Benefits from the other health plan attached stating the exact amount of benefits paid. If this information is not attached, the claim will be denied, as it will not be possible to determine liability under this Plan. Once the Explanation of Benefits is submitted for a claim, Delta Health Systems will then coordinate benefits and process the claim for payment of any covered expense allowed under this Plan.

COBRA

In accordance with the Consolidated Omnibus Budget Reconciliation Act (COBRA), when health care coverage ends, you or your covered dependents may be eligible to continue your benefits at your own expense for a temporary period. To be eligible, you and your covered dependents must:

- experience a qualifying event that causes the loss of coverage, and
- make an election to continue coverage within 60 days of the date coverage terminated or the date of the Qualifying Event Notification, whichever is later (see Applying for Coverage in this section).

The following chart lists qualifying events, which is eligible to continue coverage and how long benefits may continue.

The Reason Coverage Stopped Qualifying Event	Who May Continue Qualified Beneficiary(ies)	Longest Period of Continuation Coverage
Your employment stops for any reason other than gross misconduct	You and your dependents	18 months
Any reduction in hours that prevents you from meeting the eligibility requirements See *Eligibility* at the beginning of this Summary Plan Description for more information	You and your dependents	18 months
You divorce or legally separate	Ex-spouse and/or dependent children	36 months
Your dependent children no longer meet the eligibility requirements	Former Dependents	36 months
You become entitled to Medicare	Dependents	36 months
You die	Dependents	36 months

A qualified beneficiary is:

- you, your spouse or domestic partner, and dependent child(ren) enrolled for coverage immediately before the qualifying event, and
- a child born, adopted or placed for adoption during the continuation period (if family coverage is in effect).

Any qualified person who acquires a newly eligible dependent while continuing coverage will be permitted to cover that dependent for the balance of the period as stated above. Coverage for that dependent is subject to the enrollment requirements as described under the section entitled *Eligibility*.

The benefits provided under continuation coverage will be the same as those provided to active employees, their spouses or children who are covered under the Trust. If the plan benefits change, benefits under continuation coverage will also change.

Continuation Coverage Options

Delta Health Systems must give you written notice of your continuation rights, obligations, and contribution costs within fourteen (14) days of receiving notice of a qualifying event. At that time you and your dependent(s) will be given the opportunity to select one of the following coverage options:

- Full Coverage: medical, prescription, dental and vision benefits;
- Core Coverage: medical and prescription benefits only; or
- Dental and/or Vision only.

Although you can drop coverage (i.e. dental and/or vision) after your initial continuation coverage election, you cannot add coverage at a later date.

Multiple Qualifying Events

If an employee or a dependent is disabled (as defined by the Social Security Administration) at the time of a qualifying event, or within 60 days of a qualifying event, and notifies the company within 60 days of the classification, the disabled individual and all other covered participants may continue coverage for an additional 11 months, for up to a total of 29 months. Notice of a disability award must be provided to Delta Health Systems within 60 days after it is issued, and within the initial 18-month period of continuation coverage. If the Social Security Administration determines that the disability no longer exists, you or your dependents must notify Delta Health Systems within 30 days. During the additional 11-month period of coverage, contributions may be increased up to 150% of the regular cost of coverage.

If coverage is continued because of a qualifying event for which the continuation period is 18 months, this 18-month period can be extended to 36 months from the initial qualifying event, if the second qualifying event would have allowed 36 months of extended coverage. For example, an employee terminates employment, elects continuation coverage for his family for up to 18 months and remits the contributions. Two months later, one of his children reaches the maximum eligibility age; that former dependent child can now elect continuation coverage for him/herself for 34 months (36 months minus the two months already received).

Applying for Coverage

In the following circumstances, it is your or your dependent's responsibility to notify Delta Health Systems of the following events within 60 days in order to elect continuation coverage:

- one of your dependents loses coverage due to your divorce or legal separation, or
- domestic partnership is terminated, dissolved, or nullified, or
- a dependent no longer meets the eligibility requirements, or
- your death

If notice is given more than 60 days after the Qualifying Event occurs, continuation coverage rights will be forfeited.

Delta Health Systems will notify you, your spouse and/or dependent children of the right to elect continuation coverage if one of the following events takes place:

- your termination,
- your reduction in your work hours or
- your death.
- A valid election to continue coverage must be made within 60 days from the later of:
- the notification date, or
- the date coverage terminates.

An election is deemed made on the date the signed election form is sent back to Delta Health Systems (postmark on the envelope).

If a valid election for continuation coverage is not made within the 60-day election period, the option of electing continuation coverage will be forfeited.

Cost of Coverage

If you or your dependents choose to continue coverage, you will have to pay the full cost of the coverage plus 2% for administrative costs; payments must be made retroactive to the date coverage terminated.

Your contributions must be received by Delta Health Systems on the first of each month that coverage is to be in effect. Your first contribution is due within 45 days of the date you elect continuation coverage, although it is recommended that payment be submitted with the election form. There is a 30-day grace period for payment of regularly scheduled contributions; if the contribution is not received or postmarked before the expiration of the grace period, continuation coverage will end and will not be reinstated. For example, if March is your first month for COBRA benefits, that contribution will be due no later than 45 days from the date of your election; thereafter, your contribution for April will be due April 1, but if it is not received by, or postmarked to, Delta Health Systems by April 30, it will not be accepted and your right to COBRA coverage for the remainder of that COBRA eligibility period will be terminated.

Important: No benefit claim will be paid unless the required payment has been received for the period in which the claim occurred.

When Continuation Coverage Ends

Continuation coverage will terminate if one of the following events occurs:

- you or your dependents fail to make timely payments,
- you or your dependents reach your maximum period allowed under the continuation period,
- the Trust discontinues all medical, prescription benefit, vision and dental care plans offered to employees,
- SSA determines that the disabled qualified beneficiary is no longer disabled,
- You or your dependents become entitled to Medicare,
- you become covered, as an employee or dependent, under another group health plan or
- your employer ceases to make contributions to the Trust and provides other group health plan coverage for its employees.

COBRA coverage may also be terminated for any reason the Plan would terminate coverage of a Participant not receiving COBRA coverage (such as fraud).

Legislation relating to COBRA occasionally changes. This Plan will remain in compliance with all applicable laws or any future IRS guidance, even if it conflicts with Plan provisions.

Notice to Terminating Employees

The California Department of Health Care Services may pay the cost of COBRA continuation coverage for certain persons losing employment:

- Persons eligible for Medi-Cal may qualify for the Health Insurance Premium Payment (HIPP) Program. To inquire about eligibility requirements or to enroll, email the Department of Health Care Services at HIPP@dhcs.ca.gov or visit their website at:

  http://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx

- Persons disabled by HIV/AIDS who under the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act of 1990 may qualify for the Health Insurance Continuation Program (CARE/HIPP). For additional information on CARE/HIPP contact the California AIDS Hotline at 1 (800) 367-2437.

CLAIMS AND APPEALS PROCEDURES

These procedures apply to claims, and appeals of denied claims, for benefits directly by the Trust under its Indemnity Medical PPO Plan 4. These procedures do not apply to claims for benefits provided by the Trust through health maintenance organizations (HMOs), nor do they apply to claims for benefits provided by the Trust under its Indemnity Dental and Vision Plans. For the procedures that apply to those benefits, please refer to the separate booklets applicable to those plans.

Applicability

These procedures apply to claims, and appeals of denied claims, for benefits provided directly by the Trust under its Indemnity Medical Plan (the "Plan").

These procedures do NOT apply to claims for benefits provided by the Trust through health maintenance organizations (HMOs) nor do they apply to claims for benefits provided by the Trust under its Indemnity Dental and Vision Plans. For the procedures that apply to those benefits, please refer to the separate booklets applicable to those plans.

Eligibility Determinations: Appeals of eligibility determinations that are unrelated to any specific claim and that are not "rescissions The procedures for filing an Eligibility Determination appeal are the same as filing an appeal on a Post-Service claim, with the following exceptions:

- Written notice by the Plan will be provided within 30 days of the date of the Board's decision.
- External review is not available for these types of appeals. Any references in the Appeals Process relating to External Review do not apply to Eligibility Determinations.
- Any portion of the Appeal Procedures that is specific to a claim for benefits does not apply to Eligibility Determinations (i.e. references to diagnosis, medical necessity).

Definitions

These definitions will help you understand the rules for filing claims for benefits and appealing the denials of such claims. A "claim" is a request for benefits under the Plan submitted in accordance with the procedures described in this Plan Description Booklet.

- The following are not "claims":
  - Inquiries about Plan benefits or eligibility that are unrelated to any specific claim. Requests for prior approval, when prior approval is not required under the Plan.
  - There are four types of claims: Post-Service Claims, Pre-Service Claims, Urgent Care Claims, and Concurrent Claims. The rules for submitting, processing and appealing claims depend on the type of claim involved.

- There are four types of claims, which are outlined below:
  - A "Post-Service Claim" is a request for payment or reimbursement after you receive care, where approval was not required prior to obtaining services.
    - This includes claims for services received in an Emergency.
    - A rescission of coverage is treated like a denial of a Post-Service Claim. A rescission of coverage is a cancellation or discontinuance of coverage that has a retroactive effect, except to the extent it (1) is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage, (2) due to the request of the individual (or their representative), or (3) due to the request of an Exchange.

- "Pre-Service Claim" is a request for benefits where the payment will be reduced or services will not be covered unless you receive approval prior to obtaining care.
- An "Urgent Care Claim" is a type of Pre-Service Claim where the time period for making a determination is reduced because the usual time for processing the claim either: (i) could seriously jeopardize your life, health or ability to regain maximum function; or (ii) would subject you to severe pain that cannot be adequately managed without the care that is the subject of the claim.
    - The attending provider will determine whether a claim is an Urgent Care Claim and the Trust will defer to such determination
    - Benefits in an Emergency do not require prior approval. Therefore, claims for benefits provided I an Emergency are Post-Service claims.
- A "Concurrent Claim" is where the Trust, or entity acting on behalf of the Trust, has approved an ongoing course of treatment to be provided over a period of time or a specified number of treatments.

Use of an Authorized Representative

Your authorized representative, such as your spouse, may file a claim or appeal a denied claim for you, provided that you have previously designated the individual to act on your behalf. A form can be obtained from the Trust Administrator to designate an authorized representative. The Trust Administrator may request additional information to verify that this person is authorized to act on your behalf. A health care professional with knowledge of your medical condition will be permitted to act as your authorized representative for an Urgent Care Claim without written verification.

FILING A CLAIM

Post-Service Claim

If you use a PPO Provider, the PPO Provider will file your claim for you, and you will not need to submit bills to the Trust Administrator.

If you use a non-PPO Provider, you must:

- Obtain a medical claim form from the Trust Administrator or your district office.
- Complete and sign the form and give it to your Doctor for completion.
- Return the completed claim form, with the itemized bills attached, to the Trust Administrator at the address indicated on the claim form.
- Claim forms must be used; cancelled checks or receipts are not acceptable.
- For charges to be covered under the Plan, claim forms must be filed no later than one (1) year from the date medical services or supplies are obtained. A claim is considered to be filed when it is received by the Trust Administrator, regardless of whether it contains all the information necessary to render a decision. Claims filed after this one (1) year deadline will be denied, and the Trust will not pay and is not responsible for paying any late filed claims.
- If you have any questions about filing a claim or need any assistance completing the claim form, the staff of the Trust Administrator will be pleased to help. They can be reached Monday through Friday, 7:30 a.m. to 5:00 p.m., at 1(800) 556-5918.

Pre-Service Claim

A Pre-Service Claim must be filed if you wish to obtain a Plan benefit that requires Pre-Authorization (Pre-Certification) or pre-approval. Pre-Service Claims must be submitted as follows:

Benefit:	Submit Claim to:
Non-Emergency Hospital Admissions	Anthem Blue Cross, by calling (800) 274-7767 at least ten (10) days before the admission.
Durable Medical Equipment that costs $2,000 or more to rent or purchase	Anthem Blue Cross
Gastrointestinal Bypass Surgery for morbid obesity	Anthem Blue Cross
Mental Illness and Substance Abuse Benefits	Anthem Blue Cross
Chiropractic Services	Chiropractic Health Plan of California (CHPA). If you use a Contract Provider, he or she must contact CHPA in accordance with Section VI.M. If you use a non-Contract Provider in an Emergency, you must file a claim with CHPA.

Failure to file a proper Pre-Service Claim. If you fail to properly file a Pre-Service Claim, you will be notified of the failure and the proper procedures for filing the claim as soon as possible, but not later than five (5) days following the failure (or twenty-four (24) hours in the case of Urgent Care Claims). Notification may be oral, unless you request written notice.

TIMELINES FOR PROCESSING CLAIMS

The following timelines are mandated by federal law; you may voluntarily agree to extend the timelines to process any type of claim.

Post-Service Claim

You will be notified of a denial within thirty (30) days after your claim is filed, unless an extension of time for processing the claim is necessary due to matters beyond the control of the Trust.

- If such an extension if necessary, you will be notified in writing, within the initial 30-day period, of the circumstances requiring the extension of time and the date by which the Trust expects to render a decision, which will not be more than forty-five (45) days from the date the claim was filed.
- If the extension is due to your failure to submit the information necessary to decide the claim, the extension notice will describe the required information, and you will be allowed at least forty-five (45) days from receipt of the extension notice to provide such information. The time period for making the decision will be suspended from the date on which the extension notice is sent to

you to the earlier of: (i) the date on which your response is received by the Trust; or (ii) the due date specified in the extension notice for furnishing the requested information.

Pre-Service Claim

You will be notified of the decision, whether adverse or not, within a reasonable period of time appropriate to the medical circumstances, but not later than fifteen (15) days after your claim is filed, unless an extension of time for processing the claim is necessary due to matters beyond the control of the Trust.

- If such an extension is necessary, you will be notified, within the initial 15-day period, of the circumstances requiring the extension of time and the date by which the Trust expects to render a decision, which will not be more than thirty (30) days from the date the claim was filed.
- If the extension is due to your failure to submit the information necessary to decide the claim, the extension notice will describe the required information, and you will be allowed at least forty-five (45) days from receipt of the extension notice to provide such information. The time period for making the decision will be suspended from the date on which the extension notice is sent to you to the earlier of: (i) the date on which your response is received by the Trust; or (ii) the due date specified in the extension notice for furnishing the requested information.

Urgent Care Claim

You will be notified of the decision, whether adverse or not, within a reasonable period of time appropriate to the medical circumstances, but not later than 72 hours after your claim is filed, unless you fail to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan. In the case of such a failure, you will be notified as soon as possible, but not later than twenty-four (24) hours after the claim is filed, of the specific information necessary to complete the claim, and you will be allowed a reasonable period of time, taking into account the circumstances, but not less than forty-eight (48) hours, to provide the specified information. You will be notified of the decision as soon as possible, but not later than forty-eight (48) hours after the earlier of: (i) the Trust's receipt of the specified information; or (ii) the end of the period given to you to provide the specified information.

Concurrent Claim

Any reduction or termination by the Trust or entity acting on behalf of the Trust (other than by Plan amendment or termination) of an ongoing course of treatment, before the end of such period of time or number of treatments, is a claim denial. You will be notified of the denial sufficiently in advance of the reduction or termination to allow you to appeal and obtain a decision on appeal before the benefit is reduced or terminated. Any request by you to extend an ongoing course of treatment beyond the approved period of time or number of treatments that is an Urgent Care Claim will be decided as soon as possible, taking into account the medical exigencies, and you will be notified of the decision, whether adverse or not, within twenty-four (24) hours after the claim is filed, but only if such claim is filed at least 24 hours prior to the expiration of the prescribed period of time or number of treatments. Otherwise, the decision will be made as soon as possible, but not later than 72 hours after the claim is filed.

The Trust Administrator or PPO Provider will provide you, automatically and free of charge, with any new or additional evidence or rationale considered, relied upon, or generated in connection with your claim while it is under review. You will be provided with the new or additional rationale sufficiently in advance of the date on which the Trust Administrator or PPO Provider is required to provide you with an adverse benefit determination. This is to give you time to respond to the new or additional rationale. If the new/additional evidence or rationale is received so late that it would be impossible to provide it to you in time to give you a reasonable opportunity to respond, the period for providing a notice of adverse benefit determination will be paused for a reasonable period of time in order to give you an opportunity to respond. As soon as a

reasonable period of time has passed you will be provided with the adverse benefit determination notice in a reasonable and prompt manner.

Notice of Claim Denial

If your claim is denied, in whole or in part, you will be notified of the denial in writing (except for Urgent Care Claims, in which case notice may be provided orally, followed by a written notice within three (3) days after the oral notification). Such written notice of denial will contain the following information:

- Information sufficient to identify the claim involved, including the date of service, the health care provider, and the claim amount (if applicable).
- The specific reason(s) for the denial, including the denial code (and its corresponding meaning) and a description of the Plan's standard(s), if any, that was used in denying the claim.
- Reference to the specific Plan provision(s) on which the denial is based.
- If applicable, a statement that an internal rule, guideline, protocol, or other similar criterion was relied upon in denying the claim and that a copy of such rule, guideline, protocol, or other criterion will be provided to you, free of charge and upon request.
- If the denial is based on a medical necessity or experimental treatment or similar exclusion or limit, a statement that an explanation of the scientific or clinical judgment for the decision will be provided to you, free of charge and upon request.
- A description of any additional material or information necessary for you to perfect your claim and an explanation of why such material or information is necessary.
- A description of the Plan's internal appeals procedure and external review process, including the time limits applicable to such procedures and information on how to initiate an appeal.
- For Urgent Care Claims, a description of the expedited review process applicable to such claims.
- A statement of your right to submit the claim to binding arbitration following a denial of a claim on appeal under this section or a denial of a claim under the external review process.
- A statement regarding the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under the Affordable Care Act to assist individuals with internal claims and appeals procedures and external review processes.
- A statement that you are entitled to receive, upon request and free of charge, the diagnosis code and the treatment code (and their corresponding meanings) associated with the denial.
- A statement in Spanish (and/or other non-English language, if applicable) that you are entitled to receive, upon request and free of charge, a Spanish (or, if applicable, other non-English) version of the notice, as well as an explanation of how you can access the oral language services provided by the Trust.

FILING AN APPEAL

If your claim is denied, in whole or in part, or if you experience a rescission of coverage (defined in the Definitions section of this booklet) you may request a review of the denial by filing an appeal.

Pre- Service, Urgent Care, and Concurrent Claims

Your appeal must be submitted to the entity that decided the initial claim. The Board of Directors will not review denied Pre-Service, Urgent Care, or Concurrent Claims.

Your appeal must be in writing, with the following exceptions:

- Appeals of Urgent Care Claims may be submitted orally.

- If your request for a planned hospital admission has been denied, and services have not been obtained, call Anthem Blue Cross at (800) 274-7767. If, on the other hand, services have already been received, submit a written appeal to Anthem Blue Cross. Any denial of a Pre-Service, Urgent Care, or Concurrent Claim on appeal cannot be submitted to the Board of Directors for a second review. You may, however, submit the disputed claims to the external review process and/or arbitration (see sections on "External Review of Claims" and "Recourse After a Claim Denial on Appeal").

Post-Service Claim

Your appeal must be filed within 180 days after you receive the written claim denial notice.

- An appeal is considered to be filed when it is received by the Trust Administrator, regardless of whether it contains all the information necessary to render a decision.
- If you do not file your appeal within this 180-day period, you will have waived your right to have your claim reconsidered. The Board, at its discretion, may consider a late appeal, if it concludes that there was reasonable cause for the delay in filing.
- Your appeal must be in writing and include your name, mailing address, telephone number, the basis of the appeal (i.e., the reasons you disagree with the notice of denial), and any documentary proof you may wish to submit in support of your appeal that has not been previously provided to the Trust Administrator.
- Appeals should be addressed to the Board of Directors and must be mailed to the Trust Administrator at:

Delta Health Systems
P.O. Box 1931
Stockton, CA 95201

The Board possesses full discretion to decide appeals of denied Post Service Claims and to interpret the terms of the Trust Agreement, the Plan Document and any other documents relevant to such claims.

Appeals Procedure

You will be provided, automatically and free of charge with:

- Any new or additional evidence or considered, relied upon, or generated in connection with your appeal while it is under review; and
- Any new or additional rationale for a denial at the internal appeals stage.

This information will be provided to you as soon as possible, sufficiently before the decision on appeal is made, so that you will have a reasonable opportunity to respond before a final decision on appeal is rendered. If the new/additional evidence or rationale is received so late that it would be impossible to provide it to you in time to give you a reasonable opportunity to respond, the period for providing a notice of adverse benefit determination will be paused for a reasonable period of time in order to give you an opportunity to respond. As soon as the reasonable period of time has passed you will be provided with the adverse benefit determination notice in a reasonable and prompt manner.

TIMELINES FOR PROCESSING APPEALS

Post-Service Claim
A decision will be made no later than the date of the Board of Directors' meeting which occurs at least thirty (30) days after an appeal is filed, unless special circumstances require an extension of time for review.

- If such an extension is required, you will be notified in writing prior to the commencement of the extension of the special circumstances requiring the extension of time and the date by which the decision will be rendered, which will be no later than the third meeting of the Board after the appeal is filed. You will be notified by mail within five (5) days after the Board makes its decision.

- If the extension is due to your failure to submit the information necessary to decide the appeal, the extension notice will describe the required information, and you will be allowed at least forty-five (45) days from receipt of the extension notice to provide such information. The time period for making the decision will be suspended from the date on which the extension notice is sent to you to the earlier of: (i) the date on which your response is received by the Trust; or (ii) the due date specified in the extension notice for furnishing the requested information.

Pre-Service Claim
You will be notified of the decision, whether adverse or not, within a reasonable period of time appropriate to the medical circumstances, but not later than thirty (30) days after your appeal is filed.

Urgent Care Claim
You will be notified of the decision, whether adverse or not, as soon as possible, taking into account the medical exigencies, but not later than seventy-two (72) hours after your appeal is filed.

Notice of Claim Denial on Appeal
If your claim is denied on appeal, in whole or in part, you will be notified of the denial in writing (except for Urgent Care Claims, in which case notice may be provided orally, followed by a written notice within three (3) days after the oral notification). Such written notice of denial will contain the following information:

- Information sufficient to identify the claim involved, including the date of service, the health care provider, and the claim amount (if applicable).
- The specific reason(s) for the denial on appeal, including the denial code (and its corresponding meaning) and a description of the Plan's standard(s), if any, that was used in denying the claim on appeal (including a discussion of the decision).
- Reference to the specific Plan provision(s) on which the denial on appeal is based.
- If applicable, a statement that an internal rule, guideline, protocol, or other similar criterion was relied upon in denying the claim on appeal and that a copy of such rule, guideline, protocol, or other criterion will be provided to you, free of charge and upon request.
- If the denial is based on a medical necessity or experimental treatment or similar exclusion or limit, a statement that an explanation of the scientific or clinical judgment for the decision will be provided to you, free of charge and upon request.
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim.
- A statement of your right to request an external review by an independent review organization, including a description of the external review process.
- A statement of your right to submit your claim to binding arbitration.

- A statement regarding the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under the Affordable Care Act to assist individuals with the external review process.
- A statement that you are entitled to receive, upon request and free of charge, the diagnosis code and the treatment code (and their corresponding meanings) associated with the denial.
- A statement in Spanish (and/or other non-English language, if applicable) that you are entitled to receive, upon request and free of charge, a Spanish (or, if applicable, other non-English) version of the notice, as well as an explanation of how you can access the oral language services provided by the Trust.

Failure to Follow Procedures

If the Trust, or an entity acting on the Trust's behalf (such as Anthem Blue Cross), fails to follow these claims and appeals procedures, you will be deemed to have exhausted the administrative remedies available under the Plan and entitled to submit your claim to external review and/or binding arbitration.

You will not be deemed to have exhausted the administrative remedies under the Plan if a failure is: (1) de Minimis; (2) non-prejudicial; (3) attributable to good cause or matters beyond the control of the Trust; (4), in the context of an ongoing, good faith exchange of information; and (5) not reflective of a pattern or practice of non-compliance.

Recourse after a Claim Denial on Appeal

If your claim is denied on appeal, in whole or in part, and you are dissatisfied with the decision, you have the following options:

- You may submit the disputed claim to the external review process.
- In the alternative, you may submit the disputed claim to binding arbitration unless the claim is less than the jurisdictional limit of the small claims court, in which case you must file an action in small claims court and do not have the right to arbitrate your claim. Other than a small claims action, you do not have the right to file a civil action concerning your disputed claim.
- You may also submit the disputed claim to binding arbitration after you have exhausted the external review process.

EXTERNAL REVIEW OF CLAIMS

General Rules

- Use of an Authorized Representative. You or your authorized representative may request an external review of a disputed claim by an independent review organization ("IRO") in accordance with the procedures described in this section.

- Types of External Review. There are two types of external review: standard external review and expedited external review. You may request an expedited external review if:

    - Your Urgent Care Claim has been denied at the initial level, and you have filed an appeal.; or
    - Your Urgent Care Claim has been denied on appeal; or

- Your Concurrent Claim has been denied on appeal, and such denial concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency services, but you have not yet been discharged from a facility.

How to Request External Review

- All requests for external review must be submitted to the Trust Administrator at:

Delta Health Systems
P.O. Box 1931
Stockton, CA 95201
1-800-556-5918

- Requests for standard external review must be in writing.

Deadlines for Requesting External Review

- If your claim has been denied on appeal, your request for external review must be submitted within four (4) months of the date that you receive the notice of claim denial on appeal described.
- If your claim has been denied, but a decision on appeal has not yet been reached (either because you have an Urgent Care Claim on appeal or because you are deemed to have exhausted the administrative remedies available under the Plan), your request for external review must be submitted within four (4) months of the date that you receive the notice of claim denial.

Claims Eligible for External Review

- External review is available for:
  - Any claim that has been denied on appeal.
  - Any Urgent Care Claim that has been denied at the initial level, but only if you have also filed an appeal. .
  - Any unresolved claim, but only if you are deemed to have exhausted the administrative remedies available under the Plan.

- External review is not available for claims denials due to your failure to meet the Plan's requirements for eligibility.

- Availability of external review will be limited and only be available for the following:
  - A claim denial that involves medical judgment, as determined by the external reviewer, including (but not limited to) denials based on:
    - The Trust's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit; or
    - The Trust's determination that a treatment is experimental or investigational.
    - The Trust's determination that a participant or beneficiary is not entitled to a reasonable alternative standard for a reward under a wellness program.
  - A rescission of coverage.

Preliminary Review by the Trust Administrator

The Trust Administrator will conduct a preliminary review of your request to determine whether:

- You are/were covered under the Plan at the time the health care item or service is/was requested or provided;
- The denial relates to your failure to meet the Plan's requirements for eligibility
- The denial involves a medical judgment or a rescission of coverage;
- You have exhausted (or are deemed to have exhausted) the Plan's internal claims and appeals procedures; and
- You have provided all of the information and forms required to process an external review.
- The Trust Administrator will complete such preliminary review within the following timelines: For standard external review: within five (5) business days after the Trust Administrator receives your request.
- For expedited external review: immediately upon the Trust Administrator's receipt of your request.

The Trust will notify you as to whether your request is eligible for external review as follows:

- For standard external review: notification will be provided in writing, within one (1) business day after completing the preliminary review.
- For expedited external review: notification will be provided via telephone or fax, immediately after completing the preliminary review.

- The notification will state one of the following:
    - That your request is complete and eligible for external review; or
    - That your request is complete but, not eligible for external review, the reasons for ineligibility, and the contact information for the Employee Benefits Security Administration; or
    - That your request is not complete, the information or materials needed to complete your request, and instructions on perfecting (i.e., completing) your request by submitting the required information or materials within the four (4) month filing period, or within a 48-hour period following receipt of the notification, whichever is later.

Review by an Independent Review Organization (IRO)

Assignment to an IRO. If, after completing the preliminary review, the Trust Administrator determines that your request is eligible for external review, it will assign your request to an accredited independent review organization (IRO), which will conduct the external review.

- The IRO will not be eligible for any financial incentive or payment based on the likelihood that the IRO would support the denial of benefits.
- The Trust Administrator may rotate assignment among IROs with which it contracts.

Acceptance for External Review/Submission and Consideration of Information

- The IRO will timely notify you in writing of your request's eligibility and acceptance for external review.

- Within ten (10) business days of receiving this notice, you will be allowed to submit additional written information regarding your claim, which the IRO must consider when conducting the external review.
- If you submit such additional written information, the IRO will, within one (1) business day of receipt, forward that information to the Trust Administrator.
- Upon receipt of any such information, the Trust or an entity acting on behalf of the Trust. may reconsider the denial of your claim. Reconsideration by the Trust will not delay the external review. However, if upon reconsideration, the Trust reverses the denial; the Trust Administrator will provide written notice of its decision to you and the IRO within one (1) business day after making that decision. Upon receipt of such notice, the IRO will terminate its external review.
- Provision of Information to IRQ by Trust. The Trust will provide the IRO with any documents and information considered in denying the claim as follows:
- For standard external review: within five (5) business days after the external review is assigned to the IRO.
- For expedited external review: expeditiously (i.e., via telephone, fax, courier, overnight delivery, etc.) after the external review is assigned to the IRO.
- Failure by the Trust to comply with this requirement will not delay the external review. However, the IRO may then terminate the external review and make a decision to reverse the denial, in which case the IRO will notify you and the Trust Administrator within one (1) business day of making its decision.

External Review Procedure:

- The IRO will review all of the information and documents timely received.
- In reaching a decision, the IRO will review the claim de novo (as if it is new) and will not be bound by any decisions or conclusions reached during the Plan's internal claims and appeals process. However, the IRO will be bound to observe the terms of the Plan to ensure that the IRO decision is not contrary to such terms, unless the terms are inconsistent with applicable law. The IRO also must observe the Plan's requirements for benefits, including the Plan's standards for clinical review criteria, medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit.
- In addition to the documents and information provided, the IRO, to the extent the information or documents are available and appropriate, may consider additional information, including information from your medical records, recommendations or other information from your treating (attending) health care providers, other information from you or the Trust, reports from appropriate health care professionals, appropriate practice guidelines and applicable evidence-based standards, the Plan's applicable clinical review criteria, and/or the opinion of the IRO's clinical reviewer(s) and/or legal expert(s).

Notice of the Final External Review Decision

- The IRO will provide notice of its final external review decision to you and the Trust Administrator as follows: For standard external review: such notification will be provided in writing within 45 days after the IRO receives your request for external review
- For expedited external review: such notification will be provided as expeditiously as your medical condition or circumstances require, but in no event more than seventy-two (72) hours after the IRO receives your request for external review. If such notice is not in writing, the IRO must provide written confirmation of its decision to you and the Trust Administrator within forty-eight (48) hours after the date of providing the non-written notice.

The IRO's decision notice must contain the following:

- A general description of the reason for the request for external review, including information sufficient to identify the claim (including the date of service, the health care provider, the claim amount (if applicable), and the reason for the previous denial).
- The date the IRO received the request to conduct the external review, and the date of the IRO decision.
- References to the evidence or documentation considered in reaching its decision, including the specific coverage provisions and evidence-based standards.
- A discussion of the principal reason(s) for the IRO's decision, including the rationale for its decision and any evidence-based standards that were relied on in making the decision.
- A statement that the IRO's determination is binding, except to the extent that the dispute is submitted to binding arbitration pursuant to applicable State law.
- Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under the Affordable Care Act to assist with external review processes.
- The diagnosis code and its corresponding meaning, if previously provided, and the treatment code and its corresponding meaning, if previously provided.
- A statement in Spanish (and/or other non-English language, if applicable) that you are entitled to receive, upon request and free of charge, a Spanish (or, if applicable, other non-English) version of the notice, as well as an explanation of how you can access the oral language services provided by the Trust.

Procedure Following IRO's Final Decision

- If the IRO's final external review decision reverses the Trust's decision to deny your claim, the Trust Administrator must, upon receiving such notice from the IRO, immediately provide coverage or payment (including immediately authorizing or immediately paying benefits) for your claim.
- If, on the other hand, the IRO's final decision upholds the Trust's denial, and you are dissatisfied with the IRO's external review determination, you may submit your dispute to binding arbitration.

GENERAL PLAN INFORMATION

Name of Plan	Gold Coast Joint Benefits Trust
Name and Address of Board of Directors	Board of Directors Gold Coast Joint Benefits Trust Physical Address: 1234 W. Oak Street Stockton, CA 95203 Mailing Address: P.O. Box 2330 Stockton, CA 95201
Plan Identification Numbers	Federal Identification Number is 95-4286060 Plan Identification Number is 001 Group Plan Designation Number is 644
Type of Plan	Employee Health and Welfare Plan
Description of Plan	This Plan is a welfare plan providing medical, dental, mental health, chiropractic and vision benefits to eligible Employees and dependents under a self-funded arrangement. Dental and vision benefits are described in separate booklets. Plan fees and claims are paid directly by the Trust with contributions made by the participating employers or Plan participants as provided in the Collective Bargaining Agreement and Trust Participation Agreement.
Plan Year	Records of the Plan are kept on a fiscal year basis ending June 30th.
Type of Administration	The Board of Directors has engaged Delta Fund Administrators to perform the routine administration of the Trust as Trust Administrator and Delta Health Systems as Claims Payer.
Agent for Service of Legal Process	Delta Fund Administrators, LLC 1234 W. Oak Street Stockton, CA 95203 Service of Legal Process may also be made upon the Board of Directors at the above address or upon a member of the Board of Directors.
Plan Administrator	Gold Coast Joint Benefits Trust has fiduciary responsibilities.
Name and Address of Claims Payer	Delta Health Systems P.O. Box 80 Stockton, CA 95201 1 (800) 556-5918
Name, Title and Business Address of the Plan Directors	There are 14 Directors (7 Employer Directors and 7 Employee Directors) serving on the Board at any one time. A listing of the current Board of Directors, and their mailing addresses, may be obtained from the Trust Administrator.

Description of Relevant Provisions of any Applicable Collective Bargaining Agreement	The program is maintained pursuant to various collective bargaining agreements.
Requirements regarding Eligibility for Participation and Benefits	The Plan's requirements with respect to eligibility for the Indemnity Medical PPO Plan 4 are shown in the Eligibility Provisions section of this booklet.
Source of Contributions	Contributions to the Trust are made by the participating public agencies in accordance with the collective bargaining agreements on behalf of active full-time Employees, part-time Employees and retirees.
Sufficiency of Contributions	The benefits established by the Plan have been adopted by the Board of Directors based on the best information available to them as to the cost of benefits and the contributions which they anticipate receiving under the applicable collective bargaining agreements. The Board of Directors reserve the right to modify contributions and/or benefits at any time, or to reduce or even eliminate benefits if necessary to maintain the financial soundness of the Plan.

GENERAL PRIVACY RULES

This section describes how medical information about you may be used and disclosed and how you can get access to this information.

The Gold Coast Joint Benefits Trust, as the sponsor of the Gold Coast Joint Benefits Trust Indemnity PPO Plan 4 (the "Plan") is required by law to maintain the privacy of protected health information and to provide you with notice of its legal duties and privacy practices with respect to your protected health information, and to notify you if there is a breach of your unsecured protected health information.

This notice describes the Plan's legal duties and privacy practices including:

- The Plan's uses and disclosures of protected health information;
- Your privacy rights with respect to such information;
- The Plan's duties with respect to such information;
- The person or office to contact for further information about the Plan's privacy practices.

NOTICE OF USES AND DISCLOSURES

Required Uses and Disclosures

Upon your request, the Plan is required to give you access to certain protected health information, which includes all individually identifiable health information in order to inspect and copy it. Use and disclosure of your protected health information may be required by the Secretary of the Department of Health and Human Services to investigate or determine the Plan's compliance with the privacy regulations.

Uses and disclosures to carry out treatment, payment and health care operations without your consent or authorization. The Plan and its business associates will use protected health information without your consent, authorization or opportunity to agree or object to carry out "treatment, payment and health care operations" as defined below.

- Treatment is the provision, coordination or management of health care and related services. For example, your pharmacy may contact your treating physician to refill your prescription for medication.

    - *Payment* includes, but is not limited to actions to make coverage determinations and to provide payment for the treatment you receive. For example, the Plan use and disclose your protected health information to pay and manage your claims, coordinate your benefits and review health care services provided to you.

    - *Health care operations* include, but are not limited to quality assessment and improvement, reviewing competence or qualifications of health care professionals, underwriting, premium rating and other insurance activities relating to creating or renewing insurance contracts and related business services. For example, the Plan may use information about your claims to refer you to a disease management program, project future benefit costs and audit the accuracy of its claims processing functions.

Other uses and disclosures for which consent, authorization or opportunity to object is not required. Use and disclosure of your protected health information is allowed without your consent, authorization or request under the following circumstances:

- When required by law. The Plan may use and disclose your protected health information when required by law, and when the use or disclosure complies with and is limited to the relevant requirement of such law.
- When permitted for purposes of public health activities. For example, protected health information may be used or disclosed if you have been exposed to a communicable disease or are at risk of spreading a disease or condition, if authorized by law.
- Reports about victims of abuse, neglect or domestic violence to government entities. The Plan will disclose your protected health information in these reports only if the Plan is required or authorized to do so by law, or if you otherwise agree.
- To a public health oversight agency. The Plan will provide protected health information as requested to government agencies that have the authority to audit our operations. This includes uses or disclosures in civil, administrative or criminal investigations; inspections; licensures or disciplinary actions (for example, to investigate complaints against providers); and other activities necessary for appropriate oversight of government benefit programs (for example, to investigate Medicare or Medicaid fraud).
- When required for judicial or administrative proceedings, provided certain conditions are met. Those conditions include that satisfactory assurances are given to the Plan that the requesting party has made a good faith attempt to provide written notice to you, the notice provided sufficient information about the proceeding to permit you to raise an objection and no objections were raised or were resolved in favor of disclosure by the court or tribunal.
- When required for law enforcement purposes. The Plan may release protected health information if asked to do so by a law enforcement official in the following circumstances: (1) to respond to a court order, subpoena, warrant, summons or similar process; (2) to identify or locate a suspect, fugitive, material witness or missing person, (3) to assist the victim of a crime if, under certain limited circumstances, the Plan is unable to obtain the person's agreement, (4) to investigate a death the Plan believes may be due to criminal conduct, (5) to investigate criminal conduct, and (6) to report a crime, its location or victims or the identity, description or location of the person who committed the crime (in emergency circumstances).
- When required to be given to a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death or other duties as authorized by law. Also, disclosure is permitted to funeral directors, consistent with applicable law, as necessary to carry out their duties with respect to the decedent.
- Organ procurement. The Plan may disclose protected health information to facilitate organ donation and transplantation.
- Medical research. The Plan may disclose protected health information for medical research projects, subject to strict legal restrictions.
- When consistent with applicable law and standards of ethical conduct if the Plan, in good faith, believes the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public.
- Special government functions. The Plan may disclose protected health information to various departments of the government, such as the U.S. military or U.S. Department of State.
- When authorized by and to the extent necessary to comply with workers' compensation or other similar programs established by law.

Uses and disclosures that require that you be given an opportunity to agree or disagree prior to the use or disclosure. Disclosure of your protected health information to family members, other relatives and your close personal friends is allowed if the information is directly relevant to the family or friend's involvement with your care or payment for that care and you have either agreed to the disclosure or have been given an opportunity to object and have not objected.

Uses and disclosures that require your written authorization or consent.
In general, the Plan will obtain a written authorization before using or disclosing your protected health information whenever it is required to do so under the privacy rules. For example, we will not supply confidential information to another company for its marketing purposes (unless it is for Health Care Operations), for sale (unless under strict legal restrictions), or to a potential employer with whom you are seeking employment without your signed authorization. Your written authorization generally will be obtained before the Plan will use or disclose psychotherapy notes about you from your psychotherapist. The Plan may use and disclose psychotherapy notes when needed by the Plan to defend against litigation filed by you. The Plan will not disclose to third parties the results of genetic testing in a manner which includes individually identifying characteristics without your written authorization, nor will it use or disclose your genetic information for underwriting purposes.

The Plan may require your consent to disclose protected health information, even to carry out treatment, payment or health care operations, to certain individuals or organizations. For example, if your union representative is helping you with a claim, the Plan may require you to sign a consent form before it will disclose protected health information to that person.

Other uses and disclosures not described in this notice will be made only with your written authorization.

You may revoke an authorization that you previously have given by sending a written request to our Privacy Officer, but not with respect to any actions the Plan has already taken.

RIGHTS OF INDIVIDUALS

Right to Request Restrictions on Protected Health Information Uses and Disclosures
You may request the Plan to restrict uses and disclosures of your protected health information to carry out treatment, payment or health care operations, or to restrict uses and disclosures to family members, relatives, friends or other persons identified by you who are involved in your care or payment for your care. While the Plan will consider all requests for restrictions carefully, the Plan is not required to agree to your request. However, the Plan must comply with your request to restrict disclosure of your protected health information for payment or health care operations purposes if you paid for these services in full, out of pocket.

Right to Receive Confidential Communications of PHI
The Plan will accommodate reasonable requests to receive communications of protected health information by alternative means or at alternative locations. The Plan must agree to your request if you state that disclosure of the information will put you in danger. You or your personal representative will be required to complete a form to request restrictions on uses and disclosures of your protected health information. Such request should be made to the individual identified on Page 93, section entitled, Whom to Contact at Plan for Information."

Right to Inspect and Copy Protected Health Information
Except under certain circumstances limited by law, you have a right to inspect and obtain a copy of your

protected health information "in a designated record set" for as long as the Plan maintains the protected health information.

"Protected health information" includes all individually identifiable health information transmitted or maintained by the Plan regardless of form.

"Designated record set" includes the medical records and billing records about individuals maintained by or for a covered health care provider; enrollment, payment, billing, claims adjudication and case or medical management record systems maintained by or for a health plan; or other information used in whole or in part by or for the covered entity to make decisions about individuals. Information used for quality control or peer review analysis and not used to make decisions about individuals is not in the designated record set.

The requested information will be provided within 30 days. A single 30-day extension is allowed if the Plan is unable to comply with the deadline. If the information you request is in an electronic health record, you may request that these records be transmitted electronically to yourself or a designated individual. If you request copies of your protected health information, the Plan may charge a reasonable fee to cover the cost.

You or your personal representative will be required to complete a form to request access to the protected health information. Requests for access to protected health information should be made to the individual identified in Section 5. If access is denied, you and your personal representative will be provided with a written denial setting forth the basis for the denial, a description of how you may exercise rights to review and a description of how you may complain to the Secretary of the U.S. Department of Health and Human Services.

Right to Amend Protected Health Information

You have the right to request that the individual identified in Section 5 amend your protected health information or a record about you in a designated record set for as long as the protected health information is maintained by the Plan. You or your personal representative will be required to complete a form to request amendment of the protected health information. The Plan may deny your request if you ask us to amend information that: (i) was not created by the Plan, unless the person who created the information is no longer available to make the amendment, (ii) is not part of the protected health information we keep about you, (iii) is not part of the protected health information that you would be allowed to see or copy, or, (iv) is determined by the Plan to be accurate and complete.

The Plan has 60 days after the request is made to act on the request. A single 30-day extension is allowed if the Plan is unable to comply with the deadline. If the request is denied in whole or part, the Plan must provide you with a written denial that explains the basis for the denial. You or your personal representative may then submit a written statement disagreeing with the denial and have that statement included with any future disclosures of your protected health information.

The Right to Receive an Accounting of Protected Health Information Disclosures

You have the right to request a list of protected health information disclosures, which is also referred to as an accounting.

The list will not include disclosures the Plan has made as authorized by law. For example, the accounting will not include disclosures made for treatment, payment, and health care operation purposes (except as noted in the last paragraph of this subsection (d)). Also, no accounting will be made for disclosures made directly to you or under an authorization that you provided or those made to your family or friends. The list

will not include disclosures the Plan has made for national security purposes or law enforcement personnel or disclosures made before April 14, 2003.

The list provided by the Plan will include disclosures made within the last six years (subject to the April 14, 2003 beginning date) unless you specify a shorter period. The first list you request within a 12 month period will be free. You may be charged a reasonable fee for providing any additional lists within a 12-month period.

If the accounting cannot be provided within 60 days, an additional 30 days is allowed if the individual is given a written statement of the reasons for the delay and the date by which the accounting will be provided.

You may also request and receive an accounting of disclosures made for payment, treatment, or health care operations during the prior three years for disclosures made as of January 1, 2014 for electronic health records acquired before January 1, 2009, or January 1, 2011 for electronic health records acquired on or after January 1, 2009.

Personal Representatives

You may exercise your rights through a personal representative. Your personal representative will be required to produce evidence of his/her authority to act on your behalf before that person will be given access to your protected health information or allowed to take any action for you. Proof of such authority may take one of the following forms: (1) A power of attorney for health care purposes, notarized by a notary public, (2) A court order of appointment of the person as the conservator or guardian of the individual, or (3) An individual who is the parent of a minor child.

The Plan retains discretion to deny access to your protected health information to a personal representative to provide protection to those vulnerable people who depend on others to exercise their rights under these rules and who may be subject to abuse or neglect. This also applies to personal representatives of minors.

Right to Request a Paper Copy

If you agree to receive this Privacy Notice electronically, you have the right to obtain a paper copy of this Privacy Notice upon request from the individual identified on page 88, under the section entitled "Whom to Contact at the Plan for More Information."

THE PLAN'S DUTIES

General Duty

The Plan is required to comply with the terms of this notice. However, the Plan reserves the right to change its privacy practices and to apply the changes to any protected health information received or maintained by the Plan prior to that date. If a privacy practice is changed, a revised version of this notice will be provided to all past and present participants and beneficiaries for whom the Plan still maintains protected health information. The revised notice will be mailed to all active and retired plan participants. Any revised version of this notice will be distributed within 60 days of the effective date of any material change to the uses or disclosures, the individual's rights, the duties of the Plan or other privacy practices stated in this notice.

Minimum Necessary Standard

When using or disclosing protected health information or when requesting protected health information from another covered entity, the Plan will make reasonable efforts not to use, disclose or request more than the Limited Data Set, or if necessary, the minimum necessary information necessary to accomplish the intended purpose of the use, disclosure or request, taking into consideration practical and technological limitations.

However, the minimum necessary standard will not apply in the following situations:

- Disclosures to or requests by a health care provider for treatment;
- Uses or disclosures made to the participant or beneficiary;
- Disclosures made to the Secretary of the U.S. Department of Health and Human Services;
- Uses or disclosures that are required by law; and
- Uses or disclosures that are required for the Plan's compliance with legal regulations.

De-Identified Information

This notice does not apply to information that has been de-identified. De-identified information is information that does not identify an individual and with respect to which there is no reasonable basis to believe that the information can be used to identify the individual.

In addition, the Plan may use or disclose "summary health information" for obtaining premium bids or modifying, amending or terminating the group health plan, which summarizes the claims history, claims expenses or type of claims experienced by individuals for whom a plan sponsor has provided health benefits under a group health plan; and from which identifying information has been deleted in accordance with HIPAA.

YOUR RIGHT TO FILE A COMPLAINT WITH THE PLAN OR THE HHS SECRETARY

If you believe that your privacy rights have been violated, you may file a complaint with the Privacy Officer named in Section 5 below, or with the Secretary of the U.S. Department of Health and Human Services. To file a complaint with the Plan, put your complaint in writing and address it to the Privacy Officer named in Section 5 below. The Plan will not retaliate against you for filing a complaint. You may also contact the Privacy Officer if you have questions or comments about our privacy practices.

You may file a complaint with the Secretary of the U.S. Department of Health and Human Services online at https://ocrportal.hhs.gov/ocr/cp/complaint_frontpage.jsf or by mailing your complaint to the appropriate

the HHS Regional office. The list of regional offices can be found at the following link:

http://www.hhs.gov/ocr/office/about/rgn-hqaddresses.html.

If you need help filing a complaint or have a question about the complaint or consent forms, please e-mail OCR at OCRComplaint@hhs.gov.

WHOM TO CONTACT AT THE PLAN FOR MORE INFORMATION

If you have any questions regarding this notice or the subjects addressed in it, you may contact:

Akara C. Whiten, JD, CIPP Compliance Director and Privacy Officer
Delta Health Systems
P.O. Box 1227
Stockton, CA 95219
Phone: (209) 939-3430
Fax: (209) 939-3930
Email: Akara.Whiten@delapro.com

DISCRIMINATION IS AGAINST THE LAW

Gold Coast Joint Benefits Trust ("Trust") complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The Trust does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

The Trust:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
    - Teletype (844) 301-5698 (TTY)
    - Written information in other formats (large print, audio)

- Provides free language services to people whose primary language is not English, such as:
    - Qualified interpreters
    - Information written in other languages

If you need these services, contact Delta Health Systems at (800) 556-5918, (844) 301-5698 (TTY).

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

Akara C. Whiten, JD, CIPP Compliance Director and Privacy Officer
Delta Health Systems
P.O. Box 1227
Stockton, CA 95219
Phone: (209) 939-3430
Fax: (209) 939-3930
Email: Akara.Whiten@delapro.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Akara C. Whiten is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201 1-800-368-1019, 800-537-7697 (TDD)

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

ATTENTION: FREE LANGUAGE ASSISTANCE This chart displays, in various languages, the phone number to call for free language assistance services for individuals with limited English proficiency.	
Language	Message About Language Assistance
Spanish	ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1 (800) 556-5918 (TTY: 1-844-301-5698).
Chinese	注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1 (800) 556-5918 （TTY：1-844-301-5698）
French	ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1 (800) 556-5918 (ATS : 1-844-301-5698).
Italian	ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1 (800) 556-5918 (TTY: 1-844-301-5698).
German	ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1 (800) 556-5918 (TTY: 1-844-301-5698).
Russian	ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1 (800) 556-5918 (телетайп: 1-844-301-5698)
Vietnamese	CHÚ Ý: N□u b□n nói Ti□ng Vi□t, có các d□ch v□ h□ tr□ ngôn ng□ mi□n phí dành cho b□n. G□i s□ 1 (800) 556-5918 (TTY: 1-844-301-5698).
Persian	**توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1 (800) 556-5918 (TTY: 1-844-301-5698) تماس بگیرید.**
Hindi	ध्यान द□: य□द आप □हदी बोलते ह □तो आपके □लए मुफ्त म□ भाषा सहायता सेवाएं उपलब्ध ह□। 1 (800) 556-5918 (TTY: 1-844-301-5698) पर कॉल कर□।
Tagalog	PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1 (800) 556-5918 (TTY: 1-844-301-5698).
Japanese	注意事項 日本語を話される場合、無料の言語支援をご利用いただけます。 1 (800) 556-5918 （TTY: 1-844-301-5698）まで、お電話にてご連絡ください。
Arabic	**ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان اتصل برقم 1-800-556-5918 (رقم هاتف الصم والبكم: 1844-301-5698).**
Korean	주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1 (800) 556-5918 (TTY: 1-844-301-5698) 번으로 전화해 주십시오.
Thai	เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1 (800) 556-5918 (TTY: 1-844-301-5698).
Lao	ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1 (800) 556-5918 (TTY: 1-844-301-5698).
Gujarati	**સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો** 1 (800) 556-5918 (TTY: 1-844-301-5698).
Serbo-Croatian	OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1 (800) 556-5918 Telefon za osobe sa oštećenim govorom ili sluhom: (TTY- 1-844-301-5698).

DEFINITIONS

Below is a listing of key phrases that appear in this booklet that may not have been fully described herein. To give you a better understanding of your benefits, you need to know the definition of these terms.

Ambulatory Surgery Center (ASC)	Ambulatory Surgery Center (ASC), also known as outpatient surgery centers, surgicenters, or same day surgery centers, are health care facilities where surgical procedures and certain pain management and diagnostic services not requiring an overnight stay are performed.
Benefit Percentage Payable	The percentage the Plan will pay of any Covered Expense. The percentage the Plan pays depends on whether you are using a PPO Provider, if your Covered Expense is for a Hospital admission, whether your Hospital admission has been pre-certified.
Benefit Year (Calendar Year)	The period of twelve (12) consecutive months from January 1 through December 31 of each year. Annual deductibles and out-of-pocket maximums begin accumulating again at the beginning of each Benefit Year,
Certification	A determination that has been made by the Utilization Review Organization that a surgical procedure or hospitalization has been approved as medically necessary for a specified number of days.
Claim	A request for benefits under the Plan submitted. The rules for submitting, processing and appealing claims depend on the type of claim involved. Instructions for submitting claims can be found on pages 70-72 of this booklet. There are four types of claims: Post-Service Claims Pre-Service Claims Urgent Care Claims Concurrent Claims. The following are not claims: Inquiries about Plan benefits or eligibility that are unrelated to any specific claim. Requests for prior approval, when prior approval is not required under the Plan.
Coinsurance	Coinsurance, shown as a percentage, is the amount the Plan and the participant share in the cost of covered, medically necessary benefits. The coinsurance amount in the charts of this document refers to the amount the Plan pays after covered care or services are received *and* the claim has been processed.
Contract (PPO) Provider	A hospital or other provider which has negotiated a contract with this health Plan to provide a service or supply covered under the Plan at a pre-determined fee which will normally result in a savings to both the Plan and to the Plan participant. The PPO Provider is not entitled to payment for any amount in excess of the pre-determined fee. Contract provider is referred to as PPO Provider throughout this document.
Copay	Copay, shown as a fixed dollar amount, refers to the amount you pay, at the time covered care or services are received.

Covered Expense	The amount allowed by the Plan for a particular service or supply based on all Plan provisions. Covered expenses shall not include out-of-pocket expenses incurred by a Participant as the result of non-compliance with the Hospital Contracting or Hospital Utilization Review provisions of this Plan.
Deductible	The amount a participant must pay per calendar year before the Plan pays.
Denied Claim	A denial, reduction, or termination of, or failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination or failure to provide or make payment that is based on a determination of a participant's or beneficiary's eligibility to participate in the Plan, and including a denial, reduction, or termination of, or failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate.
Domestic Partner	A person who has legally established a Domestic Partnership with an Employee in accordance with California Family Code Sections 297 by registering the Domestic Partnership with the Secretary of the State of California. A Domestic Partnership may be formed between same-sex partners or opposite-sex partners where at least one partner is age 62 or older and meets certain eligibility criteria under the Social Security Act.
Durable Medical Equipment	Equipment which meets all of the following criteria: (a) it can withstand repeated use; (b) it is designed and used only to treat bodily injury or sickness; (c) it is appropriate for medical treatment in the home; (d) it has no value to the patient or the patient's family in the absence of the bodily injury or sickness being treated; (e) it is not an item commonly found in the household; and (f) it is not sporting or athletic equipment. Rental or purchase of medical equipment and supplies, including dialysis, which are: ordered by a physician, usable only by the patient, not primarily for the patient's comfort or hygiene, not for environmental control, not primarily used for exercise, and manufactured specifically for medical use. Rental charges that exceed the reasonable purchase price of the equipment are not covered. Durable Medical Equipment that exceeds $2,000 must be pre-authorized by the Professional Review Organization for medical necessity.
Eating Disorder Program	A medically supervised inpatient or outpatient program at a duly licensed facility for the specific treatment of Anorexia Nervosa or Bulimia and is not a program primarily for the treatment of obesity, compulsive eating, weight reduction or weight control.
Effective Date	The date on which coverage for an eligible employee or his or her eligible dependents begins.
Emergency / Medical Emergency	An emergency medical condition is a medical condition that manifests itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in the health of the individual (and in the case of a pregnant women, her unborn child) to be in serious jeopardy, cause serious impairment of bodily functions, or cause a dysfunction of any body part or organ.

Employee	All persons covered by a collective bargaining agreement between a district and a union, employees of a district covered by a participation agreement, persons retired from employment with a district, and persons serving on the governing board of a district.
Essential Health Benefits	The Affordable Care Act (ACA) requires the Plan cover ten essential health benefit categories to include at least the following items and services: Ambulatory patient services (outpatient care you get without being admitted to a hospital) Emergency services Hospitalization (such as surgery) Maternity and newborn care (care before and after your baby is born) Mental health and substance use disorder services, including behavioral health treatment (this includes counseling and psychotherapy) Prescription drugs Rehabilitative and habilitative services and devices (services and devices to help people with injuries, disabilities, or chronic conditions gain or recover mental and physical skills) Laboratory services Preventive and wellness services and chronic disease management Pediatric services For more information regarding essential health benefits, please visit www.healthcare.gov.
Expense Incurred	The fee or charge for covered medical services or supplies that is usual and customary in a case of comparable nature and severity in the particular geographic area concerned. Expense is considered to be incurred on the date the service or supply is rendered or obtained. For a supply or service furnished by a PPO Provider, the term expense incurred means only the pre-determined fee.
Experimental / Investigational Treatment	Any procedure, device, drug, treatment, or medicine, or the use thereof, which falls within any of the following categories: Which is considered by any governmental agency or subdivision, including but not limited to the Food and Drug Administration, the Office of Health Technology Assessment, or the Centers for Medicare and Medicaid Services (CMS) in its Medicare Coverage Issues Manual to be experimental or investigational; or Which is not covered under Medicare reimbursement laws, regulations or interpretations; or Which is not commonly and customarily recognized by the medical profession in the state where treatment is rendered as appropriate for the condition being treated in that: The medical procedure, equipment, treatment or course of treatment, or Drug or medicine is under investigation or is limited to research; The techniques are restricted to use at centers which are capable of carrying out disciplined clinical efforts and scientific studies; The procedures are not proven in an objective way to have therapeutic value or benefit; and The procedure's or treatment's effectiveness is medically questionable.
Gross Lien	The total benefits paid or payable to or on behalf of the injured Participant (injured party).

Group Health Coverage	Coverage under an employer-maintained plan that provides health care.
Health Care Reform	The Patient Protection and Affordable Care Act (PPACA), commonly called the Affordable Care Act (ACA) or Health Care Reform is a United States federal statute signed into law on March 23, 2010. Legislation related to the Affordable Care Act (ACA) occasionally changes. This Plan will remain in compliance with all applicable laws or any future guidance, even if it conflicts with Plan provisions.
Health Insurance Coverage	Medical care benefits (provided directly, through insurance or reimbursement, or otherwise) under any hospital or medical service policy or certificate, hospital or medical service plan contract, or health maintenance organization contract offered by a health insurer. It includes group and individual health insurance coverage, short-term, limited-duration insurance, and coverage under a Medicaid plan or a state children's health insurance program. It does not, however, include: (i) coverage only for accident, or disability income insurance; (ii) coverage issued as a supplement to liability insurance; (iii) liability insurance; (iv) workers' compensation or similar insurance; (v) automobile medical payment insurance; (vi) credit-only insurance; (vii) coverage for on-site medical clinics; or (vii) other similar insurance coverage, specified in regulations, under which benefits for medical care are secondary or incidental to other insurance benefits.
Home Health Care Agency	A hospital, agency, or other service that is recognized by Medicare and certified by the proper authority of the state in which it is located to provide home health care services of a Home Health Aide, Certified Nursing Aide, Licensed Vocational Nurse, Registered Nurse, Physical Therapist, Occupational Therapist, or Speech Therapist.
Hospital	An institution that is: (a) licensed as an acute care facility by the proper authority of the state in which it is located; (b) recognized as a hospital by the Joint Commission on Accreditation of Hospitals (JCAH); (c) a state licensed and JCAH recognized mental health or psychiatric facility or an alcoholic or drug treatment facility, provided that these facilities are providing a treatment program for these specific diagnosed conditions and are operating within the scope of their license; and (d) a state licensed birthing center. A hospital does not include any institution, or part thereof, that is used primarily as a convalescent home, rest home, home for the aged, nursing home, custodial care facility, training center, residential care facility or half-way house.
Medical Emergency	An emergency medical condition is a medical condition that manifests itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in the health of the individual (and in the case of a pregnant woman, her unborn child) to be in serious jeopardy, cause serious impairment of bodily functions, or cause a dysfunction of any body part or organ.

Medically Necessary	Services or supplies that are appropriate and necessary to diagnose or treat an illness, condition or injury and are: Consistent with the standards of good medical practice generally accepted and provided by the organized medical community; Not experimental, educational, or investigational; Within the standards of good medical practice within the organized medical community; Not solely for the convenience of the patient, Physician, or supplier; The most appropriate supply or level of service which can be safely provided. For Hospital stays, this means that acute care as an inpatient is necessary due to the kind of services the Participant is receiving or the severity of the Participant's condition, and that safe and adequate care cannot be received as an outpatient or in a less intensified medical setting. Based on the criteria listed above, the Trust Administrator shall make the determination of whether a service or supply is medically necessary under this Trust. The Trust Administrator may use Professional Review Organizations or other professional medical opinion to determine if health care services are Medically Necessary. The fact that a physician or any health care provider may order or recommend services, treatment, supplies or confinement does not , of itself, make them medically necessary.
Medicare	Part A, the basic hospital portion, and Part B, the voluntary supplemental medical portion, of the U.S. Public Law-89-97, Health Insurance for the Aged Act, including any future amendments.
Mental Health Conditions	Conditions generally accepted in the relevant medical community and consistent with the current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM) or the most current version of the International Classification of Diseases (ICD).
Mental Health Hospital Inpatient	Psychiatric hospitals or psychiatric wards (when they are a sub-unit of a regular hospital), are hospitals or wards specializing in the treatment of serious mental disorders, such as clinical depression, schizophrenia, and bipolar disorder.
Mental Health Therapy Outpatient	The benefit includes individual or group counseling sessions provided by a Psychiatrist, Psychologist, Licensed Clinical Social Worker (L.C.S.W.), or Licensed Marriage Family and Child Counselor (M.F.C.C.).
Mental Health Parity and Addiction Equity Act (MHPAEA)	The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) requires group health plans to ensure that financial requirements such as copays, deductibles and treatment limitations applicable to mental health or substance abuse disorder benefits are no more restrictive than the predominant requirements limitations applied to substantially all medical benefits.
Net Recovery	The total amount paid or payable to or on behalf of the injured party, less attorney's fees and litigation costs actually expended by or on behalf of the injured party.
Non-Contract (Non-PPO) Provider	A physician, hospital, lab, or other provider who does not participate in the Plan's network or Preferred Provider Organization.
Nurse / Registered Nurse(R.N.)	A registered graduate nurse licensed under the appropriate laws to provide nursing care or services. The term shall not include the Participant's spouse, child, brother, sister or parent, or any other person who ordinarily resides in the Participant's home.

Out-of-Pocket Maximum under the Medical Plan	The out-of-pocket maximum means that if, during one calendar year, any copays, coinsurance and deductibles, plus covered services rendered by PPO Providers paid by the individual/family exceeds the out-of-pocket maximum set forth in the Plan, the Plan will pay 100% of any additional covered charges incurred at a PPO Provider for the remainder of that calendar year for that individual/family. Any covered expense which was incurred during the last three months (October, November or December) of the preceding calendar year for which there was a percentage share of cost will be carried forward and counted toward the out-of-pocket maximum for the next plan year. Out-of-pocket expenses for services provided by a Non-PPO Provider do not apply to the out-of-pocket maximum and will continue to be paid at the applicable benefit percentage of UCR.
Out-of-Pocket Maximum under the Prescription Plan	The out-of-pocket maximum means that if, during one calendar year, covered prescription charges exceed the maximum amount established, the Plan will pay 100% of any additional covered charges incurred for the remainder of that calendar year for that participant and provided by PPO Providers. Your combined medical and prescription Out-of-Pocket maximums will not exceed the maximums established by the Department of Health and Human Services. These maximums are indexed by law and will be subject to change in subsequent years.
Outpatient Facility	A health care facility that provides outpatient services including, but not limited to, x-ray, laboratory, diagnostic services, and emergency care, and which may be operated by or in connection with a hospital. Hospitals, and Hospital emergency rooms, Hospitals, Hospital Emergency Rooms and Outpatient Surgery Centers are not Outpatient Facilities.
Outpatient Surgery Center	A state licensed freestanding outpatient surgical facility that is primarily engaged in providing surgical services for ambulatory patients on an outpatient basis, where the patient is admitted to and discharged from the facility within 24 hours . Outpatient Surgery Centers are also referred to as ambulatory surgical centers or outpatient surgicenters. Hospitals are not Outpatient Surgery Centers.
Partial Mental Health Hospitalization or Day Care Programs	Outpatient programs designed as a substitute for acute inpatient admissions or step-down from inpatient treatment. The programs are often run by the same facility and therapists which provide inpatient services six to eight hours per day for a fixed time period, usually two weeks.
Participating Employer	A participating employer under the Trust is a district covered under a current participation agreement.
Pharmacist / Licensed Pharmacist	A person who is licensed to practice pharmacy by the governmental authority having jurisdiction over the licensing and practice of pharmacy.
Physician	A doctor licensed in the United States to practice medicine and/or perform surgery. The term also refers to licensed dentists, physical / speech / occupational therapists, or chiropractors, and other licensed or certified practitioners who perform services that are covered under the Plan and that are within the scope of his or her license or certificate.

Plan	The Indemnity Medical Plan provided by the Trust as described in this booklet and as amended by the Board of Directors. The term Plan also refers to any one or more of the Plans offered under the Indemnity Medical Plan. When not capitalized, the term plan refers to a plan of benefits not offered under the Indemnity Medical Plan (for instance plan may refer to one of the HMO plans offered by Gold Coast Joint Benefits Trust.)
Plan Participant	Any employee of a participating employer of the Gold Coast Joint Benefits Trust, that is eligible for Medical, Prescription, Dental and Vision expense coverages under this Health Plan. Plan participant is also used to refer to eligible dependents covered under this Plan.
Plan Year (Fiscal Year)	The period of twelve (12) consecutive months from July 1 through June 30 of each year.
Post-Service Claim	Any claim that involves payment or reimbursement for medical care that has already been provided. This includes claims for services received in an Emergency. A rescission of coverage is treated as a denial of a Post-Service Claim. A rescission of coverage is a cancellation or discontinuance of coverage that has a retroactive effect, except to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage. A rescission of coverage can occur even if such rescission has no adverse effect on any particular benefit at that time.
Pre-determined Fee	The payment amount that a PPO Provider has negotiated and contractually agreed upon with the Plan to accept as payment for a service or supply covered under this Plan.
Pre-Service Claim	Any claim for a benefit under the Plan for which, under the terms of the Plan, prior approval is required as a condition of receiving the benefit.
Preferred Provider Organization (PPO)	An organization under contract with the Trust through which Hospitals, laboratory and radiology facilities, Physicians and other providers of healthcare services contract to provide hospitalization and medical services to Participants payable on the basis of negotiated rates.
Prescription Drug / Drug	Any medication or article which may be lawfully dispensed, as provided under the Federal Food, Drug, and Cosmetic Act, including any amendment thereto, only upon a written or oral prescription of a Physician or dentist licensed by law to administer it. The term "Drug" also includes insulin and diabetic supplies, including syringes, needles and test material.
Preventive Benefits	Preventive services are those defined under the Affordable Care Act (ACA).
Protected Health Information (PHI)	Any information, whether oral or recorded in any form or medium that (a) is created or received by a health care provider, health plan, public health authority, employer, life insurer, or school or university; and (b) relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual.

Reimbursement or Recovery	The Plan's right to recover any medical expense payments: (a) made because of an injury caused by a third party, and (b) for which the Plan participant later recovers from the third party or the third party's insurer; or (c) if payments in excess of the correct amount due are made in error, the Plan may recover all excess amounts paid. Recovery can be made by reducing or suspending future plan payments or by requiring the Plan Participant or the provider/facility to pay back the overpayment in full, or installments, until the overpayment is recovered.
Rescission of Coverage	"Rescission" means a cancellation or discontinuance of coverage under the Plan that has a retroactive effect. The Plan will not rescind coverage with respect to an individual after the individual is covered under the Plan unless: 1. The individual or a person seeking coverage on behalf of the individual performs an act, practice, or omission that constitutes fraud, or 2. The individual makes an intentional misrepresentation of material fact in relation to Plan coverage. Rescission does not include: 1. A cancellation or discontinuance of coverage that only has a prospective effect; or 2. A cancellation or discontinuance of coverage that is effective retroactively to the extent that it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage; 3. Termination of eligibility under the terms of the Plan after termination of employment due to a delay in administrative record-keeping; 4. A cancellation or discontinuance of coverage that is effective retroactively due to the request of the individual (or their representative). The request must be made without any direct or indirect influence from an employer or plan, and without any adverse action or retaliation against, interference, coercion, intimidation, or threat to the individual; or 5. A cancellation or discontinuance of coverage that is effective retroactively due to the request of an Exchange.
Sickness	A sickness or disease which does not arise out of or in the course of employment or any occupation for wage or profit and includes pregnancy, childbirth, or related medical conditions.
Skilled Nursing Facility	An institution which: (a) is licensed by the state in which it is located to provide skilled nursing care to resident patients for an illness or injury; (b) is approved by Medicare as a skilled nursing facility; (c) is recognized by the Joint Commission on Accreditation of Hospital; (d) provides staffing as services listed under the definition of Convalescent Hospital; and (e) is not a board and care facility whose primary purpose is custodial care for the elderly or persons dependent on drugs or alcohol.
Subrogation	A provision that allows the Health Plan to receive reimbursement from any source from which a participant or covered dependent may receive money on account of an injury to the participant or covered dependent caused by a third party.

Substance Abuse	Any diagnosed condition, confinement or treatment related to the chemical dependency on Alcohol or Drugs.
Third Party Liability	Another person, organization or entity which has caused an injury to a Plan participant by some wrongful act or negligence and is liable or responsible to make a financial settlement or award to the Plan participant for any medical expense, suffering or damages.
Totally Disabled	A condition resulting from bodily injury or sickness which: (a) causes you or your dependent to be confined to a hospital; (b) completely and continuously keeps you from performing your occupation or engaging in any work for wage or profit; or (c) keeps a dependent from performing the normal activities of a person in good health of the same age and sex. For a retiree or dependent spouse, it means the inability, due to Sickness or injury, to engage in the substantial and material activities engaged in prior to the start of disability.
Trust	The Gold Coast Joint Benefits Trust as established by the Trust Agreement.
Trust Administrator	Delta Fund Administrators, LLC, P.O. Box 2330, Stockton, CA 95201.
Urgent Care Center	A medical facility other than a hospital emergency department where ambulatory patients can be treated on a walk-in basis, without an appointment, and receive immediate care. Urgent Care Centers and Walk-in Centers, which are typically open after-hours, and provide the same services as a family or primary medical care physician. Outpatient Surgery Centers and Hospital emergency departments are not Urgent Care Centers.
Urgent Care Claim	Any claim for medical care or treatment with respect to which the application of time periods for making non-urgent care determinations (a) could seriously jeopardize your life or health or your ability to regain maximum function; or (b) would, in the opinion of a professional provider with knowledge of your condition, subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. The attending provider will determine whether a claim is an Urgent Care Claim, and the Trust will defer to such determination. Benefits in an Emergency do not require prior approval; therefore, claims for benefits provided in an Emergency are Post-Service Claims.
Usual, Customary and Reasonable (UCR)	A fee or charge for a service or supply which is allowed at the prevailing health care cost, which reflects current statistical data of actual billed charges for each particular procedure billed in each geographical service area. In determining UCR, the complexity and nature of the services are considered.
Utilization Review	The review of hospital admissions and surgical procedures by an organization that utilizes the services of Physicians and Registered Nurses to determine the medical necessity and length of stay required for each specific hospitalization or surgery. Utilization Review includes Pre-Authorization, Ongoing Review, and Discharge Planning, and Outpatient Surgery Review.