TABLE OF CONTENTS

INTRODUCTION

County of San Joaquin (County) is the Plan Sponsor and Plan Administrator of this self-funded health benefit plan (Plan). Questions concerning coverage or applicability of Plan provisions should first be directed to San Joaquin Health Administrators (the Claims Administrator). San Joaquin Health Administrators (SJHA) provides certain administrative services under an Administrative Services Agreement with the County.

Not all defined terms herein are used in their usual meaning and some have meanings which limit their application, therefore, please refer to Definitions beginning on page 18 for a helpful understanding of the defined terms which are capitalized within this Combined Self-funded Health Care Plan Document and Summary Plan Description (Plan Document).

Please keep in mind that you have enrolled in a managed care program which is very different from health care coverage provided by a traditional indemnity insurance program. The managed care program provides the services of contracting Hospitals, physicians and other health care providers to serve you in an organized, qualitative and cost-effective manner. While this Plan provides a full range of health care services, you are required to take an active part in ensuring the success of your health care delivery system. We ask that you take time to read this Summary Plan Description as it will help you understand your responsibilities and benefits as a Participant.

GRANDFATHERED HEALTH PLAN

The County believes this Plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to the plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator at (209) 468-3370. You may also contact the U.S. Department of Health and Human Services at www.healthreform.gov.

CHOOSING YOUR PRIMARY CARE PHYSICIAN

You and each of your enrolled Family Members must select a Primary Care Physician from the Participating Provider Directories for the Plan. Each Participant's Primary Care Physician is responsible for the direction and coordination of the Participant's complete medical care. Your Primary Care Physician will arrange for referrals to other Participating Providers for laboratory tests, x-rays, specialty care, hospitalization or any other health care service that may be needed. Any services and supplies obtained without the advance referral of the Primary Care Physician will not be paid for by this Plan, except for Emergency Care, gynecological exams, mammograms, chiropractic care, and mental health and substance abuse treatment.

The Customer Service Department can provide assistance in the selection of your Primary Care Physician. Every effort will be made to help you establish and maintain a satisfactory Primary Care Physician-Participant relationship. You are required to notify the Claims Administrator of your selection of a Primary Care Physician within 31 days of the commencement of your coverage. If you fail to make and notify the Claims Administrator of this selection, your coverage may be subject to termination for failure to establish and maintain the Primary Care Physician-Participant relationship required by this Plan. If you elect to change Primary Care Physicians for yourself or any of your Family Members, you must contact the Customer Service Department so the change can be recorded. Prior to notifying the Claims Administrator of your selection, please contact the Primary Care Physician of your choice to ensure that his or her practice is accepting new patients.

REFERRALS TO SPECIALISTS

Each Participant's Primary Care Physician is responsible for the direction and coordination of the participant's complete medical care for services and supplies covered thereunder. The Participant's Primary Care Physician will arrange for laboratory tests, x-rays, referrals to specialists, hospitalization, or any other health care service covered hereunder that may be indicated and will, when required, obtain a referral from the Claims Administrator authorizing such services. Except for Emergency Care and some laboratory tests and x-rays, any such services obtained without the advance authorization from the Claims Administrator will not be paid for. If a specialist recommends a subsequent referral to another specialty, such subsequent referral is also subject to approval by the Participant's Primary Care Physician. If a particular subsequent referral is troublesome or outside the scope of practice of the Participant's Primary Care Physician, the Primary Care Physician may request help from, or defer the determination to, the Claims Administrator's Medical Director, who in turn may consult an appropriate specialist or committee.

EMPLOYEE CLINICS

A Participant may select a Primary Care Physician at the Family Practice Clinic or other facilities of San Joaquin County Health Care Services. If an outside Primary Care Physician is selected, the Participant may obtain Medically Necessary care and prescriptions for illness or injury without obtaining a referral from the Participant's Primary Care Physician. However, the Participant's Primary Care Physician must arrange for any referrals to specialists or non-emergency hospitalization. Prior authorization by the Claims Administrator must be obtained for any services specified on page 2, or this Plan will not pay for those services.

EMERGENCY CARE

Remember to contact your Primary Care Physician as soon as possible so your Emergency Care can be coordinated with the benefits of the Plan. If it is necessary for you to use a Hospital emergency room, an emergency clinic, or an urgent care center, you are required to pay the applicable Copayment for each visit as described in the attached Schedule of Benefits. For life-threatening illnesses or injuries, or conditions requiring immediate treatment (see definition of Emergency Care for description as to what constitutes a condition requiring immediate treatment), all participating Hospitals provide 24-hour Emergency Care. For minor emergencies or unexpected illnesses which occur after-hours or on weekends, care is usually available through your Primary Care Physician. Covered Services and Supplies in a Hospital emergency room are limited to Medically Necessary Emergency Care. If you use the emergency room for non-emergency treatment, you will be responsible for payment of all charges.

PRIOR AUTHORIZATION

Certain Covered Services and Supplies require Prior Authorization by the Claims Administrator in order to be covered. This means that your Primary Care Physician must contact the Claims Administrator to request that the services or supply be approved for coverage before it is rendered (applicable telephone numbers appear on the plan identification card). Remind your Primary Care Physician that some Covered Services and Supplies require Prior Authorization. Verify that Prior Authorization has been achieved before the service or supply is actually rendered. Covered Services and Supplies that require Prior Authorization are:

- Non-emergency services in a participating Hospital Outpatient department (including MRI studies and other diagnostic tests or surgery), except for routine lab and x-ray.
- Home health agency services.
- Non-emergency ambulance transportation; generally not covered.
- Speech and occupational therapy; initial evaluation of a speech or hearing disorder.
- Purchase or rental of Durable Medical Equipment, Orthotics (i.e., orthopedic appliances) or Prosthetics.
- Surgery (inpatient or outpatient)
- Non-emergency oral surgical services; generally not covered.
- Private room accommodations and special duty nursing.
- Physical Therapy
- Skilled Nursing Facility Services
- Hospital admissions
- Weight control and nutritional counseling after the initial evaluation/consultation.
- Organ transplant operations (See Exclusions and Limitations for a description of non-covered services and pertinent restrictions).
- Referral to a non-participating provider, generally not covered.

IDENTIFICATION CARDS

Each Participant receives an identification card. Show your identification card each time you visit your Primary Care Physician or the Participating Provider to whom you have been referred, and show your card each time you fill a prescription. Be prepared to pay the required Copayments indicated in the attached Schedule of Benefits at this time. You will be responsible only for Copayments for specific Covered Services and Supplies and for all charges related to services and supplies not covered by this Plan. You will not receive a bill for Covered Services and Supplies. You do not need to submit a claim form.

CERTIFIED CONFINEMENTS

All non-emergency Hospital and Skilled Nursing Facility admissions must be pre-approved by the Claims Administrator. When your Primary Care Physician recommends a Medically Necessary, non-emergency admission to a Hospital or Skilled Nursing Facility, you should remind your Primary Care Physician's office to call the Claims Administrator for certification. Show your identification card to the admission clerk at the Hospital or Skilled Nursing Facility when you are admitted. Ask the clerk if your admission has been certified by the Claims Administrator. If it has not been certified, notify your Primary Care Physician immediately. The telephone number your Primary Care Physician should call for certification of a Hospital admission is shown on the Plan identification card. For Emergency Care admissions, you must request certification from the Claims Administrator within 24 hours of admission, or as soon as is reasonably possible thereafter. Pre-admission certification for Emergency Care is not required.

SCHEDULE OF BENEFITS

Participants are responsible for the payment of Copayments amd co-insurance upon receipt of some of the Covered Services and Supplies described below. The maximum Out-of-Pocket (OOP) payable in each Plan Year shall be $1,000 per participant and in no event more than $2,500 for the Subscriber and all his or her enrolled family members. When a Participant or Family Unit has paid the applicable maximum Out-of-Pocket, all Covered Services and supplies will be provided with no further out-of-Pocket expense for the balance of the Plan Year, except the Out-of-Pocket maximum excludes deductibles, costs above UCR, emergency room, prescriptions, chiropractic, and durable medical equipment.

Benefit Category	**Specifics/Limits**	**Copayments San Joaquin County Health Care Services**	**Copayments Network Provider**
Maternity Care	All Medically Necessary Services to 45 days after delivery	$15/visit	$15/visit
Mental Health Services	Psychotherapy for Acute Inpatient Services and Supplies and physician care	None	$100 per admission, except when admitted in case of emergency; Plan pays 90%; participant pays 10%
	Outpatient visit for crisis intervention and evaluation	$15 individual/$10 Group	$15/visit
Basic Services and Supplies	Ambulance service when Medically Necessary	Plan pays 90%; participant pays 10%	Plan pays 90%; participant pays 10%
	Initial evaluation for speech & hearing disorders	$15	$15/evaluation
	Allergy Test or Treatment	$15/visit	$15/visit
	Family planning, sterilization, abortion (if medically necessary)	$15/visit	$15/visit
	Medical/surgical service and supplies to diagnose and correct infertility	20% always (payment of which does not contribute to maximum OOP)	50% always (payment of which does not contribute to maximum OOP)
Preventive Care	Well baby/Toddler care (0 to 5 years of age)	$15	$15
	Pediatric (6 years of age & older) & adult immunizations	$15	$15/immunization
	Physical Examinations:		
	(6 through 17 years of age)	$15	$15/exam
	(18 years of age & older)	$15	$25/exam
	Hearing test (under 18 only)	$15/exam	$15/exam
	Eye exam/refraction (under 18 only)	Not available	$15/exam

Benefit Category	Specifics/Limits	Copayments San Joaquin County Health Care Services	Copayments Network Provider
Hospital Services & Supplies	All Inpatient Services and Supplies; semiprivate room, intensive care unit	No charge	$100 per admission, except when admitted in case of emergency; Plan pays 90%; participant pays 10%
	Outpatient Surgery	No charge	Plan pays 90%/ participant pays 10%
	Outpatient Emergency Care (copayment waived if admitted)	$30/visit if emergency room; $10/visit if Urgent Care (payment of which does not contribute to maximum OOP)	$40/visit if emergency room; $20/visit if urgent care facility (payment of which does not contribute to maximum OOP)
Continued Care Services	Skilled Nursing Facility, part-time intermittent home health care or Hospice Care (collectively, up to 60-day period per condition)	Plan pays 90%; participant pays 10%	Plan pays 90%; participant pays 10%
Participating Physician & Surgeon Services	Doctor visits in Hospital or Skilled Nursing Facility	$15	$15
	Doctor office visits, office consultations and office surgeries	$15	$15/visit
	Surgeon, assistant surgeon, anesthesiologist	$15	$15
	Home visit (if Medically Necessary)	$15	$15/visit
	Emergency Room physician	$15	$15
Prescribed Medical Services & Supplies	X-ray, lab, radiotherapy	No charge	Plan pays 90%; participant pays 10%
	Podiatry	$15	$15/visit
	Physical therapy, speech & occupational therapy (collectively, up to 60 visits per Plan Year)	$15/visit	$15/visit
	Durable Medical Equipment, Prosthetic and orthotic devices, breast prostheses	20% always (payment of which does not contribute to the maximum OOP)	50% always (payment of which does not contribute to the maximum OOP)
Supplemental Benefits	Outpatient Prescription Drugs (see endorsement for details)	$10 generic	$10 generic
		$20 brand on formulary	$20 brand on formulary
		$35 non-formulary	$35 non-formulary
	Chiropractic Care in conjunction with valid diagnostic code (see endorsement for details)	Not Available	Plan pays up to $25 per visit up to 20 visits per Plan Year

COVERED SERVICES AND SUPPLIES

This section describes the Covered Services and Supplies of this Plan. See the attached Schedule of Benefits for the specific Copayments that are required to be paid to Participating Providers for certain Covered Services and Supplies. You are also responsible for all charges in excess of limitations and for services and supplies not covered by this Plan. See Exclusions and Limitations for a description of limitations and non-covered services and supplies.

PARTICIPATING PROVIDER AND SURGEON SERVICES

Upon the referral of, or treatment by, the Participant's Primary Care Physician, this Plan covers the following Medically Necessary services and supplies when ordered and performed by a Participating provider or Surgeon:

- Surgery, assistant surgery and anesthesiology (Inpatient or Outpatient).
- Hospital and office visits.
- Home visits if the Participant is too ill or disabled to be seen during regular hours at the physician's office, subject to the judgment of the Participant's Primary Care Physician.
- Office visits for allergy treatment.
- Medical consultation services (includes consultation services of surgeons and specialists).
- Emergency Care in a Hospital emergency room, emergency clinic or urgent care center (see definition of Emergency Care for an understanding as to the appropriate use of Emergency Care).

You pay for any applicable Copayments and you pay for:

- Any services and supplies received during a Hospital confinement not certified by the Claims Administrator.
- Any physician charges incurred in connection with the use of the Hospital Emergency room, emergency clinic or urgent care center for non-emergency treatment.

PREVENTIVE CARE SERVICES

Upon referral of, or treatment by, the Participant's Primary Care Physician, this Plan covers the following preventive care services when ordered and performed by a Participating provider:

- Well baby care during the first two years of life, including newborn Hospital visits, office visits and routine immunizations.
- Periodic examinations including all routine diagnostic testing and laboratory services appropriate for such examinations after the age of two years. The frequency of these examinations is determined by the age, health status and medical needs of the participant and are generally as follows.

Age Range	**Frequency**
Newborn to age 2	9 well baby visits
Ages 2 through 6	annually
Ages 7 through 17	once every 2 years
Ages 18 through 40	once every 3 years
Ages 41 through 65	once every 2 years
Ages 66 and older	annually

Note: The frequency of such examinations shall not be augmented by a participant's desire for physical examinations, reports or related services for the purpose of obtaining or maintaining employment, licenses, insurance, school admission, school sports clearances, immigration or other reasons which are not related to medical needs. Such non-medically oriented examinations are covered hereunder but will not be in addition to the above-stated frequency guidelines.

- Pediatric (2 years of age an older) and adult routine immunizations as recommended by the American Academy of Pediatrics for children and by the U.S. Public Health Services for adults.
- Hearing tests and Eye refractions for Participants who are under 18 years of age.
- Testing for venereal disease.
- Voluntary family planning services and supplies, including surgical procedures for sterilization and medically necessary abortion.
- Services and supplies for the purpose of diagnosing the cause of infertility, including examinations, diagnostic surgical services and related Hospital or Facility costs in connection with such surgery.
- Treatment for infertility, including Pergonal (or other like drug) therapy, artificial insemination or plastic repair of the Fallopian tubes, (but not for reversal of voluntary sterilization).

You pay for any applicable Copayments and you pay for:

- All charges incurred for any other treatment of infertility such as, but not limited to, in vitro fertilization, embryo transfers, implantation of penile prostheses and reversal of voluntary sterilization.
- Hearing tests and Eye refractions for Participants who are over 18 years of age.
- Artificial insemination services beyond one treatment plan of up to twelve cycles per lifetime.

ORAL SURGERY AND SPECIAL DENTAL SERVICES

Upon referral of the Participant's Primary Care Physician, this Plan covers the following oral surgical services and supplies when ordered and performed by a Participating Provider.

- Emergency Care for the treatment of Acute injuries or fractures of the facial bones, including bones of the jaw, but not including treatment to, or replacement of, teeth.
- Subject to Prior Authorization, the treatment of neoplasms (tumors) of the face, facial bones or mouth; conservative prosthodontic/splint treatment of temporomandibular joint disorders and surgical treatment of the joint itself.

You pay for any applicable Copayments and you pay for:

- Charges for treatment to, or replacement of, teeth.
- Orthodontic procedures.
- Extraction of Teeth.
- Dental Prostheses or orthoses.
- General dental care.
- Treatment of dental abscesses.
- Braces, bridges, dental plates or any other dental services or procedures involving the teeth or structures supporting the teeth except as described above.
- Surgery to correct malocclusion.
- Surgical realignment of the jaw relating to temporomandibular joint disorder.
- Non-emergency oral surgical care which has not received Prior Authorization.

PRESCRIBED MEDICAL SERVICES AND SUPPLIES

Upon referral of, or treatment by, the Participant's Primary Care Physician, this Plan covers the following Outpatient Covered Services and Supplies when ordered and performed by a Participating Provider:

- Diagnostic x-ray examinations (also covered when you are a Hospital Inpatient).
- Radiation x-ray therapy (also covered when you are a Hospital Inpatient).
- Laboratory tests (also covered when you are a Hospital Inpatient).
- Services and supplies for the purpose of diagnosing allergies, including skin testing, x-rays, laboratory tests and other diagnostic studies.
- Subject to Prior Authorization, services by a Participating Physical Therapist for Short-term physical therapy. The frequency of visits may also be limited by treatment plan determined to be appropriate by the Participating Physical Therapist. In no event will therapy be provided for more than 60 visits per Plan Year (including occupational and speech therapy visits).
- Subject to Prior Authorization, services by a Participating Audiologist or Speech Therapist for an initial hearing and/or speech evaluation.
- Subject to Prior Authorization, services by a Participating Speech Therapist or Occupational Therapist for short-term therapy. The frequency of visits may also be limited by the treatment plan determined to be appropriate by the therapist. In no event will therapy be provided for more than 60 visits per Plan Year (including physical therapy visits).
- Breast Prostheses following mastectomy, including reconstructive surgery and surgically implanted prostheses.
- Subject to Prior Authorization, the purchase or rental of Durable Medical Equipment, Orthotics or Prosthetics from an authorized supplier.
- Mammography services for screening or diagnostic purposes to detect breast cancer by a Participating Provider upon referral of the Participant's Primary Care Physician or Gynecologist. The frequency of these examinations is determined by the age, health status and medical needs of the Participant and are generally as follows:
  A baseline mammogram for women 35 to 39 years of age.
  A mammogram every two years for women 40 to 49 years of age, or more frequently based on the woman's physical condition.
  A mammogram every year for women 50 years of age an older.
- Podiatry services, limited to open cutting operations, removing nail roots, and care necessary in the treatment of a metabolic or peripheral vascular disease.
- Medical management of Attention Deficit Disorder, with or without hyperactivity.

You pay for any applicable Copayments and you pay for:

- Any services rendered by a Participating Physical Therapist or Speech Therapist or Occupational Therapist for Long-term therapy or Chronic conditions.
- Replacement, repair and maintenance of Prosthetics, Orthotics and Durable Medical Equipment, except for replacement or non-routine repair of prosthetic and orthotic devices which are no longer appropriate because the Participant has outgrown them through the natural maturation process or which have been worn out or damaged not as a result of abuse.
- Podiatry services, unless specifically approved by this plan.

HOSPITAL INPATIENT SERVICES AND SUPPLIES

This Plan covers the following Medically Necessary Inpatient Services and Supplies when ordered and performed by a Participating Provider during a Certified Confinement in a Participating Hospital:

- Use of a room of two or more beds.
- Meals and general nursing care.
- Subject to Prior Authorization, private room accommodations and/or special duty nursing when Medically Necessary.
- Intensive care service.
- Use of operating and specialized treatment rooms.
- Surgical and anesthetic supplies furnished by the Hospital as a regular service.
- Functional devices implanted by surgical means.
- Hospital ancillary services such as physical therapy, Short-term medical rehabilitation services, laboratory, pathology, radiology and any professional component for these services.
- Oxygen.
- Non-experimental medications and drugs supplied by and used in the Hospital.
- Administration of blood, blood products and blood plasma.

You pay for any applicable Copayments and you pay for:

- Personal or convenience items.
- Drugs and medications taken home from the Hospital.
- Any part of the Hospital stay not certified by the Claims Administrator
- Services and supplies not Medically Necessary
- Experimental services and supplies.
- If higher priced accommodations are used without Prior Authorization, the Participant shall pay the difference between the actual amount incurred and the rated charged by that Hospital for a room of two or more beds.

HOSPITAL OUTPATIENT SERVICES AND SUPPLIES

This Plan covers the following Medically Necessary Outpatient Services and Supplies when ordered and performed by a Participating Provider at a Participating Hospital, Participating Emergency Clinic, Participating Urgent Care Center or other Participating Outpatient Facility:

- Covered Services and Supplies in connection with surgical treatment, including operating room and treatment room, medical supplies such as splints and casts, and non-experimental drugs and medications furnished by and administered at the Hospital or Facility.
- Covered Services and Supplies furnished in connection with Emergency Care, including emergency room, laboratory tests, x-rays, medical supplies such as splints and casts, non-experimental drugs and medications furnished by and administered at the Hospital or Facility.
- Covered Services and Supplies furnished in connection with hemodialysis for Chronic renal disease.

You pay for any applicable Copayments and you pay for:

- Drugs and medications taken home from the Hospital or Facility.
- All charges incurred when you use the emergency room or emergency facility for non-emergency treatment.

PREGNANCY AND MATERNITY CARE

This Plan covers Medically Necessary services and supplies when ordered and performed by a Participating Provider for pregnancy and childbirth including any complications.

You pay for any applicable Copayments and you pay for:

- Any Covered Services and Supplies received prior to the effective date of coverage hereunder, even though pregnancy terminates after the effective date.
- Any part of the Hospital stay not certified by the Claims Administrator.
- Drugs or medications taken home from the Hospital.
- Any charges incurred by your baby beyond 30 days of its birth unless said baby is enrolled hereunder within 30 days of its birth.
- Any charges incurred by your dependent child's baby.

Note: You must enroll your new baby in the Plan in order to receive coverage beyond 30 days of its birth.

MENTAL HEALTH SERVICES

Upon referral of the Participant's Primary Care Physician and subject to prior Authorization, this Plan covers Inpatient mental health care when ordered and performed by a Participating Mental Health Professional for the treatment of an Acute phase of a mental health condition during a Certified Confinement in a Participating Hospital. Coverage is limited to the Hospital Inpatient Covered Services and Supplies described beginning on page 7, and the services of a Participating Mental Health Professional during a Certified Confinement.

You pay for any applicable Copayments and you pay for:

- Any part of a Hospital stay not certified by the Claims Administrator.
- Any services and supplies not Medically Necessary.
- Any drugs or medications taken home from the Hospital.

This Plan covers Medically Necessary Outpatient treatment when ordered and performed by a Participating Mental Health Professional for treatment of a mental health condition.

ALCOHOLISM AND SUBSTANCE ABUSE SERVICES

This Plan covers the following services for alcoholism and substance abuse treatment when ordered and performed by a Participating Provider:

- All of the Covered Services and Supplies described in this Summary Plan Description when Medically Necessary for the diagnosis, Emergency Care, detoxification or treatment, subject to all applicable exclusions, limitations and Copayments described in the Plan.
- Referral assistance to community resources for rehabilitative or ancillary non-medical support services.

You pay for any applicable Copayments and you pay for:

- Any charges incurred which are excluded under the applicable benefit categories described herein.

CONTINUED CARE PROGRAM

Subject to Prior Authorization, the following services and supplies of either a Participating Skilled Nursing Facility, Home Health Agency or Hospice Care Program will be covered on a Short-term basis (i.e., therapy limited to a 60 day period commencing with the date of the first treatment or in lieu of confinement or further confinement in a Hospital (or in the case of home health services, in lieu of Skilled Nursing Facility or Hospital confinement) when the Participant's Primary Care Physician determines that such therapy is Medically Necessary and appropriate:

If Participating Skilled Nursing Facility:

- Use of a room of two or more beds, meals, services of a dietitian and general nursing care.
- Use of a Skilled Nursing Facility's specialized treatment room.
- Routine laboratory examinations.
- Oxygen.
- Non-experimental drugs and medications furnished by and administered at the Skilled Nursing Facility.
- Administration of blood, blood products and blood plasma.

You pay for any applicable Copayments and you pay for:

- Any part of a Skilled Nursing Facility stay which has not been certified by the Claims Administrator.
- Skilled Nursing Facility confinement in excess of the 60 day limitation period specified above.
- Blood, blood plasma or blood products which are not replaced from blood bank donations.

If higher priced accommodations are used without Prior Authorization, the Participant shall pay the difference between the actual amount incurred and the rate charged by that Facility for a room of two or more beds.

If Participating Home Health Agency Services:
Home health services by a Participating Home Health Agency for intermittent or part-time, skilled nursing care by a registered nurse or licensed vocational nurse, provided each service is requested by the Participant's Primary Care Physician and has received prior Authorization, including:

- Physical, speech and occupational therapy.
- Medical Supplies and equipment provided by a Participating Home Health Agency.

You pay for any applicable Copayments and you pay for:

- Any home health services that exceed the cost of a confinement at a skilled Nursing Facility.
- Any services and supplies for Custodial Care.
- Homemaker Services.
- Any services and supplies without Prior Authorization.
- Home health services by a home health aide.
- Home health services beyond the 60 day limitation period specified above.

Note: Home health services may be provided after a Participant's discharge from an admission in a Participating, Skilled Nursing Facility for the remainder of the 60 day limitation period specified above to the Continued Care Program benefit, if not already exhausted. In no event will the services of a Participating Skilled Nursing Facility and Participating Home Health Agency under this Continued Care Program benefits be provided individually or in the aggregate beyond the 60 day limitation period specified above for the treatment of the same condition.

If Hospice Care Program:
This coverage pays benefits for services incurred for a terminally ill person while in a Hospice Care Program. Certification of the terminal illness must be given to the Third Party Administrator by the primary attending physician in order for a terminally ill person to be considered in a hospice care program.

Benefits will be paid if the hospice services or the hospice confinement is:

- Provided while the terminally ill person is a Participant.
- Ordered by the supervising physician as part of the hospice care program.
- Charged for by the hospice care program.
- Provided within six (6) months of the terminally ill person's entry or re-entry (after a remission period) in the hospice care program.

All periods of care in a hospice care program will be considered related and to have occurred in the one period of care unless separated by at least three (3) consecutive months.

You pay for any applicable Copayments and you pay for:

- Any services and supplies without Prior Authorization.
- Any services and supplies for Custodial Care.
- Homemaker Services.

MEDICAL TRANSPORTATION SERVICES

This Plan covers emergency ambulance transportation by a licensed ambulance company to the first Hospital or urgent care center which actually accepts the Participant for Emergency Care. Emergency ambulance services are covered only when it is not medically appropriate to transport the Participant by ordinary public or private vehicle.

Subject to Prior Authorization, Non-emergency ambulance transportation will be provided for the transfer of a Participant from a Hospital to another Hospital or Facility or from a Hospital or Facility to home when Medically Necessary and requested by a Participating Provider. This Plan will pay Customary and Reasonable charges for the covered ambulance services described above.

You pay for any applicable Copayments and you pay for:

- Transportation by airplane, passenger car, taxi or other form of public conveyance which is not of an emergency nature or not Medically Necessary.
- Non-emergency ambulance transportation or transportation by airplane, passenger car, taxi or other form of public conveyance which has not received Prior Authorization.

EMERGENCY CARE SERVICES BY NON-PARTICIPATING PROVIDERS

If a Participant requires Emergency Care, either inside or outside the Service Area, when a Participating Provider is not available, all the benefits described in the Plan Document, subject to applicable exclusions and limitations, will be covered until such time as it is medically appropriate for the Participant to return to the care of a Participating Provider. Non-contracting providers may require the Participant to make immediate full payment for services or may allow the Participant to pay any applicable Copayments and bill the County for the unpaid balance. If the Participant has to pay the full bill for services rendered, the County will reimburse the Participant up to the Customary and Reasonable amount as determined by the Claims Administrator, for any services covered hereunder, less any Copayments due for such services. If the Participant pays a Non-contracting provider for any Copayments applicable to specific Covered Services and Supplies, such payments shall apply against the final payment by the County to the non contracting provider for services covered hereunder.

You pay for any applicable Copayments and you pay for:

- Any amount in excess of the Customary & Reasonable amount as determined by the Claims Administrator.
- Charges for any non-emergency services and supplies of a non-participating provider which have not received Prior Authorization.
- Charges for any services and supplies which would not have been a benefit of this Plan if received from a Participating Provider.

SUPPLEMENTAL BENEFITS

This plan covers Outpatient prescription drugs and Chiropractic services as specified in the plan endorsements.

EXCLUSIONS AND LIMITATIONS

1) Any services and supplies rendered prior to the Participant's effective date of coverage under the plan or after a Participant's coverage under the plan ends.
2) Any services and supplies not provided within the Schedule of Benefits, Covered Services and Supplies, or attached Endorsements.
3) All Covered Services and Supplies must be provided by the Participant's Primary Care Physician, or under the supervision of, or with the authorization and referral of the Participant's Primary Care Physician or the claims Administrator, except in the case of routine gynecological examinations, mammograms, Emergency care, Chiropractic care, mental health and substance abuse treatment, or primary services provided by San Joaquin County Health Care Services.
4) Services and supplies provided or ordered by non-participating providers are covered only for Emergency Care when a participating provider is not available or, subject to Prior Authorization, when requested and referred by a participating Provider.
5) Covered Services and Supplies other than preventive care services will be provided only when furnished in connection with the Medically Necessary diagnosis and treatment of an illness, disease or injury. Services and supplies required for such diagnosis and treatment other than non-participating provider services must be ordered by a Participating Provider in accordance with the standards maintained by the Claims Administrator.
6) Care in a Hospital or Skilled Nursing Facility which has not been predetermined to be a Certified Confinement by the Claims Administrator, except in the case of Emergency Care.
7) Covered Services and Supplies furnished by a Hospital shall be limited to those customarily furnished by a Participating Hospital and ordered by an attending physician in connection with the Medically Necessary diagnosis and direct care and treatment of an illness, disease or injury for which hospitalization was certified.
8) Inpatient room and board charges in connection with a hospital confinement primarily for diagnostic tests which could have been performed safely on an outpatient basis.
9) Any services and supplies furnished for Custodial Care, or services and supplies furnished by an institution which is primarily a place for rest, a place for the aged, a nursing home, or any institution of like character.
10) Benefits of the Continued Care Program shall be limited

to those services customarily furnished by the Participating Skilled Nursing Facilities, Home Heath Agencies, and Hospice Care Programs and are subject to Prior Authorization. Only those Covered Services and Supplies which are consistent with the degree of disability and medical needs of the participant on referral of his or her Primary Care Physician are eligible. Such services and benefits will continue only while the Participant is under the direct and active medical supervision of a Participating Provider for a condition necessitating the Continued Care Program.

11) In no event will physical, speech, or occupational therapy provided on an Outpatient basis be provided individually, or in any combination with each other, or in combination with services provided under the Continued Care Program, beyond 60 visits per Plan Year. The frequency of visits may also be limited by the treatment plan determined to be appropriate by the therapist.
12) General dental care, extraction of teeth, treatment of dental abscesses, braces, bridges, dental plates or other dental Prostheses or orthoses, or any other dental services or procedures involving the teeth or structure supporting the teeth, except as specifically provided in Oral Surgery and Special Dental Services.
13) Services, supplies and medicines provided in connection with those organ transplants which are Experimental in nature, as determined by the Claims Administrator through its professional review process and in accordance with generally accepted medical practice in the local medical community. Services and supplies provided in connection with donations of organs. Benefits shall be limited to Medical necessary services and supplies in connection with organ transplants where the Participant is the recipient.
14) A Participant's choice of Participating Hospital for organ transplant operations, and choice of facilities and providers for certain other procedures and services may be restricted to selected university medical centers, facilities and providers. Contact the Claims Administrator for assistance.
15) Chiropractic services shall be limited to 20 visits per Plan Year as provided in the Chiropractic Endorsement.
16) Outpatient prescription drugs and medicines shall be provided in accordance with the Outpatient Prescription Drug Endorsement.
17) Eye glasses, contact lenses, hearing aids and batteries. No benefits are provided for surgical procedures for the correction of visual acuity in lieu of eye glasses or contact lenses except for intraocular lenses in connection with cataract removal.
18) Blood, blood plasma and blood products which are not replaced by blood bank donations.
19) Services and supplies for treatment of conditions where the Participant is entitled to care or reimbursement through the Veterans' Administration or other governmental agency or program and for which such care is reasonably available.
20) Services rendered by a person who resides in the Participant's home, or by an immediate relative of the Participant.
21) If the Participant receives Covered Services and Supplies for which he or she would not be liable for payment in the absence of coverage under the plan, the County shall not be responsible for payment to the Participant or the provider for such services and supplies.
22) If services or supplies are received hereunder for which the Participant is entitled to benefits from an Other Plan or from Workers' Compensation coverage, or for which he or she is entitled to collect damages because of another person's actions, the County is entitled to recover the reasonable value of the services provided. The Participant is required to furnish the necessary claim forms, assignments or liens, and to assist the Claims Administrator and the County in recovery, or to reimburse the County from the settlement or damages the Participant receives.
23) Experimental services and supplies.
24) Services and supplies for personal comfort (e.g., television, telephone) or beautification.
25) Any of the following services for which Prior Authorization has not been obtained: Durable Medical Equipment, orthotics, Prosthetics, non-emergency oral surgical services, home health agency services, non-emergency ambulance transportation, non-emergency services in a Hospital Outpatient department, physical therapy, speech therapy, occupational therapy, initial evaluation of a speech or hearing disorder, referral to a non-participating provider, elective surgery or treatment, ongoing weight control program or nutritional counseling, cardiovascular rehabilitation, pulmonary rehabilitation, private room accommodations, special diets, special duty nursing, organ transplant operations, Skilled Nursing Facility and Hospital admissions.
26) Initial benefits for medically necessary Durable Medical Equipment are limited to purchase, rental or repair, whichever is less expensive; and replacement or repair only when outgrown by the user or due to wear and tear resulting from normal use. No benefits are provided for routine maintenance or for devices not medical in nature, such as whirlpools, saunas, elevators, bicycles, Lifecycles, exercise equipment; spare or alternative use items; more than one device for the same part of the body or more than the piece of equipment that serves the same function.
27) Wheelchairs provided as a benefit are limited to Standard Wheelchairs.
28) Services and supplies in connection with transsexual surgery, the reversal of voluntary sterilization, in vitro fertilization, embryo transfer, Gamete interfallopian transfers, or any services and supplies related to donor sperm or sperm preservation for artificial insemination.
29) Benefits for the treatment of infertility or impotency are limited to those Covered Services and Supplies specified in Preventive Care Services. Artificial insemination services beyond one treatment period of up to twelve cycles per lifetime.
30) Services and supplies in connection with the implantation of penile Prostheses.
31) Long-term rehabilitation services and supplies.
32) Services and supplies in connection with abortions which are not Medically Necessary.
33) Cosmetic or surgical procedures, except reconstructive

surgery necessary to repair a functional disorder as a result of disease or injury, or incident to a mastectomy performed after July 1, 1980. This exclusion includes surgical excision or reformation of any sagging skin on any part of the body including, but not limited to the breasts, eyelids, face, neck, abdomen, arms, legs or buttocks; any services and supplies performed in connection with the enlargement, reduction, implantation or change in the appearance of a portion of the body; hair transplantation or hair analysis; chemical face peels or abrasion of the skin; electrolysis depilation; or any surgical or non-surgical procedures which are primarily for Cosmetic purposes.

34) Services or supplies related to preservation and/or storage of body parts, fluids or tissues.
35) Home modifications or improvements; consultations of an environmental engineer.
36) Acupuncture; sleep therapy; sex therapy; vocational rehabilitation; exercise programs; educational, recreational, art, dance or music therapy.
37) Weight control or nutritional counseling benefits are limited to those Covered Services and Supplies provided through San Joaquin County Health Care Services in conjunction with a diagnosis of: diabetes, including tentative diagnosis of diabetes; cardiovascular disease, including hypertension; obesity in excess of 20% above normal body weight for height and age; malnutrition; and other diet-related diseases. Prior authorization is required for treatment beyond the initial referral period.
38) Biofeedback services are limited to the treatment of migraine headaches.
39) Podiatry services are limited to open cutting operations, removing nail roots and care necessary in the treatment of a metabolic or peripheral vascular disease.
40) Surgery to correct malocclusion, surgical realignment of the jaw relating to temporomandibular joint disorder.

REIMBURSEMENT PROVISIONS FOR OUT-OF-AREA CLAIMS

Non-participating physicians and health care facilities may require immediate payment for their services and supplies. For instance, you may have to pay when treated for Emergency Care out of the Service Area. If you pay a bill for Covered Services and Supplies, submit a copy of the paid bill to the Claims Administrator for reimbursement. Include all of the following information on a separate sheet of paper.

- A statement that you are a Participant.
- The patient's name, address and the identification number and group number from the Participant's identification card.
- Name and address of the provider of service (if not on the bill).

If you receive a bill for Covered Services and Supplies from a non-participating provider, you may ask the Claims Administrator to pay the provider directly. Send the bill to the Claims Administrator according to the procedures listed above, and include your authorization for payment to the provider.

- All such claims must be submitted to the Claims Administrator within 60 calendar days from the date expenses are incurred beyond which no coverage is available. The Claims Administrator will act on all claims within 45 calendar days after they are received unless additional information is required. If more information is needed, you will be notified in writing. When the Claims Administrator receives the necessary information, action will be taken within 45 calendar days. If all or part of the claim is denied you will receive written notice of the decision including:
- The reason for denial.
- Reference to pertinent Plan provision(s) on which the denial is based.

Notice of your right to request reconsideration of the denial, and an explanation of the grievance procedure.

COORDINATION OF BENEFITS

When you have coverage under this health plan and an Other Plan, Covered Services and Supplies of this health plan are coordinated with the benefits of the Other Plan so that the combination of the two coverages will not provide benefits exceeding the expenses incurred. The County reserves the right to obtain reimbursement from such Other Plan for the cost of services provided but not in excess of the amount payable under such Other Plan. Participants must execute any assignment necessary to facilitate such payment to the County or any of its Participating Providers. In the Coordination of Benefits with an Other Plan, the Claims Administrator uses the guidelines for determining Primary Carrier and Secondary Carrier responsibility which have been established by the National Association of Insurance Commissioners.

<u>Order of Benefit Determination:</u> The rules establishing the order of benefit determination are:

a. The benefits of a health plan which covers the Participant other than as a Dependent shall be the Primary Carrier.
b. When a health plan covers the Participant as a Dependent child and the parents are not separated or divorced, and each spouse is covered by a health plan which covers the Participant as a Dependent, the health plan of the spouse with the earliest birth date in the Plan Year shall be the Primary Carrier. If, however, one of the health plans does not include the provisions of this paragraph, the provisions of this paragraph shall not apply and the health plan which does not include these provisions will be the Primary Carrier.
c. When a health plan covers a Dependent child and the parents are separated or divorced and the parent with custody not remarried, the health plan of the parent with custody shall be the Primary Carrier.
d. When a health plan covers a Dependent child whose parents are divorced and the parent with custody has remarried, the health plan of the parent with custody is the Primary Carrier. The health plan of the stepparent is Secondary Carrier and the health plan of the parent without custody determines benefits third.
e. When a health plan covers a Dependent child , and the

parents are separated or divorced and there is a court decree which would otherwise establish financial responsibility for the medical, dental or other health care expenses, then, notwithstanding rules © and (d) above, the health plan which covers the child as Dependent of the parent with such financial responsibility shall be the Primary Carrier.

f. When a health plan covers a Participant as a laid-off or retired Member, or Dependent of such person, such health plan shall be the Secondary Carrier.
g. A health plan which does not have a Coordination of Benefits provision regarding laid-off or retired Members shall be the Primary Carrier if the lack of such provisions would result in each health plan determining its level of responsibility after the other.
h. When rules (a) through (g) above do not establish an order of benefits determination, the health plan which has covered the Participant for the longer period of time shall be the Primary Carrier.

ACTS OF THIRD PARTIES

If you and/or any of your Family Members are injured through the wrongful act, negligence or omission of another person, this plan provides Covered Services and Supplies on the condition that you will do the following:

- Furnish to the Plan Administrator a lien to be filed with the person or entity whose act caused the injuries, his or her agent or the court
- Reimburse the County when you collect damages from such person or entity to the extent of benefits provided; and
- If you recovered the reasonable value of services and supplies in settlement of such claim, pay the difference between such reimbursement and the fees paid by the County, if any, to the Participating Providers who rendered such service and supplies.

COUNTY'S RIGHT OF RECOVERY

Whenever payments for Covered Services and Supplies have been made hereunder and such payments exceed the maximum amount of payment provided by the benefits or eligibility of this Plan, irrespective of to whom paid, the Claims Administrator, on behalf of the County, shall have the right to recover such excessive amounts from the Participant for whom, or with respect to his or herself or any of his or her Family Members, such payments were made. (Including, but not limited to, any other insurance company, other organization, or persons.)

PARTICIPANT'S LIABILITY FOR PAYMENT

When you receive care from your Primary Care Physician or from a Participating Provider to whom he or she has referred you, you are responsible for any applicable Copayments and for payment for non-covered services and supplies or benefits in excess of specified limitations. If the Claims Administrator fails to pay a Participating Provider for Covered Services and Supplies, you will not be liable to the provider for any sums owed by the County. If the Claims Administrator fails to pay a non-participating provider, you may be liable for payment. If you receive services and supplies from a non-participating provider, other than Medically Necessary Emergency Care, or without Prior Authorization, you will be responsible for payment.

PREMIUMS

The County is responsible for paying its share of the premiums, if any, and collecting the employee's share of the premium through authorized payroll deductions. Participants who are not on retiree payroll should make arrangements through the County to pay applicable premiums.

ELIGIBILITY PROVISIONS

For Retired Beneficiaries and Designated Non-employees: The County establishes the conditions of employment or affiliation with this group which must be met by all Employees, Retired Beneficiaries, Designated Non-employees and Family Members in order for each to be eligible for coverage. If you meet these conditions and if you work or permanently reside in the Service Area, you may enroll in this Plan. Only the County may except or waive provisions regarding eligibility or effective dates of coverage.

For Family Members: Retired Beneficiaries and Designated Non-employees who enroll in this Plan may also include Family Members who satisfy the eligibility requirements for enrollment. The following types of persons describe those family members eligible to join the Plan:

- The legal spouse (excluding common law marriages) of the Retired Beneficiary or Designated Non-employee.
- Each natural or legally adopted child, or any other child for whom a Court has issued a qualified order for the Subscriber or his or her spouse to provide coverage, as long as the child is under 26 years of age.
- A natural or legally adopted child who has been enrolled in the Plan prior to reaching 26 years of age and who is incapable of self-support because of mental retardation or physical incapacity which commenced prior to the age of 26 years of age. Coverage may be continued as long as the information pertaining to the disability and dependency is furnished to the Claims Administrator within 30 days of the child's 26th birthday and thereafter on each birthday.

COMMENCEMENT OF COVERAGE

The County specifies the time and conditions under which coverage shall start and remain in effect. The following describes the commencement of coverage provisions:

- For Retired Beneficiaries, Designated Non-employees and any of their Family Members enrolled on the effective date of the Agreement, coverage will begin on the date this health plan becomes effective for this group.
- For Retired Beneficiaries, Designated Non-employees and any of their Family Members becoming enrolled subsequent to the effective date of the Agreement, coverage will begin on the First day after you and they have satisfied eligibility requirements.
- For Children born, adopted or covered by court order after your own coverage commences, coverage will be effective at the date of birth, date physical custody begins, or effective date of the qualified court order, receptively. In the adoption of foreign child, custody is considered to begin on the date of the child's departure from his or her native land.
- For other Family Members who become eligible after your coverage commences (e.g., by marriage) coverage begins on the first of the month after you apply to enroll them, as long as you apply within 31 days of the date they become eligible.

OPEN ENROLLMENT

If you or any of your Family Members do not enroll when first eligible, you may enroll during the County's next Open Enrollment period. This usually occurs once a year at a time determined by the County. Coverage will begin after the Open Enrollment period on the effective date established by the County.

TERMINATION PROVISIONS

You can terminate your coverage:

- If you cease to pay your premiums.

You can terminate your dependents' coverage:

- By giving written notice to the County that you wish to disenroll your dependents at open enrollment.

The County can terminate your coverage:

- By giving 60 days notice that the County does not wish to continue this Plan,

Coverage will terminate:

- If you cease to be an eligible Retiree according to the provisions listed in Eligibility Provisions, coverage will be terminated for you and any enrolled Family Members effective on the last day of the pay period in which final premiums are paid.
- If an individual Family Member ceases to be eligible according to the provisions listed in Eligibility Provisions, coverage will be terminated only for that person effective on the first day following the pay period in which loss of eligibility occurs.
- On midnight of the last day of the pay period in which entry of the final decree of dissolution of marriage or annulment occurs, a spouse shall cease to be an eligible Family Member. Children of the spouse who are not also the natural or legally adopted children of the Subscriber shall cease to be eligible Family Members at the same time.
- If you permit any other person to use your identification card, termination will be effective on the first day of the month following written notice by the Plan Administrator.
- If you make a false statement as to your health status or that of any of your Family Members, or obtain or attempt to obtain Covered Services and Supplies by means of false, misleading, or fraudulent information, acts or omissions, the Plan Administrator may terminate your coverage upon 15 days notice.
- If you or any of your Family Members refuse to establish and maintain relationships with your Primary Care Physicians and other providers to assure continuity of health care and appropriate use of available Covered Services and Supplies, termination will be effective after 15 days notice from the Plan Administrator.
- If a Participant voluntarily discontinues Medicare coverage while still eligible hereunder, termination will be effective on the date of such discontinuance of Medicare coverage.

RE-ENROLLMENT

If you terminate coverage any of your Family Members, you may apply for re-enrollment during the County's next Open Enrollment period.

If your coverage has been terminated for cause (misuse of your identification card or inappropriate use of Covered Services and Supplies), you may apply for re-enrollment by following the procedure listed above except you cannot apply until at least six months has elapsed since your coverage was terminated. If you have been terminated twice for cause, you will not be permitted to re-enroll.

COBRA

Most businesses are subject to The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). If the employer who provides coverage under the *plan* is subject to the federal law which governs this provision (Title X of P. L. 99-272), you may be entitled to continuation of coverage. Check with your employer for details.

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

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

Qualified Beneficiary means a person enrolled for this COBRA continuation coverage who, on the day before the Qualifying Event, was covered under this *plan* as either an *employee* or *dependent.* Qualified Beneficiary does not include any person who was not enrolled during the Initial Enrollment Period, including any *dependents* acquired during the COBRA continuation period.

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

. For Employees and Dependents:
  . The *employee's* termination of employment, for any reason other than gross misconduct; or
  . A reduction in the *employee's* work hours.
. For Retired Employees and their Dependents:
  . Cancellation or a substantial reduction of retiree benefits under the plan due to our filing for Chapter 11 bankruptcy, provided that:
  . The *plan* expressly includes coverage for retirees.
. For Dependents:
  . The death of the *employee;*
  . The *spouse's* divorce or legal separation from the *employee;*
  . The end of a *child's* status as a dependent *child*, as defined by the *plan;* or
  . The *employee's* entitlement to Medicare.
  .

ELIGIBILITY FOR COBRA CONTINUATION
An *employee* or *dependent* may choose to continue coverage under the *plan* if his or her coverage would otherwise end for a Qualifying Event.

Exceptions: A *beneficiary* is not entitled to continue coverage if, at the time of the Qualifying Event, that *beneficiary* is: (1) entitled to Medicare*; or (2) covered under any other group health plan, unless the other group health plan contains an exclusion or limitation relating to a pre-existing condition of the *beneficiary.* If one *beneficiary* is unable to continue coverage for these reasons, other entitled *beneficiaries* may still choose to continue their coverage.

*Entitlement to Medicare will not preclude a person from continuing coverage for which the person became eligible due to Qualifying Event 2.

TERMS OF COBRA CONTINUATION
Notice. We will notify either the *employee* or *dependent* of the right to continue coverage under COBRA, as provided below:

1. For Qualifying Events 1, or 2, we will notify the *employee* of the right to continue coverage.
2. For Qualifying Events 3(a) or 3(d) above, a *dependent* will be notified of the COBRA continuation right.
3. You must inform us within 60 days of Qualifying Events 3(b) or 3(c) above if you wish to continue coverage. We in turn will promptly give you official notice of the COBRA continuation right.

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

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

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

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

Cost of Coverage. We may require that you pay the entire cost of your COBRA continuation coverage. This cost, called the "required monthly contribution", must be remitted to us each month during the COBRA continuation period.

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

1. A *spouse* whose COBRA continuation began due to divorce, separation or death of the *employee;*
2. A *child* if neither the *employee* nor the *spouse* has enrolled for this COBRA continuation coverage (if more than one *child* is so enrolled, the required monthly contribution will be the two-party or three-party rate depending on the number of *children* enrolled); and
3. A *child* whose COBRA continuation began due to the person no longer meeting the dependent *child* definition.

Subsequent Qualifying Events. Once covered under the COBRA continuation, it's possible for a second Qualifying Event to occur. If that happens, you and your *dependents*, who are Qualified Beneficiaries, may be entitled to an extended COBRA continuation period, subject to the following conditions:

1. This period will in no event continue beyond 36 months from the date of the first Qualifying Event, except as provided in item 2 below.

For example: A *child* may have been originally eligible for COBRA continuation due to termination of the *employee's* employment, and enrolled for this COBRA continuation as a Qualified Beneficiary. If, during the COBRA continuation period, the *child* reaches the upper age limit of the *plan*, the

child is eligible for an extended continuation period which would end no later than 36 months from the date of the original Qualifying Event (the termination of employment).

2. If the extended COBRA continuation period is due to the *employee* becoming entitled to Medicare, the extended period will not continue beyond 36 months from the date such *employee* became entitled to Medicare.

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

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

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

1. The end of 18 months from the Qualifying Event, if the Qualifying Event was termination of employment or reduction in work hours;*
2. The end of 36 months from the Qualifying Event, if the Qualifying Event was the death of the *employee*, divorce or legal separation, or the end of dependent *child* status;*
3. The end of 36 months from the date the *employee* became entitled to Medicare, if the Qualifying Event was the *employee's* entitlement to Medicare;
4. The date the *plan* terminates;
5. The end of the period for which required monthly contributions are last paid;
6. The date the *beneficiary* becomes covered under any other group health plan, unless the other group health plan contains an exclusion or limitation relating to a pre-existing condition of the *beneficiary*, in which case this COBRA continuation will end at the end of the period for which the pre-existing condition exclusion or limitation applied; or
7. The date the *beneficiary* becomes entitled to Medicare.

*For a *beneficiary* whose COBRA continuation coverage began under a *prior plan*, this term will be dated from the time of the Qualifying Event under that *prior plan.*

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

If your COBRA continuation under this *plan* ends in accordance with items 1 or 2, you are eligible for medical conversion coverage. We will provide notice of this conversion right within 180 days prior to such termination date.

EXTENSION OF CONTINUATION DURING TOTAL DISABILITY

If at the time of termination of employment or reduction in hours, you are determined to have been disabled for Social Security purposes, you may be entitled to up to 29 months of continuation coverage after your original Qualifying Event.

Eligibility for Extension. To continue coverage for up to 29 months from the date of the original Qualifying Event:

1. You must satisfy the legal requirements for being totally and permanently disabled under the Social Security Act on the date of the original Qualifying Event; and

You must be determined and certified to be so disabled by the Social Security Administration as of the date of the original Qualifying Event.

Notice. You must furnish us with proof of the Social Security Administration's determination of disability during the first 18 months of the COBRA continuation period and no later than 60 days after the date of the Social Security Administration's determination of such disability.

Cost of Coverage. For the 19th through 29th months that you continue to be totally disabled, the cost (called the "required monthly contribution") shall be subject to the following conditions:

1. This charge shall be **150%** of the *employee's* rate, and must be remitted to us each month during the period of extended continuation coverage.
2. We may require that you pay the entire cost of the extended continuation coverage.
3. We must receive timely payment of the required monthly contribution each month in order to maintain the extended continuation in force.

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

1. The end of the month following a period of 30 days after the Social Security Administration's final determination that you are no longer totally disabled;
2. The end of 29 months from the Qualifying Event;
3. The date the *plan* terminates;
4. The end of the period for which required monthly contributions are last paid;
5. The date the *beneficiary* becomes covered under any other group health plan, unless the other group health plan contains an exclusion or limitation relating to a pre-existing condition of the *beneficiary*, in which case this COBRA continuation will end at the end of the period for which the pre-existing condition exclusion or limitation applied; or
6. The date the *beneficiary* becomes entitled to Medicare.

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

Post-Cobra Continuation For Qualifying Beneficiaries

Subject to payment of the required monthly contribution as stated in the *plan*, coverage under this *plan* may be continued for the *employee* and the *spouse*, under Section 2807.5 of the

Labor Code, in accordance with the following provisions. This continuation may be elected following the CONTINUATION OF COVERAGE shown above (the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), or Title X of P.L. 99-272).

Requirements. The *employee* and *spouse* may continue coverage under this *plan* if:

1. The *employee*, or the *employee* on behalf of himself or herself and the *spouse*, was entitled to, and had elected to continue coverage under, COBRA, as described in the preceding section;
2. The *employee* or *spouse* has not elected to continue coverage under any other available continuation;
3. The *employee* has worked for the employer for at least the prior five years; and
4. The *employee* is at least 60 years old on the date his employment with us ended.

Notice and Election. We will notify the *employee* or *spouse* of the right to continue coverage at least 90 days prior to the date continuation of coverage under COBRA is scheduled to end.

To elect this continuation, you must notify the employer in writing within 30 days prior to the date continuation coverage under COBRA is scheduled to end. This continuation may be chosen for both the *employee* and *spouse*, the *employee* only, or the *spouse* only. But if you fail to elect this continuation when first eligible, you may not elect this continuation at a later date. Notice of continued coverage, along with the initial required monthly contribution, must be delivered to us within 45 days after you elect this continuation.

Cost of Coverage. This continuation is subject to payment of required monthly contributions to the employer at the time they are due. We may require that you pay the entire cost of your continuation coverage. The rate for continuation coverage under this section shall be 213% of the applicable *employee's* rate. For purposes of determining required monthly contribution payable, the *spouse* continuing coverage alone under this Labor Code Section 2807.5 continuation will be considered to be an *employee*.

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

1. The end of the period for which required monthly contributions are last paid;
2. The date the *plan* terminates;
3. The date the *employee* or *spouse* becomes covered under any group health plan not maintained by the employer;
4. The date the *employee* or *spouse* becomes entitled to Medicare;
5. The date the *employee* or *spouse* reaches age 65; or
6. For the *spouse*, five years from the date the *employee's* employment with us ended.

If your continuation under this *plan* ends in accordance with item 6, you are eligible for medical conversion coverage.

GRIEVANCE PROCEDURE

Through the Claims Administrator any Participant who has a problem with his or her coverage, or questions the Plan's determination on a claim or authorization request, is entitled to an appeal review.

First Appeal: You have the right to appeal to the Claims Administrator's Grievance Coordinator, in writing, within 180 calendar days after receipt of written notification of a denial of service. Include any supporting documents and an explanation of the reason(s) you feel the claim should be paid, or the service should be authorized. The Grievance Coordinator will submit your appeal for review by the Utilization Management Manager and the Medical Director. The decision, after review, will be in writing. If your appeal is partially or totally denied, the notice will include the specific reasons for the decision, references to the pertinent Plan provisions as outlined in this Benefit Booklet on which the decision was based, and notice of your right to a final appeal

Second (final) Appeal: If you still do not understand or agree with the decision, you have the right to appeal in writing within 60 calendar days to the County. The Participant should submit any information (comments, documents, records, or any other information) in support of his claim with his appeal letter, which should be sent to the County Benefits Manager.

The Plan Administrator will conduct a full and fair review of the appeal taking into account all comments, documents, records and other information submitted by the Participant relating to the claim, without regard to whether the information was submitted or considered in the initial benefit determination. A decision with regard to the claim appeal will be made in writing. If the decision is to continue to deny benefits, the notification will include the specific reason(s) for the decision and reference to the pertinent Plan provisions on which the decision is based.

The Plan Administrator's determination shall be final and binding.

A Plan Participant may not take legal action on a denied claim for service until he/she has exhausted the Plan's appeal procedures. No such action shall be brought later than three years following the date a written claim is submitted or request for service is received by the Claims Administrator.

DEFINITIONS

Acute: Sudden on set or abrupt change of health status of an illness, injury or condition requiring prompt attention (which may include hospitalization), but which is of limited duration. Opposite of Chronic.

Agreement: The Administrative Services Agreement, this Participant Handbook, the Group Application, the Notice of Acceptance, the Participating Provider Directories, the Participant Identification Card issued by the, Claims Administrator, and any addenda, endorsements or amendments thereto.

Certified Confinement: The admission and length of stay of a Participant in a Hospital or Skilled Nursing Facility, for which admission has been certified by the Claims Administrator as appropriate prior to the Participant's confinement. In the event the Participant is confined for Emergency Care, the Participant shall request within 24 hours of admission, or as soon as is reasonably practicable thereafter, that the Claims Administrator certify said confinement. Care in a hospital or skilled nursing facility which has not been certified by the Claims Administrator is excluded from coverage hereunder.

Chronic: Designating a disease, illness or medical problem showing little positive change, or reasonable prognosis for positive change, or of slow progression, as determined by the Claims Administrator through its professional review process. Opposite of Acute.

Coordination Of Benefits: Allocation of responsibility to pay for health care between two or more group health plans.

Copayment: A Participant's share of costs for Covered Services and Supplies, usually paid to the Participating Provider at the time care is rendered. Where Copayments are expressed as a percentage, said Copayments are based on a percentage of the amount the provider bills the Plan for the Covered Service or Supply. The specific Copayment amounts and Out-of-pocket maximums that apply to the various Covered Services and Supplies are listed in the attached Schedule of Benefits.

Cosmetic Surgery: Surgical procedures, usually plastic surgery, directed toward preserving appearance or correcting unattractive scars or burns. Cosmetic Surgery services, except reconstructive surgery necessary to repair a functional disorder as a result of disease or injury, or incident to a mastectomy performed after July 1, 1980, are not provided hereunder.

Covered Services and Supplies: Medical, surgical, mental health, Hospital and other services and supplies rendered by health care providers which are benefits hereunder.

Custodial Care: Care provided primarily for the non-medical maintenance of a patient or which is designed essentially to assist a patient in meeting his or her activities of daily living and which is not primarily provided for its therapeutic value in the treatment of a sickness or bodily injury. Activities of daily living include such things as: bathing, feeding, dressing, walking and taking oral medicine. Custodial Care services are not provided hereunder.

Dependent: Those individuals in a Subscriber's Family Unit who meet the criteria of the definition of dependent as used in the Internal Revenue Code and Regulations of the United States, subject to any County prerequisites to the contrary described in the Plan Document.

Designated Non-employee: Designated individuals who are compensated by commissions or on the basis of contracts or subcontracts with the County, or are affiliated with this group in some other manner, to whom the County has agreed to extend eligibility for Plan participation. Such individuals, if covered hereunder, must be designated in the Agreement and meet the County's eligibility prerequisites specified therein.

Durable Medical Equipment: Equipment designed for repeated use which is Medically Necessary to treat an illness or injury to correct a functional disorder, or to prevent further deterioration of the patient's medical condition. Durable Medical Equipment includes items such as Standard Wheelchairs, Hospital beds, oxygen and oxygen supplies, and other items that the Claims Administrator determines are Durable Medical Equipment.

Emergency Care: Services and supplies required for the alleviation of severe pain or the immediate diagnosis and treatment of an unforeseen illness or injury which, in the opinion of the attending physician, if not immediately diagnosed and treated, could lead to further disability or death.

Experimental: Any procedure, treatment, therapy, drug, biological product, facility, equipment, device, or supply that the Claims Administrator has determined, at their sole discretion, not to have been demonstrated as safe, effective and efficacious for use in treatment of sickness, Injury or condition at issue, as compared with the conventional means of treatment and diagnosis. Experimental also includes services, supplies, drugs, and procedures that have been determined to be investigational, educational or the subject of clinical trial. In making this determination, the Claims Administrator shall refer to evidence from the national medical community which may include one or more of the following sources:

- evidence from national medical organizations such as the National Centers for Health Services Research;
- peer-reviewed medical and scientific research;
- publications from organizations such as the American Medical Association;
- professionals, specialists and experts; and
- written protocols, and consent forms used by the proposed treating facility or other facility administering substantially the same drug, device or medical treatment.

Family Member: Any individual of a Subscriber's Family Unit who meets all applicable eligibility requirements and the County's prerequisites specified within the Plan Document.

Family Unit: A unit comprised of a Subscriber and each person whose eligibility for Covered Services and Supplies is based upon such person's relationship with, or dependency upon, such Subscriber.

Hospice - Hospice means an agency that provides counseling and medical services and may provide room and board to a terminally ill Participants and which meets all of the following tests:

- It has obtained any required state or governmental Certificate of Need approval-
- It provides service twenty-four (24) hours per day, seven (7) days per week.
- is under the direct supervision of a physician.
- It has a nurse coordinator who is a Registered Nurse (RN).
- It has a social service coordinator who is licensed.
- It is an agency that has as its primary purpose the provision of hospice services.
- It has a full time administrator.
- It maintains written records of services provided to the patient.
- It is licensed if licensing is required.

Hospital: An institution which is licensed under state and local laws and regulations to provide, on the order of a physician, diagnostic and therapeutic services for the medical diagnosis, treatment and care of persons in need of Acute Inpatient Hospital care and which is accredited by the Joint Commission on Accreditation of Health care Organizations.

Inpatient: An individual confined as a bed patient in a Hospital or Skilled Nursing Facility who requires routine or specialized Hospital services.

Inpatient Services and Supplies: Covered Services and Supplies rendered in a Hospital or Skilled Nursing Facility while the individual is confined as a bed patient.

Long-Term: Used in reference to the treatment of an Acute condition beyond two months or treatment of a Chronic condition. Long-term rehabilitation services and supplies are excluded from coverage hereunder.

Medically Necessary: Determined by the Claims Administrator through its professional review process to be necessary and appropriate for treatment of the patient's illness or injury according to standards of medical practice generally accepted and provided by the medical community within or proximate to the Service Area. The fact that a Participating Provider may prescribe, order, recommend or approve a service, supply or hospitalization does not, in itself make it Medically Necessary or make the charge an allowable Covered Service or Supply, even though it is not specifically listed as an exclusion or limitation. The Plan Administrator, reserves the right to review all claims to determine if a service, supply or hospitalization is medically necessary according to the previously mentioned standards.

Medicare: The program of medical care Coverage set forth in Title XVIII of the Social Security Act, as amended by Public Law 89-97 including any amendments which may be enacted in the future.

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).

Open Enrollment: A period occurring at least once each year, as established by the County, with the concurrence of the Claims Administrator, during which time Employees, and any of their Family Members who did not, or chose not to, enroll when first eligible may enroll in this health plan.

Open Transfer Period: A period occurring at least once each year, as established by the County with the concurrence of the Claims Administrator, during which time Retied Beneficiaries may transfer coverage between this plan and other plans offered by the County.

Other Plan: For the purpose of Coordination of Benefits for a Participant covered by two or more health plans, any health plan, other than this Plan, providing benefits or services for Hospital or medical care or treatment whose benefits or services are provided by any group, indemnity, fee-for-service, health insurance, self-funded employee welfare benefit plan or any other coverage on a group basis or any coverage under labor-management trusts, union welfare plans, employee organization plans, or group coverage sponsored by or provided through a school or educational institution.

Out-of-pocket: The Copayment amounts that are the Participant's responsibility each Plan Year. The specific maximum Out-of-pocket that applies hereunder for the plan is listed in the attached Confined Schedule of Benefits.

Outpatient: An individual who requires medical treatment or attention and who is not consumed as a bed patient in a Hospital or Skilled Nursing Facility.

Outpatient Services and Supplies: Covered Services and Supplies rendered in a physician's office, in an appropriate licensed Facility or as non-hospitalized treatment in that part of a Hospital designed for accommodating ambulatory or emergency patients.

Participant: Any eligible person who is enrolled in the Plan in accordance with Memoranda of Understanding and Resolutions adopted by the Board of supervisors of the County of San Joaquin.

Participating Hospital: Hospitals with which the Claims Administrator, on behalf of the County of San Joaquin, has agreements to assure Participants access to Hospital care.

Participating Physician: A doctor of medicine or osteopathy who has a written agreement with either the County or a network through the Claims Administrator, on behalf of the County, to provide Covered Services and Supplies to Participants.

Participating Provider: A Participating Physician or other individual trained and licensed to Provide Covered Services and Supplies, or a Facility or other legal entity designed and licensed to provide Covered Services and Supplies, having a written agreement with either the County of San Joaquin or the Claims Administrator's network, on behalf of the County, to provide Covered Services and Supplies to Participants. Such

licensed individuals and Facilities include but are not limited to the following Participating Providers: Surgeons, Ophthalmologist, Anesthesiologists, Audiologists, Oral/Dental Surgeons, Speech Therapists, Occupational Therapists, Emergency Clinics, Urgent Care Centers, Laboratories, Outpatient Surgical Facilities, and Home Health Agencies.

Plan Year: Corresponds to County Fiscal Year pay periods. Contact Human Resources Division of County for specific dates each year.

Primary Care Physician: Any physician who has the responsibility for providing initial and primary care to Participants, maintaining the continuity of patient care, initiating referral for specialist care, and who is listed in the current Participating Provider Directory as a Primary Care Physician.

Primary Carrier: A health plan which has primary responsibility for the provision of benefits for a Participant covered by two or more health plans. The Primary Carrier determines the application of its benefits without talking the existence of any Other Plan into consideration.

Prior Authorization: Requirement that a Participant's physician request approval from the Claims Administrator prior to the Participant obtaining certain Covered Services and Supplies. Requests for Prior Authorization will be denied if not Medically Necessary or contrary to the medical efficacies of the Claims Administrator's medical policy guidelines.

Prosthetic (or Prostheses): Replacement of a missing body part or organ by an artificial substitute.

Retired Beneficiaries: Retired employees who qualify for the County's pension benefits by virtue of age, years of service with the County and such other requirements as the County's pension program may impose. Such individuals, if covered hereunder, must be designated in the Agreement and meet the eligibility prerequisites specified therein. Deferred Retired Beneficiaries are also eligible to participate in this Plan.

Secondary Carrier: A health plan which has secondary responsibility for the provision of benefits for a Participant covered by two or more health plans. The Secondary Carrier determines the application or its benefits after a determination of benefits is made by the Primary Carrier.

Short-Term: Treatment of Acute conditions for up to two months per condition, commencing with the date of first treatment. Short-term treatment is not provided hereunder if the Claims Administrator determines that such treatment cannot be expected to result in the improvement of a Participant's condition within a period of two months.

Skilled Nursing Facility: A Facility which is licensed under state and local laws and regulations to cooperate as a skilled nursing facility, and which is accredited by the Joint Commission on Accreditation of Health care Organizations.

Standard Wheelchair: A fixed-arm wheelchair with "swing-away" foot rests that does not include any additional attachments and is not motorized or considered lightweight, sporting or custom.

Subscriber: A Retired Beneficiary or Designated Non-Employee enrolled hereunder who is responsible for payment of Copayments and any applicable premiums and whose employment or other status, except family dependency, is the basis for eligibility hereunder.

Substance Abuse Disorders: 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).

Total Disability: With respect to a Participant who is not a Dependent, an illness or injury which prevents him or her from engaging in any occupation for compensation or profit. With respect to a Dependent of a Subscriber, an illness or injury which prevents the Dependent from engaging in substantially all of his or her normal activities

Usual, Customary and Reasonable: Usual - The "usual" charge is that charge usually charged, for a given service or supply, by an individual physician to his or her private patients (i.e., his or her own usual fee). Customary - A charge is "customary"- when it is within the range of the usual charges charged by physicians of similar training and experience, for the same service or supply within the same specific and limited geographic area (socio-economic-economic area of a metropolitan area or socio-economic area of a county) as determined by the Claims Administrator through its professional review process. Reasonable - The charge is "reasonable" when it meets the above two criteria or is justifiable as determined by the Claims Administrator through its professional review process in consideration of the special circumstances of the particular case in question.

OUTPATIENT PRESCRIPTION DRUGS ENDORSEMENT

Covered Services and Supplies

The provisions of the Plan Document notwithstanding, this Plan will provide Participants with Outpatient prescription drug coverage subject to the following conditions:

1. Drugs and medications must be ordered by a Participating Provider and obtained at a Participating Pharmacy.
2. Covered drugs and medications include:
   a) Drugs which may be dispensed only with a written prescription of a physician in accordance with applicable state laws.
   b) Insulin for the treatment of diabetes.
   c) Hypodermic syringes and/or needles required for the injection of insulin in the treatment of diabetes.
   d) Oral contraceptives.
   e) A maximum of two inhalers per prescription may be obtained at one time.
3. Maintenance medications are available through a mail order program as an alternative to pharmacy pickup; a 90-day supply can be obtained for two co-payments at the appropriate level.
4. The amount of medication provided by a pharmacist when **filling** a prescription will be limited to a 30-day supply. Subject to Prior Authorization, a larger supply may be provided where Medically Necessary.
5. The pharmacist will substitute generic drugs and medications, when available, for brand name drugs and medications unless medically contraindicated.
6. Except for inhalers, referenced above, "prepackaged" drugs or medications which are packaged in standardized containers from a prescription drug manufacturer shall not be dispensed in more than one standardized container per prescription.

Exclusions and Limitations

The Outpatient prescription drug benefits described above are subject to the following exclusions and limitations:

1. Drugs or medications purchased prior to the effective date of the Participant's coverage under this Outpatient prescription drug benefit.
2. Drugs or medications dispensed after termination of the participant's coverage.
3. Patent or over-the-counter medicines, or medicines not requiring a written prescription order.
4. Medical or surgical appliances or Durable Medical Equipment.
5. Injectable medications except for insulin or inhalants prescribed as Medically Necessary.
6. Hypodermic syringes or needles except for the administration of insulin.
7. Oxygen and oxygen supplies.
8. Cosmetics, health or beauty aids, dietary supplements, appetite suppressants or any other diet drugs or medications.
9. Vitamins and vitamins in combination with fluoride or minerals (e.g., Tri-Vi-Flor, Matema 1-60). Note: vitamins which by law require a prescription (e.g., vitamin K) are a benefit, provided they are dispensed as a single item and not in combination with vitamins classified as "over-the-counter" drugs.
10. Prescriptions not written by a Participating Provider or prescriptions not supplied by a participating Pharmacist, except for (a) in the case of an emergency, or (b) antibiotics prescribed by a licensed dentist.
11. Any prescriptions which provide more than a 30-day supply.
12. Any "prepackaged" drugs or medications which are dispensed to a Participant in more than one standardized container per prescription.
13. Drugs or medications dispensed in connection with any conditions coming within the exclusions or limitations listed in the Plan Document, except for antibiotics prescribed by a licensed dentist. This benefit is intended to provide prescription drugs on an Outpatient basis as a supplement to basic drug coverage provided on an Inpatient basis under the Plan Document; it is not a supplement to provide coverage for all drugs under all circumstances.
14. Bee sting kits.

All medications hereunder are limited to those included in the Plan Administrator's published drug formulary, available upon request.

CHIROPRACTIC CARE ADDENDUM

Notwithstanding the chiropractic care exclusion in the Plan Document, this health plan will cover the services described below, subject to the applicable conditions, limitations and exclusions stated in the Plan Document and this Endorsement. This Endorsement also specifies any applicable Copayment requirements and Out-of-pocket limitations.

Maximum Allowable Benefit

Chiropractic Covered Services are limited to 20 visits per Plan Year. The maximum benefit is $25 per office visit for all covered services. Any services rendered after the maximum allowable benefit has been obtained are the financial responsibility of the Member and are excluded from coverage hereunder.

Member Copayments

Copayments paid by member for chiropractic services do not accumulate towards the Copayment Maximum for non-chiropractic services covered under the Agreement.

Description of Covered Chiropractic Services

Covered Chiropractic Services are those services which are Medically Necessary to restore a Member to his or her presymptomatic status just prior to an acute injury or illness and which are determined to be generally furnished for the diagnostic and/or treatment of a neromusculo-skeletal disorder associated with that injury or illness, including:

1. Chiropractic manipulations and adjustments.
2. Diagnostic radiology and laboratory services generally provided by chiropractors.
3. Chiropractic consultations.
4. Treatment for the Aggravation of an illness or injury requiring chiropractic treatment.
5. Treatment for the Exacerbation of an illness or injury requiring chiropractic treatment.

Exclusions and Limitations

The following are excluded from coverage:

1. Services beyond the scope of a Participating Chiropractor's license to practice chiropractic.
2. Any chiropractic treatment or service which is determined to be not Medically Necessary.
3. Services provided on an inpatient basis or outside of a Chiropractor's office.
4. Preventive care services.
5. Services for examination and/or treatment of strictly non-neuromusculoskeletal disorders.
6. Rental or purchase of air conditioners, air purifiers, therapeutic mattresses, supplies or any other similar devices, appliances, or equipment whether or not their use or installation is for the purpose of providing therapy or easy access.
7. Physical therapy not associated with spinal or joint manipulation.
8. Maintenance care.
9. Expenses incurred for any service provided before commencement of a Member's coverage or after a Member's coverage terminates.
10. Services or costs exceeding the maximum dollar benefit limit per Member per Plan Year.
11. All applicable exclusions and limitations contained within the member's Plan Contract, except those excluding chiropractic services.

Definitions applicable to this supplemental benefit

Aggravation: A new incident or injury in the same bodily area where a previous injury has occurred.

Exacerbation: A flare-up of an existing illness or injury.

Maintenance Care: A regime designated to provide for the patient's continued well-being or for maintaining the optimum state of health while minimizing reoccurrence of clinical status.

SUMMARY PLAN DESCRIPTION

NAME OF PLAN	County Managed Care Plan
PLAN YEAR	May 1st through April 30th
PLAN SPONSOR AND ADMINISTRATOR	County of San Joaquin c/o Human Resources Division 44 N. San Joaquin St. Suite 330 Stockton, CA 95202
CLAIMS ADMINISTRATORS	
Medical	San Joaquin Health Administrators P.O. Box 31570 Stockton CA 95213-1570
Advice Nurse	(800) 655-8294
Claims & Benefits	(888) 876-7526 (209) 942-6324
Utilization Review & Referral Authorization*	(209) 942-6324
*For physicians and other providers only.	
Prescription Drugs	MedImpact or Blue Shield (for Medicare participants)

*Physicians, pharmacists and other providers call San Joaquin Health Administrators for utilization review and authorization.