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Name of the Plan	• Select-Exclusive Plan
Benefit Booklet	• This booklet has been prepared to furnish you with a description of your benefits provided through this Plan. Review this booklet carefully, so you will be familiar with the benefits available to you and your family.
Type of Plan and Description	• This Plan is a self-funded, managed care health plan with claims processing and other services deemed necessary for the operation of the Plan performed by the Claims Administrator on behalf of the County of San Joaquin.
Plan Administrator	• Director of Human Resources County of San Joaquin 44 N. San Joaquin Street, Suite 330 Stockton, CA 95202
Plan Interpretation and Plan Administration	• The Plan Administrator is responsible for the day-to-day functions and operation of the Plan. The Plan Administrator may employ claims processing agents, accountants, actuaries, consultants, counsel, and other service providers or agents as it shall deem advisable. The reasonable compensation for such service providers and agents and any other expenses incurred by the Plan Administrator in the administration of the Plan shall be paid for by the self-insurance trust fund. • The Plan Administrator shall have full power to construe the Plan and to determine all questions that may arise hereunder relating to (a) the eligibility of individuals to participate in the Plan and (b) the amount of benefits to which any participant may become entitled hereunder, and (c) any other issues that may arise under the Plan. All decisions made, and actions taken, by the Plan Administrator shall be final, conclusive and binding on all persons having or claiming any interest under the Plan. • If any information is provided over the telephone or in writing by any staff of the Claims Administrator or the County that is not consistent with the language of this Plan, the provisions in this Benefit Booklet will supersede and represent the benefit coverage of this Plan.
Plan Modification	• If this Plan is modified, any claims incurred prior to the amendment date will be paid in accordance with the Plan provisions in effect prior to the modification. Any claims incurred on or after the amendment date will be paid in accordance with the new provisions.

ADMINISTRATIVE DETAILS

Plan Effective Date	• July 9, 2007 • Updated May 2017
Plan Year	• July through June (coincides with County's bi-weekly payroll schedule)
Contract Claims Administrator; Provider Network; Utilization Management Organization	Lucent Health 10951 White Rock Road, Ste 100 Rancho Cordova, CA 95670
Non-Grandfathered Health Plan	• This Plan is a "non-grandfathered health plan" under the Affordable Care Act. A non-grandfathered plan must meet health care reforms legislated by the Act. Specifically, this Plan must provide preventive services and screenings to you without any cost sharing when the services are performed by a Participating Provider; and emergency services performed by Participating and non-participating providers in an emergency department of a hospital are subject to the same coinsurance and copayment. • Questions regarding what protections apply to a non-grandfathered health plan may be directed to the plan administrator at 468-3370. You can also read additional information from the U.S. Department of Health and Human Services at www.healthcare.gov.

24-hour Advice Nurse Line	• San Joaquin County uses Anthem Blue Cross' advice nurse program. You can call them anytime, day or night, to speak with a nurse. The nurse line is free to Participants and available through a toll-free call. • (800) 700-9184
Eligibility problems ***COBRA*** ***HIPAA notices***	• San Joaquin County Human Resources 44 N. San Joaquin Street, Suite 330 Stockton, CA 95202 • (209) 468-9552
To Change Your Primary Care Physician (PCP)	• Customer Service Department Lucent Health • 1-877-789-8488
Verification of eligibility ***Selecting Primary Care Physician*** ***Benefit questions*** ***Claim submission*** ***Claim status questions*** ***Appeals*** ***Utilization review*** ***Prior Authorization***	• Lucent Health • 1-877-789-8488 • You can also refer to your ID card for the appropriate address and telephone numbers.

PLAN PROVISIONS

Advice Nurse	• The advice nurse can answer questions about your health and give you health information for you and your family. If your Physician's office is closed, the advice nurse can help you decide if your health concerns are urgent, or if you can be treated at home or wait until business hours for an appointment. The advice nurse can also assist you in finding community health resources that may be able to help you.
ID Cards	• You and each of your covered dependents will receive a Medical Plan Identification Card, which you should present each time you receive medical services or supplies or prescription drugs.
Participating Providers	• **In order to receive benefits under this Plan, you must obtain Covered Services and Supplies from Participating Providers,** except in the case of emergency care, chiropractic/acupuncture care, or with prior authorization when a Participating Provider is not available.
Choosing Your Primary Care Physician (PCP)	• Each Plan Participant must select a Primary Care Physician (PCP) who is a Participating Provider in this Plan. Your PCP will direct and coordinate your medical care and refer you for laboratory tests and x-rays, specialty care, hospitalization and any other health care service you need. • **This Plan will not pay for any services and supplies you obtain without the advance referral of your PCP,** except as provided for emergency care, OB-GYN services, mammograms, and chiropractic/acupuncture care.
Changing Your Primary Care Physician (PCP)	• During the Plan Year, you may change your Primary Care Physician (PCP) by calling the Customer Service Department of the Claims Administrator. Changes must be received by the 10th of the month to be effective the first of the following month. Changes received after the 10th will be effective the first of the second month. For example, a change request received on January 10 will be effective February 1, while a change request receive on January 11 will be effective March 1. It is advisable to contact your new PCP in advance to ensure that his or her practice is accepting new patients.

Referrals to Specialists	• Your Primary Care Physician (PCP) is responsible for directing and coordinating your complete care for Covered Services and Supplies. **You must obtain a referral from your PCP before consulting with, or obtaining treatment from, any specialist.** If a specialist recommends a referral to another specialist, your PCP must also provide a second referral. • **This Plan will not pay for services obtained without a referral from your PCP**, except as provided for Emergency or Urgent Care, OB-GYN services (to a provider within your PCP's medical group), mammograms, chiropractic/ acupuncture care, and mental health/substance abuse treatment.
Emergency Care	• A medical emergency is defined as the treatment for a new injury, sudden and serious illness, or an unforeseen deterioration or complication of an existing injury, illness or condition already known to the person. Such an emergency is one that results from an injury or illness which, if not treated immediately, may result in serious medical complications, loss of life or permanent impairment to bodily function. • If you have a medical emergency, go to the nearest hospital or treatment facility. • You must contact your Primary Care Physician as soon as possible in order to allow your physician to coordinate your services. • **If you go to an emergency room and the situation is later determined not to qualify as an emergency, the cost of your emergency services (hospital and physician) will not be covered by the Plan, and you will be financially responsible for all charges.** • Note: Any condition which has existed for more than twenty-four (24) hours before you seek care at an emergency room will generally not be considered a medical emergency.

Urgent Care	• Urgent care is defined as immediate treatment of a minor injury, or treatment of an illness, for which the Participant's Primary Care Physician (PCP) is unavailable. • Appropriate use of an urgent care clinic would include: referral by the Advice Nurse or your PCP; a minor injury or illness that occurs when your PCP is unavailable, or as an alternative to treatment in the Emergency Room. • **If you go to an urgent care clinic and the situation is later determined not to qualify as urgent, the cost of your urgent care services will not be covered by the Plan, and you will be financially responsible for all charges.** • Note: Any condition that has existed for more than forty-eight (48) hours before you seek care at an urgent care clinic will generally not be covered.
Prior Authorization	• Certain Covered Services and Supplies require prior authorization by the Claims Administrator, or their designated agent, or benefits will not be paid. Your Physician will contact the Claims Administrator, or their designated agent, to request approval before the service is provided. • **To avoid costly medical bills, verify that prior authorization has been obtained before you receive Covered Services or Supplies.** Refer to the Covered Benefits section to find out what services require prior authorization.
Pre-Admission Authorization	• This Plan requires Pre-Admission Authorization to verify the need for non-emergency hospitalization or surgery before the admission or surgery takes place. Your Physician and Hospital are familiar with these procedures and normally request this certification on your behalf; however, it is ultimately the Plan Participant's responsibility to ensure that the Pre-Admission Authorization is obtained. • A Participant's choice of participating Hospital may be restricted based on the medical complexity of the illness or injury.

	• In the case of an emergency surgery or emergency hospital admission, authorization must be requested 24 hours from the time of admission. An emergency admission is one that involves the sudden onset of severe medical symptoms that: (a) could not have been reasonably anticipated; (b) require immediate medical treatment; or (c) can be considered life threatening. • In the case of childbirth, authorization will only be required for a hospital stay in excess of 48 hours following a normal vaginal delivery or 96 hours following a cesarean section. • **This Plan will not pay for any Services and Supplies unless the required authorization is obtained.**
Concurrent Review	• Once a hospital admission has occurred or outpatient treatment has begun, the Claims Administrator, or their designated agent, provides ongoing review to monitor the medical necessity, appropriateness of treatment, and length of treatment.
Discharge Planning	• At the time of discharge from the hospital, the Claims Administrator, or their designated agent, will evaluate your transfer from an Inpatient, acute-care Hospital to an alternate setting if medically required and/or assess the need for home health care or other Medically Necessary services.
Case Management	• Selected cases may require case management to provide ongoing review and coordination of medical care to ensure that the Plan Participant is receiving appropriate medical benefits in the most cost effective manner. • The Utilization Management organization, in consultation with the Plan Administrator, reserves the right to modify Plan benefits on a case-by-case basis to ensure that appropriate and cost-effective care can be obtained in accordance with Case Management services. Each treatment plan will be reviewed and individually tailored to a specific Participant's needs and should not be considered appropriate or recommended for any other Participant, even one with the same diagnosis.

PLAN PROVISIONS

Deductible	• Deductibles are the amount a Plan Participant must pay for Covered Expenses before the Plan begins to pay each Plan Year. The deductible does <u>not</u> apply to physician office visits and prescription drugs. • The maximum deductible that applies to a Plan Participant in a Plan Year is shown in the Schedule of Benefits as the "per person deductible." The maximum deductible that applies to the entire family in a Plan Year is shown in the Schedule of Benefits as the "per family deductible." • The Plan Year begins in July and ends in June each year and coincides with the County's bi-weekly payroll schedule. • Covered Expenses incurred within 90 days of the end of the Plan Year and applied to the deductible will count toward the deductible for that year and will also count toward the deductible for the next Plan Year. • If you elect to obtain all of your and your covered dependents' care ***exclusively*** at Health Care Services, you will receive a 50% reduction in your per person and family deductible for the Plan Year. However, **<u>all</u> services by all family members must be obtained through or referred by Health Care Services.** A signed Attestation is required to participate in this Plan option.
Co-payment/Co-insurance	• Co-payments and/or co-insurance are the amount a Plan Participant must pay the provider of service for a particular covered benefit. The co-payment and co-insurance amount is paid each time you receive the covered service until the out-of-pocket maximum is reached. You will be responsible for the co-payments and co-insurance amounts as shown in the Schedule of Benefits, and you will be responsible for all charges related to services and supplies not covered by this Plan. • Participating Providers will bill the Plan in order to receive payment for covered charges. You usually will not need to submit a claim.

Out-of-Pocket Maximum	• The Out-of-Pocket Maximum is the maximum amount of expenses (deductibles, co-payments, and co-insurance) an individual or family will be required to pay for Covered Services and Supplies during a Plan Year. If, during one Plan Year, out-of-pocket expenses exceed the maximum, the Plan will pay 100% of any additional covered charges incurred for the remainder of that Plan Year for the individual or family. • Exceptions: The Out-of-Pocket Maximum does not include non-covered services, unauthorized services, charges in excess of contract or allowable rates; or your share of cost for prescription drugs, chiropractic/acupuncture care, infertility treatment, and durable medical equipment.

SCHEDULE OF BENEFITS

COVERED EXPENSES	PARTICIPANT SHARE OF COST
	Performed by or referred to a Participating Provider in the Select-Exclusive Plan
Deductible for <u>EXCLUSIVE</u> use of Health Care Services providers and facilities for <u>all</u> services	$125 per person $250 per family
Acupuncture/Chiropractor • Up to 20 visits combined per Plan year	Deductible applies Plan pays up to $25 per visit (does not apply to out-of-pocket maximum)
Alcohol and Drug Dependency • Outpatient Treatment	$5 co-payment at Health Care Services
• Inpatient Treatment	Deductible applies $100 co-payment per admission, waived at Health Care Services
Ambulance • Covered if emergency or pre-authorized	Deductible applies
Chiropractor/Acupuncture • Up to 20 visits combined per Plan year	Deductible applies Plan pays up to $25 per visit (does not apply to out-of-pocket maximum)
Doctor Office Visit – Non-Preventive • Physical Exam • In-office consultation by specialist • Hearing Tests – up to age 18 • Allergy Testing or treatment	$5 co-payment at Health Care Services
Durable Medical Equipment, Orthotics or Prosthetics	Deductible applies 50% for least expensive of purchase, rental or repair (does not apply to out-of-pocket maximum)
Emergency Room • Hospital facility charge – waived if admitted	Deductible applies $40 co-payment at Health Care Services
• Emergency Room Physician	Deductible applies

COVERED EXPENSES	PARTICIPANT SHARE OF COST
	Performed by or referred to a Participating Provider in the Select-Exclusive Plan
Home Health • Maximum 60 days per condition combined with Skilled Nursing Facility	Deductible applies
Hospice • 6 months, renewed as necessary	Deductible applies
Hospital Inpatient or ICU • Hospital Inpatient services and supplies	Deductible applies $100 co-payment per admission, waived at Health Care Services
• Surgeon, assistant surgeon and/or anesthesiologist	Deductible applies
• Hospital or Skilled Nursing Facility doctor visit	Deductible applies
Immunization	$10
Infertility Treatment	Deductible applies 50% (does not apply to out-of-pocket maximum)
Laboratory Services	Deductible applies
Mental Health • Outpatient Treatment	$5 co-payment per visit at Health Care Services
• Inpatient/Day Care	Deductible applies $100 co-payment per admission, waived at Health Care Services
Outpatient Surgery	Deductible applies
Prescription Drugs (Outpatient) • Generic mandatory when available. • 30-day supply • Does not apply to out-of-pocket maximum	$5 Generic $15 Brand on Formulary Non-formulary not covered

SCHEDULE OF BENEFITS

COVERED EXPENSES	PARTICIPANT SHARE OF COST
	Performed by or referred to a Participating Provider in the Select-Exclusive Plan
Prescription Drugs (Outpatient – continued) • 90-day supply at pharmacy or mail order • Does not apply to out-of-pocket maximum	$10 Generic $30 Brand on Formulary Non-formulary not covered
Preventive Care Services Recommended under the Affordable Care Act	No charge
Rehabilitation Therapy (Physical, Speech or Occupational Therapy)	Deductible applies $10 co-payment per visit
Skilled Nursing Facility • Maximum 60 days per condition combined with Home Health	Deductible applies
Urgent Care Center	Deductible applies $40 co-payment per visit
X-rays	Deductible applies

PLAN MAXIMUMS	
Maximum Out-of-Pocket Does not include non-covered services, unauthorized services, charges in excess of contract or allowable rates; or your share of cost for prescriptions, chiropractic/acupuncture care, infertility treatment, and durable medical equipment.	• $1,000 per person • $2,500 per family • Once the annual maximum is met, this Plan pays 100% of eligible expenses for the balance of the Plan Year.
Maximum Benefits Paid for Each Participant	• No Lifetime Limit

	• This Plan covers only the services and supplies described in this section.
Acupuncture	• Acupuncture services when provided by a Physician or licensed acupuncturist. Referral by your Primary Care Physician is not required. • Benefits are limited to $25 per visit, inclusive of all services, and 20 visits per Plan year, combined with chiropractic treatment.
Abortion	• Therapeutic abortion procedure and any complications arising out of an abortion. Therapeutic abortion is performed when the mother's mental or physical health is endangered or when the fetus has a known condition incompatible with life. Elective abortion is not covered.
Alcoholism & Drug Addiction	• Detoxification and treatment due to alcoholism or drug addiction. • **All non-emergency Inpatient hospitalization requires Prior Authorization by the Claims Administrator in order for benefits to be paid** and must be ordered and performed by a Participating Provider, unless otherwise authorized, in order to be covered.
Allergy	• Allergy testing and treatment, including allergy injections.
Ambulance	• Emergency ambulance services to the nearest facility that can treat the condition and which accepts the Participant for emergency care, when it is not medically appropriate to provide transportation by an ordinary public or private vehicle. • Non-emergency ambulance transportation, with prior authorization, to transfer the Participant between facilities or between facility and home.
Blood	• Blood and blood plasma, including blood processing and administration services. The Plan will also cover processing, storage and administration charges for autologous blood (a patient's own blood) when a Participant is scheduled for a surgery that can reasonably be expected to require blood.
Chemotherapy	• **Benefits payable only with prior authorization.**

Chiropractor Services	• Consultations, diagnostic radiology and laboratory services, and manipulations and adjustments provided by a Chiropractor, in his/her office, to relieve neuromusculoskeletal disorders. Referral by your Primary Care Physician is not required. • Benefits are limited to $25 per visit, inclusive of all services, and 20 visits per Plan year, combined with acupuncture treatment.
Dental Services	• Services of a physician, including dentist or oral surgeon, treating: • accidental injury to the facial bones including bones of the jaw; • tumors of the face, facial bones or mouth; • prosthodontic/splint treatment of temporomandibular joint disorders; • surgical treatment of the jaw for conditions resulting from external trauma to the jaw. • **Benefits payable only with prior authorization.**
Durable Medical Equipment	• Rental or purchase of medical equipment and supplies which are: ordered by a Physician, able to withstand repeated use, usable only by the patient, not primarily for the patient's comfort or hygiene, not for environmental control, not primarily used for sport or exercise, and manufactured specifically for medical use. • Benefit for wheelchair is limited to a standard fixed-arm wheelchair with “swing-away” foot rests that does not include any additional attachments and is not motorized or custom. • The initial benefit will be the least expensive of purchase, rental or repair. Thereafter, the Plan will pay charges for replacement or repair for wear and tear due to normal use, or when the Participant has outgrown the equipment. • **Benefits payable only with prior authorization.**

Emergency Care	• In an emergency, care provided by the most convenient treatment facility or readily available medical help, whether or not it is a contract provider, until it is medically appropriate for the Participant to return to the care of, or be transferred to, a Participating Provider or Primary Care Provider. • A medical emergency is defined as the treatment for a new injury, sudden and serious illness, or an unforeseen deterioration or complication of an existing injury, illness or condition already known to the person. Such an emergency is one that results from an injury or illness which, if not treated immediately, may result in serious medical complications, loss of life or permanent impairment to bodily function. • Any condition that has existed for more than twenty-four (24) hours before you seek care at an emergency room will generally not be considered a medical emergency. • **If you use an emergency room for non-emergency treatment, you will be responsible for payment of all charges.** • Usual, Customary and Reasonable fees will be covered for emergency services provided by a non-participating provider. • The Claims Administrator must be notified within 24 hours of any emergency hospital admission. If the emergency admission was to a non-Contract Hospital, coverage will continue only until the Participant is medically stable and able to be transferred to a participating Hospital.
Family Planning	• Voluntary family planning services and supplies, including oral contraceptives and surgical procedures for sterilization.
Foot Care	• Foot care that is necessary for treatment of metabolic or peripheral vascular disease, including complications resulting from diabetes; open cutting operations and removal of nail roots, including services and supplies necessary to determine appropriate treatment; and orthotics prescribed in lieu of surgery. • **Benefits payable only with prior authorization.**
Hearing Tests	• Routine hearing tests for dependents under 18 years of age, and hearing tests for adults that are Medically Necessary following an injury or illness.
Hemodialysis	• **Benefits payable only with prior authorization.**

Home Health Care	• Services of a participating Home Health Agency including, but not limited to, skilled nursing care; physical, occupational, and speech therapy; and medical supplies and equipment provided by the Home Health Agency, as requested by the Participant's Physician and approved by the Claims Administrator. • Benefits will be provided for maximum of 60 days for the combined Home Health Care and Skilled Nursing Facility benefits. • **Benefits payable only with prior authorization.**
Hospice	• Services provided to a family unit when a Participant has a terminal prognosis and has been admitted to a formal program of Hospice care within six (6) months of entry or re-entry into the program. • **Benefits payable only with prior authorization.**
Hospital Inpatient Services	• Inpatient services, supplies and facilities for the treatment of injury or illness, including the hospital's charges for room and board up to the semi-private room rate. • Private room, special duty nursing or intensive care when Medically Necessary. • **All non-emergency Inpatient hospitalizations require Prior Authorization by the Claims Administrator in order for benefits to be paid** and must be ordered and performed by a Participating Provider, unless otherwise authorized, in order to be covered.
Immunizations	• Pediatric and adult routine immunizations as recommended by the U.S. Public Health Services for children and adults residing within the United States, but not including immunizations required for employment or travel.
Infertility	• Services and supplies necessary for the purpose of diagnosing the cause of infertility and treatment for infertility, including Clomid or other like drug therapy, surgical repair of the Fallopian tubes (except for reversal of tubal ligation), or one treatment plan of up to 12 cycles of artificial insemination per lifetime. • **Benefits payable only with prior authorization.**
Jaw Function	• See Dental Services.

Laboratory Services	• Clinical laboratory services when ordered by a Physician to diagnose an illness or injury.
Mammography	• Mammography services for screening or diagnosis of breast cancer by a Participating Provider upon referral of the Participant's Primary Care Physician or Gynecologist.
Mental Health Inpatient Services	• Inpatient mental health care that is ordered and performed by a Participating Provider to treat a mental health condition in a Participating facility. • **All non-emergency Inpatient hospitalization requires Prior Authorization by the Claims Administrator in order for benefits to be paid** and must be ordered and performed by a Participating Provider, unless otherwise authorized, in order to be covered.
Mental/Nervous Disorders	• Mental health consultations, counseling, and psychological testing.
Nutritional Counseling	• See Weight Control Counseling.
Occupational Therapy	• See Rehabilitation Therapy.
Office Visits	• Office visits for services by your Primary Care Physician or OB-GYN and other Physicians and health care providers to whom you are referred by your Primary Care Physician.
Oral Surgery	• See Dental Illness or Injury.
Orthotics	• **Benefits payable only with prior authorization.**
Outpatient Services	• **All non-emergency Outpatient procedures require Prior Authorization by the Claims Administrator in order for benefits to be paid** and must be ordered and performed by a Participating Provider, unless otherwise authorized, in order to be covered.

Physical Therapy	• See Rehabilitation Therapy.
Pregnancy/Maternity	• Medically Necessary services and supplies for pregnancy and childbirth, including complications, which is Medically Necessary to preserve the life of the mother. • Charges for a newborn baby will be covered for 30 days, beginning on the day of birth, only if the mother or father is covered by this Plan as the Subscriber or the Subscriber's spouse. Charges beyond 30 days will only be covered if the baby is enrolled in the Plan as a dependent within 60 calendar days of his/her birth.
Prescription Drugs	• Drugs and medicines listed in the Plan Administrator's formulary, which may be dispensed only with a written prescription of a Physician in accordance with applicable State laws, subject to the following conditions: 1. A covered prescription must be obtained at a participating pharmacy, except in case of emergency. 2. When filling a single prescription, a maximum 30-day supply of a dispensed drug or medication, or one standardized container of a "prepackaged" drug or medication, can be obtained at a pharmacy at one time, except for inhalers, which are limited to two per refill. Subject to prior authorization, a larger supply may be provided where Medically Necessary. 3. A 90-day supply of a maintenance medication may be obtained at participating pharmacies and by mail order. 4. **Generic drugs will be dispensed**, unless no generic exists or your Physician obtains prior authorization for a particular brand name drug due to medical necessity. 5. Medical or surgical supplies or equipment are not covered, except for test strips for testing blood glucose level and hypodermic syringes and needles required for the injection of insulin.
Process for Approving Use of Non-Formulary Drugs	• **Process for approving use of non-formulary drugs:** • The pharmacy contacts your Physician whenever a prescription is received for a non-formulary medication.

- Your Physician can do the following:

    1. Change the prescription to a drug listed on the formulary; or

    2. Submit a Prior Authorization form to the Claims Administrator and request to have the drug covered. The Prior Authorization form is available on Claims Administrator's provider web site. Your Physician must provide the following information:

        - The medical condition that the drug is intended to treat

        - Other drug(s) already used to treat the condition, and reasons why the doctor believes formulary alternatives cannot be used. Valid reasons include:

            - Ineffectiveness
            - Demonstrated side effects
            - Contraindicated with other drugs being taken by the participant
            - Underlying medical condition

- The doctor can fax the Prior Authorization form to the Claims Administrator; and if the Claims Administrator has any questions, they will contact your Physician. Your Physician will receive a response from Claim Administrator's pharmacist within 1 business day.

- When the request for the non-formulary drug is approved, the Participant will pay the brand name on formulary co-pay.

- If the doctor refuses to participate in the process described above, the Participant will pay 100% of the drug cost under the Select-Exclusive Plan.

- The Participant has the right to file an appeal if the Claims Administrator's Medical Director denies the Physician's request for Prior Authorization of a non-formulary drug.

Preventive Care Services	• Preventive Care Services including physical exams, preventive screenings (including screenings for cancer, HPV, diabetes, cholesterol, blood pressure, hearing and vision) immunizations, health education, intervention services and HIV testing as required by the Affordable Care Act. • A complete list of the preventive care services recommended under the Affordable Care Act is available online at www.healthcare.gov/law/about/provisions/services/lists.html. Services recommended under the Act are subject to Federal regulations. • **If the primary purpose of your office visit is other than preventive care, you pay the Participant Share of Cost as shown in the Schedule of Benefits beginning on page 10. The Participant Share of Cost applies even if you receive a covered preventive service during the visit.**
Prosthetic Appliances	• Surgical implants and artificial limbs or eyes to replace body parts lost or damaged by illness or injury. • **Benefits payable only with prior authorization.**
Radiation Therapy	• **Benefits payable only with prior authorization.**
Reconstructive Surgery	• Medically Necessary treatment to repair or alleviate bodily damage caused by illness or injury. Breast prostheses, implants and reconstruction of the other non-diseased breast to produce a symmetrical appearance are covered only following a Medically Necessary mastectomy. • **Benefits payable only with prior authorization.**
Rehabilitation Therapy (Physical, Speech & Occupational Therapy)	• Evaluation and physical, speech and/or occupational therapy in an Outpatient or skilled nursing setting, when significant improvement of the Participant's condition is likely. • A combined maximum of 60 visits per Plan year for all therapies are covered. • **Benefits payable only with prior authorization.**

Second Surgical Opinion	• Consultation by a specialist or surgeon prior to recommended surgery, upon request by either the Participant, the Claims Administrator, or the Plan Administrator. • **Consultation by a non-contract Physician payable only with prior authorization.**
Skilled Nursing Facility	• Medically Necessary Inpatient services and supplies at a Participating Skilled Nursing Facility for up to 60 days per condition. • **Any admission to a Skilled Nursing Facility requires prior authorization by the Claims Administrator in order for benefits to be paid.** The Participant must remain under the active supervision of a Physician treating the illness or injury for which the confinement was ordered. • Benefits will be provided for maximum of 60 days for the combined Home Health Care and Skilled Nursing Facility benefits.
Speech Therapy	• See Rehabilitation Therapy.
Surgery	• Inpatient or Outpatient services of a Physician or Surgeon when provided or referred by the Participant's Primary Care Physician. • **Benefits payable only with prior authorization.**
Transplant	• Hospital and professional services provided in connection with transplant surgery for: 1. a Plan Participant who receives the organ or tissue; 2. a Plan Participant who donates the organ or tissue; or 3. an organ or tissue donor who is not a Plan Participant, if the recipient is a Plan Participant. Benefits are reduced by any amounts paid or payable by the non-participant's own insurance coverage. • **Benefits payable only with prior authorization.**

Urgent Care	• Urgent care is defined as immediate treatment of a minor injury, or treatment of an illness, for which the Participant's PCP is unavailable. • Appropriate use of an urgent care clinic would include: referral by the Advice Nurse or your PCP; a minor injury or illness that occurs when your PCP is unavailable; or as an alternative to treatment in the Emergency Room. • **If you go to an urgent care clinic and the situation is later determined not to qualify as urgent, the cost of your urgent care services will not be covered by the Plan, and you will be responsible for all charges.** • Any condition that has existed for more than forty-eight (48) hours before you seek care at an urgent care clinic will generally not be considered urgent care.
Vision Screen - Pediatric	• Routine vision screening only for dependents under 18 years of age when performed by Participant's Primary Care Physician. Screenings or other services performed by an optometrist, ophthalmologist or other eye specialist, are covered under the County's vision plan.
Weight Control Counseling	• Weight Control Counseling and Nutritional Counseling 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. • **Benefits are payable only with prior authorization.**
Well Baby/Child Care	• See Preventive/Well Person Examinations.
X-Rays	• Diagnostic x-ray services when ordered by a Physician to diagnose an illness or injury. • **Benefits payable only with a prior authorization include: nuclear medicine, MRI, MRA, CT scan and PET scan.**

General Exclusions	• The Plan will not provide benefits for any of the services listed in this section regardless of medical necessity or recommendation of a health care provider.
Charges above UCR	• Charges in excess of the contract or Usual, Customary and Reasonable fee (UCR) or the amount of covered expense as determined by the Plan.
Government Services	• Services furnished or paid by any government agency, unless this restriction is prohibited by law.
Medicare	• Any amounts paid by Medicare as the primary coverage for services or supplies that are covered by this Plan, including treatment of 'end stage renal disease'.
Non-covered services	• Any services and supplies not specifically listed in this Benefit Booklet as Covered Services.
Non-participating provider	• Services and supplies provided by a non-participating provider without prior authorization, except in the case of Medically Necessary emergency or urgent care.
Referral or Prior Authorization not Obtained	• Any services and supplies that are provided without the referral of the Participant's Primary Care Physician and without required prior approval by the Claims Administrator.
Scope of license	• Charges for a service or supply that is not within the scope of the provider's license.
Services by relatives or household members	• Charges for medical care provided by a person who lives in the Participant's home or who is related to the Plan Participant or his or her dependent by blood or marriage.
Services for which payment is not required	• Charges for services for which the Plan Participant would not have been billed if s/he did not have medical "insurance".
Services while not eligible under Plan	• Charges for services received prior to the date coverage begins under this Plan or after coverage is terminated.

GENERAL EXCLUSIONS

Third party liability	• Charges for any illness, injury, disease or other condition for which a third party may be liable or legally responsible by reason of negligence, an intentional act or breach of any legal obligation on the part of such party. If benefits are paid under this Plan, the Participant is required to cooperate with the Claims Administrator and the Plan Administrator in securing reimbursement, as stated in the section entitled Acts of Third Parties/Subrogation.
Worker's Compensation	• Charges for services and supplies that result from an injury, condition or illness arising out of or in the course of any occupation or employment for wage or profit, or for which the covered person is entitled to benefits under any Workers' Compensation, employer's liability or occupational disease law, whether or not any such policy is actually in force. If benefits are paid under this Plan, the Participant is required to cooperate with the Claims Administrator and the Plan Administrator in securing reimbursement, as stated in the section entitled Acts of Third Parties/Subrogation.

Medical Exclusions	• No payment will be made under this Plan for medical expenses incurred for the following:
Abortion	• Voluntary termination of a pregnancy, except as specifically provided in Covered Benefits.
Biofeedback	• Charges for biofeedback other than for migraine headache.
Chiropractic	• Charges for chiropractic services in excess of $25 per visit and 20 visits per Plan year combined with acupuncture treatment.
Cosmetic Surgery	• Charges for cosmetic or reconstructive surgery primarily for the purpose of beautification, such as: surgical removal of excess or sagging skin; enlargement, reduction, implantation or changing the appearance of any part of the body; hair transplantation; liposuction; chemical face peels or skin abrasion; electrolysis; wigs. • This exclusion does not apply to implants and reconstruction following a Medically Necessary mastectomy or for Medically Necessary correction of a functional disorder as a result of disease or injury.
Dental Services	• General dental care; treatment, extraction or replacement of teeth; general anesthesia provided for dental procedures; treatment of dental abscesses; orthodontia, braces, bridges, dental plates, or any other dental services and supplies involving the teeth or structure supporting the teeth; surgery to correct malocclusion, structural jaw abnormalities or temporomandibular joint disorder, except as specifically provided in Covered Benefits.
Diet and Weight Control	• Charges for dietary control, or surgery or any other treatment of obesity not listed in Covered Benefits, including, but not limited to food and food supplements, vitamins, laboratory tests in association with weight reduction programs, gastric bubble, gastric stapling or banding, intestinal by-pass or any other similar procedures.

MEDICAL EXCLUSIONS

Drugs and Medicines	• Prescription drugs not on the Plan's formulary or prior authorized by the Claims Administrator. • Charges for over-the-counter drugs, medicines and supplies that can be purchased without a prescription. • Prescriptions not written by a Participating Provider or prescriptions not supplied by a participating pharmacy, except in case of an emergency or antibiotics prescribed by a licensed dentist. • Drugs dispensed by and taken home from a Hospital or other facility.
Durable Medical Equipment	• Replacement or repair of Durable Medical Equipment resulting from abuse or use for which it was not intended; purchase, rental or repair of items not medical in nature, including items for personal comfort, sport or exercise, home modification, or environmental control; purchase or rental of more than one device for the same function or body part.
Eating Disorders	• Charges for Inpatient or Outpatient eating disorder programs except for medically supervised eating disorder programs at a duly licensed facility for the specific treatment of Anorexia Nervosa or Bulimia.
Experimental/ Investigational Treatment	• Charges for treatments, procedures, equipment, drugs or dosages, devices, services, supplies, tests, or medical treatment (generally, individually or collectively called "Regimens") which, when used for treatment of a specific illness or injury, are experimental, investigational or oriented toward research. In making a determination, the following sources may be considered: 1. Evidence from national medical organizations Food and Drug Administration, American Medical Association, National Institutes of Health; 2. Peer-reviewed medical and scientific research; 3. Professionals, specialists and experts; and 4. Written protocols and consent forms used by the proposed treating facility or other facility administering substantially the same Regimen.

Fertility Services	• Services and supplies related to the reversal of voluntary sterilization, in vitro fertilization (IVF) including medication necessary for IVF, embryo transfer, Gamete interfallopian transfer, or preservation of sperm or ova, treatment of infertility except as provided under covered benefits. Artificial insemination services beyond one treatment plan of up to twelve cycles per lifetime.
Foot Care	• Charges for routine foot care such as removal or reduction of corns and calluses or clipping of toenails, except as provided in Covered Benefits.
Hearing Services	• Routine hearing tests for Participants 18 years of age and older, except when used to diagnose symptoms resulting from an injury or illness. • Hearing aids and batteries.
Hospitalization not Pre-authorized	• Non-emergency care in a hospital or Skilled Nursing Facility that has not been pre-authorized by the Claims Administrator.
Immunization	• Immunizations required for your work or for foreign travel.
Infertility	• Services and supplies related to reversal of voluntary sterilization, in vitro fertilization (IVF) including medication necessary for IVF, embryo transfer, Gamete interfallopian transfer, or preservation of sperm for artificial insemination, transsexual surgery, impotency, penile implants. Artificial insemination services beyond one treatment plan of up to twelve cycles per lifetime.
Inpatient Services	• Charges for Inpatient room and board, if hospitalization is for any service that could have been performed safely on an Outpatient basis including, but not limited to, primarily diagnostic tests, physical therapy, medical observation, convalescent or rest care, or treatment of chronic pain.
Jaw Function	• See Dental Services.
Mental and Nervous	• Services for the treatment of conditions not defined as mental or substance-related disorders in the current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM).

MEDICAL EXCLUSIONS

Non-medical Services and Supplies	• Non-medical, personal comfort, convenience, or beautification services and supplies, or home modifications or improvements, even if prescribed by a Physician. This includes training, education or instruction materials, air conditioners, purifiers, humidifiers or dehumidifiers, cosmetics, wigs, telephones, televisions, corrective shoes, heating pads, whirlpools, hot tubs, waterbeds, hot water bottles and any other clothing or equipment whose primary purpose is not for the therapeutic treatment of a medical illness or injury.
Non-traditional Therapies	• Sleep therapy; sex therapy; vocational rehabilitation; exercise programs; education, recreation, art, dance, or music therapy.
Not Medically Necessary	• Charges not ***Medically Necessary*** for the diagnosis and treatment of an illness, injury or pregnancy, except physical exams as provided in Covered Benefits.
Prescription Drugs	• Prescription and over-the-counter drugs and medicines not listed in the Plan Administrator's formulary. Exceptions to the formulary must receive prior authorization from the Claims Administrator. • Supplies in excess of 30 days for a single medication obtained at a pharmacy, except when prior authorized. Maintenance medications are limited to a 90-day supply and must be filled at either a participating Choice 90 pharmacy or by mail order. • Anabolic steroids. • Drugs when used for cosmetic purposes and hair loss drugs. • Devices of any type, even when dispensed with a prescription. These include, but are not limited to, therapeutic devices, artificial appliances, braces, support garments, or any similar device. Please refer to Durable Medical Equipment benefit sections. • Experimental or investigational medications and drugs not approved by the Food and Drug Administration (FDA).

	• Impotence drugs, e.g. Viagra. • Oxygen and oxygen supplies. Please refer to Durable Medical Equipment sections. • Pen devices or needle cartridges. • Weight management drugs and appetite suppressants.
Rehabilitation Therapy	• More than 60 visits for all physical, speech and/or occupational therapy visits per Plan year while not confined as an Inpatient in a hospital.
Residential or Custodial Care	• Charges for services provided by a rest home, home for the aged, nursing home, residential care facility, or any other similar facility that is primarily for Custodial Care. (This exclusion is not intended to omit Medically Necessary services at a transitional living center.)
Sexual Function or Identity	• Services and supplies related to impotency or penile implants or surgery primarily to transfer the characteristics of the body to those of the opposite sex and any complication therefrom.
Tissue storage	• Services or supplies related to the preservation and/or storage of body parts, fluids or tissues, except Blood as described under Covered Services.
Vision services	• Eyeglasses, contact lenses and vision examinations; surgery to correct vision in lieu of eye glasses or contact lenses, except intraocular lenses in connection with cataract removal or other treatment of illness or injury to the eyes.
Vitamins	• Vitamins, minerals, food supplements, and digestive enzymes that can be purchased without a prescription. • Vitamins requiring a prescription are not covered when dispensed in combination with other, non-prescription vitamins.

ELIGIBILITY AND PLAN PARTICIPATION

Eligible Subscribers

• To be eligible for coverage as a Subscriber under this Plan, you must be:

1. an elected official or a contract, regular, exempt, civil service, job-share, or designated part-time employee of the County of San Joaquin, San Joaquin County Employees' Retirement Association, Law Library, Local Agency Formation Commission, Mountain House Community Services District, or Historical Society; and

receive regular pay for the minimum number of hours required to receive health benefits as specified in the applicable Contract, Memorandum of Understanding, or Resolution Implementing Certain Terms and Conditions of Employment; or

2. a Retiree (if coverage in this Plan is extended to retirees) of one of the agencies listed above or of the former San Joaquin Local Health District; or

3. a surviving spouse of a deceased Retiree, who was married for at least one year prior to retirement and was the designated San Joaquin County Employees' Retirement Association beneficiary of that Retiree (if coverage in this Plan is extended to retirees); or

4. a surviving spouse of an employee who is killed in the performance of his or her duty or dies as a result of an accident or injury caused by external violence or physical force incurred in the performance of his or her duty; or

5. a surviving child of a deceased retiree or of an employee killed as described in (4) above, who does not have a parent enrolled as a Subscriber, and who meets the eligibility criteria to be enrolled in the Plan as a dependent.

Eligible Dependents

• Your eligible dependents are:

1. your spouse under a legally valid marriage. A marriage certificate is required.

2. your same-sex domestic partner as well as partners of the opposite sex over age 62. A Certificate of Registration with the Secretary of State is required.

3. your, your spouse's, or domestic partner's children under

age 26. Birth or adoption certificates are required. Applicable Court orders are required and may be requested semi-annually. Failure to provide such proof upon request will result in termination of coverage for that dependent.

4. dependent children who have been enrolled in the Plan prior to reaching age 26 and who are incapable of self-support because of mental retardation or physical incapacity which commenced prior to age 26. Proof of incapacity should be submitted by a Physician at least 30 calendar days prior to the date termination would occur. Proof may be requested annually. Failure to provide such proof upon request will result in termination of coverage for that dependent.

• The term "children" includes, natural children, legally adopted children, and children under legal guardianship or for whom a Court has issued a Qualified Medical Child Support Order. Children shall not include any person who is in full-time military service, a foster child, or any individual other than as stated above.

• Other than survivors designated as Eligible Subscribers, no dependents of an employee can be enrolled in this Plan unless the employee is also enrolled, and no dependents of a retiree can be enrolled in this Plan unless the retiree is enrolled in this or a qualifying Medicare plan through the County.

Enrollment application required

• You must complete a written enrollment application for yourself and any dependents you wish to cover and submit it with the certificates and/or Court orders as described above, before you and/or your family members can receive benefits under this Plan, except as provided for newborn infants during the first month of life.

When you may enroll

• Initial Eligibility

• When you are a newly eligible employee, you should submit your enrollment application for yourself and your eligible dependents as soon as possible after you become eligible. If you delay in completing your application, all required contributions will be deducted from your paycheck, retroactive to the Effective Date of your coverage.

• When you become a Retiree, you should submit an enrollment application to Retirement within 30 calendar days

of the Effective Date of your retirement (if coverage in this Plan is extended to retirees).

- You may enroll your eligible dependents by the latter of (a) the date you enroll yourself or (b) within 30 calendar days of the date you become eligible as an employee or retiree.

Enrolling New Dependents

- You must enroll newly acquired dependents by submitting an enrollment application within 60 calendar days of the birth, marriage, Domestic Partnership, adoption, or Court order that made them eligible, or they will not be eligible to be enrolled until the next open enrollment period.

Enrolling after a Change in Status

- **Any eligible person may only be enrolled within 60 calendar days of the following status changes:**

  - loss of coverage under another health plan,

  - issuance of a Court-order for coverage of a person who meets the definition of an eligible dependent; or

  - change of child custody for a child who previously resided outside the service area of the Plan.

Open Enrollment

- **Any eligible person who is not enrolled during one of the above periods may only be enrolled during an open enrollment period.**

- At least once each year the County will schedule a period during which eligible employees and Retirees may enroll or disenroll themselves and/or their dependents from coverage in this Plan, in accordance with the applicable Contract, Memorandum of Understanding, or Resolution Implementing Certain Terms and Conditions of Employment.

Effective Date of Coverage

- These are the Effective Dates of coverage for you and the family members you enroll in this Plan and for whom the required contributions are paid:

1. Newly eligible employee or Retiree

For an employee, coverage becomes effective for you and your eligible dependents on the first Monday of the bi-weekly pay period following the date you meet the eligibility requirements.

For a Retiree, coverage becomes effective for you and your

eligible dependents on the first day of either the month in which you retire or the following month, depending on when your employee coverage terminates (if coverage in this Plan is extended to retirees).

2. Any person enrolled during an open enrollment period will be effective on the date established by the County for that open enrollment.

3. A newborn infant will be covered for 30 days, beginning on the day of birth, only if the mother or father is covered by this Plan as the Subscriber or Subscriber's spouse. You must enroll the newborn within 60 calendar days of birth, or his/her coverage will terminate at 12:01 AM on the 31st day of life.

4. A legally adopted child or a child who has been placed in your permanent legal guardianship will be covered on the date the child is placed in your physical custody, if you enroll the child within 60 calendar days of placement or the Court order for guardianship.

5. Dependents who become newly eligible as a result of either marriage, loss of coverage under another plan, a Court order requiring the Subscriber to provide coverage.

Dependents of an employee will be covered effective on the first Monday of the pay period following the date the employee submits an application for their enrollment.

Dependents of a Retiree will be covered effective on the first day of the month following the date the Retiree submits an application for their enrollment.

Dual Coverage

- If a Participant is enrolled as a dependent of both parents or as both a Subscriber and a dependent, the Plan will cover deductibles, co-payments and co-insurance for Covered Services but will not increase the benefit maximum for any covered service or supply.

Payment of Required Contributions

- Employees

  - The County is responsible for paying its share of the required contributions and collecting the employee's share of the required contributions through authorized payroll deductions, in accordance with the Memorandum of Understanding or the Resolution Implementing Certain Terms and Conditions of Employment for your

representation unit.

- If you have insufficient hours to qualify for a County contribution toward this Plan, you must pay the required contribution to the Human Resources Division/Benefits Office, or to the County's COBRA administrator, or coverage will terminate for any periods of time for which required contributions are not paid.

- Retirees (if coverage under this Plan is extended to retirees)

  - The San Joaquin County Employees' Retirement Association (SJCERA) is responsible for collecting your required contributions through authorized payroll deductions or deductions from the retiree's sick leave bank.

  - If you do not receive a pension check because of a deferred retirement, or if your pension check is insufficient to pay the applicable Plan required contribution, you must pay the required contributions to SJCERA or coverage will be terminated. Coverage that is terminated due to non-payment cannot be reinstated.

Termination of Employee Benefits

• As an employee you become ineligible for benefits under this Plan if

1. you cease to be an eligible employee according to the provisions described under Eligibility and Plan Participation, or

2. your required contributions are not paid during an unpaid leave of absence, or

3. you are paid for less than 41 hours or the number of hours specified in the applicable Contract, Memorandum of Understanding, or Resolution Implementing Certain Terms and Conditions of Employment, and you do not pay the required contributions.

• Coverage under this Plan will cease for you and your dependents on the earliest of the following dates:

1. the date the group Plan terminates; or

2. 12:01AM on the first Monday after the last pay period for which required contributions were paid.

Termination of Benefits of an Employee's Dependents

• It is your responsibility to submit an enrollment form to terminate your dependents' coverage within 60 calendar days of the date they are no longer eligible for dependent coverage or when they are deceased. You may also terminate your dependents' coverage during an open enrollment period or within 60 calendar days of the date they become covered under another plan. Benefits will cease for your dependents at 12:01AM on the first Monday of the first pay period that begins:

1. in the month following the 26th birthday of a dependent child.

2. in the month after you fail to provide proof of disability, or a valid Court order for guardianship at the request of the County or the Claims Administrator;

3. after a divorce from your spouse or dissolution of domestic partnership is final;

4. after you apply to delete a dependent who has become covered under another plan;

5. after you apply to delete a dependent pursuant to a Court

order or stipulation that directs another party to cover that dependent;

6. after the last pay period for which required contributions were paid; or

7. on the date established by the County for dependents dropped during an open enrollment.

Termination of Retiree Benefits

• You may terminate coverage under this Plan for yourself and/or your covered dependents at any time. If you voluntarily terminate coverage and do not transfer coverage to either another County-sponsored plan or a plan sponsored by another employer within 30 calendar days, you and any affected family members will not be eligible to enroll in this Plan in the future.

• Coverage under this Plan will cease for you and your dependents on the earliest of the following dates:

1. the date the group Plan terminates;

2. 12:01AM on the day after the last month for which required contributions were paid.

Termination of Benefits of a Retiree's Dependents

• It is your responsibility to submit an enrollment form to terminate your dependents' coverage within 60 calendar days of the date they are no longer eligible for dependent coverage or when they are deceased. You may also terminate your dependents' coverage during an open enrollment period or within 60 calendar days of the date they become covered under another plan. Benefits will cease for your dependents at 12:01AM on the first day of the month:

1. following the 26th birthday of a dependent child ;

2. after you fail to provide proof of disability, or a valid Court order for guardianship at the request of the County or the Claims Administrator;

3. after a divorce from your spouse or dissolution of domestic partnership is final;

4. after you apply to delete a dependent who has become covered under another plan;

5. after you apply to delete a dependent pursuant to a Court

order or stipulation that directs another party to cover that dependent;

6. after the last month for which required contributions were paid; or

7. established by the County for dependents dropped during an open enrollment.

Certificate of Creditable Coverage

• Under the Health Insurance Portability and Accountability Act (HIPAA), you and/or your covered dependents will receive a certification of creditable coverage when you or your dependents' active coverage ends under the Plan, and you are not enrolled in another County-sponsored plan. This certification can be used to satisfy waiting periods and pre-existing condition limitations, if any, applicable under another health care plan.

• Certificates will be mailed to your address on file with County Human Resources. You should keep your certificate with your important personal documents.

ACTS OF THIRD PARTIES (SUBROGATION)

Subrogation & Reimbursement Provision

- It is not the intent of this Plan that any Participant should be reimbursed for more than 100% of covered expense as defined in the Coordination of Benefits provision. Therefore, the Plan maintains the right to seek reimbursement on its own behalf; the Right of Subrogation.

- The Plan also reserves the right to seek reimbursement upon a Plan Participant's receipt of settlement, judgment, or award; the Right of Third Party Liability Reimbursement.

- The Plan reserves the right of recovery, either by Subrogation or Third Party Liability, for eligible expenses payable by the Plan, which are a result of illness or injuries suffered from an accident due to the negligent conduct of a third party. These expenses are payable in part or in whole by such third party, another person, an insurance company, or from a judgment or settlement.

- As a condition of receiving benefits under this Plan, the Plan Participant agrees to the Plan's right to recovery under Third Party Liability or Subrogation rights against any third party negligence up to the amount of expenses incurred by the Plan. Payment of benefits will be contingent upon the Participant's cooperation with the Claims Administrator by providing the Plan with all required information and assistance in the recovery of such payment or overpayment to the extent of such payment by this Plan. The term "information" includes any instruments and documents as the Plan Administrator may reasonably require to enforce its rights.

- The Plan Administrator shall maintain discretionary authority with regard to asserting Third Party Liability reimbursement and Subrogation rights of the Plan. The Plan Administrator has delegated to the Claims Administrator, and its designated agents, the right to perform ministerial functions required to assert the Plan's rights; however, the Plan Administrator shall retain discretionary authority.

- If you or your family member takes no action to recover money from any source, then the County, at its discretion, may initiate its own direct action for reimbursement. You and/or your dependent will not take any action that would prejudice these reimbursement rights and will cooperate in doing whatever is reasonably necessary to assist in any recovery effort.

Intent

- The intent of Coordination of Benefits (COB) is to ensure that the sum of benefits paid under this Plan plus benefits paid under all other plans will not exceed the actual amount of covered expense for a treatment or service.

- Covered expense is defined as the allowed amount or the Usual, Customary and Reasonable amount for a service or treatment.

- Therefore, the full billed amount of a claim will not necessarily be paid, even when benefits are received through more than one health plan.

Effect on Benefits

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

Payment Determination

- If a person is covered under this Plan and under one or more other plans, the following rules apply:

  1) The primary plan pays benefits without regard to any other plan that also may cover the same claim.

  2) The secondary plan calculates its benefits as if no other plan existed. This calculation is of the maximum benefit amount that can be paid.

  3) The secondary plan subsequently ascertains the amount the primary plan did not pay on the claim and reimburses to the extent that the combined benefits do not exceed the maximum allowed amount by the secondary plan.

- If this Plan is not primary, it will not pay benefits for services or supplies that are

  1) not paid by the primary plan because they are obtained outside the network, or without the required referrals and authorizations under the primary plan; or

  2) not covered benefits of this Plan, regardless of coverage under the primary plan.

Order of Benefit

- If a person is covered under this Plan and under one or more

Determination

other plans, the rules set forth below apply.

1) A plan that does not provide for Coordination of Benefits will pay its benefits first.

2) A plan that covers a person as an employee will pay its benefits before the plan that covers the person as a dependent.

3) A plan that covers a person as a dependent is primary to one that covers a person as a retiree or disabled individual.

4) A plan covering a person as an active employee or eligible dependent is primary to a COBRA plan. Only those services that are excluded as pre-existing by the primary plan will be eligible for coordination of benefits.

5) A plan covering a person as a dependent is primary to Medicare with the exception of a person who qualifies for Medicare due to 'end stage renal disease'. A plan covering a person as a retiree or disabled individual is secondary to Medicare.

6) When a child is covered by the plans of both parents, unless they are divorced or legally separated, the plan of the parent whose birthday occurs earlier in the calendar year will pay first. This rule applies to the month and day of birth, without regard to the year. However, if the other plan's Coordination of Benefits provisions do not use the parents' birthdays to determine which of the parents' plans pay first, the provisions of this paragraph shall not apply, and the other plan will be the primary carrier.

7) If a child's parents are divorced or legally separated, payment will be made by: (a) the plan of the parent with custody before the plan of a stepparent or of the parent without custody; or (b) the plan of a stepparent before the plan of the parent without custody. However, if, by court decree, one parent is held responsible for the child's health care expenses, payment will be made first by the plan of that parent.

8) When the rules above do not apply, the plan that has covered the person for the longer period of time will pay its benefits first. A new plan is not established when coverage under one health plan or carrier is replaced within one day by that of another.

Coordination with Medicare	• Medicare is the secondary payor for: (a) active employees and their dependents who are eligible for Medicare regardless of age; and (b) the first thirty (30) months of treatment for 'end stage renal disease' for employees and their dependents under age 65. • Benefits will be coordinated with Medicare for any services or supplies to the extent that the Plan participant is eligible for coverage under Parts A or B of Medicare, whether or not he or she has actually enrolled in Medicare or claimed Medicare benefits.
Coordination of Benefits (PPO and HMO)	• Preferred Provider Organizations (PPO): Where this Plan is coordinating benefits with another health plan that has entered into a Preferred Provider Agreement with a medical or hospital provider, this Plan's covered expenses will not exceed the lesser of this Plan's PPO rate or UCR (whichever is applicable) or the other plan's PPO rate. • Health Maintenance Organizations (HMO): Where this Plan is coordinating benefits with a Health Maintenance Organization, this Plan will coordinate only on co-payments, and will not assume primary status when services are obtained from the HMO's out-of-network providers.
Exchange of Information	• Any Plan Participant who claims primary benefits under this Plan must provide all information that is needed to coordinate benefits. In addition, all information that is needed to coordinate benefits may be exchanged with other companies, organizations, or persons only for this express purpose.
Reimbursement for Payment by Other Plan	• This Plan will reimburse a provider for benefits paid by another plan that should have been paid as primary under this Plan. The amount of the reimbursement will be up to the amount paid by the other plan, but not more than is payable under this Plan.

COORDINATION OF BENEFITS

Explanation of Benefits Required

• When a Plan Participant has primary coverage under Medicare or another health plan, a claim submitted for payment under this Plan must include an Explanation of Benefits from the other health plan stating the amount of benefits paid, or it is not possible to determine liability under this Plan. If this information is not provided, the claim may be denied.

• Medicare is the primary payor for active employees and their dependents who are eligible for Medicare due to 'end stage renal disease'. For the purposes of the calculation of the benefits, if the person has not enrolled in Medicare Part B, the Claims Administrator will calculate benefits as if they had enrolled. If the person has enrolled in Medicare Part D, the prescription drug benefits under this Plan are primary.

COBRA

- The Consolidated Omnibus Budget Reconciliation Act of 1985 (Public Law 99-272, Title X), "COBRA," requires this Plan to offer Participants the opportunity for a temporary extension of health coverage called Continuation of Coverage at group rates in certain instances where coverage under this Plan would otherwise terminate.

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

- You have a right to choose Continuation of Coverage for you and/or your covered dependents if you lose your group health coverage because of certain qualifying events. Domestic partners and children of domestic partners are not eligible for COBRA Continuation of Coverage.

- If your benefits would otherwise terminate for you or your eligible dependents, coverage may be continued if you pay the required contribution. You may continue to make payments and receive coverage unless one of the following happens: (a) you do not pay the required contributions on time; (b) you become eligible, as an employee or dependent, under another group health plan that does not exclude coverage for pre-existing conditions; (c) you become entitled to Medicare; or (d) you become covered under another group health plan which contains a pre-existing condition limitation that you have satisfied with proof of creditable coverage.

- The required contribution is due to the County's COBRA Administrator on the first (1st) day of the month for each month of coverage. Any required contribution received after the end of the coverage month will be considered an untimely payment and will be cause for termination of Continuation of Coverage under COBRA, after which coverage cannot be reinstated.

CONTINUATION OF COVERAGE (COBRA)

Qualified Persons and Qualifying Events

- A Participant may qualify for continued coverage for up to eighteen (18) months after coverage would otherwise terminate due to: (a) termination of employment for any reason other than gross misconduct; or (b) any reduction in work hours causing a loss of Plan eligibility.

- A Plan Participant may qualify for continued coverage for up to 29 months if the employee and/or covered dependent is disabled at the time of the qualifying event or becomes disabled within 60 days thereafter. This determination can only be made by the Social Security Administration. Notice of the disability award must be provided to the County's COBRA Administrator within 60 calendar days after it is issued and within the initial 18 month period of COBRA eligibility. There will be an increased contribution rate for this extended period of coverage.

- The spouse and dependent children of the covered employee who were on the Plan on the original qualifying event date and children who are born to or placed for adoption with the covered employee during a period of COBRA continuation coverage, may continue coverage for up to 36 months if they would otherwise lose coverage due to: (a) the death of the covered employee; (b) divorce or legal separation; (c) the covered employee's election to drop out of the group health Plan upon his or her entitlement to Medicare; or (d) a child ceases to be a dependent as defined in this Benefit Booklet.

- Any qualified person who acquires a new dependent while continuing coverage will be permitted to cover that dependent for the balance of that period as stated above. Coverage for that dependent is subject to the enrollment requirements described in the section entitled "Eligibility and Plan Participation". Domestic partners and children of domestic partners are not covered under COBRA.

Notice to Employees

- If a dependent qualifies for COBRA due to divorce, legal separation, or ceasing to be a dependent child, either you or the dependent must notify the County's COBRA Administrator. This notice should be given before the qualifying event, or as soon as possible thereafter. Notice given more than 60 calendar days after the qualifying event will not be accepted.

Notice to Qualified Persons	• The County will give you written notice of your continuation rights, obligations, and contribution costs after receipt of the notice described above or after any other qualifying event (termination of employment; death of the employee, etc.) which would otherwise result in a loss of coverage under this Plan.
Written Elections by the Qualified Person	• You or a qualified dependent must make written election within 60 calendar days after the later of: (a) the date coverage would otherwise terminate; or (b) the date of the County's written COBRA notification. • The election form must be returned within this 60-day period; otherwise, the self-pay option for coverage under COBRA expires. You must pay for your COBRA continuation coverage retroactive to the date coverage would have terminated. Initial payment must be received by the County's COBRA Administrator within 45 calendar days of making your election, although it is recommended that payment be submitted with the election form. No benefit claim will be honored unless the required payment has been received for the period in which the claim was incurred.
Monthly Cost	• The Qualified Beneficiary(ies) must pay the monthly cost to the County's COBRA Administrator. Usually the monthly cost will not exceed 102% of the total average monthly cost for coverage of similarly situated active employees whose coverage has not terminated. However, when a disabled Qualified Beneficiary(ies) continues beyond 18 months, the monthly cost for the 19th through the 29th month will increase to 150% of that total average monthly cost. • If you do not elect and pay for Continuation of Coverage under COBRA, coverage under this Plan will terminate.

Family and Medical Leave (FMLA)

• Any provisions of this Plan that provide termination of coverage during an unpaid Leave of Absence and/or reinstatement of coverage following an employee's return to being actively at work or in paid status are modified by the following provisions of the Federal Family and Medical Leave Act of 1993 (FMLA), where applicable:

1. The Employee's coverage will be continued during a leave of absence that qualifies as a leave of absence under FMLA, and the County will continue to pay the required contributions as long as the employee pays his/her normal payroll deduction for coverage. The County will continue to pay its share of required contributions for dependents as long as the employee pays his/her normal payroll deduction for dependent coverage. If the employee is not on payroll, required contributions must be paid to the Human Resources Division/Benefits Office to maintain coverage.

2. Upon the Employee's return to work following a FMLA leave, any coverage under the Plan that was cancelled as a result of the FMLA leave will be reinstated in accordance with the eligibility provisions of the Plan.

Procedure for claim submission

• 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 the following information on a separate sheet of paper:

1. a statement that you are a Participant,
2. the patient's name, address and Plan identification number, and
3. the name and address of the provider of service, if not on the bill.

• If you receive a bill for authorized or emergency Covered Services and Supplies from a non-participating provider, contact the provider and give him/her the address to mail claims that is printed on your ID card.

Timely Filing

• A claim must be submitted to the Claims Administrator within 150 calendar days from the date services or treatment is rendered or as soon as reasonably possible and, except in the absence of legal capacity of the Participant, no later than one (1) year after services are rendered.

• If you receive authorized services from a non-network provider, claims for those services must be submitted to the Claims Administrator within 180 calendar days from the date services or treatment is rendered or as soon as reasonably possible and, except in the absence of legal capacity of the Participant, no later than one (1) year after services are rendered.

• If more information is needed, you will be notified in writing. When the Claims Administrator receives the necessary information, it will take action within 15 calendar days. You will receive written notice of the decision. If all or part of the claim is denied, the written notice will include the reason for the denial, reference to pertinent Plan provisions on which the denial is based, notice of your right to appeal, and an explanation of the grievance procedure.

Participant's Liability for Payment

• When you receive Covered Services and Supplies from your Primary Care Physician or a Participating Provider to whom he or she has referred you, you are responsible for paying:

a) the applicable Plan deductibles, co-payments and co-insurance

b) charges for non-Covered Services and Supplies

c) charges for unauthorized services and supplies, and

d) charges in excess of benefit limitations.

• Claims are processed for payment or denial based upon information submitted with the claim; therefore, to avoid unnecessary delay, it is very important that the claim be complete. Failure to supply necessary information to enable the Claims Administrator to properly evaluate the Plan's liability on a claim may result in denial of that claim.

• If the Claims Administrator fails to pay a provider for Covered Services and Supplies, you will also become liable to the provider for sums owed by the Plan Administrator if you fail to do the following:

a) Supply the provider's billing service with correct billing information, even though you presented your health Plan card at the time services were provided.

b) Contact the Claims Administrator if you receive a denial of payment (see Appeal Procedure).

c) Contact the Claims Administrator if you receive a bill from your provider.

d) Respond to the Claims Administrator's requests for additional information, including but not limited to: (1) how and where an injury occurred and (2) whether you and/or your family member has any other health coverage.

• If you receive services and supplies from a non-participating provider without prior authorization, other than Medically Necessary emergency or urgent care, you will be responsible for payment.

Right of Recovery

• If the Plan pays more than the correct amount due for Covered Services and Supplies, the Plan Administrator or its agent may recover all excess amounts from the Provider or Participant for whom, or for whose dependent, such payments were made. Recovery can be made by reducing or suspending future Plan payments or by requiring the Plan Participant to pay back the overpayment in full or installments, until the overpayment is recovered.

Procedure for Appeal of Denied Claims	• When a claim for benefits is submitted, the Claims Administrator will determine your eligibility and the amount of benefits payable. If it is determined that benefits are not payable, the following procedure applies:
Written Notice	• The Claims Administrator will give you written notice when your claim for urgent care, pre-service (services requiring prior authorization) or post-service (services already provided) benefits is totally or partially denied. This notice will include the following: (a) the reason or reasons for the denial of your claim; and (b) a description of any additional material or information needed from your Provider so that the claim may be reviewed and reconsidered for possible payment. Upon request, the Claims Administrator will provide you information contained in the notice in Spanish.
Standard Internal First Appeal	• You have the right to appeal to the Claims 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 Claims Administrator will review your appeal and provide a decision 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 standard internal second appeal.
Standard Internal Second 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.
Standard Internal Second Appeal (Cont.)	• If your appeal for urgent care, pre-service or post-service benefits is denied based on determinations of medical judgment or for a rescission of coverage (other than for non-payment of contributions), you may request an External Review.

APPEAL PROCEDURE

Expedited Internal Appeal for Urgent Care Benefits

- You have the right to request an expedited internal appeal from the Claims Administrator if the timeframe for completion of a standard internal appeal would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function. The Claims Administrator will review the documentation you provide and decide whether it is an urgent care claim by applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine. The Claims Administrator will notify you of a decision as expeditiously as possible and no later than 72 hours of receipt of the request as long as sufficient information is received to review the claim. The Claims Administrator may provide its decision orally, but will follow up with written notification.

Standard External Review for Pre-Service and Post-Service Benefits

- Unless an Expedited External Review (see below) is warranted, **the Standard Internal Appeal process must be exhausted before external review is available.**

- You have the right to file a written request for an external review with the federal Office of Personnel Management (OPM) within four months after the date of receipt of the Plan Administrator's denial of your Standard Internal Second Appeal.

- The review of your appeal will be conducted by an independent third party (examiner) with clinical and legal expertise and with no financial or personal conflicts with the Claims Administrator or the Plan Administrator.

- Within five business days of receipt of the request for external review, the Claims Administrator will provide to the examiner all of the documents and any information considered in denying your claim or internal appeal.

- The examiner will provide you written notice of the final external review decision within 45 days after receipt of your request. If the examiner determines that your request is not eligible for external appeal, the examiner will notify you in writing.

- The decision by the OPM is final and binding.

Expedited External Review for Urgent Care Benefits

- You have the right to request an expedited external review from the OPM if you receive an adverse decision on a claim or appeal that involves a medical condition for which the timeframe for completion of an expedited internal appeal, or the timeframe for completion of a standard external review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function and you have filed a request for an expedited internal appeal. You also have the right to request an expedited external review from the OPM if the appeal concerns an admission, availability of care, continued stay, or health care item or service for which you received services but have not been discharged from a facility.

- The review of your appeal will be conducted by an independent third party (examiner) with clinical and legal expertise and with no financial or personal conflicts with the Claims Administrator or Plan Administrator.

- Immediately upon receipt of the request for external review, the Claims Administrator will provide to the examiner all of the documents and any information considered in denying your claim or internal appeal.

- The examiner will provide you written notice of the final external review decision as expeditiously as the medical circumstances require and within 72 hours after receipt of your request. If you are in the course of ongoing treatment for that condition, the examiner will provide a decision within 24 hours and may initially make notification orally followed by written communication within 48 hours. If the examiner determines that your request is not eligible for external appeal, the examiner will notify you in writing.

- The decision by the OPM is final and binding.

Submission of Request for External Review

- You have the right to request an external review in writing by sending it electronically to DisputedClaim@opm.gov; by faxing it to 202-606-0036, or by sending it by mail to: P.O. Box 791, Washington, DC 20044. For external review of urgent care services, you may also initiate an expedited review by calling 877-549-8152.

- If you have questions or concerns during the external review process, you may call 877-549-8152.

- If you wish to submit additional written comments to the external reviewer, mail to P.O. Box 791, Washington, DC 20044. Any additional information you share with the external reviewer will be shared with the Claims Administrator in order to give the Claims Administrator an opportunity to reconsider the denial.

- You are the only person who has the right to file a disputed claim with OPM. Parties acting as your representative must include a copy of your specific written authorization with the review request. An exception is permitted for expedited review requests wherein a health care professional with knowledge of your medical condition may act as your representative without your express authorization.

- In order to adjudicate an appeal, OPM requires that you or your authorized representative submit the following information:
  - The denial of benefits or coverage that you received from the Claims Administrator or Plan Administrator;
  - Your name;
  - Your health plan ID number;
  - Your phone number and mailing address;
  - The state and county in which you have coverage;
  - An indication whether you are seeking review of an urgent care claim;
  - An indication whether you are seeking a review involving medical judgment, or due to the rescission or termination of coverage;
  - A brief statement of the reason for the review request;
  - The name of County of San Joaquin as the insurer;
  - The prior authorization number (applicable on urgent care and pre-service claims) or the claim number (applicable on post-service claims);
  - If an authorized representative is requesting review on your behalf, evidence of authorization; and

Submission of Request for External Review (Cont.)

- Any additional information necessary to process the request for review that may be required by regulation or guidance issued by the U.S. Department of Health and Human Services.

- You may choose to also submit additional information, including:
  - A statement about why you believe the Claims Administrator or Plan Administrator's decision was wrong based on specific benefit provisions in the Benefit Booklet;
  - Copies of documents that support the claims, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms;
  - Copies of all letters you sent to the Claims Administrator and Plan Administrator about the claim;
  - Copies of all letters the Claims Administrator and Plan Administrator sent to you;
  - Your daytime phone number and best time to call;
  - Your e-mail address if you would like to receive OPM's decision via e-mail.

Limitation of Action

- A Participant may not take legal action on a denied claim or service until he has exhausted the Plan's Standard Internal 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

	• This section defines words that are used in this Plan to help you better understand your benefits.
Accident	• Any unforeseen or unexplained sudden external bodily injury occurring by chance without intent.
Cosmetic Surgery, Procedures or Drugs	• Surgical procedures or drugs directed toward preserving or enhancing appearance. Cosmetic procedures and drugs, except reconstructive surgery necessary to repair a functional disorder as a result of disease or injury, or incident to a mastectomy, are not covered.
Covered Person	• Any Eligible Employee or Eligible Dependent whose coverage became effective and has not terminated.
Covered Services and Supplies	• Medical services and supplies for which benefits are payable under this Plan.
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 covered.
Day Care Mental Health Programs	• Outpatient programs designed as a substitute for Inpatient admissions or step-down from Inpatient treatment. The programs provide six to eight hours per day for a fixed time period and are often run by the same facility and therapists who provide Inpatient services.
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.
Effective Date	• The date on which coverage for an eligible employee, retiree and/or his or her eligible dependents begins.

Experimental	• Any procedure, treatment, therapy, drug, biological product, facility, equipment, device or supply that the Claims Administrator has determined not to have been demonstrated as safe, effective and efficacious for use in treatment of the sickness, injury or condition at issue, as compared with 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: • 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; • Written protocols and consent forms used by the proposed treating facility or other facility administering substantially the same drug, device or medical treatment.
Family and Medical Leave Act of 1993 (FMLA)	• A Federal Law that requires a covered employer to provide job-protected leave for certain family and medical reasons and to continue the employer's contribution toward health coverage for up to 12 weeks for eligible employees.
Home Health Care Agency	• An organization that is recognized by Medicare and certified by the proper authority of the state in which it is located to provide home health care services. Covered Services are Medically Necessary health care and do not include assistance with activities of daily living.
Hospice	• An organization that is licensed by the State and local jurisdictions where it is located and certified by Medicare, to provide a coordinated program of care to the family of a terminally ill Participant.
Hospital	• An institution that is licensed as an acute care facility in the state in which it is located and is approved by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and/or certified by Medicare.
Inpatient	• An individual confined as a bed patient in a Hospital or Skilled Nursing Facility.

Medically Necessary	• Services and supplies that are appropriate and necessary to diagnose or treat an illness, condition or injury and are: 1. consistent with the standards of good medical practice generally accepted and provided by the organized medical community 2. not solely for the convenience of the patient, Physician or supplier 3. not experimental or investigational 4. the most appropriate supply or level of service that can be safely provided. • Just because a service is prescribed by a Physician does not mean the service is Medically Necessary or covered by this Plan. • The Plan Administrator reserves the right to review all claims for medical necessity and may use the services of medical, dental and other consultants.
Medicare	• Title XVIII (health insurance for the aged) of the United States Social Security Act as amended by U.S. Public Law 89-97, including any future amendments.
Mental Health Conditions	• Conditions generally accepted in the relevant medical community and consistent with the current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM) or the most current version of the International Classification of Diseases (ICD).
Outpatient	• An individual who receives medical services and who is not confined as a bed patient in a Hospital or Skilled Nursing Facility.
Participant	• Any eligible person who is enrolled in this Plan in accordance with Memoranda of Understanding and Resolutions adopted by the Board of Supervisors of the County of San Joaquin.
Participating Provider	• A licensed Physician or other individual, facility or legal entity that has a written agreement with either the County of San Joaquin, the Claims Administrator or the County's network provider to provide Covered Services and Supplies to Participants within the scope of his/her/its license. Participating Providers include but are not limited to: Physicians, oral surgeons, physical therapists, speech therapists, occupational therapists, social workers, psychologists, marriage child and family counselors, emergency clinics, urgent care centers, laboratories, Outpatient surgical facilities, Hospitals, skilled nursing facilities, and Home Health Agencies.

Physician	• A doctor of medicine or osteopathy licensed to practice medicine and perform surgery.
Plan	• The Medical and prescription drug coverage and benefits described in this booklet.
Plan Year	• The Plan Year runs from July through June and coincides with the County's Fiscal Year bi-weekly pay periods.
Service Area	• The geographic area in which Covered Services and Supplies are available from Participating Providers. Participants must either work or maintain a permanent residence within the Service Area.
Skilled Nursing Facility	• A facility that is licensed to provide skilled nursing care by the State and local jurisdictions where is it located; is approved by Medicare as a Skilled Nursing Facility; is not primarily engaged in the care and treatment of drug addiction, alcoholism, obesity, weight reduction, mental disorders, or tuberculosis; and is not a rest home or facility whose primary purpose is Custodial Care.
Subrogation	• A provision that allows the Plan to receive reimbursement from any source that has accepted liability for an accident or injury, as recovery for benefits paid by the Plan.
Subscriber	• The employee, retiree, survivor, or other designated Participant who is the principle enrollee and whose eligibility is the basis for enrollment of any family members.
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).
Usual, Customary and Reasonable (UCR)	• The prevailing fee or charge for a service or supply in the geographical area where the service or supply is provided. In determining UCR, the complexity and nature of the services are considered.

San Joaquin County Employee Benefits Plans
Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE READ IT CAREFULLY.

Notice Effective Date: July 1, 2013

Background: The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires health plans to notify plan participants and beneficiaries about its policies and practices and protect the confidentiality of their health information. This document is intended to satisfy HIPAA's notice requirement with respect to all health information created, received, or maintained by San Joaquin County's employee benefit plans (the "Plan"). The HIPAA Privacy Standards will supersede any discrepancy between the information in this Notice and the Privacy Standards.

The Plan needs to create, receive, and maintain records that contain health information about you to administer the Plan and provide you with health care benefits. This notice describes the Plan's health information privacy policy with respect to your medical, prescription drug, dental, and/or Section 125 Flexible Benefits Programs. The notice tells you the ways the Plan may use and disclose health information about you, describes your rights, and the obligations the Plan has regarding the use and disclosure of your health information. However, it does not address the health information policies and practices of your health care providers.

San Joaquin County's Pledge Regarding Health Information Privacy

The privacy policy and practices of the Plan protects confidential health information that identifies you or could be used to identify you and relates to a physical or mental health condition or the payment of your health care expenses. This individually identifiable health information is known as "protected health information" (PHI). Your PHI will not be used or disclosed without a written authorization from you, except as described in this notice or as otherwise permitted by federal and state health information privacy laws. In the event your unsecured PHI is used or disclosed in violation of the privacy policy and practices of the Plan or the HIPAA Privacy Rule, you will receive notification of such breaches.

Privacy Obligations of the Plan

The Plan is required by law to:

- Make sure that health information that identifies you is kept private;
- Give you this notice of the Plan's legal duties and privacy practices with respect to health information about you; and
- Follow the terms of the notice that is currently in effect.

How the Plan May Use and Disclose Health Information About You

The Plan, its business associates, and their agents/subcontractors, if any, will use or disclose PHI without your authorization or opportunity to agree or object, to carry out treatment, payment and health care operations. The Plan will disclose PHI to a business associate only if the Plan receives satisfactory assurance that the business associate will appropriately safeguard the information. The following are the different ways the Plan may use and disclose your PHI:

- **For Treatment.** The Plan may disclose your PHI to health care providers for the provision, coordination or management of health care and related services by one or more health care providers. It also includes, but is not limited to, consultations and referrals between one or more of your providers. For example, the Plan may disclose to a treating orthopedist the name of the radiology facility where you obtained x-rays so that the orthopedist may ask for your x-rays from the radiologist.

- **For Payment.** The Plan may use or disclose your PHI for activities undertaken by the Plan to obtain premiums or to determine or fulfill its responsibility for coverage and provision of benefits under the Plan, or to obtain or provide reimbursement for the provision of health care. Payment includes, but is not limited to, actions to make eligibility or coverage determinations, billing, claims management, collection activities, subrogation, reviews for medical necessity and appropriateness of care, utilization review and pre-authorizations. The Plan may disclose PHI to stop-loss carriers, excess loss carriers, or managing general underwriters (MGUs) for underwriting and other purposes in order to obtain and maintain stop-loss or excess loss coverage related to benefits claims under the Plan. For example, the Plan may tell a doctor whether you are eligible for coverage or what percentage of the bill might be paid by the Plan.

- **For Health Care Operations.** The Plan may use and disclose your PHI to enable it to operate or operate more efficiently or make certain all of the Plan's participants receive their health benefits. The Plan may use your PHI to conduct quality assessment and improvement activities, population-based activities relating to improving health or reducing health care costs, contacting health care providers and patients with information about treatment alternatives, reviewing the competence or qualifications of health care professionals, evaluating health plan performance, underwriting, premium rating and other insurance activities relating to creating, renewing or replacing health insurance contracts or health benefits. It also includes disease management, case management, conducting or arranging for medical review, legal services and auditing functions including fraud and abuse detection and compliance programs, business planning and development, business management and general administrative activities. For example, the Plan may use information about your claims to refer you to a disease management program, project future benefit costs or audit the accuracy of its claims processing functions.

- **To the County.** The Plan may disclose your PHI to designed County personnel so they can carry out their Plan-related administrative functions, including the uses and disclosures described in this notice. Such disclosures will be made only to the County's Director of Human Resources (the Plan Administrator) and/or the members of the County's Benefits staff. These individuals will protect the privacy of your health information and ensure it is used only as described in this notice or as permitted by law.

Unless authorized by you in writing, your health information: (1) may not be disclosed by the Plan to any other County employee or department and (2) will not be used by the County for any employment-related actions and decisions or in connection with any other employee benefit plan sponsored by the County.

- **To a Business Associate.** Certain services are provided to the Plan by third party administrators and service providers known as "business associates." For example, the Plan may input information about your health care treatment into an electronic claims processing system maintained by the Plan's business associate so your claim may be paid. In so doing, the Plan will disclose your PHI to its business associate so it can perform its claims payment function. However, the Plan will require its business associates, through contract, to appropriately safeguard your health information.

- **Treatment Alternatives.** The Plan may use and disclose your PHI to tell you about possible treatment options or alternatives that may be of interest to you.

- **Health-Related Benefits and Services.** This Plan may use and disclose your PHI to tell you about health-related benefits or services that may be of interest to you.

- **Individual Involved in Your Care or Payment of Your Care.** The Plan may disclose PHI to a close friend or family member involved in or who helps pay for your health care. The Plan may also advise a family member or close friend about your condition, your location (for example, that you are in the hospital), or death.

- **As Required by Law.** The Plan will disclose your PHI when required to do so by federal, state or local law, including those that require the reporting of certain types of wounds or physical injuries.

Special Use and Disclosure Situations

The Plan may also use or disclose your PHI under the following circumstances:

- **Lawsuits and Disputes.** If you become involved in a lawsuit or other legal action, the Plan may disclose your PHI in response to a court or administrative order, a subpoena, warrant, discovery request, or other lawful due process.

- **Law Enforcement.** The Plan may release your PHI if asked to do so by a law enforcement official, for example, to identify or locate a suspect, material witness, or missing person or to report a crime, the crime's location or victims, or the identity, description, or location of the person who committed the crime.

- **Workers' Compensation.** The Plan may disclose your PHI to the extent authorized by and to the extent necessary to comply with workers' compensation laws and other similar programs.

- **Military and Veterans.** If you are or become a member of the U.S. armed forces, the Plan may release medical information about you as deemed necessary by military command authorities.

- **To Avert Serious Threat to Health or Safety.** The Plan may use and disclose your PHI when necessary to prevent a serious threat to your health and safety, or the health and safety of the public or another person.

- **Public Health Risks.** The Plan may disclose health information about you for public health activities. These activities include preventing or controlling disease, injury or disability; reporting births and deaths; reporting child abuse or neglect; or reporting reactions to medication or problems with medical products or to notify people of recalls of products they have been using.

- **Health Oversight Activities.** The Plan may disclose your PHI to a health oversight agency for audits, investigations, inspections, and licensure necessary for the government to monitor the health care system and government programs.

- **Research.** Under certain circumstances, the Plan may use and disclose your PHI in a limited data set for medical research purposes.

- **National Security, Intelligence Activities, and Protective Services.** The Plan may release your PHI to authorized federal officials: (1) for intelligence, counterintelligence, and other national security activities authorized by law and (2) to enable them to provide protection to the members of the U.S. government or foreign heads of state or to conduct special investigations.

- **Organ and Tissue Donation.** If you are an organ donor, the Plan may release medical information to organizations that handle organ procurement or organ, eye, or tissue transplantation or to an organ donation bank to facilitate organ or tissue donation and transplantation.

- **Coroners, Medical Examiners, and Funeral Directors.** The Plan may release your PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or to determine the cause of death. The Plan may also release your PHI to a funeral director, as necessary, to carry out his/her duty.

Your Rights Regarding Health Information About You

Your rights regarding the health information the Plan maintains about you are as follows:

- **Right to Inspect and Copy.** You have the right to inspect and copy your PHI. This includes information about your plan eligibility, claim and appeal records, and billing records, but does not include psychotherapy notes.

To inspect and copy health information maintained by the Plan, submit your request in writing to the Plan Administrator. The Plan may charge a fee for the cost of copying and/or mailing your request. In limited circumstances, the Plan may deny your request to inspect and copy your PHI. Generally, if you are denied access to health information, you may request a review of the denial.

- **Right to Amend.** If you feel that health information the Plan has about you is incorrect, or incomplete, you may ask the Plan to amend it. You have the right to request an amendment for as long as the information is kept by or for the Plan.

To request an amendment, send a detailed request in writing to the Plan Administrator. You must provide the reason(s) to support your request. The Plan may deny your request if you ask the Plan to amend health information that was: accurate and complete, not created by the Plan; not part of the health information kept by or for the Plan; or not information that you would be permitted to inspect or copy.

- **Right to An Accounting of Disclosures.** You have the right to request an "accounting of disclosures." This is a list of disclosures of your PHI that the Plan has made to others, except for those necessary to carry out health care treatment, payment or operations; disclosures made to you; or in certain other situations.

To request an accounting of disclosures, submit your request in writing to the Plan Administrator. Your request must state a time period, which may not be longer than six years prior to the date the accounting was requested.

- **Right to Request Restrictions.** You have the right to request a restriction on the health information the Plan uses or discloses about you for treatment, payment, or health care operations. You also have the right to request a limit on the health information the Plan discloses about you to someone who is involved in your care or the payment for your case, like a family member or friend. For example, you could ask that the Plan not use or disclose information about a surgery you had.

To request restrictions, make your request in writing to the Plan Administrator. You must advise us: (1) what information you want to limit; (2) whether you want to limit the Plan's use, disclosure, or both; and (3) to whom you want the limit(s) to apply.

Note: ***The Plan is not required to agree to your request.*** A restriction agreed to by the Plan is not effective to prevent uses or disclosures when required by the U.S. Department of Health and Human Services to investigate or determine the Plan's compliance with the Privacy Standards or uses or disclosures that are otherwise required by law.

- **Right to Request Confidential Communications.** You have the right to request that the Plan communicate with you about health matters by alternative means or at alternative locations if you clearly state that the disclosure of all or part of the information to which the request pertains could endanger you.

To request confidential communications, make your request in writing to the Plan Administrator. The Plan will make every attempt to accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

- **Right to a Paper Copy of this Notice.** You have the right to a paper copy of this notice. You may write to the Plan Administrator to request a written copy of this notice at any time.

Changes to this Notice

The Plan reserves the right to change this notice at any time and to make the revised or changed notice effective for health information the Plan already has about you, as well as any information the Plan receives in the future.

Complaints

If you believe your privacy rights under this policy have been violated, you may file a written complaint with the Plan Administrator at the address listed below. Alternatively, you may complain to the Secretary of the U.S. Department of Health and Human Services, generally within 180 days of when the act or omission complained of occurred. ***You will not be penalized or retaliated against for filing a complaint.***

Other Uses and Disclosures of Health Information

Other uses and disclosures of health information not covered by this notice or by the laws that apply to the Plan will be made only with your written authorization. If you authorize the Plan to use or disclose your PHI, you may revoke the authorization, in writing, at any time. If you revoke your authorization, the Plan will no longer use or disclose your PHI for the reasons covered by your written authorization; however, the Plan will not reverse any uses or disclosures already made in reliance on your prior authorization.

Contact Information

If you have any questions about this notice, please contact:

The Director of Human Resources
44 N. San Joaquin Street, Suite 330
Stockton, CA 95202
(209) 468-3370