

CITY OF STOCKTON
CURRENT EMPLOYEE MEDICAL PLAN BENEFIT RECAP

ORIGINAL
 PLAN

Basic Benefits

Plan Pays This Portion of Allowed Rate If Member Providers Used

No Deductible

No Lifetime \$ Max. on Basic Benefits

Rx	100%	After \$1 employee co-pay. Prescr. drugs & insulin. (No birth control or vitamins).
Hospitalization	100%	To 100 days per confinement period. Renewable after 30 days out of hosp. Semi-private room rate. Pre-admit certification req'd. if non-emerg. Concurrent utilization review req'd.
Surgeon/Anesthesiologist	100%	
Outpatient Surgery	100%	
Outpatient Lab/Xray	100%	Max. \$720 per yr. Balance to Major Med.
Radiation/Chemotherapy/Dialysis	100%	
Emergency Room	100%	1st treatment of accid. inj. within 72 hrs. if health endangering or life threat. acute illness. Otherwise applied to Major Med.
ER Physician	100%	For surgery.
	\$15	For other approved emergency services. Balance to Major Med. (Non-emerg. illness applied to Major Med.)
OB Maternity	100%	Normal or C-Section for emp. or spouse.
Ambulance	\$50	Ground. Balance to Major Med.
	\$100	Air. Balance to Major Med.
Additional Accident Benefits	\$500	For hosp. & prof. services w/in 90 days of inj. if not covered by Basic Benefits.

Major Medical Benefits

Deductible: \$100 per person per cal. yr. (\$300 max. per Family)

Lifetime Max.	\$300,000	-	Renewable - Up to \$1,000 per year.
Phys. Office Visits	80%	-	Only when ill. No well baby care, routine physicals or immunizations.
Chiropractic Visits	80%	-	Of allowable amounts. Subject to utilization review.
Other Covered Services	80%	-	When not paid in full by Basic Ben.
Outpatient Psychotherapy	\$15	-	Per visit to a total of fifty (50) visits per year for mental or nervous disorder. No alcohol/drug dependency.
Inpatient Psychiatric	80%	-	To max. \$3,500 per year. No alcohol/drug dependency.

EMPLOYEE MAXIMUM OUT-OF-POCKET: After the plan pays \$2,400 in benefits for covered Major Medical expenses incurred by a person during a single year, the Plan will then pay 100% of covered expenses for that person for the remainder of the year.

CITY OF STOCKTON
EMPLOYEE MEDICAL PLAN

The benefits of this medical plan are provided for Medically Necessary treatment of covered illness, disease or injury for those eligible employees and dependent family members.

THE BENEFITS OF THIS PLAN ARE PROVIDED ONLY FOR SERVICES THAT ARE CONSIDERED MEDICALLY NECESSARY. THE FACT THAT A PHYSICIAN PRESCRIBES OR ORDERS THE SERVICE, DOES NOT, IN ITSELF, MAKE IT MEDICALLY NECESSARY OR A COVERED EXPENSE.

Benefits are subject to all terms and conditions of this Medical Plan Booklet.

PART ONE: DEFINITIONS

A. Administrator: San Joaquin Foundation for Medical Care
555 West Benjamin Holt Drive, Suite 223
P. O. Box "O"
Stockton, California 95201
(209) 951-4560

Employer: City of Stockton
Risk Management
City Hall
Stockton, California 95202
(209) 944-8507

- B. The Employee/Retiree is the person whose name is on the identification card.
- C. The Spouse is the employee's spouse under a legally valid marriage between persons of the opposite sex.
- D. A Child is the Employee's child, stepchild or legally adopted child.
- E. A Family Member is the Employee enrolled Spouse and each enrolled eligible Child.
- F. The Plans Effective Date is May 1, 1988.
- G. A Member is the Employee or Family Member.
- H. The Effective Date is the date the member's coverage under the plan begins.
- I. Medically Necessary services or supplies are those determined to be:
1. Appropriate and necessary for the symptoms, diagnosis or treatment of the medical condition, and
 2. Provided for the diagnosis or direct care and treatment of the medical condition, and
 3. Within standards of good medical practice within the organized medical community, and
 4. Not primarily for the convenience of the covered employee or family member, the Physician or another provider, and
 5. The most appropriate supply or level of service which can safely be provided. For hospital stays, this means that acute care as an inpatient is necessary due to the kind of services the Member is receiving or the severity of the Member's condition, and that safe and adequate care cannot be received as an outpatient or in a less intensified medical setting.

J. A Hospital is a facility which provides diagnosis, treatment and care of persons who need acute inpatient hospital care under the supervision of Physicians. It must be licensed as a general acute care hospital or acute psychiatric hospital according to state and local laws. It must also be registered as a general or acute psychiatric hospital by the American Hospital Association and meet accreditation standards of the Joint Commission on Accreditation of Hospitals.

K. Psychiatric Health Facility means a health facility which provides 24-hour inpatient care for mentally disordered, incompetent or other persons as described in Division 5 (commencing with Section 5000) or Division 6 (commencing with Section 6000) of the Welfare and Institutions Code or Department of Health Services.

L. An Outpatient Surgical Center is a facility other than a medical or dental office, whose main function is performing surgical procedures on an outpatient basis. It must be licensed as an outpatient clinic according to state and local laws and must meet all requirements of an outpatient clinic providing surgical services and approved by Medicare.

M. A Skilled Nursing Facility is an institution that provides continuous skilled nursing services. It must be licensed according to state and local laws and be recognized as a Skilled Nursing Facility under Medicare.

N. A Day Care Center is an outpatient psychiatric facility which is part of or affiliated with a Hospital. It must be licensed according to state and local laws to provide outpatient care and treatment of Mental and Nervous Disorders under the supervisor of psychiatrists.

O. A Physician means:

1. A doctor of medicine (M.D.) or a doctor of osteopathy (D.O.) who is licensed to practice medicine or osteopathy where the care is provided, or
2. One of the following providers, but only when the provider is licensed to practice where the care is provided, is rendering a service within the scope of that license, is providing a service for which benefits are specified in the Medical Plan, and when benefits would be payable if the services were provided by a Physician as defined in 1. above:

- | | |
|---|---|
| a. A dentist (D.D.S) | h. A marriage, family and child counselor (M.F.C.C.)* |
| b. An optometrist | i. A physical therapist (P.T. or R.P.T.)* |
| c. A dispensing optician | j. A speech pathologist* |
| d. A podiatrist or chiropodist | k. An audiologist* |
| e. A psychologist | l. An occupational therapist (O.T.R.)* |
| f. A chiropractor (D.C.) | m. A mental health nurse* |
| g. A clinical social worker (C.S.W. or L.C.S.W.)* | |

Note: The providers indicated by asterisks (*) are covered only by referral of a Physician as defined in 1. above.

P. A Year is a twelve month period starting each January 1 at 12:01 a.m. Pacific Standard Time.

Q. Custodial Care is care provided primarily to meet the needs of the Member. This includes help in walking, bathing or dressing. It also includes preparing food or special diets, feeding, administration of medicine which is usually self-administered or any other care which does not require continuing services of medical personnel.

- R. Special Care Units are special areas of a Hospital which have highly skilled personnel and special equipment for acute conditions that require constant treatment and observation.
- S. Experimental procedures are those that are mainly limited to laboratory and/or animal research.
- T. Investigative procedures are those that have progressed to limited use on humans, but which are not widely accepted as proven and effective procedures within the organized medical community.
- U. Mental or Nervous Disorders are those conditions, excluding drug or alcohol dependence, which are listed in the International Classification of Diseases as diagnostic codes 290-319. One or more of these conditions may be specifically excluded in the Plan.
- V. Accidental Injury is physical harm or disability which is the result of a specific unexpected incident caused by an outside force. The physical harm or disability must have occurred at an identifiable time and place. Accidental Injury does not include illness or infection, except infection of a cut or wound.
- W. A Totally Disabled Employee is one who, because of illness or injury, is unable to work for income in any job for which he or she is qualified or for which he or she becomes qualified by training or experience, and who is in fact unemployed. A Totally Disabled Family Member is one who is unable to perform all activities usual for a person of that age.
- X. Customary and Reasonable Charge is a charge which falls within the common range of fees billed by a majority of providers for a procedure in a given geographic region, or which is justified based on the complexity or the severity of treatment for a specific case.
- Y. Negotiated Rate is the fee Contracting Providers agree to accept as payment in full for covered services. It is always lower than the Customary and Reasonable charge for that service in the same geographical area.
- Z. A Non-Participating Provider is a provider who does not have a contract in effect with the Administrator or other Foundation in the State of California.
- AA. A Contracting Provider is a provider who has an Agreement in effect with the Administrator (SJFMC). Contracting providers agree to accept the Negotiated Rate as payment in full for covered services, except deductibles and co-insurance, unless the member has another health plan.

PART TWO: UTILIZATION REVIEW

- A. The Benefits of this plan are provided for services that are Medically Necessary. The Services must be ordered by the attending Physician for the direct care and treatment of a covered illness, injury or condition. Services must be standard medical practice where received for the illness, injury or condition being treated and must be legal in the United States.
- B. All hospital admissions will be reviewed for Medical Necessity by the Administrator. The review may occur before a hospital admission (Pre-Admission Review), during the hospital stay (Concurrent Utilization Review) or following discharge from the Hospital at the time the claim is submitted (Retrospective Review).
- C. Hospital admissions are subject to Pre-Admission and Concurrent Utilization Review which include the following types of review:

1. "Pre-Admission review" to determine if a scheduled inpatient admission is Medically Necessary. Pre-Admission Review is required on all non-emergency admissions.

The Member must initiate Pre-Admission Review by instructing his or her Physician to notify the Review Department within at least three working days prior to the scheduled admission. The Physician may identify the appropriate review organization by asking the Member for a copy of his or her Identification Card. The Member should confirm with the Hospital at the time of admission that pre-admission authorization has been obtained by his or her Physician.

If the Review Department determines the admission to be medically unnecessary, the Member and his or her Physician will be notified in writing.

2. "Admission Review" to determine if an admission is Medically Necessary when pre-admission authorization was not obtained.
3. "Continued Stay Review" to determine if a continued inpatient stay is Medically Necessary. If the review organization determines that a hospital confinement or continued stay is not Medically Necessary, the member and his or her attending Physician will be notified in writing by the review organization.

THE MEMBER IS RESPONSIBLE FOR ANY EXPENSE INCURRED AFTER THE TIME SPECIFIED IN SUCH NOTICE.

- D. Review Department also does Ambulatory Review on all outpatient claims for medically necessary services.
- E. Claims are subject to Retrospective Review. That review may result in a determination that all, or part, of the hospital stay or other services was not medically necessary, and the consequent denial of all, or part, of any claim.
- F. The payment of benefits is subject to all the terms, conditions, limitations and exclusions of the Plan. Benefits are not payable for services not covered under the Plan.

PART THREE: BASIC BENEFITS

The Benefits described below are provided for covered services received for treatment of a covered illness, injury or condition. These benefits are subject to all provisions of the Plan which may limit benefits or result in benefits not being payable.

A. HOSPITAL: Services are provided according to the following:

1. Inpatient

a. Payment - The services listed below are paid at 100 percent.

b. Days Covered - The services listed below are limited to a total of 100 days in each confinement period. When 30 days pass without inpatient care, the 100-day allowance renews. When less than 30 days pass between hospital stays, those hospital stays are in the same confinement period. However, the 100-day allowance renews automatically for a Member if:

- (1) The Member is an Employee and returns to work full-time after discharge, or
- (2) The Member is hospitalized due to Accidental Injury which occurs after discharge.

c. Covered Services

- (1) Accommodations in a room of two or more beds, or the prevailing charge for two-bed room accommodations in that Hospital if a private room is used.
- (2) Services in Special Care Units.
- (3) Operating, delivery and special treatment rooms.
- (4) Supplies and ancillary services including laboratory, cardiology, pathology, radiology and any professional component of these services.
- (5) Physical Therapy, radiation therapy, chemotherapy, and hemodialysis treatment. ←
- (6) Drugs and medicines approved for general use by the Food and Drug Administration which are supplied by the Hospital for use during the Member's stay.
- (7) Blood transfusions, but not the cost of blood, blood products or blood processing.

d. Conditions of Service

- (1) Services must be those which are regularly provided by a Hospital.
- (2) Services are provided only for the number of days required to treat the Member's illness, injury or condition.

2. Admissions for Dental Care

a. Covered Services: Listed inpatient hospital services, subject to the conditions of service stated above, when a hospital stay of three days or less for dental treatment is required due to an unrelated medical condition of the Member, and has been ordered by a Physician (M.D.) and a Dentist (D.D.S).

b. Conditions of Service:

- (1) The Administrator makes the final determination as to whether the dental treatment could have been safely rendered in another setting due to the nature of the procedure of the Member's medical condition.
- (2) Hospital stays for the purpose of administering general anesthesia are not considered necessary.

3. Outpatient

a. Payment - The services listed below are paid at 100 percent.

b. Covered Services

- (1) Emergency room use, supplies, ancillary services, drugs and medicines as listed above, including diagnostic laboratory and x-ray, exams, etc.
- (2) Care received when outpatient surgery is performed. Covered services are operating room use, supplies, ancillary services, drugs and medicines as listed above. These services are also payable when outpatient surgery is performed at an Outpatient Surgical Center.
- (3) Radiation therapy, chemotherapy and dialysis treatment.

c. Conditions of Service

- (1) Services must be those which are regularly provided by a Hospital.
- (2) Emergency room care must be for the first treatment of a medical emergency. A medical emergency is an unexpected acute illness or Accidental Injury which could permanently endanger health if immediate medical treatment is not received.
- (3) Emergency room care for an Accidental Injury must be received within 72 hours of the injury date.
- (4) Surgery.

4. Pregnancy and Maternity Care (Employee and Spouse Only)

- a. Listed inpatient or outpatient services, subject to the conditions of service stated above, when provided for pregnancy, maternity care and abortion.
- b. Routine nursery care of a newborn Child if the Child's natural mother is an Employee or enrolled Spouse, subject to the conditions of service stated above.

B. SKILLED NURSING FACILITY: Benefits for expense incurred are provided according to the following:

1. Payment - Skilled nursing facility services are paid at 100 percent.
2. Days Covered - Skilled nursing facility services are provided on the basis of the number of days available for inpatient hospital care as stated above. Two days of skilled nursing facility care are provided for each of those days that has not been used.
3. Covered Services
 - a. Accommodations in a room of two or more beds, or the prevailing charge for two-bed room accommodations in that facility if a private room is used.
 - b. Special treatment rooms.
 - c. Laboratory exams.
 - d. Physical, occupational and speech therapy. Oxygen and other gas therapy.
 - e. Drugs and medicines approved for general use by the Food and Drug Administration which are used in the facility.
 - f. Blood transfusions, but not the cost of blood, blood products or blood processing.

4. Conditions of Service

- a. The Member must be transferred directly from a covered inpatient stay to the Skilled Nursing Facility.
- b. The Member must be referred to the Skilled Nursing Facility by a Physician for further care and treatment of the illness or injury for which he or she was hospitalized.
- c. Services must be those which are regularly provided by a Skilled Nursing Facility.
- d. The services must be consistent with the illness, injury, degree of disability and medical needs of the Member. Benefits are provided only for the number of days required to treat the Member's illness or injury.
- e. The Member must remain under the active medical supervision of a Physician. The Physician must be treating the illness or injury for which the Member is confined in the Skilled Nursing Facility.

C. AMBULANCE: Benefits for expense incurred are provided according to the following:

1. Maximums

- a. \$50.00 per trip for ground ambulance service.
- b. \$100.00 per trip for air ambulance service.

2. Covered Services

- a. Base charge and mileage.
- b. Non-reusable supplies.
- c. Monitoring, electrocardiograms (EKG's or ECG's), cardiac defibrillation, cardiopulmonary resuscitation (CPR), and administration of oxygen and intravenous (IV) solutions in connection with ambulance service. An appropriately licensed person must render the services.

3. Conditions of Service

- a. Ground or air ambulance transportation of the Member must be to an acute care Hospital. Upon reaching the Hospital, the Member must be admitted as an inpatient or receive emergency outpatient care as stated above.
- b. Services must be provided by an air ambulance or a licensed ambulance company.
- c. Air ambulance transportation must be from the place the Member is first disabled to the nearest Hospital where appropriate treatment is provided.

D. PROFESSIONAL: Benefits for expense incurred are provided according to the following:

1. Physician's Care

- a. Payment Method and Maximum - Payment for covered expense incurred is based on the Modified 1974 RVS unit values established by the California Medical Association Relative Value Studies, 5th Edition (RVS). The maximum benefit for each service is the amount obtained by multiplying the RVS unit value of that service by the appropriate unit allowance for the service performed.

Medicine.....	\$ 6.00	Pathology.....	\$ 1.25
Surgery.....	\$116.55	Radiology.....	\$ 11.55
Anesthesia (15 min.).....	\$ 32.80		

Maximum Benefits Payable:

Normal OB, Total Procedure.....	\$ 925.00
C-Section, Total Procedure.....	\$1,100.00

b. Covered Services

- (1) Surgery and surgical assistance.
- (2) Anesthesia during surgery.
- (3) Consultations requested by the attending Physician for a covered illness, injury or condition. This includes one psychiatric consultation during each illness to determine whether that illness is functional or organic.
- (4) Extra time spent when the Physician is detained to treat a Member in critical condition who requires constant care.
- (5) Visits during a covered inpatient stay (except those relating to surgery), limited to one a day unless additional visits are needed due to the Member's medical condition. Visits include those during medical hospital stays and those during skilled nursing facility stays.
- (6) Radiation therapy.
- (7) X-ray and laboratory testing to a calendar year maximum of \$720.00 for each family member.

2. Related Services

- a. Payment is provided for the covered expense incurred up to the stated maximums.
- b. Covered Services - Up to \$15.00 for non-surgical treatment by a Physician in the emergency room of a Hospital when the Member is receiving care for a medical emergency.
- c. Pregnancy and Maternity Care (Employee and Spouse Only) - Payment is provided for all professional services of Part when provided for pregnancy, maternity care and abortion.

E. ORGAN AND TISSUE TRANSPLANTS: Benefits are provided for services in connection with a non-Investigative organ or tissue transplant for:

1. An enrolled Member who receives the organ or tissue, and
2. An enrolled Member who donates the organ or tissue, and
3. An organ or tissue donor who is not an enrolled Member, if the organ or tissue recipient is an enrolled Member. Benefits are reduced by any amounts paid or payable by that donor's own coverage.

F. ACCIDENTAL INJURY: Accidental injury benefits are provided if a Member is accidentally injured while covered under the Plan. Benefits are provided for 100 percent of eligible expense incurred within 90 days of the injury date, up to a \$500.00 maximum benefit for each injury. Eligible expense is expense incurred for treatment of the injury, but does not include expense for which other benefits of this Part Three are provided or expense which exceeds the Modified 1974 CRVS allowance for professional services.

PART FOUR: MAJOR MEDICAL BENEFITS

The benefits described below are provided for covered expense incurred for treatment of a covered illness, injury or condition. Expense is incurred on the date the Member receives the service or supply for which the charge is made. These benefits are subject to all provisions of the Plan, which may limit benefits or result in benefits not being payable.

A. NON-COVERED EXPENSE: Covered expense under Major Medical Benefits does not include:

1. Any amount paid under Basic Benefits.
2. Any amount in excess of the basic Modified CRVS allowance for professional services.

B. DEDUCTIBLE

1. Each Member must meet a deductible amount of \$100.00 for covered expense incurred during any Year. Any amount exceeding the RVS allowance for professional services is not applied toward the deductible. When a total of \$300.00 in deductibles has been met by an enrolled family during any Year, no deductible is required for any other Family Member in that Year.
2. Covered expense incurred during the last quarter of a Year and applied toward the deductible for that Year is also applied toward the deductible for the next Year.

C. PAYMENT: Payment is provided as follows for covered expense incurred in excess of the deductible. Covered expense for services of a Physician is based on the RVS unit values established by the California Medical Association Relative Value Studies, 5th Edition (RVS), as modified by the Reimbursement Committee. All payments are subject to any maximum amounts stated below.

1. First Level Payment - Until the Plan pays \$2,400.00* in benefits for covered expense a Member incurs in a Year:
 - a. Payment is provided for 50 percent of the covered expense incurred by that Member for outpatient psychotherapy and psychological testing, and
 - b. Payment is provided for 80 percent of the covered expense incurred by that Member for all services other than outpatient psychotherapy and psychological testing.
2. Second Level Payment - After the Plan pays \$2,400.00* in benefits for covered expense a Member incurs in a Year:
 - a. Payment continues to be provided for 50 percent of the covered expense incurred by that Member for outpatient psychotherapy and psychological testing, and
 - b. Payment is provided for 100 percent of the covered expense incurred by that Member for the rest of that Year for all services other than outpatient psychotherapy and psychological testing.

*NOTE: Any benefits paid by Medicare (up to the amount that would have been paid to a Member without Medicare) are included in this amount.

D. MAXIMUM BENEFITS

1. Benefits paid for outpatient psychotherapy and psychological testing are limited to a \$15.00 maximum payment for each visit to a total of 50 visits per calendar year.
2. Benefits paid under Mental or Nervous Disorders for inpatient hospital care or confinement in a psychiatric health facility, inpatient Physician's care and outpatient visits to a Day Care Center are limited to \$3,500.00 maximum payment for expense incurred by each Member during a Year.

3. All Major Medical Benefits are limited to a maximum amount of \$300,000.00 during each Member's lifetime. Any benefits paid by Medicare (up to the amount that would have been paid to a Member without Medicare) are included in this amount.

Lifetime Maximum - The total of all benefits payable on behalf of a member during his/her lifetime shall not exceed the medical Maximum, except as provided in the Restored Maximum section below. The maximum shall be the amount accumulated claims paid by this Plan and Blue Cross (the prior self-insured plan) provided by the City of Stockton. The lifetime maximum shall not begin again for an eligible person who leaves the Plan and returns at a later date.

4. Up to \$1,000.00 in Major Medical Benefits received are automatically restored each January 1.

Any additional limits on the number of visits or days covered are stated under the specific benefit.

E. COVERED EXPENSE

1. Hospital

a. Covered Services

- (1) Inpatient services and supplies, including Special Care Units, except private room charges over the prevailing two-bed room rate of the Hospital.
- (2) Outpatient services and supplies for which Basic Benefits are not available.

b. Conditions of Service

- (1) Services must be those which are regularly provided and billed by a Hospital.
- (2) Benefits are provided only for the number of days required to treat the Member's illness, injury or condition.

2. Professional Services

a. Covered Services

- (1) Services of a Physician for which Basic Benefits are not available.
- (2) Services of an anesthetist.
- (3) Services of a registered nurse.

b. Calculation of Covered Expense - The maximum covered expense for professional services is the amount obtained by multiplying the Modified 1974 RVS unit value indicated for that service by the appropriate unit allowance.

Medicine.....	\$ 6.00	Pathology.....	\$ 1.25
Surgery.....	\$116.55	Radiology.....	\$ 11.55
Anesthesia (15 min.).....	\$ 32.80		
Normal OB, Total Procedure.....	\$ 925.00		
C-Section, Total Procedure.....	\$1,100.00		

3. Additional Services and Supplies
 - a. The following ambulance services:
 - (1) Base charge, mileage and non-reusable supplies of a licensed ambulance company for ground service to transport a Member to and from a Hospital.
 - (2) Base charge, mileage and non-reusable supplies of an air ambulance from the area where the Member is first disabled to transport a Member to the nearest Hospital where appropriate treatment is provided.
 - (3) Monitoring, electrocardiograms (EKG's or ECG's), cardiac defibrillation, cardiopulmonary resuscitation (CPR) and administration of oxygen and intravenous (IV) solutions in connection with ambulance service. An appropriately licensed person must render the services.
 - b. Radiation therapy, chemotherapy and hemodialysis treatment.
 - c. Surgical implants.
 - d. Artificial limbs or eyes.
 - e. The first pair of contact lenses and the first pair of eyeglasses when required as a result of eye surgery.
 - f. Rental or purchase of dialysis equipment. Dialysis supplies. Rental or purchase of other medical equipment and supplies which are:
 - (1) Ordered by a Physician, and
 - (2) Of no further use when medical need ends, and
 - (3) Usable only by the patient, and
 - (4) Not primarily for the Member's comfort or hygiene, and
 - (5) Not for environmental control, and
 - (6) Not for exercise, and
 - (7) Manufactured specifically for medical use.Rental charges that exceed the reasonable purchase price of the equipment are not covered.
 - g. Blood transfusions, including blood processing and the cost of unreplaced blood and blood products.
4. Dental Injury - Services of a Physician (M.D.) or Dentist (D.D.S.) treating an Accidental Injury to natural teeth which occurs while the Member is covered under the Plan. Services must be received during the six months following the date of injury. Damage to natural teeth due to chewing or biting is not Accidental Injury.

5. Pregnancy and Maternity Care (Employee and Spouse Only).
 - a. All Major Medical Benefits when provided for pregnancy, maternity care and abortion.
 - b. Major Medical hospital benefits for routine nursery care of a newborn Child, if the Child's natural mother is an Employee or enrolled Spouse.
 - c. Initial Pediatric Exam.
6. Organ and Tissue Transplants - Services in connection with a non-Investigative organ or tissue transplant for:
 - a. An enrolled Member who receives the organ or tissue, and
 - b. An enrolled Member who donates the organ or tissue, and
 - c. An organ or tissue donor who is not an enrolled Member, if the organ or tissue recipient is an enrolled member. Benefits are reduced by any amounts paid or payable by that donor's own coverage.
7. Mental or Nervous Disorders
 - a. Covered Services
 - (1) Benefits for a psychiatric health facility shall include, but are not limited to the following services:
 - (a) Psychiatry;
 - (b) Clinical psychology;
 - (c) Psychiatric nursing;
 - (d) Social work;
 - (e) Rehabilitation;
 - (f) Drug administration;
 - (g) Appropriate food services; and
 - (h) Facility fee (room and board)
 - (2) Inpatient hospital services stated above.
 - (3) Outpatient visits to a Day Care Center.
 - (4) The following services of a Physician, limited to one visit a day:
 - (a) Visits during a covered inpatient stay.
 - (b) When a covered Member is not confined in a hospital or Psychiatric Health Facility, the Plan will pay the Covered Charges of a physician for psychiatric treatment up to one visit per day, a maximum payment of \$15.00 per day and a total of 50 visits each Calendar Year. The Plan will also provide benefits for prescription drugs and medicines necessary for treatment of mental, emotional or nervous conditions.
 - b. Conditions of Service
 - (1) Services must be for treatment of a Mental or Nervous Disorder which can be improved by standard medical practice.
 - (2) Inpatient services must be for treatment of the acute phase of the Mental or Nervous Disorder. The acute phase is the recent, severely intensified stage of the disorder.
 - (3) The Member must be under the direct care and treatment of a Physician for the condition being treated.
 - (4) Services must be those which are regularly provided by a Hospital.
 - (5) Benefits are provided only for the number of days required to treat the Member's illness, injury or condition.

PART FIVE: PRESCRIPTION DRUG BENEFITS

Prescription Drug Benefits are provided for eligible Members. Benefits described in this Part are provided for expense incurred for prescription drugs only if benefits have not been provided for elsewhere in this Plan. Expense is incurred on the date the Member receives the drug for which the charge is made.

NOTE: For those Retirees who retired prior to January 1, 1985 under 65 years of age, see Part Four: Major Medical Benefits, E. Covered Expense, Item 3.h. (Page Eleven).

A. PAYMENT

1. When the Member presents his or her Identification Card (issued by the Employer) at a participating pharmacy (a pharmacy which has signed an agreement with the Administrator), the Member pays a \$1.00 deductible for each prescription and each refill. A list of participating pharmacies is available from the Employer or Administrator.
2. When the Member does not present his or her Identification Card, or goes to a non-participating pharmacy, payment is provided to the Member for the reasonable charge for covered expense incurred, less \$1.00 deductible for which the member is responsible. The reasonable charge is determined by the Administrator. This benefit is payable only if the Member files a properly-completed claim form with the Administrator within 90 days of the date of purchase.

B. COVERED EXPENSE

1. Drugs and medications which the law restricts to sale by prescription.
2. Insulin.

C. CONDITIONS OF SERVICE

1. The drug or medication must:
 - a. Be prescribed in writing by a Physician.
 - b. Be approved for general use by the Food and Drug Administration.
 - c. Be for the direct care and treatment of the Member's illness, injury or condition. Dietary supplements, health aids or drugs for the purpose of birth control are not included.
 - d. Be purchased from a licensed retail pharmacy.
 - e. Not be used while the Member is an inpatient in any facility, unless it is not usually supplied by or used in that facility.
2. The prescription must not exceed either a 34-day supply or 100 units, whichever is greater.

PART SIX: BENEFITS FOR MEDICARE-ELIGIBLE MEMBERS

For all Medicare-eligible Members, the Employer provides the benefits of this Plan, with all deductibles and co-payments applied, less any benefits paid or payable by Medicare. However, the \$1.00 deductible for which the Member is responsible under Prescription Drug Benefits still applies. All benefit limitations of this Plan still apply.

PART SEVEN: EXTENSION OF BENEFITS

- A. If a Member is Totally Disabled when coverage ends and is under the treatment of a Physician, the benefits of this Plan may continue to be provided for services treating the totally disabling illness or injury. No benefits are provided for services treating any other illness, injury or condition.
- B. A Member confined as an inpatient in a Hospital or Skilled Nursing Facility is considered Totally Disabled as long as the inpatient stay is Medically Necessary, and no written certification of the total disability is required.
- C. A Member not confined as an inpatient who wishes to apply for total disability benefits must submit written certification by the Physician of the total disability. The Administrator must receive this certification within 90 days of the date coverage ends under this Plan. At least once every 90 days while benefits are extended, the Administrator must receive proof that the Member's total disability is continuing.
- D. Benefits are provided until one of the following occurs:
1. The Member is no longer Totally Disabled, or
 2. The maximum benefits of this Plan are paid, or
 3. The Member becomes covered under another group health plan that provides coverage without limitation for the disabling illness or injury, or
 4. A period of 12 consecutive months has passed since the date coverage ended.

→ PART EIGHT: EXCLUSIONS AND LIMITATIONS

Benefits of the Plan are not provided for or in connection with the following:

- A. Services or supplies that are not Medically Necessary as defined. Experimental or Investigative procedures.
- B. Services received before the Member's effective date or during an inpatient stay that began before the Member's effective date. Services received after the Member's coverage ends, except as specifically stated under Extension of Benefits.
- C. Any amounts in excess of the RVS allowance for professional services or negotiated rates of contracting providers.
- D. Services not specifically listed in the Plan as covered services.
- E. Services for which the Member is not legally obligated to pay. Services for which no charge is made to the Member. Services for which no charge is made to the Member in the absence of insurance coverage, except services received at a non-governmental charitable research Hospital. Such a Hospital must meet the following guidelines:
1. It must be internationally known as being devoted mainly to medical research, and
 2. At least ten percent of its yearly budget must be spent on research not directly related to patient care, and
 3. At least one-third of its gross income must be spent on research not directly related to patient care, and

4. It must accept patients who are unable to pay, and
 5. Two-thirds of its patients must have conditions directly related to Hospital Research.
- F. Work-related conditions if benefits are recovered or can be recovered, either by adjudication, settlement or otherwise, under any workers' compensation, employer's liability law or occupational disease law, even if the member does not claim those benefits.
- G. Conditions caused by an act of war. Conditions caused by release of nuclear energy, whether or not the result of war.
- H. Charges for services, supplies or treatments furnished by or covered under a government plan or law, except:
1. Medi-Cal;
 2. Services rendered in a hospital owned or managed by the State of California; and
 3. Charges billed to us by the United States Government for:
 - a. Services rendered by Veterans Administration facilities to a veteran for treatment of a non-service connected disability; and
 - b. Inpatient medical care provided by military hospitals to non-active military personnel and their dependents.
- I. Any services to the extent that the Member is entitled to receive Medicare benefits for those services, whether or not Medicare benefits are actually paid.
- J. Professional services received from a person who lives in the Member's home or who is related to the Member by blood or marriage.
- K. Inpatient room and board charges in connection with a hospital stay primarily for rehabilitative care, environmental change, physical therapy or treatment of chronic pain. Custodial Care or rest cures. Services provided by a rest home, a home for the aged, a nursing home or any similar facility. Services provided by a Skilled Nursing Facility, except as specifically stated in Skilled Nursing Facility under Basic Benefits.
- L. Inpatient room and board charges in connection with a hospital stay primarily for diagnostic tests which could have been performed safely on an outpatient basis.
- M. Hyperkinetic syndromes, learning disabilities, behavioral problems, mental retardation or autistic disease of childhood. Mental or Nervous Disorders, except as specifically stated under Major Medical Benefits. Substance abuse.
- N. Braces, other orthodontic appliances or orthodontic services.
- O. Dental plates, bridges, crowns, caps or other dental prostheses, dental services, extraction of teeth, or treatment to the teeth or gums, except as specifically stated for Admissions for Dental Care under Basic Benefits and Dental Injury under Major Medical Benefits. Cosmetic dental surgery or other services for beautification.
- P. Hearing aids and routine hearing tests.

- Q. Optometric services, eye exercises including orthoptics, routine eye exams and routine eye refractions. Eyeglasses or contact lenses, except as specifically stated under Major Medical Benefits.
- R. Outpatient occupational therapy.
- S. Outpatient speech therapy, except following surgery, injury or non-congenital organic disease.
- T. Cosmetic surgery or other services for beautification.
- U. Procedures or treatments to change characteristics of the body to those of the opposite sex.
- V. Sterilization reversal. Artificial insemination and in vitro fertilization.
- W. Orthopedic shoes (except when joined to braces) or shoe inserts, air purifiers, air conditioners, humidifiers, exercise equipment and supplies for comfort, hygiene or beautification. Educational services, nutritional counseling or food supplements. Telephone consultations.
- X. Routine physical exams or tests which do not directly treat an actual illness, injury or condition, including those required by employment or government authority.
- Y. Benefits of the Plan are not provided for or in connection with services or supplies for the treatment of an illness, injury or condition causing the Member to be Totally Disabled, if:
 1. The Plan becomes effective within 60 days after termination of a prior carrier's plan and is issued in replacement of such plan, and
 2. The Member was Totally Disabled on the date that the prior carrier's plan terminated, and
 3. The Member is entitled to an extension of benefits under Section 1399.62 of the California Health and Safety Code, Section 10128.2 of the California Insurance Code or to any similar extension of coverage for the totally disabling condition.
- Z. A dependent daughter's pregnancy, maternity care and abortion.
- AA. Benefits of this Plan are not provided for or in connection with services primarily for weight reduction or treatment of obesity. This exclusion will not apply to surgical treatment of obesity if:
 1. Surgical treatment of obesity is necessary to treat another life-threatening condition involving obesity, and
 2. It has been documented that non-surgical treatments of the obesity have failed.
- BB. Benefits of this Plan are not provided for or in connection with any illness, 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 third party. Nevertheless, the Administrator will advance the benefits of this Plan to the Member subject to the following:
 1. The Employer will automatically have a lien, to the extent of benefits advanced, upon any recovery, whether by settlement, judgement or otherwise, that the Member receives from the third party, the third party's insurer, or the third party's guarantor. The lien will be in the amount of benefits paid by the Administrator under this Plan for the treatment of the illness, disease, injury or condition for which the third party is liable.

2. The Member agrees to advise the Administrator, in writing, within 60 days of his or her claim against the third party and to take such action, furnish such information and assistance, and execute such papers as Administrator may require to facilitate enforcement of its rights. The Member also agrees to take no action which may prejudice the rights or interests of the Employer under this Plan. Failure of the member to give such notice to the Administrator or cooperate with the Plan Administrator or actions of the Member that prejudice the rights or interests of the Employer will be a material breach of this Plan and will result in the Member being personally responsible for reimbursing the Employer's health plan.

CC: Benefits of this Plan are not provided for or in connection with acupuncture.

DD. Benefits of this Plan are not provided for or in connection with any eye surgery solely for the purpose of correcting refractive defects of the eye such as near-sightedness (myopia) and astigmatism.

PART NINE: BINDING ARBITRATION

- A. Any dispute between the Member and Employer regarding the decision of the Administrator must be submitted to binding arbitration if the amount in dispute exceeds the jurisdictional limits of the small claims court. This arbitration is begun by the Member making written demand on Administrator.
- B. This arbitration will be held before a designated neutral arbitrator appointed by the county medical association of the county in which the services were provided. If the county medical association declines or is unable to appoint an arbitrator, the arbitration will be conducted according to the rules of the American Arbitration Association.
- C. Any dispute regarding a claim for damages within the jurisdictional limits of the small claims court will be resolved in such court.
- D. THE ARBITRATION FINDINGS WILL BE FINAL AND BINDING.

PART TEN: COORDINATION OF BENEFITS

This coordination of benefits provision applies to this Plan when an employee or the employee's covered dependent has medical care coverage under more than one Plan. The benefits of the Plan may be reduced if the member has any other group health, dental or vision coverage so that the benefits and services the Member receives from all group coverages do not exceed 100 percent of the covered expense.

A. Definitions - Plan means any of the these which provides benefits or services for, or because of, medical, dental or vision care or treatment:

1. Group, blanket or franchise insurance coverage;
2. Group Blue Cross, Group Blue Shield, service plan contracts, group practice, individual practice and other group prepayment coverage;
3. Any group coverage under labor-management trusteed plans, union welfare plans, employer organization plans or employee benefit organization plans;
4. Government programs providing hospital, medical and surgical benefits, however, Plan does not include Title XVIII (Medicare) or XIX (Medicaid) of the Social Security Act, or Medi-Cal, and does not include a law or plan when, by law, its benefits are excess to those of any private insurance plan or other non-governmental plan.

Each contract or other arrangement for coverage described above is a separate plan. Also, if an arrangement has two parts and the coordination of benefits provisions apply to only one of the two, each of the parts is a separate Plan.

Plan shall not include individual or family policies or individual, or family subscriber contracts.

This Plan is the part of the Policy which provides benefits for medical care.

Allowable Expense means any medically necessary and reasonable and customary expense for health care, when the expense is covered at least in part by one or more Plans covering the person for whom claim is made.

When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered as both Allowable Expense and a benefit paid.

Claim Determination Period means a calendar year.

B. Effect on the Benefits of this Plan

This section applies when, in accordance with the Order of Benefit Determination Rules, this Plan is a Secondary Plan as to one or more other Plans. In that event, the benefits of this Plan may be reduced under this section. Such other Plan or Plans are referred to as "the other Plans" in the following paragraphs.

The benefits of this Plan will be reduced when the sum of:

1. The benefits that would be payable for the Allowable Expenses under this Plan in absence of this coordination of benefits provision; and
2. The benefits that would be payable for the Allowable Expenses under the other Plans, in the absence of provisions with a purpose like that of this coordination of benefits provision, whether or not claim is made,

exceeds those Allowable Expenses in a Claim Determination Period. In that case, the benefits of this Plan will be reduced so that they and the benefits payable under the other Plans do not total more than those Allowable Expenses. When the benefits of this Plan are reduced, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of this Plan.

C. Order of Benefit Determination Rules

1. The benefits of the Plan which covers the person as an employee, member or subscriber (that is, other than as a dependent) are determined before those of the Plan which covers the person as a dependent.
2. Except as stated in 3. below, the benefits of a Plan which covers the person on whose expenses claim is based as a dependent child of a parent whose date of birth (excluding year of birth) occurs earlier in a calendar year shall be determined before the benefits of a Plan which covers such person as dependent child of a parent whose date of birth (excluding year of birth) occurs later in a calendar year. If both parents have the same date of birth (excluding year of birth), the benefits of the Plan which covered the parent longer are determined before the benefits of the Plan which covered the parent for a shorter time. However, if the other Plan does not have this rule, but instead has a rule based upon the gender of the parent and, if as a result, the Plans do not agree on the order of benefits, the rule in the other Plan will determine the order of benefits.

3. If two or more Plans cover a person as a dependent child of divorced or separated parents, benefits for the child are determined in this order:
 - a. First, the Plan of the parent with custody of the child;
 - b. Then, the Plan of the spouse of the parent with custody of the child; and
 - c. Finally, the Plan of the parent not having custody of the child.

However, if the specific terms of a court decree state that one of the parents is responsible for health care expenses of the child, the benefits of that Plan are determined first.

4. The benefits of a Plan which covers a person as an employee who is neither laid off nor retired (or as that employee's dependent) are determined before those of a Plan which covers that person as a laid off or retired employee (or as that employee's dependent). If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of the benefits, this rule 4. is ignored.
5. If none of the above rules determines the order of benefits, the benefits of the Plan which covered an employee, member or subscriber for the longer period of time are determined before those of the Plan which covered that person for the shorter period of time. The following rules shall apply to determine the length of time a person has been covered under a Plan:
 - a. Two successive plans will be considered one continuous plan if a person is eligible for coverage under the second plan within 24 hours after the first plan terminated. A change in the amount or scope of benefits provided by a plan, a change in the carrier insuring the plan or a change from one type of plan to another does not, of itself, establish the start of a new plan for purposes of paragraph 5.
 - b. If a person became effective after the effective date of the current group plan and there is no information to the contrary, the length of time for such person shall be measured from his/her effective date under the current plan. If a person became effective on the effective date of current group plan, the length of time for such person shall be measured from his/her original effective date under any prior plans the group may have had. If such date cannot be determined, the length of time shall be measured from his/her effective date under the current plan.

D. Right to Receive and Release Necessary Information

Certain facts are needed to apply these coordination of benefits provisions. The Administrator has the right to decide which facts it needs. We may get the needed facts from or give them to any other organization or person. The Administrator need not tell, or get the consent of, any person to do this. Each person claiming benefits under this Plan must give the Administrator any facts it needs to pay the claim.

E. Facility of Payment

Any payment made under another Plan may include an amount which should have been paid under this Plan. If so, the Administrator may pay that amount to the organization which made that payment. That amount will then be treated as though it were a benefit paid under this Plan. The Administrator will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means the reasonable cash value of benefits provided in the form of services.

F. Right of Recovery

If the amount of the payments made by the Administrator is more than it should have paid under this coordination of benefits provision, we may recover the excess from one or more of the following:

1. The persons we have paid or for whom we have paid;
2. Insurance companies; or
3. Other organizations.

The "amount of payments made" includes the reasonable cash value of any benefits provided in the form of services.

PART ELEVEN: CONDITIONS OF ENROLLMENT

A. Eligibility

1. Employee Eligibility - The persons eligible to enroll as employees are:
 - a. All active, full-time employees including council members.
 - b. All retirees under age 65.
2. Family Member's Eligibility - The following persons are eligible for coverage as Family Members of the Employee:
 - a. The Employee's Spouse.
 - b. Unmarried Children to the 19th birthday.
 - c. Unmarried Children from the 19th to the 23rd birthday who are going to school and who qualify as dependents for federal income tax purposes. Risk Management must receive this information in writing within 31 days of the date the child would otherwise become eligible. ←
 - d. Unmarried Children enrolled before age 23 who, after reaching age 23 depend on the Employee for support and are unable to work due to mental retardation or physical handicap. A Physician must certify this disability in writing. This certification must be received by Risk Management within 31 days of the Child's 23rd birthday. After the Child's 25th birthday, Risk Management may request proof of continuing dependency and disability, but not more often than yearly.

B. Application for Enrollment

1. In addition to the dependents enrolled on the initial application, the Employee must file an application with Risk Management to enroll:
 - a. A new Spouse within a time period ending 31 days after marriage.
 - b. A newly-acquired Child within a time period ending 31 days after the birth or the acquiring of the Child.
2. If the Employee does not file the application timely, the Member will not be covered under the Plan until the first of the following month in which application is received by Risk Management.

C. Effective Dates

If premiums are paid for an eligible person within the time period stated in the Plan, the Effective Date of coverage for that person is:

1. The first day of the month after 30 days' active employment. (This 30 day waiting period is waived for employees who reinstate within 6 months from date of termination.)
2. The date of retirement.

3. Family Member's Effective Date

- a. If the application of a person enrolling as a Employee includes application for an eligible Spouse or Child, coverage for that Spouse or Child begins on the Employee's Effective Date.
- b. For a new Spouse of an Employee who is already enrolled under the Plan, coverage begins on the first day of the month following marriage, but only if an application to enroll the Spouse has been filed within 31 days of marriage.
- c. For a newly-acquired Child (except a newborn) of an Employee who is already enrolled under the Plan, coverage begins on the first day of the month after acquiring the Child, but only if an application to enroll the Child has been filed within 31 days of acquiring the Child.
- d. For a Child born to an Employee or Spouse who is already enrolled under the Plan, coverage begins at birth. This coverage ends on the day following the 31st day of life if Risk Management Department does not receive an application to enroll the Child and any premium charges that are due.
- e. For a Spouse or Child for whom the Employee does not file an application within the time limits stated above under Application for Enrollment, coverage begins the first day of the month following approval of the completed application.

PART TWELVE: TERMINATION OF COVERAGE

No written notice is sent to the member when coverage is cancelled. A Member's coverage is cancelled under the following conditions:

A. Employee

1. On the date the medical plan is cancelled, or
2. On the next premium due date after the Employee no longer meets the eligibility requirements established by the Employer, or
3. At the end of the period for which premium has been paid when the required premium for the next period is not paid, or
4. On the next premium due date after the Employer receives written notice of the Employee's voluntary cancellation of coverage, or
5. When an Employee retires unless the employee is eligible for the Retiree Plan.

If premium is paid, coverage may continue for an Employee who is granted a temporary leave of absence up to two months.

B. Spouse

1. On the date the Employee's coverage is cancelled (except as described under Continuation of Coverage), or
2. On the next premium due date after final decree of divorce, annulment or dissolution of marriage, or

3. At the end of the period for which premium has been paid when the required premium for the next period is not paid.

C. Child

1. On the date the Employee's coverage is cancelled (except as described under Continuation of Coverage), or
2. On the next premium due date after the Child age 19 or over is no longer attending school, no longer qualifies as a dependent for federal income tax purposes or reaches age 23, or
3. On the next premium due date after marriage, or
4. At the end of the period for which premium has been paid when the required premium for the next period is not paid.
5. At the first of the month when a child becomes eligible under the armed forces.

PART THIRTEEN: CONTINUATION OF COVERAGE

- A. After the death of the active Employee, coverage continues for enrolled Family Members for a period of six months or until one of the following occurs:

1. The surviving Spouse remarries, or
2. The Member becomes enrolled under another group health plan, or
3. The Member's coverage cancels as described under Termination of Coverage.

Coverage for all surviving Children is cancelled when coverage of the surviving Spouse is cancelled.

- B. After the death of a retired Employee, coverage continues for enrolled Family Members for a period of six months or until one of the following occurs:

1. The Member turns age 65, or
2. The surviving Spouse remarries, or
3. The Member becomes enrolled under another group health plan.

- C. If eligible Employees stop working because of labor dispute, the Union may arrange for coverage to continue as follows:

1. Premium automatically increases by 20 percent on the premium due date after work stops, or
2. The union is responsible for collecting premiums for at least 75 percent of the Employees who stop work because of the labor dispute. If at any time participation falls below 75 percent, coverage may be cancelled. This cancellation is effective ten days after written notice to the union. The union is responsible for notifying the Employees.
3. Coverage during a labor dispute may continue up to six months. After six months, coverage is cancelled automatically without notice from the Employer.

PART FOURTEEN: GENERAL PROVISIONS

A. Workers' Compensation Insurance

The Plan does not affect any requirement for coverage by workers' compensation insurance. It also does not replace that insurance.

B. Providing of Care

The Employer is not responsible for providing any type of hospital, medical or similar care. Also, the Employer is not responsible for the quality of any type of hospital, medical or similar care received.

C. Non-Regulation of Providers

Benefits provided under the Plan do not regulate the amounts charged by provider of medical care.

D. Benefits Not Transferable

Only eligible Members are entitled to receive benefits under the Plan. The right to benefits cannot be transferred.

E. Independent Contractors

All providers are independent contractors. The Employer is not liable for any claim or demand for damages connected with any injury resulting from any treatment.

F. Availability of Care

If there is an epidemic or public disaster and the Member cannot obtain care, the Employer refunds the unearned part of the premium charge paid by that Member. A written request for that refund and satisfactory proof of need for care must be sent to Employer within 31 days. This payment fulfills the obligation of the Employer under the employee medical plan.

G. Medical Necessity

The benefits of the Plan are provided only for services that are Medically Necessary. The services must be ordered by the attending Physician for the direct care and treatment of a covered illness, injury or condition, except for dental care and lenses following surgery as specifically stated. They must be standard medical practice where received for the illness, injury or condition being treated and must be legal in the United States. When an inpatient stay is necessary, services are limited to those which could not have been performed before admission.

H. Expense in Excess of Benefits

The Employer is not liable for any expense the Member incurs in excess of the benefits of the medical plan.

I. Area of Service

The benefits of the Plan are provided for covered services received anywhere in the world.

J. Payment to Providers

The Administrator pays contracting providers directly for the benefits of the Plan. Also, the Administrator may pay non-contracting providers of service directly when the Member assigns benefits in writing. These payments fulfill the obligation of the Employer to the Member for those services.

K. Notice of Claim

Properly completed claim forms itemizing the services received and the charges must be sent to the Administrator by the member or the provider of service. These claim forms must be received by the Administrator within 12 months of the date services are received. The Employer is not liable for the benefits of the Plan if claims are not filed within this time period. Claim forms must be used; cancelled checks or receipts are not acceptable.

L. Right of Recovery

When the amount paid by the Administrator exceeds the amount for which the Employer is liable under the Plan, the Administrator on behalf of the Employer has the right to recover the excess amount. This amount may be recovered from the Employee, the person to whom payment was made or any other plan.

AMENDMENT TO HEALTH PLAN
#1

Employer: City of Stockton

Effective Date: January 1, 1988

This amendment is to amend the plan.

PART ONE: DEFINITIONS

A. Consultant: Norman C. Harris Insurance Associates
2087 Grand Canal Boulevard
P.O. Box 850
Stockton, CA 95201
(209) 464-3333

Amendment for continuation of coverage under Federal Regulations COBRA.

CONTINUATION OF COVERAGE - COBRA

A. Qualifying events for Continuation Coverage for Members covered under this Plan are:

1. Death of Employee.
2. Termination of Employee's employment for reasons other than gross misconduct.
3. Reduction of Employee working hours resulting in loss of coverage.
4. Divorce or legal separation of Employee from Employee's Spouse.
5. Eligibility of Employee for Medicare.
6. Loss of a Child's dependent status under requirements of the plan.

B. Notice of Continuation Coverage

1. The Employer provides written notice, at the time coverage commences under the Plan, to each Employee and Spouse of Employee of their right and their dependent Children's right to elect Continuation Coverage when eligible.
2. The Employer provides written notice of Continuation Coverage to the Plan Consultant within 30 days from the date of Employee's
 - a. Death, or
 - b. Termination of employment, or
 - c. Reduction of work hours resulting in loss of coverage, or
 - d. Eligibility for Medicare benefits.

3. The Family Member must provide notice to the Employer of the following:
 - a. Member's divorce or legal separation, or
 - b. Member's loss of eligibility as a dependent Child under this Plan because of age or marriage.
4. The Employer (itself or by its Plan Consultant) provides notice of Continuation Coverage to the Member within 14 days of the date of receipt of notice of any qualifying event.
5. The Member must provide notice to the Employer of the Member's intention to elect Continuation Coverage within 60 days from the date notice to elect Continuation Coverage is received from either the Employer or the Plan Consultant.
6. The Consultant provides notice of a Member's election of Continuation Coverage to Employer together with payment of appropriate subscription charges, within 45 days following, but in no event later than the end of a period of 150 days after the occurrence of a qualifying event, in order for that Member to be entitled to Continuation Coverage.

C. Payment of Premium Charges

The Consultant is responsible to Employer for the timely payment of subscription charges due for the continuation of any Member's coverage under this Plan.

D. Commencement of Continuation Coverage

1. Employee

If the Employer receives timely notice of an election of Continuation Coverage, together with timely payment of appropriate subscription charges, a Continuation Coverage period not to exceed 18 months for Employee and/or Family Members for whom Continuation Coverage is elected by the Employee, and who were enrolled under this Plan at the time of the qualifying event, will commence upon:

- a. Reduction in Employee's working hours resulting in loss of coverage.
- b. Employee's termination from employment for reasons other than gross misconduct.

2. Spouse

If the Employer receives timely notice of an election of Continuation Coverage, together with timely payment of appropriate premium charges, a Continuation Coverage period not to exceed 36 months for a Spouse and any dependent Children for whom Continuation Coverage is elected, and who were enrolled under this Plan at the time of the qualifying event, will commence upon:

- a. The death of Employee, or
- b. Notice of legal separation, final decree of divorce, annulment or dissolution of marriage between Employee and enrolled Spouse, or
- c. Employee eligibility for Medicare.

3. Dependent Children

If Employer receives timely notice of an election of Continuation Coverage, together with timely payment of appropriate premium charges, a Continuation Coverage period not to exceed 36 months for dependent Children enrolled under this Plan at the time of the qualifying event will commence upon:

- a. Loss of eligibility because of age or marriage, or
- b. Any one of the conditions listed above (except when Children of a divorced or legally separated Spouse of a Employee remain enrolled as Family Members of that Employee).

E. Termination of Continuation Coverage

1. Employee

Continuation Coverage which commenced under paragraph D.1., above, for a Employee and/or any Family members of the Employee will terminate at the end of the period for which premium charges have been paid when the first of the following events occurs:

- a. A period of 18 months has elapsed, or
- b. This Plan is cancelled, or
- c. The required premium charges for the next period are not paid, or
- d. The Member becomes eligible for Medicare, or
- e. The Member becomes covered as an employee under another group health plan, or
- f. The Employer receives written notice of the Member's voluntary cancellation of coverage.

2. Spouse and Dependent Children

Continuation Coverage which commences under either paragraph D.2. or D.3., above, will terminate for the Spouse and Dependent Children at the end of the period for which premium charges have been paid when the first of the following events occurs:

- a. A period of 36 months has elapsed, or
- b. This Plan is cancelled, or
- c. The required premium charges for the next period are not paid, or
- d. The Member becomes eligible for Medicare, or
- e. The Member becomes eligible for coverage under any other group health plan, or
- f. The Employer receives written notice of the Member's voluntary cancellation of coverage.

F. Other Provisions Applicable to Continuation Coverage:

1. A new Spouse or dependent of a Member enrolled under Continuation Coverage is not eligible for Continuation Coverage (except a Child born during the period the Employee is receiving Continuation Coverage. Such newborns are covered for the first 31 days of life for care of illness or injury. TO CONTINUE COVERAGE, THE NEWBORN MUST BE ENROLLED AS A FAMILY MEMBER WITHIN 60 DAYS, AND CONTINUATION COVERAGE OF THE CHILD WILL TERMINATE WHEN HIS OR HER PARENT'S CONTINUATION COVERAGE ENDS).
2. For the purposes of determining the proper premium charges for Continuation Coverage:
 - a. A Spouse whose Continuation Coverage commences under paragraph d.2, above, will be considered a Employee, and
 - b. A Child whose Continuation Coverage commences under paragraph D.3., above, will be considered a Employee.
3. If a Member is covered under another carrier's continuation coverage when the Group changes coverage to this plan, the term of Continuation Coverage provided to that Member under the plan will be reduced by the period coverage was continued under the prior carrier's plan.

AMENDMENT TO HEALTH PLAN
#2

Employer: City of Stockton

This amendment is to amend the plan.

For those employees who retired prior to January 1, 1985, prescriptions are covered under the Medical portion of the contract, Major Medical Benefits. You must meet the calendar year deductible and benefit payments will be paid at 80% of covered charges.

All contract exclusions and limitations apply including eligibility, coordination of benefits, and treatment for those covered illnesses, disease or injury as specified in the master plan.

PART FOUR: MAJOR MEDICAL BENEFITS

E. COVERED EXPENSE

Includes the following additions to Item 3 - Additional Services and Supplies:

- h. Drugs and medicines approved for general use by the Food and Drug Administration that are available only if prescribed by a Physician. The drug or medicine must be dispensed by a Physician or a licensed pharmacist. Drugs prescribed for Mental or Nervous Disorders and substance abuse are included.
- i. Injectable insulin prescribed by a Physician.

Also, PART FIVE: PRESCRIPTION DRUG BENEFITS in its entirety does not apply to this employee group.

11/8/88

3. Family Member's Effective Date

a. If the enrollment card of a person enrolling as an employee includes coverage for an eligible spouse or child, coverage for that spouse or child begins on the employee's effective date.

b. For a new spouse of an employee who is already enrolled under the plan, coverage begins on the date of marriage, but only if the enrollment card has been filed within 31 days of the date of marriage.

c. For newly acquired child (except a newborn) of an employee who is already enrolled under the plan, coverage begins on the date you acquire the child, but only if the enrollment card to add the child has been filed within 31 days of acquiring the child.

d. For a child born to an employee or spouse, who is already enrolled under the plan, coverage begins at birth. This coverage ends on the date following 31 days of life if the Risk Management Department does not receive the enrollment card to enroll the child.

e. For a spouse or child for whom the employee does not file an enrollment card within the time limit stated above, coverage begins the first of the month following completion of the enrollment card.