SISC

Self-Insured Schools of California

Schools Helping Schools

COMPANIONCARE PLAN

October 1, 2023

Benefit Booklet

SPD00121/40003A/2530 (10/23)

Dear Plan Member:

This Benefit Booklet

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COMPLAINT NOTICE

All complaints and disputes relating to coverage under this *plan* must be resolved in accordance with the grievance procedures. Grievances may be made by telephone (please call the Member Services number on your Identification Card) or in writing (write to the Member Services Department named on your identification card marked to the attention of the Member Services Department). If you wish, the Member Services will provide a Complaint Form which you may use to explain the matter.

Claims Administered by:

ANTHEM BLUE CROSS

on behalf of

ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY

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YOUR BENEFITS

This plan requires that the member maintains enrollment in both parts of Medicare, A and B with no break in coverage, and also maintains MedD pharmacy coverage through SISC with no break in coverage. This is a packaged plan that requires enrollment in both this medical plan and the corresponding SISC pharmacy plan. If either the Medicare Parts A and/or B related to the medical plan or MedD pharmacy coverages terminates, both Companion Care and MedD portions will terminate the same day. The benefits described in this *benefit booklet* are payable only for covered services to supplement *Medicare* benefits, except as specifically stated in HOSPITAL BENEFITS AFTER MEDICARE IS EXHAUSTED and BENEFITS OUTSIDE THE UNITED STATES.

The benefits of this *plan* are provided only for services that *Medicare* determines to be allowable and

The Plan Pays:

The *Medicare* Part A deductible.

Benefits (UP TO

If you choose to use the 60-day lifetime reserve, the *Medicare co-payment* for *hospital stays* from the 91st through 150th day.

SKILLED NURSING FACILITY BENEFITS

You Pay:

Any additional *skilled nursing facility* services you receive after *Medicare* has paid the 100 day maximum allowance during a *benefit period* for these services.

Medicare Pays:

When you are admitted within 30 days of a covered inpatient *hospital stay* of three or more consecutive days, covered Part A services for up to 100 days for each *benefit period*, EXCEPT FOR THE *MEDICARE CO-PAYMENT* FROM THE 21ST TO THE 100TH DAY. *MEDICARE* DOES NOT PAY FOR SERVICES BEYOND THE 100TH DAY DURING A

20% of Allowable Charge amount for the covered *hospital* outpatient services listed below.

Covered Services:

Outpatient medical care.

Outpatient surgical treatment.

Radiation therapy, chemotherapy and hemodialysis treatment.

PROFESSIONAL SERVICES AND SUPPLIES

(Part B Professional Services Only)

The *plan* provides a different payment allowance for Part B Professional services described under this *plan* when you receive these services from a *physician* or *participating provider*. *Participating providers* have agreed to accept our *negotiated rate* as payment in full for covered services. A list of *participating providers* is available from us on request.

Professional Services of a Participating Provider:

When you receive Professional services from a *participating provider*, that provider has agreed to accept the and *Medicare's* combined payments as payment in full. You will be responsible only for charges in excess of the yearly maximum allowances stated in the section entitled COVERED SERVICES, and charges for services that are not covered.

Professional Services of a Non-Participating Provider:

When you receive Professional services from a *non-participating provider*, that provider is not obligated to accept the and *Medicare's* combined payments as payment in full, and may bill you for the balance of any unpaid charges. However, some *physicians* accept assignment of *Medicare* benefits. A *physician* who accepts *Medicare* assignment may not collect more than *Medicare's* Allowable Charge.

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Medicare Pays:

80% of

Professional Services and Supplies *(Non-Participating Providers)*

You Pay:

Amounts in excess of our yearly maximum benefits for certain services as stated in the section entitled COVERED SERVICES.

Amounts in excess of Allowable Charge amount.

Medicare Pays:

80% of Allowable Charge for covered professional services and supplies.

The Plan Pays:

The *Medicare* Part B deductible.

When Professional Services are rendered by a *non-participating provider* (whether or not the *physician* or provider accepts *Medicare* assignment):

20% of *Medicare's* Allowable Charge for covered professional services and supplies, subject to the stated maximums described in the section entitled COVERED SERVICES.

Note: *Non-participating providers* may not consider the combined *Medicare* and the *plan* payments noted above to be payment in full, and may bill you for the balance of any unpaid charges. You will be responsible for billed amounts in excess of allowable charge, and charges in excess of the stated maximums in the section entitled COVERED SERVICES.

Special Note Regarding *Participating* or *Non-Participating Providers* Who Accept *Medicare*

A *physician's* services for home or office visits.

Diagnostic radiology and laboratory services.

Routine and diagnostic mammograms, mastectomy, complications from a mastectomy, reconstructive surgery of both breasts following mastectomy, and breast prostheses following mastectomy.

Medical supplies, rental or purchase

BENEFITS OUTSIDE THE UNITED STATES

The *plan* provides the benefits listed below when you require medical care outside the *United States* during a temporary absence of less than six (6) months. These benefits are subject to all provisions of the *plan*, which may limit benefits or result in benefits not being payable.

Special Instructions for Foreign Claims Submission

When you submit a claim to the *claims administrator* for medical care services rendered outside the *United States*, you must include any canceled checks, receipts or other documents you receive in connection with those services along with your properly completed claim form.

If you receive drugs or medicines during an inpatient or outpatient hospital admission outside the *United States*, you should ask the provider of service to include the chemical or generic name of the drug on your bill.

INPATIENT HOSPITAL SERVICES

Your *hospital* care must be rendered in a facility which is properly licensed and accredited as a *hospital* in the country where services are rendered. The *plan* provides benefits for services of a *hospital* as follows:

1. Days Covered

THE COVERED SERVICES LISTED BELOW ARE LIMITED TO A TOTAL OF 90 DAYS FOR EACH *HOSPITAL STAY*. IF THERE ARE FEWER THAN 60 DAYS BETWEEN *HOSPITAL STAY*S, THAT ENTIRE PERIOD WILL BE CONSIDERED TO BE ONE *HOSPITAL STAY*.

2. Payment

The *plan* provides payment for **100%** of billed *reasonable charges* for *medically necessary* inpatient services listed below when provided by a *hospital*. You pay any amounts in excess of *reasonable charges*.

3. Covered Services

The following services of a *hospital* are covered:

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.

Services in *special care units*.

Operating and special treatment rooms.

Supplies and ancillary services including laboratory, cardiology, pathology, radiology and any professional component of these services.

Physical therapy, radiation therapy, chemotherapy and hemodialysis treatment.

Drugs and medicines (equivalent to those approved for general use by the Food and Drug Administration in the *United States*) which are supplied by the *hospital* for use during your *stay*.

Blood transfusions, but not the cost of blood, blood products or blood processing.

4. **Conditions of Service**

Services must be those which are regularly provided and billed by a *hospital*.

Services are provided only for the number of days required to treat your illness, injury or condition.

OUTPATIENT HOSPITAL SERVICES

1. Payment

The *plan* provides payment for **100%** of billed *reasonable charges* for *medically necessary* outpatient services listed below when provided by a *hospital*. You pay any amounts in excess of *reasonable charges*.

2. Covered Services

Emergency room use, supplies, ancillary services, drugs and medicines as listed under Inpatient Hospital Covered Services.

Care received when outpatient surgery is performed. Covered services are operating room use, supplies, ancillary services, drugs 2 TfloBT/F1 10.02 Tf1 0 0 1 235.82 215.3 Tm0 g0 G[ )]TJETQq0.4

3. **Conditions of Service**

Services must be those which are regularly provided and billed by a *hospital*.

Emergency room care must be for the first treatment of an *emergency*.

PROFESSIONAL MEDICAL BENEFITS

Your professional medical care must be rendered by a provider who is properly licensed and accredited as a *physician* in the country where services are provided. The *plan* provides benefits for professional medical services as follows:

1. **Payment**

The *plan* provides payment for **100%** of covered expense incurred for *medically necessary* services listed below. Covered expense is expense incurred for a covered service, but not more than a *reasonable charge*.

2. **Covered Services**

Surgery and surgical assistance.

Anesthesia during surgery.

Visits during a covered *hospital stay* (except those relating to surgery), limited to one per day unless additional visits are needed due to your medical condition.

EXCLUSIONS AND LIMITATIONS

No payment will be made under this *plan* for expenses incurred for or in connection with any of the items below. (The titles given to these exclusions and limitations are for ease of reference only; they are not meant to be an integral part of the exclusions and limitations and do not modify their meaning).

Not Medically Necessary. Services or supplies that are not *medically necessary*, as defined.

Experimental or Investigative. Any *experimental* or *investigative* procedure or medication.

Services outside the United States. Services and supplies provided outside the *United States*, except as specifically stated in the section entitled BENEFITS OUTSIDE THE UNITED STATES.

Crime or Nuclear Energy. Conditions that result from: (1) your commission of or attempt to commit a felony; or

Services of Relatives. Professional services received from a person who lives in your home or who is related to you by blood or marriage.

Voluntary Payment. Services for which you have no legal obligation to pay, or for which no charge would be made in the absence of insurance coverage or other health plan 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;
2. At least **10%** of its yearly budget must be spent on research not directly related to patient care;
3. At least one-third of its gross income must come from donations or grants other than gifts or payments for patient care;
4. It must accept patients who are unable to pay; and
5. Two-thirds of its patients must have conditions directly related to the *hospital's* research.

Private Contracts. Services or supplies provided pursuant to a private contract between the *member* and a provider, for which reimbursement under the Medicare program is prohibited, as specified in Section 1802 (42 U.S.C. 1395a) of Title XVIII of the Social Security Act.

Inpatient Diagnostic Tests. 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.

Mental or Nervous Disorders or Substance Abuse. Academic or educational testing, counseling, and remediation. Any treatment of *mental or nervous disorders* or substance abuse, including rehabilitative care

Custodial Care and Rest Cures. Inpatient room and board charges in connection with a *hospital stay* primarily for environmental change or physical therapy. *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* HOSPITAL INPATIENT BENEFITS (PART A).

Exercise Equipment. Exercise equipment, or any charges for activities, instrumentalities, or facilities normally intended or used for developing or maintaining physical fitness, including, but not limited to, charges from a physical fitness instructor, health club or gym, even if ordered by a *physician*.

Personal Items. Any supplies for comfort, hygiene or beautification.

Education or Counseling. Any educational treatment, nutritional counseling or food supplements. Any services that are educational, vocational, or training in nature except as specifically provided or arranged by the *claims administrator*.

Telephone, Facsimile Machine and Electronic Mail Consultations. Consultations provided using telephone, facsimile machine , or electronic mail.

Routine Exams or Tests. Routine physical exams or tests which do not directly treat an actual illness, injury or condition, including those required by employment or government authority, except as specifically MEDICAL BENEFITS (PART B).

Acupuncture. Acupuncture, acupressure, or massage to control pain, treat illness or promote health by applying pressure to one or more specific areas of the body based on dermatoses or acupuncture points.

Eye Surgery for Refractive Defects. Any eye surgery solely or primarily for the purpose of correcting refractive defects of the eye such as near-sightedness (myopia) and/or astigmatism. Contact lenses and eyeglasses required as a result of this surgery.

Outpatient Prescription Drugs and Medications. Outpatient prescription drugs or medications and insulin. Any non-prescription, over-the-counter patent or proprietary drug or medicine. Cosmetics, dietary supplements, health or beauty aids.

Contraceptive Devices. Contraceptive devices prescribed for birth control except as specifically stated MEDICAL BENEFITS (PART B).

Private Duty Nursing. Inpatient or outpatient services of a private duty nurse.

Lifestyle Programs. exercise, imagery or nutrition. This exclusion will not apply to cardiac rehabilitation programs approved by the *claims administrator*.

Scalp hair prostheses. Scalp hair prostheses, including wigs or any form of hair replacement.

Clinical Trials. Services and supplies provided in connection with a clinical trial except for routine costs associated with a clinical trial for which *Medicare* provides benefits.

Medicare Part B Deductible. Any charges you incur that are applied toward your *Medicare* Part B deductible.

SUBROGATION AND REIMBURSEMENT

These provisions apply when the *plan* pays benefits as a result of injuries or illnesses you sustained and you have a right to a Recovery or have received a Recovery from any source.

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and/or automobile medical payments coverage, whether by lawsuit, settlement or otherwise. Regardless of how you or your representative or any agreements characterize the money you receive as a Recovery, it shall be subject to these provisions.

Subrogation

The *plan* has the right to recover payments it makes on your behalf from any party responsible for compensating you for your illnesses or injuries. The following apply:

The *plan* has first priority from any Recovery for the full amount of benefits it has paid regardless of whether you are fully compensated, and regardless of whether the payments you receive make you

You must not do anything to prejudice the *plan*'s rights.

You must send the *plan* copies of all police reports, notices or other papers received in connection with the accident or incident resulting in personal injury or illness to you.

You must promptly notify the *plan* if you retain an attorney or if a lawsuit is filed on your behalf.

You must immediately notify the *plan* if a trial is commenced, if a settlement occurs or if potentially dispositive motions are filed in a case.

The *plan administrator* has sole discretion to interpret the terms of the Subrogation and Reimbursement provision of this *plan* in its entirety and reserves the right to make changes as it deems necessary.

parent, or other representative, shall be subject to this provision. Likewise, if the relatives, heirs, and/or assignees make any Recovery because of injuries sustained by the covered person, that Recovery shall be subject to this provision.

The *plan* this provision.

The *plan* shall be secondary in coverage to any medical payments provision, no-fault automobile insurance policy or personal injury protection policy regardless of any election made by you to the contrary. The *plan* shall also be secondary to any excess insurance policy, including, but not limited to, school and/or athletic policies.

COORDINATION OF BENEFITS

If you are covered by more than one group health plan, your benefits under This Plan will be coordinated with the benefits of those Other Plans. These coordination provisions apply separately to each *member*, per *calendar year*, and are largely determined by California law. Any coverage you have for medical or dental benefits will be coordinated as shown below.

DEFINITIONS

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

Allowable Expense is any necessary, reasonable and customary item of expense which is at least partially covered by any plan covering the person for whom claim is made. When a Plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered will be deemed to be both an Allowable Expense and a benefit paid. An expense that is not covered by any plan covering the person for whom a claim is made is not Allowable Expense.

The following are not Allowable Expense:

1. Use of a private hospital room is not an Allowable Expense unless the patient's stay in a private *hospital* room is *medically necessary* in terms of generally accepted medical practice, or one of the plans routinely provides coverage for *hospital* private rooms.

2.

Other Plan is any of the following:

1. Group, blanket or franchise insurance coverage;
2. Group service plan contract, group practice, group individual practice and other group prepayment ;
3. Group coverage under labor-management trusteed plans, union benefit organization plans, employer organization plans, employee benefit organization plans or self-insured employee benefit plans.

The term "Other Plan" refers separately to each agreement, policy, contract, or other arrangement for services and benefits, and only to that portion of such agreement, policy, contract, or arrangement which reserves the right to take the services or benefits of other plans into consideration in determining benefits.

Principal Plan is the plan which will have its benefits determined first.

This Plan is that portion of this *plan* which provides benefits subject to this provision.

EFFECT ON BENEFITS

1. If This Plan is the Principal Plan, then its benefits will be determined first without taking into account the benefits or services of any Other Plan.
2. If This Plan is not the Principal Plan, then its benefits may be reduced so that the benefits and services of all the plans do not exceed Allowable Expense.
3. The benefits of This Plan will never be greater than the sum of the benefits that would have been paid if you were covered under This Plan only.

ORDER OF BENEFITS DETERMINATION

The first of the following rules which applies will determine the order in which benefits are payable:

1. A plan which has no Coordination of Benefits provision pays before a plan which has a Coordination of Benefits provision.
2. A plan which covers you as a *subscriber* pays before a plan which covers you as a dependent. But, if you are a Medicare beneficiary and also a dependent of an employee with current employment status under another plan, this rule might change.
   plan which covers you as a dependent, then the plan which covers you as a dependent pays before a plan which covers you as a *subscriber*.

   For example: You are covered as a retired *employee* under this plan and a Medicare beneficiary (Medicare would pay first, this plan would pay second). You are also covered as a dependent of an active employee under another plan provided by an employer group of 20 or more employees (then, according to Medic In this situation, the plan which covers you as a dependent of an

3. For covered drugs, including drugs covered under the pharmacy plan. The *plan* will pay secondary to Medicare for

HOW COVERAGE BEGINS AND ENDS

HOW COVERAGE BEGINS

ELIGIBLE STATUS

1. **Subscriber.** You are eligible to enroll as a *subscriber* if you are a *retired employee* who is actively enrolled under both Part A and Part B of *Medicare*. A *retired employee* is retired from active full-time employment, is eligible to receive health plan benefits as part of the pension plan and was covered under a sponsored health plan immediately prior to retirement.

2. **Dependents.** The *subscriber* *spouse*, *domestic partner* or unmarried *child* are eligible to be enrolled as a *dependent*, provided that the *spouse, domestic partner* or unmarried *child* is actively enrolled under Part A and Part B of *Medicare*.

Note: Any *member* that is on a retiree SISC *plan* is required to enroll in Medicare Part A and B when eligible to enroll and stay enrolled.

Definition of Dependent

1. **Spouse** is the *subscriber*

f. Either of the following:

   i. Both persons are members of the same sex; or

   ii. One or both of the persons meet the eligibility criteria under Title II of the Social Security Act as defined in 42 U.S.C. Section 402(a) for old-age insurance benefits or Title XVI of the Social Security Act as defined in 42 U.S.C. Section 1381 for aged members. Notwithstanding any other provision of this section, persons of opposite sexes may not constitute a domestic partnership unless one or both of the persons are over the age of 62 and are registered with the State of California.

g. Both persons are capable of consenting to the domestic partnership.

h. Neither person has previously filed: (1) a Declaration of Domestic Partnership with the California Secretary of State, or a similar form with another governing jurisdiction, that has not been terminated pursuant to the laws of California, or of that other jurisdiction; or, if (1) does not apply, (2) an affidavit with SISC III declaring they are part of a domestic partnership that they have not been terminated by giving SISC III written notice that it has.

i. It has been at least six months since: (1) ate Notict of tion of Domestic

Note: For the purposes of 2.j.i above, if the *subscriber*

adoption.

Legal evidence to control the health care of the child means a written document, including, but not limited to, a health facility minor release report, a medical authorization form, or relinquishment

document, other evidence of the *subscriber* *spouse* right to control the health care of the child.

d. A child for whom the *subscriber,*

ELIGIBILITY DATE

For *subscribers*, you become eligible for coverage on the first day of the month coinciding with or following the date you retire, provided your enrollment application is received on a timely basis. For the *subscriber spouse*, *domestic partner* or unmarried *child*, you become eligible on the later of (a) the date the *subscriber* becomes eligible for coverage or (b) the date the *spouse*, *domestic partner* or unmarried *child* meets the definition of a *spouse*, *domestic partner* or unmarried *child*, respectively.

ENROLLMENT

To enroll as a *subscriber,* or to enroll *dependents,* the *subscriber* must properly file an enrollment application. An enrollment application is considered properly filed, only if it is personally signed, dated, and given to the *plan administrator* within 45 days from your eligibility date. If any of these steps are not followed, your coverage may be denied.

EFFECTIVE DATE

Subject to the timely payment of the required monthly contributions, your coverage will begin as follows:

1. **Timely Enrollment.** If your enrollment application is personally signed, dated, and received by the *plan administrator* 45 days prior to your eligibility date, then your coverage will begin as follows: (a) for *subscribers*, on your eligibility date; and (b) for *dependents*, on the later of (i) the date the coverage begins, or (ii) the first day of the month after the *dependent* becomes eligible. If you become eligible before the *plan* takes effect, coverage begins on the effective date of the *plan,* provided the enrollment application is on time and in order.

2. **Disenrollment.** If you voluntarily choose to disenroll from coverage under this *plan*, you must wait until the next Open Enrollment Period to enroll. You may enroll earlier than the next Open Enrollment Period if you meet any of the conditions listed under SPECIAL ENROLLMENT PERIODS.

Important Note for Newborn and Newly-Adopted Children. If the *subscriber* (or *spouse* or *domestic partner*, if the

Loss of eligibility for coverage under an employer group health plan or health insurance includes loss of eligibility due to termination of employment or change in employment status, reduction in the number of hours worked, loss of dependent status under the terms of the *plan*, termination of the other plan, legal separation, divorce, death of the person through whom you were covered, and any loss of eligibility for coverage after a period of time that is measured by reference to any of the foregoing.

ii. If the other health plan was a state Medicaid plan or a state child health insurance program (SCHIP), including the Healthy Families Program or the Access for Infants and Mothers (AIM) Program, coverage ended because you lost eligibility under the program. You must properly file an application with the SISC III within 60 days after the date your coverage ended.

d. You properly file an application with SISC III within 31 days from the date on which you lose coverage.

2. A court has ordered coverage be provided under your employee health plan for: (i) a *spouse*; or (ii) a *domestic partner* or dependent *child*, but only if the *domestic partner* or dependent *child* meet the eligibility requirements of the *plan.* Application must be filed within 31 days from the date the court order is issued.

3. The *claims administrator* does not have a written statement from the *plan administrator* stating that prior to declining coverage or disenrolling, you received and signed acknowledgment of a written notice specifying that if you do not enroll for coverage within 31 days after your eligibility date, or if you disenroll, and later file an enrollment application, your coverage may not begin until the first day of the month following the end of the next open enrollment period.

4. You have a change in family status through marriage or establishment of a domestic partnership or the birth, adoption, or placement for adoption of a *child*. You may also enroll a new *spouse*, *domestic partner* or *child* at that time. You must enroll within 31 days of the date of the marriage, establishment of the domestic partnership or the birth, adoption, or placement for adoption of a *child*.

5. You meet or exceed a lifetime limit on all benefits under another health plan. Application must be made within 31 days of the date a claim or a portion of a claim is denied due to your meeting or exceeding the lifetime limit on all benefits under the other plan.

6. You become
plan, under a state Medicaid or SCHIP health plan, including any waiver or demonstration project conducted under or in relation to these plans. You must properly file an application with the *group* within 60 days after the date you are determined to be eligible for this assistance.

Effective date of coverage. For enrollments during a special enrollment period as described above, coverage will be effective on the first day of the month following the date you file the enrollment application.

If SISC III does not complete the determination of the continuing eligibility by the date the *child* reaches the upper age limit, the *child* will remain covered pending the determination. When a period of two years has passed, SISC III may request proof of continuing dependency due to a continuing physical or mental condition, but not more often than once each year. This exception will last until the *child* is no longer chiefly dependent on the *subscriber*, *spouse* or *domestic partner* for support and maintenance or a physical or mental condition no longer exists. A *child* is considered chiefly dependent for support and maintenance if he or she qualifies as a dependent for federal income tax purposes.

Note: If a marriage or domestic partnership terminates, the *subscriber* must give or send to SISC III written notice of the termination. Coverage for a former *spouse* or *domestic partner*, if any, ends according to the If SISC III suffers a loss as a result of the *subscriber* failing to notify them of the termination of their marriage or domestic partnership, SISC III may seek recovery from the *subscriber* for any actual loss resulting thereby. Failure to provide written notice to SISC III will not delay or prevent termination of the marriage or domestic partnership. If the *subscriber* notifies SISC III in writing to cancel coverage for a former *spouse* or *domestic partner*, if any, immediately upon termination of the *subscriber* marriage or domestic partnership, such notice will be considered compliance with the requirements of this provision.

You may be entitled to continued benefits under terms which are specified elsewhere under CONTINUATION OF COVERAGE and EXTENSION OF BENEFITS.

CONTINUATION OF COVERAGE

Most employers who employ 20 or more people on a typical business day are subject to The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). If the employer who provides coverage under the *plan* is subject to the federal law which governs this provision (Title X of P. L. 99-272), you may be entitled to a continuation of coverage. Check with your *plan administrator* for details.

DEFINITIONS

The meanings of key terms used in this section are shown below. Whenever any of the terms shown below appear in these provisions, the first letter of each word will be capitalized. When you see these capitalized

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

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

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

1. **For Subscribers and the Spouse:**

   a. The *subscriber* termination of employment, for any reason other than gross misconduct; or

   b. reduction in the *subscriber* work hours.

2. **For Retired Employees and their Dependents.** Cancellation or a substantial reduction of retiree benefits under the *plan* due to the *plan* filing for Chapter 11 bankruptcy, provided that:

   a. The *plan* expressly includes coverage for retirees; and

   b. Such cancellation or reduction of benefits occurs within one year before or after the *plans* filing for bankruptcy.

3. **For Dependents:**

   a. The death of the *subscriber;*

   b. The divorce or legal separation from the *subscriber*; or

   c. The end of a *do* partnership with the *subscriber.*

ELIGIBILITY FOR COBRA CONTINUATION

A *subscriber* or enrolled *dependent* may choose to continue coverage under the *plan* if coverage would otherwise end due to a Qualifying Event.

TERMS OF COBRA CONTINUATION

Notice. The *plan administrator* will notify either the *subscriber* or *dependent* of the right to continue coverage under COBRA, as provided below:

1. For Qualifying Events 1 or 2, the *plan administrator* or its administrator will notify the *subscriber* of the right to continue coverage.

2. For Qualifying Event 3(a), the *spouse* will be notified of the COBRA continuation right.

3. You must inform the *plan administrator* within 60 days of Qualifying Event 3(b) if you wish to continue coverage. The *plan administrator* in turn will promptly give you official notice of the COBRA continuation right.

If you choose to continue coverage you must notify the *plan administrator* within 60 days of the date you receive ceive ceive ceive ceive ceive

Subsequent Qualifying Events. Once covered under the COBRA continuation, it's possible for a second Qualifying Event to occur.

may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

EXTENSION OF CONTINUATION DURING TOTAL DISABILITY

If at the time of termination of employment or reduction in hours, or at any time during the first 60 days of the COBRA continuation, a Qualified Beneficiary is determined to be disabled for Social Security purposes, all covered *members* may be entitled to up to 29 months of continuation coverage after the original Qualifying Event.

Eligibility for Extension. To continue coverage for up to 29 months from the date of the original Qualifying Event, the disabled *member* must:

1.

d. A period of up to 12 months has passed since your extension began.

GENERAL PROVISIONS

Providing of Care. We are not responsible for providing any type of *hospital*, medical or similar care, nor are we responsible for the quality of any such care received.

Independent Contractors. The relationship with providers is that of an independent contractor. *Physicians* and other health professionals, *hospital*s, *skilled nursing facilities* and other community agencies are not the agents nor is the *claims administrator*, or any of the employees of the *claims administrator*, an employee or agent of any *hospital*, medical group or medical care provider of any type.

Non-Regulation of Providers. The benefits of this *plan*

Availability of Care. If there is an epidemic or public disaster and you cannot obtain care for covered services, we refund the unearned part of the required monthly contribution paid. A written request for that refund and satisfactory proof of the need for care must be sent to us within 31 days. This payment fulfills our obligation under this *plan*.

Medical Necessity. The benefits of this *plan* are provided only for services which the *claims administrator* determines to be *medically necessary*. The services must be ordered by the attending *physician* for the direct care and treatment of a covered condition. They must be standard medical practice where received for the condition being treated and must be legal in the United States. The process used to authorize or deny health care services under this *plan* is available to you upon request.

Expense in Excess of Benefits. We a/F1 10.00000912 0 612 792 reecarliu upndet tsautho9(ts0(n)5(ot 9(o))]ur)-23(o)6(

accordance with applicable laws and regulations. In the event SISC III recovers a payment made in error from the provider, except in cases of fraud or misrepresentation on the part of the provider, SISC III will only recover such payment from the provider within 365 days of the date the payment was made on a claim submitted by the provider. SISC III reserves the right to deduct or offset any amounts paid in error from any pending or future claim.

1. An acute condition. An acute condition is a medical condition that involves a sudden onset of symptoms due to an illness, injury, or other

BINDING ARBITRATION

Any dispute or claim, of whatever nature, arising out of, in connection with, or in relation to this *plan* or breach or rescission thereof, or in relation to care or delivery of care, including any claim based on contract, tort, or statute, must be resolved by arbitration if the amount sought exceeds the jurisdictional limit of the small claims court. Any dispute regarding a claim for damages within the jurisdictional limits of the small claims court will be resolved in such court.

The Federal Arbitration Act shall govern the interpretation and enforcement of all proceedings under this Binding Arbitration provision. To the extent that the Federal Arbitration Act is inapplicable, or is held not to require arbitration of a particular claim, state law governing agreements to arbitrate shall apply.

The *member* and the *plan administrator* agree to be bound by this Binding Arbitration provision and acknowledge that they12 0 >not to 4ch5(e giva)]TJETuJp erniheila riratidsor(a erniriat)8(itratcatiourt.rtacokn)owledge

For claims involving urgent/concurrent care:

the *claims administrator*

Upon request, the *claims administrator* will provide, without charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim.
record, or other information:

was relied on in making the benefit determination; or

was submitted, considered, or produced in the course of making the benefit determination; or

demonstrates compliance with processes and safeguards to ensure that claim determinations are made in accordance with the terms of the *plan*, applied consistently for similarly-situated claimants; or

is a statement of the *plan*

The *claims administrator* will also provide you, free of charge, with any new or additional evidence considered, relied upon, or generated in connection with your claim. In addition, before you receive an adverse benefit determination on review based on a new or additional rationale, the *claims administrator* will provide you, free of charge, with the rationale.

For Out of State Appeals You have to file Provider appeals with the Host Plan. This means Providers must file appeals with the same plan to which the claim was filed.

How Your Appeal will be Decided

When the *claims administrator* considers your appeal, the *claims administrator* will not rely upon the initial benefit determination to the earlier appeal determination. The review will be conducted by an appropriate reviewer who did not make the initial determination and who does not work for the person who made the initial determination.

If the denial was based in whole or in part on a medical judgment, including whether the treatment is experimental, investigational, or not *medically necessary*, the reviewer will consult with a health care professional who has the appropriate training and experience in the medical field involved in making the judgment. This health care professional will not be one who was consulted in making an earlier determination or who works for one who wa06 403.9 3(in3/F3a wh)]m9o.un5(the ea)-35(g)-32(app)3fit dHost Plan.

If your appeal is denied, that denial will be considered an adverse benefit determination. The notification from the *claims administrator* will include all of the information set forth in the above subsection entitled

External Review

If the outcome of the mandatory first level appeal is adverse to you and it was based on medical judgment, you may be eligible for an independent External Review pursuant to federal law.

You must submit your request for External Review to the *claims administrator* within four (4) months of the notice of your final internal adverse determination.

A request for an External Review must be in writing unless the *claims administrator* determines that it is not reasonable to require a written statement. You do not have to re-send the information that you submitted for internal appeal. However, you are encouraged to submit any additional information that you think is important for review.

For pre-service claims involving urgent/concurrent care, you may proceed with an Expedited External Review without filing an internal appeal or while simultaneously pursuing an expedited appeal through the *claims administrators* internal appeal process.

External Review decision is final and binding on all parties except for any relief available through applicable state laws.

Requirement to file an Appeal before filing a lawsuit

No lawsuit or legal action of any kind related to a benefit decision may be filed by you in a court of law or in any other forum, unless it is commenced within three years of the *Plan*'s final decision on the claim or other request for benefits. If the *Plan* decides an appeal is untimely, the *Plan*'s latest decision on the merits of the underlying claim or benefit request is the final decision date. You must exhaust the *Plan*'s internal Appeals Procedure but not including any voluntary level of appeal, before filing a lawsuit or taking other legal action of any kind against the *Plan*.

The *claims administrator* reserves the right to modify the policies, procedures and timeframes in this section upon further clarification from Department of Health and Human Services and Department of Labor.

NOTE: If you wish to appeal a decision made by *Medicare* and not by the *claims administrator*, you must initiate the appeal process by contacting your local Social Security Administration office.

If you choose to retain an attorney, expert, consultant or any other individual to assist in presentation of a claim, it must be at your own expense. Neither the plan nor the Claims Administrator will reimburse you for the costs associated with such a retention or for any other expenses you may incur in connection with such a retention.

DEFINITIONS

The meanings of key terms used in this *benefit booklet* are shown below. Whenever any of the key terms shown below appear, it will appear in italicized letters. When any of the terms below are italicized in this *benefit booklet*, you should refer to this section.

Benefit Booklet is this written description of the benefits provided under the *plan*.

Benefit period, as defined by *Medicare* for inpatient *hospital* and *skilled nursing facility* services (Part A), begins when you first enter a *hospital* after your *Medicare* insurance begins. In no event will a new benefit period start until you have been discharged and have remained out of the *hospital* or other facility as an inpatient for at least 60 consecutive days. For medical services (Part B), Benefit period is defined as a calendar *year*.

Child meets the eligibility requirements for children as outlined under HOW COVERAGE BEGINS AND ENDS.

Claims administrator refers to Anthem Blue Cross Life and Health Insurance Company. On behalf of Anthem Blue Cross Life and Health Insurance Company, Anthem Blue Cross shall perform all administrative services in connection with the processing of claims under the *plan*. The *claims administrator* is in no event the administrator for coverage as stated under CONTINUATION OF COVERAGE**,** nor is Anthem Blue Cross Life and Health Insurance Company the *plan* fiduciary or financially responsible for benefits. SISC III assumes full liability for payment of benefits described in the *plan* and thereby acts as *plan* fiduciary, and benefits are payable solely from the assets of SISC III.

Contracting hospital is a hospital which has a Standard Hospital Contract with the *claims administrator* to provide care to you.

Cosmetic services are services or surgery performed solely for beautification or to alter or reshape normal (including aged) structures or tissues of the body to improve appearance.

Creditable coverage is any individual or group plan that provides medical, hospital and surgical coverage, including continuation coverage, coverage under Medicare or Medicaid, TRICARE, the Federal Employees Health Benefits Program, programs of the Indian Health Service or of a tribal organization, a state health benefits risk pool, coverage through the Peace Corps, the State Children's Health Insurance Program, or a public health plan established or maintained by a state, the United States government, or a foreign country. Creditable coverage does not include accident only, credit, coverage for on-site medical clinics, disability income, coverage only for a specified disease or condition, hospital indemnity or other fixed indemnity insurance, Medicare supplement, long-

between the date that coverage ended and the date you become eligible under this *plan* is no more than 180 days (not including any waiting period imposed under this *plan* by the employer).

If your prior coverage was not through an employer, you will receive credit for that coverage if any lapse between the date that coverage ended and the date you become eligible under this *plan* is no more than 63 days (not including any waiting period imposed under this *plan* by the employer).

Custodial care is care provided primarily to meet your personal needs. This includes help in walking, bathing or dressing. It also includes preparing food or special diets; feeding by utensil, tube or gastrostomy; suctioning and administration of medicine which is usually self-administered or any other care which does not require continuing services of medical personnel.

If *medically necessary*, benefits will be provided for feeding (by tube or gastrostomy) and suctioning.

Dependent meets the eligibility requirements for dependents as outlined under HOW COVERAGE BEGINS AND ENDS.

Domestic partner meets the eligibility requirements for domestic partners as outlined under HOW COVERAGE BEGINS AND ENDS: HOW COVERAGE BEGINS.

Effective date is the date your coverage begins under this *plan*.

Emergency is a sudden, serious, and unexpected acute illness, injury, or condition (including without limitation sudden and unexpected severe pain), or a *psychiatric emergency medical condition*, which the *member* reasonably perceives, could permanently endanger health if medical treatment is not received immediately. Final determination as to whether services were rendered in connection with an emergency will rest solely with the *claims administrator*.

Emergency services are services provided in connection with the initial treatment of a medical or psychiatric *emergency*.

Experimental procedures and medications are those that are mainly limited to laboratory and/or animal research.

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 according to state and local laws. It must also be registered as a general hospital by the American Hospital Association and meet accreditation standards of the Joint Commission on Accreditation of Health Care Organizations.

For the limited purpose of inpatient care for the acute phase of a *mental or nervous disorder,* or substance abuse, *psychiatric health facilities*.

Investigative procedures or medications 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.

Medically necessary services, procedures, equipment or supplies are those we determine to be:

1. Appropriate and necessary for the diagnosis or treatment of the medical condition;

Participating providers are licensed health care providers that have a Participating Provider Agreement in effect with the *claims administrator* at the time services are rendered.

Physician means:

1. A doctor of medicine (M.D.) or 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 and such license is required to render that service, and is providing a service for which benefits are specified in this *benefit booklet*

   A dentist (D.D.S. or D.M.D)

   An optometrist (O.D.)

   A dispensing optician

   A podiatrist or chiropodist (D.P.M., D.S.P. or D.S.C.)

   A licensed clinical psychologist

   A chiropractor (D.C.)

   A licensed clinical social worker (L.C.S.W.)

   A marriage and family therapist (M.F.T.)

   A licensed professional clinical counselor (L.P.C.C.)*

   A physical therapist (P.T. or R.P.T.)*

   A speech pathologist*

   An audiologist*

   An occupational therapist (O.T.R.)*

   A respiratory care practitioner (R.C.P.)*

   A nurse practitioner

   A physician assistant

   A *psychiatric mental health nurse**

   A nurse midwife**

   Any agency licensed by the state to provide services for the

A registered dietitian (R.D.)* or another nutritional professional* with a or

Residential treatment center is an inpatient treatment facility where the patient resides in a modified community environment and follows a comprehensive medical treatment regimen for treatment and rehabilitation as the result of a *mental health condition* or substance abuse. The facility must be licensed to provide psychiatric treatment of *mental health conditions* or rehabilitative treatment of substance abuse according to state and local laws.

Retired employee is a former full-time *employee* who meets the eligibility requirements described in the "Eligible Status" provision in HOW COVERAGE BEGINS AND ENDS.

Severe mental disorders include the following psychiatric diagnoses specified in California Insurance Code section 10144.5: schizophrenia, schizoaffective disorder, bipolar disorder, major depression, panic disorder, obsessive-compulsive disorder, pervasive developmental disorder or autism, anorexia, and bulimia.

ild as indicated by the presence of one or more mental disorders as identified in the Diagnostic and Statistical Manual (DSM) of Mental Disorders, other than primary substance abuse or developmental disorder, resulting in behavior inappropriate to the *chil* age according to expected developmental norms. The child must also meet one or more of the following criteria:

1. As a result of the mental disorder, the child has substantial impairment in at least two of the following areas: self-care, school functioning, family relationships, or ability to function in the community and is at risk of being removed from the home or has already been removed from the home or the mental disorder has been present for more than six months or is likely to continue for more than one year without treatment.

2. The child is psychotic, suicidal, or potentially violent.

3. The child meets special education eligibility requirements under California law (Government Codetment.

Chinese

ID (TTY/TDD: 711)

Farsi

eҲɜCoÞ eҲ϶Ɔ к϶ eҲɔуҒC ЧCoЋ к϶ ҒC ҲмЌ д″ н ЧҲЛьГҒ жуҒ к″ МуCҒC ҒC Цj жуҒ ҳдЇ eҲɜɔуҲЃиЇ ЧCЊ″ снC Ɛ϶ к″ ˬ ҲАЛҒ ЧҲгМЬ È″ Ɛг йCҳдЇ к϶ t д″ ЂУҲуCC сҒƐ϶ .МфИ″ ЂУҲуCC .МуƐфɔ϶ Ёҳдɜ ˬ ЂЃҒ йМЇ ѳCC

Hindi

ID

(TTY/TDD: 711)

Hmong

Koj muaj cai tau txais qhov lus qhia no thiab kev pab hais ua koj hom lus yam tsis xam tus nqi. Hu rau tus nab npawb xov tooj lis Cov Kev Pab Cuam Rau Tswv Cuab nyob rau ntawm koj daim ID txhawm rau thov kev pab. (TTY/TDD: 711)

Japanese

ID

(TTY/TDD: 711)

Khmer

ID (TTY/TDD: 711)

Korean

. ID

. (TTY/TDD: 711)

Punjabi

Russian

(TTY/TDD: 711)

Tagalog

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Thai

(TTY/TDD: 711)

Vietnamese
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It's important that you are treated fairly

the *claims administrator* follows federal civil right laws in our health programs and activities. The *claims administrator* does
color, national origin, sex, age or disability. For people with disabilities, free aids and services are offered. For
and other written languages are offered. Interested in these services? Call the Member Services number on your ID card for help (TTY/TDD: 711). If you think the *claims administrator* failed to offer these services or discriminated based on race, color, national origin, age, disability, or sex, you can file a complaint, also known as a grievance. You can file a complaint with our Compliance Coordinator in writing to Compliance Coordinator, P.O. Box 27401, Mail Drop VA2002-N160, Richmond, VA 23279. Or you can file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Bue6 fil

NOTICE OF PROTECTION PROVIDED BY THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA)

Effective April 14, 2003, a Federal law, the Health Insurance Portability and Accountability Act of 1996

Payment includes activities undertaken by the Plan to obtain premiums or determine or fulfill its

C. The Plan will disclose PHI to the Plan Sponsor only upon receipt of a certification from the Plan Sponsor that the Plan documents have been amended to incorporate the following provisions. With respect to PHI, the Plan Sponsor agrees to:

1. Not use or disclose the information other than as permitted or required by the Plan Document or as required by law,
2. Ensure that any agents, to whom the Plan Sponsor provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such information. This Plan hires professionals and other companies, referred to as Business Associates, to assist in the administration of benefits. The Plan requires these Business Associates to observe HIPAA privacy rules.
3. Not use or disclose the information for employment-related actions and decisions,
4. Not use or disclose the information in connection with any other benefit or employee benefit Plan

   Practices).
5. Report to the Plan any use or disclosure of the information that is inconsistent with the uses or disclosures provided for of which it becomes aware,
6. Make PHI available to the individual in accordance with the access requirements of HIPAA,

E. The persons described in the section may only have access to and use and disclose PHI for Plan administration functions for the Plan. If these persons do not comply with this obligation, the Plan Sponsor has designed a mechanism for resolution of noncompliance. Issues of noncompliance (including disciplinary sanctions as approp
Officer (the Coordinator Health Benefits) at the address noted here:

Self-Insured Schools of California (SISC)
- Bakersfield, CA 93303-1847
Phone: 661-636-4410

F. Effective April 21, 2005 in compliance with **HIPAA Security** regulations, the Plan Sponsor will:

1. Implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of electronic PHI that it creates, receives, maintains or transmits on behalf of the group health plan,
2. Ensure that the adequate separation discussed in D above, specific to electronic PHI, is supported by reasonable and appropriate security measures,
3. Ensure that any agent, including a subcontractor, to whom it provides electronic PHI agrees to implement reasonable and appropriate security measures to protect the electronic PHI, and
4.