



FRESNO COUNTY ECONOMIC OPPORTUNITIES COMMISSION

EMPLOYEE HEALTH PLAN STANDARD PLAN SUMMARY PLAN DOCUMENT EFFECTIVE JANUARY 1, 2011 REVISED JANUARY 01, 2012

Plan Consultant:

Gottlieb Benefit Strategies

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559-862-4500; Fax 559-761-0661

Claims Administrator:

Pinnacle Claims Management, Inc.

PO Box 2220

Newport Beach, CA 92658

customerservice@pinnacletpa.com

800-649-9121; Fax: 949-863-9028

IMPORTANT PHONE NUMBERS & CONTACT SHEET

CLAIMS ADMINISTRATOR:

- Medical & Dental benefit & claim questions
 - Participating Provider questions
- Pinnacle Claims Management, Inc.

800.649.9121

Fax: 949.863.9028

customerservice@pinnacletpa.com

<http://www.pinnacletpa.com>

Mailing Address:

P O Box 2220
Newport Beach, CA 92658

Local Office:

1630 E. Shaw, Suite 190
Fresno, CA 93710

800.649.9121

Fax: 559.227.0022

PARTICIPATING PROVIDER NETWORK -- Medical Services

800.649.9121

<http://www.anthem.com/ca>

UTILIZATION REVIEW & CASE MANAGEMENT HOSPITAL PRE-CERTIFICATION & OUTPATIENT SURGERY

Anthem Blue Cross of California - Prudent Buyer Plan

800.274.7767

OUTPATIENT DIAGNOSTIC IMAGING

800.777.9428

OUTPATIENT PRESCRIPTION DRUG SERVICES:

Caremark / Advance PCS Health Systems

9501 Shea Blvd.

Scottsdale, AZ 85260-6719

888.665.6759

Fax: 480.661.3146

<http://www.caremark.com>

Formulary Website: <http://www.druglist.com>

VISION CARE SERVICES:

Medical Eye Services

P O Box 25209

Santa Ana, CA 92799

800.877.6372

<http://www.mesvision.com>

CHIROPRACTIC CARE NETWORK:

Optum Health Care (formerly ACN)

P.O. Box 88029

San Diego, CA 92168

800.428-6337

PLAN ADMINISTRATION:

Fresno County Economic Opportunities Commission

1920 Mariposa Mall

Fresno, CA 93721

Human Resources Office:

1900 Mariposa Mall, Suite 121

Fresno, CA 93721

559.263.1030

Fax: 559.263.1077

559.263.1070

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PLAN CONSULTANT:

Gottlieb Benefits Strategies Insurance Services

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Fresno, CA 93711

559.862-4500

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Fresno County Economic Opportunities Commission
PLAN DOCUMENT

This Plan Document is intended to give you a working knowledge of the benefits sponsored by FCEOC and administered by Pinnacle Claims Management, Inc. (PCMI). It is maintained solely for the exclusive benefits for employees and their eligible dependents in the event of illness or injury. It is important that you review this Plan Document carefully before you need to use your benefits. Terms that are capitalized throughout this Plan Document have specific meanings that are explained in this booklet, or contained in the Glossary at the back. Defined terms have the same meaning throughout this booklet.

Along with knowledge of your benefits, it is important to be aware of the most appropriate method for obtaining health care. Health care is expensive. You, the consumer can play an important part in controlling cost. Whenever possible seek outpatient care, use generic drugs, avoid walk-in clinics and hospital emergency rooms. Review your health care bills carefully for any possible errors.

Your plan benefits increase with health care Providers who have contracted to discount their fees and are designated as Participating Providers. Your benefits will be greater if you use these Participating Providers and your out-of-pocket expenses will be less. You can obtain lists and directories of Participating Providers in your area from the Human Resources Office or a PCMI office.

It is important that you fill out an enrollment form, and that you inform the Human Resources Office and PCMI immediately of any changes in your status, such as new dependents or change of address. Information supplied on the enrollment form will be used to pay claims for you and your covered dependents.

To file a claim you will need to give the Provider your name, Member Id Code or Social Security Number, and birth date as reported on your enrollment form. If the claim is for a dependent, the dependent's name, birth date, and relationship to you must be included. You must sign the Authorization to Release Information and the Provider will take all itemized bills and mail it to Pinnacle Claims Management, Inc. P O Box 2220, Newport Beach, CA 92658. Itemized bills must include each date of service, the diagnosis, a complete description of the services performed, the patient's name and the charges incurred. The Plan may require additional evidence to establish whether or not any claim should be paid. The Plan may require supplementary documentation in order to adjudicate a claim. If the patient fails to cooperate with such requests, the claim may be denied.

You should file your claims within 90 days after the expenses were incurred. Claims will still be considered for payment when it is not possible to provide notification within 90 days, but you should always file your claims as soon as possible. In no event will claims be paid if they are submitted more than 12 months after the expense was incurred, except in the absence of legal capacity.

You will receive a check and/or Explanation of Benefits as soon as possible (usually within **thirty (30) days** after receipt of claim) after all necessary information has been received. If you sign the Assignment of Benefits or utilize a Participating Provider the benefits will be paid directly to the Provider of services. You will be notified of the payment at the time the Provider's check is mailed.

While it is FCEOC's goal to provide employees and their families with comprehensive benefits, FCEOC reserves the right to reduce, change or eliminate benefits at its discretion. If this occurs, you will be sent written notice explaining the change. You may also be sent amendments to this Plan Document. Be sure to read and save all Plan communications.

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SUMMARY OF BENEFITS

All Plan benefits are subject to all of the provisions, exclusions & limitations explained in detail through out this document. The following represents only a summary of the available benefits. Please refer to the other sections within this document for additional information on your Plan benefits.

STANDARD 250 MEDICAL PLAN BENEFITS

A. GENERAL FEATURES	
Calendar Year Deductible:	\$ 250 per employee; \$ 500 per family Applies to all Covered Expense unless otherwise indicated below or within the Plan
Out of Pocket Maximum	\$ 3,000 per employee; \$ 6,000 per family
Annual Plan Maximum	\$1,250,000 per individual
Percentage Payable (For Non Emergency Treatment)	<u>With Authorization:</u> Participating Provider: 80% of Covered Expense Non-Participating Provider: 60% of Covered Expense <u>Without Authorization:</u> Participating Provider: 60% of Covered Expense Non-Participating Provider: 50% of Covered Expense
Participating Primary Care Providers (PCP)	This would encompass General & Family Practice, OB/GYN, Internist, & Pediatrician
Maternity Coverage	Participant or Spouse
Pre-Existing Conditions	6 months prior to coverage. Waived after 12 months continuous coverage under Plan (with the exception of dependent children 19 years and under)
Premium Discount for Non-Tobacco Users	All covered persons must be non-users of tobacco products of any kind to be eligible to receive the Health and Welfare \$30 per month premium discount. Tobacco users who successfully complete a smoking cessation class may be eligible for the Non-Tobacco user discount.
B. PAID HOSPITAL EXPENSES	
Inpatient Care / Outpatient Care: (Includes Room & Board, Ancillary Charges, Intensive Care) (Non Emergency Benefits)	<u>With Authorization:</u> Participating Provider: 80% of Covered Expense Non-Participating Provider: 60% of Covered Expense <u>Without Authorization:</u> Participating Provider: 60% of Covered Expense Non-Participating Provider: 50% of Covered Expense
Outpatient Care: -Emergency Room	Participating Provider: 80% of Covered Expense after \$100 Copayment For Non-Emergency use of Emergency Room \$200 Copayment will apply
-Urgent Care Center	Participating Provider: 80% of Covered Expense after \$25 Copayment Non-Participating Provider: 60% of Covered Expense after \$50 Copayment
-Surgical-centers	<u>With Authorization:</u> Participating Provider: 80% of Covered Expense Non-Participating Provider: 60% of Covered Expense <u>Without Authorization:</u> Participating Provider: 60% of Covered Expense Non-Participating Provider: 50% of Covered Expense
Preadmission Testing:	Participating Provider: 80% of Covered Expense Non-Participating Provider: 60% of Covered Expense
C. PROFESSIONAL SERVICES	
Surgeon	Participating Provider: 80% of Covered Expense Non-Participating Provider: 60% of Covered Expense
Assistant Surgeon	25% of Surgeons allowed, payable at 80% of Covered Expense
Anesthesia	Participating Provider: 80% of Covered Expense Non-Participating Provider: 60% of Covered Expense
Doctor Hospital Visit	Participating Provider: 80% of Covered Expense Non-Participating Provider: 60% of Covered Expense
Doctor Visit (Office/Home) Primary Care & Specialist	Participating Provider: \$15 co-pay, then 100% of Covered Expense. Includes office visit & exam. No Deductible applies Non-Participating Provider: 60% of Negotiated Fee or Usual & Customary, whichever is less, after Deductible has been met
D. OTHER COVERED EXPENSES	
Diagnostic X-Ray & Lab MRI's & CAT Scans must be pre-authorized or benefits reduce to 50%	Participating Provider: 80% of Covered Expense Non-Participating Provider: 60% of Covered Expense
Skilled Nursing	100% of Covered Expense for first 10 days and 80% thereafter to a maximum of 60 days per Calendar Year. The Deductible does not apply to this benefit

Acupuncture	80% of Covered Expense in Network 60% of covered Expense out of Network. Maximum benefit \$500 annual
Ambulance	80% of Covered Expense
Durable Medical Equipment	80% of Covered Expense
Hearing Aides	50% of Covered Expense up to \$1500. Benefit limited to every 3 years
Weight Management	80% to lifetime maximum of \$25,000 after mandatory evaluation period. Benefit limited to approved centers of excellence. See covered expense/limitations and exclusions for more details.
Physical Therapy	80% of Covered Expense
Chiropractic Care Optum Health Care (800) 428-6337 Under age 15 – Must have MD referral	Maximum of 10 visits per month up to 24 visits per Calendar Year; X-rays are limited to \$100 per Calendar Year for all chiropractic care. <u>Participating Provider</u> : \$15 co-pay, then 100% of Covered Expense up to a maximum of \$30 per visit - No Deductible; <u>Non-Participating Provider</u> : 80% of Covered Expense up to negotiated fee and Deductible applies.
Home Health Care	100% of Covered Expense for first 15 visits and 80% thereafter – Deductible does not apply to this benefit. A visit is equal to 4 hours or less of service.
Mental & Nervous Conditions: -Inpatient Pre-Certification is Required	Same as any other illness after deductible is applied Participating Provider: 80% of Covered Expense; Non-Participating Provider: 60% of Covered Expense.
-Outpatient	Participating Provider: Same as any other illness Non-Participating Provider: Same as any other illness
Substance Abuse: -Inpatient Pre-Certification is Required -Outpatient	Same as any other illness after deductible is applied Participating Provider: 80% of Covered Expense; Non-Participating Provider: 60% of Covered Expense. Participating Provider: Same as any other illness Non-Participating Provider: Same as any other illness
Smoking Cessation Benefit:	Smoking Cessation programs covered at 80% of Covered Expense in Network with no deductible. 60% of Covered Expense out of network, deductible applies. Annual benefit \$750. Cessation drugs are payable under the outpatient prescription drug services. Insured(s) enrolled as “Non-Smokers” receive a discounted premium rate
Well Child Care to age 18	Routine Physical Exams and Immunizations: Participating Provider: 100% of Covered Expense with no deductible. Non-Participating Provider: 80% of Usual & Customary, after Deductible has been met. Diagnostic X-Ray & Lab: 100% of Covered Expense. No Deductible applies. Non-Participating Provider: 80% of Usual & Customary, after Deductible has been met.

Adult Preventive Care 18 Years of age and over	<p>Routine Physical Exams and Immunizations: Participating Provider: 100% of Covered Expense. No Deductible once per Calendar Year. Benefits based on Gender and age. Non-Participating Provider: 80% of Usual & Customary after Deductible has been met.</p> <p>Diagnostic X-Ray & Lab: 100% Covered Expense. No Deductible applies. Benefits based on Gender and Age. Non-Participating Provider: 80% of Usual & Customary after Deductible has been met.</p>
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E. UTILIZATION MANAGEMENT - PRE-CERTIFICATION

Inpatient Admissions (800) 274-7767	Requires pre-admission review of at least 3 working days for non-emergency Hospital admissions. Within 48 hours of admission for all other admissions. Failure to obtain approval results in benefits reducing to 60% for a Participating Provider and to 50% for a Non-Participating Provider. Refer to Plan for additional information.
Outpatient Surgery (800) 274-7767	Requires prior authorization or benefits are reduced to 60% for a Participating Provider and to 50% for a Non-Participating Provider. Refer to Plan for additional information.
Outpatient Diagnostic Imaging (800) 777-9428	Requires prior authorization for all MRI's & CAT Scans or benefits are reduced to 50% of Covered Expense.

OUTPATIENT PRESCRIPTION DRUG SERVICES:

Prescription Drugs - Participating Pharmacy Only through Caremark (888) 665-6759	<u>Participating Pharmacy (30 day supply)</u>	<u>Mail Order & CVSS (90 day supply)</u>
	Preferred Generic drugs: \$ 5	\$ 5
	Preferred Name Brand: 20% (\$20 min. - \$35 max.)	20% (\$30 min - \$45 max)
	Non Preferred drugs: 20% (\$35 min. - \$60 max.)	20% (\$45 min -\$70 max)

DENTAL PLAN BENEFITS:

Refer to Delta Dental Evidence of Coverage for Dental Benefits

VISION CARE PLAN BENEFITS:

A. PARTICIPATING PROVIDER BENEFITS	Participant Pays
Comprehensive Exam – every calendar year	\$ 25 per employee or dependent
Regular Lenses & Standard Frames – every calendar year	\$ 25 per employee or dependent
Contact Lenses – Medically Necessary	\$ 25 per employee or dependent
Contact Lenses – Cosmetic	Plan allows \$125 towards the cost in lieu of other benefits (lenses & frames).
Tinting and Invisiline	Plan allows standard tinting and Invisiline lenses

B. NON-PARTICIPATING PROVIDER BENEFITS:	Plan Pays up to
Vision Examination	\$ 40
Single Vision Lenses	\$ 30
Bifocal Lenses	\$ 50
Trifocal Lenses	\$ 65
Lenticular Lenses	\$ 125
Frames	\$ 45
Tint	\$ 5
Contact Lenses – Medically Necessary	\$ 250
Contact Lenses – Cosmetic	\$ 125

EMPLOYER SPONSORED LIFE INSURANCE PLAN BENEFITS:

<i>These benefits are for employees only.</i>	Benefit Amount
Active, Full-time employees enrolled in the Medical Plan	Round basic earnings up to the nearest \$1,000, then multiply by 2
Maximum Benefit	\$350,000
Part-time regular employees, or Full-time Regular employees not covered by the Medical Plan	\$ 10,000
<i>Benefits are reduced periodically after you reach age 65.</i>	

ACCIDENTAL DEATH & DISMEMBERMENT (AD&D) PLAN BENEFITS:

<i>These benefits are for employees only.</i>	Benefit Amount
Active, Full-time employees enrolled in the Medical Plan	Round basic earnings up to the nearest \$1,000, then multiply by 2
Maximum Benefit	\$350,000
Part-time regular employees, or Full-time Regular employees not covered by the Medical Plan	\$ 10,000
<i>Benefits are reduced periodically after you reach age 65.</i>	

MEDICAL PLAN

UTILIZATION REVIEW AND CASE MANAGEMENT

Utilization Review - To get the most out of your benefit plan, and avoid any unpleasant surprises, you must understand the Utilization Review requirements. If you have any questions or are in doubt about whether Utilization Review is required for a proposed procedure, please call the Utilization Review Center at (800) 274-7767. Your Provider may take care of this requirement for you, but you and another family member or friend should be familiar with these requirements to assure that they are carried out. It is your responsibility to see that your Provider contacts the Review Center before scheduling you for any service subject to the Utilization Review program. If you receive any such service, and do not follow the procedures set forth in this section, your benefits will be reduced. ***If a pre-service claim is denied, you may request a review by writing to the Plan Administrator. Please refer to the Claims Appeal Procedures section.***

Inpatient Hospital Admission - Authorization must be given by the Utilization Review Center for all Non-Emergency Hospital confinements at least three working days prior to admission to establish Medical Necessity. In the event of an Emergency admission the Utilization Review Center must be notified within 48 hours of the admission to the Hospital. If the Physician wishes to extend the amount of days past the originally authorized stay, the Utilization Review Center must be notified before the end of the originally authorized stay. The additional days will be covered if they are Medically Necessary. When authorization is not obtained, the Percentage Payable will be reduced to 60% for a Participating Provider and to 50% for a Non-Participating Provider.

Please Note: health plans offering group health coverage generally may not, under federal law, restrict benefits for any hospital length of stay in connection with child birth for the mother or newborn child to less than 48 hours following a normal, vaginal delivery or less than 96 hours following a cesarean section, or require that a Provider obtain authorization from the Plan for prescribing a length of stay not in excess of the above period. Maternity stays in excess of 48 or 96 hours, as applicable, must be pre-certified under the Plan.

Outpatient Surgery - All surgeries performed on an outpatient basis at an Ambulatory Surgical Center, or an outpatient hospital **must be authorized by the Utilization Review Center prior to surgery**. When you do not obtain prior authorization, your benefits will be reduced to 60% for a Participating Provider and to 50% for a Non-Participating Provider.

Outpatient Diagnostic Imaging -- All Magnetic Resonance Imaging (MRI) and CAT Scans taken for diagnostic purposes must be authorized by the Utilization Review Center at 1-800-777-9428, before the procedure is done. When you do not obtain prior authorization your payable benefits for the procedure will be reduced to 50% of Covered Expense.

Weight Management and Bariatric Surgery program requires case management and prior authorization. No benefits for either Weight Management and or Bariatric procedures will be considered for payment without prior authorization and coordination through a case management team member.

Case Management - Potentially large dollar claims and/or long-term treatment claims are monitored by Anthem Blue Cross of California and through the cooperation of the patient, the Physician and Anthem Blue Cross of California, alternate health care may be considered a Covered Expense, to the benefit of all concerned.

If you are admitted to a Non-Participating Hospital during the course of the Emergency care being given, the Utilization Review Center will indicate to your Physician and the Hospital that a transfer to a Participating Hospital is necessary in order to maintain your maximum health care benefits. For all Emergency care at a Non-Participating facility, benefits will be paid at the Participating Provider Percentage Payable until the patient is eligible to be transferred (as determined by PCMI). This transfer will occur when the patient is stable enough to be moved and with the patient's consent. If the patient does not consent, benefits will be limited to the Non-Participating Provider Percentage Payable until discharge.

DISAGREEMENTS WITH COST CONTAINMENT DECISIONS

If you or your Physician disagree with a cost containment program decision, or question how it was reached, you or your Physician may request reconsideration. Requests for reconsideration (either by telephone or in writing) must be directed to the Plan Administrator. Please refer to the Claims Appeal Procedures section for information on how to do this. Written requests must include medical information that supports the Medical Necessity of the services. The address and telephone number of the Review Center is included on your written notice of determination.

EXCLUSIVE PROVIDER ORGANIZATION (EPO) & PARTICIPATING PROVIDER ORGANIZATION (PPO)

Your plan is designed to give you control of your own health care. Members have freedom of choice in selecting the hospital and physician they wish to use. The plan offers considerable financial advantages to the member if a Participating Provider is used. Your benefit level will be higher when care is obtained from a Participating Physician and Hospital. UTILIZATION OF A PRIMARY CARE PROVIDER (PCP) IS ESSENTIAL TO MAXIMIZE PLAN BENEFITS.

Participating Providers are made up of many Hospitals, doctors and medical clinics throughout California who are committed to providing you with quality health care at affordable rates. No Hospital, Physician or medical clinic is an employee or agent of PCMI or FCEOC.

HOW TO USE THIS PROGRAM

To take full advantage of the cost-saving features of the Plan, you'll need to carefully read and fully understand this explanation of how the Plan works. The Schedule of Benefits will show you how your claims are paid differently according to the Hospital and Physician you go to.

1. Select a Primary Care Physician (PCP) from the Anthem Blue Cross of California Prudent Buyer Plan Participating Provider Directory and make an appointment. Be sure to inform the Physician's office that your health plan is administered by PCMI, and bring your identification card with you to the Physician's office. It is your responsibility to verify with the Physician that the Physician is still a Participating Provider at the time of treatment.
2. If required, you will need to make a small Copayment to the Physician's office. This would be the amount you would normally be responsible for under your Plan benefits.
3. The Physician will send the bill to PCMI and no additional payment should be made by you until you receive an explanation of benefits (EOB) from PCMI's claims office. Participating Providers have agreed not to charge you more than the negotiated rate. When you choose a Participating Provider, you will not be responsible for any amount in excess of the negotiated rate for the covered services of a Participating Provider.
4. Participating Providers require automatic assignment to the Provider. This means that it is mandatory that PCMI issues all payments to the Provider. An EOB will be sent to you to notify you that the claim was processed.
5. Should you have questions regarding the program, please call PCMI's customer service department at (800) 649-9121.

PROVISIONS FOR PARTICIPATING PROVIDERS

If a Participating Provider (excluding Hospitals) refers you to a non-Participating Provider (for example, a Participating Surgeon refers you to a non-Participating Anesthesiologist) your Covered Expense will be processed at the Participating Provider Percentage Payable.

If there are no Participating Providers within 30 miles from you then you may use a Non-Participating Provider and your Covered Expense will be processed at the Participating Provider Percentage Payable of Usual Customary and Reasonable.

MEDICAL PLAN BENEFITS

Your benefits are paid by taking the amount of Covered Expense, subtracting any applicable Deductible and paying the remaining at the Percentage Payable or, in the case of Co-payments, applying the Percentage Payable to the amount of Covered Expense and then subtracting the Co-payment. If you use a Non-Participating Provider, the Percentage Payable may be reduced and Covered Expense will be no more than the Usual, Customary and Reasonable charges. Any payment for an expense that is not covered under this Plan will be the Participant's responsibility.

PLAN FACTORS

Your Plan includes one of each of the following factors:

A) Copayment: Your Participating PCP Physician and PCP authorized office visit Copayment is \$15 with the balance of the Covered Expense paid at 100%. This includes the office visit and exam. Other charges within the visit are payable at 80% of Covered Expense. If you utilize a Non-Participating PCP Provider, your benefits are payable at 60% of Covered Expense. These amounts are your responsibility and are not reimbursable, except in the case of Coordination of Benefits. The Copayment is not considered when calculating the Out of Pocket Maximum and is separate from the Deductible.

B) Deductible: Individual Deductible means the amount stated in the schedule of benefits which a covered individual must incur before major medical benefits become payable. Family Deductible is the total of two Individual Deductibles, which have been satisfied by members of the same family. When the Family Deductible shown in the schedule of benefits has been satisfied, no further Deductible will be required for any remaining members of that family for the rest of the Calendar Year. A family means a covered individual and covered dependent. Your Individual Deductible is \$250, and your Family Deductible is \$500. The Deductible is the amount of Covered Expense which must be incurred before benefits are payable. Charges that do not qualify as Covered Expense cannot be used to satisfy the Deductible. The Deductible is exclusive of the Out of Pocket Maximum and any Co-payments. All Plan benefits are subject to the Deductible unless otherwise noted.

C) Deductible Carryover: Any amounts applied toward a Deductible incurred during the last three months of a Calendar Year will also apply to the Deductible for the following Calendar Year.

D) Percentage Payable: Your Percentage Payable is 80% when you use a Participating Provider 60% when you use a Non-Participating Provider unless otherwise noted within the Plan. Percentage Payable is the percentage of Covered Expense payable after any applicable Deductible has been satisfied or is the percentage of Covered Expense calculated prior to the Copayment being applied.

E) Out of Pocket Maximum: Your Out of Pocket Maximum is \$3,000 per eligible family member per Calendar Year. The maximum amount of family Out of Pocket per Calendar Year is \$6,000. The Out of Pocket Maximum is the point at which the Covered Expense is payable at 100%. In other words, when the Plan has paid out \$3,000 in individual Plan benefits or \$6,000 in family Plan benefits, the Percentage Payable becomes 100% of Covered Expense. Your Out of Pocket Maximum must be satisfied each Calendar Year. The Deductible, non Covered Expense and Copayment are not included in calculating the Out of Pocket Maximum.

Annual Maximum: Your annual plan maximum is \$1,250,000 per year per individual.

COVERED EXPENSE

Covered Expense includes the following and are subject to any maximums indicated within the Plan:

A) Hospital for room and board to the Hospital's average semi-private room accommodations, and other Medically Necessary services or supplies used during Hospital confinement and/or qualified outpatient Hospital treatment, not to include services, drugs or supplies which are dispensed but not used in the Hospital. For Pre-Certified services, Covered Expense is paid at 80% for Participating Hospitals and 60% for Non-Participating Hospitals. For non Pre-Certified services, Covered Expense is paid at 60% for Participating Hospitals and 50% for Non-Participating Hospitals. When a Participating Hospital is used, routine newborn nursery care will be

payable as part of the mother's claim until the newborn is released from the initial Hospital stay. Hospital confinement means confinement as a registered bed patient for 24 hours or more; emergency care in the outpatient department of a hospital within 48 hours of an Accident; death of a patient while being treated in the emergency room of a Hospital; admitted as a registered bed patient directly from the emergency room. You must have all routine tests that are related to your Hospital confinement done prior to your admission to the Hospital. These tests and studies must be conducted after confinement is scheduled and within one week prior to an admission. If these tests are done on an inpatient basis, the charges for confinement will be reduced by one day.

B) Intensive Care Unit (Critical Care Unit, Coronary Care Unit, Concentrated Care Unit) means a separate Hospital area, which is solely for treatment of patients in critical condition, providing around the clock observation by special duty nurses and medical equipment. For Pre-Certified services, Covered Expense is paid at 80% for Participating Hospitals and 60% for Non-Participating Hospitals. For non Pre-Certified services, Covered Expense is paid at 60% for Participating Hospitals and 50% for Non-Participating Hospitals.

C) A Physician is covered for professional, medical, surgical, diagnostic or anesthetic services. Covered Expense is paid at 80% for Participating Providers and 60% for Non-Participating Providers. A Physician who performs services as an assistant surgeon will be paid at 25% of the surgeon's charge. An outpatient Physician visit and exam is paid at 100% of Covered Expense after a \$15 co-payment with no deductible for a Participating PCP Provider and a PCP authorized Physician visit, and 80% of the contracted rate or Usual, Customary and Reasonable, whichever is less, after your deductible for PCP authorized Non-Participating Providers. A non-authorized Participating Physician visit and all related charges are paid at 60% of Usual, Customary and Reasonable after your deductible is satisfied.

WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1988:

In compliance with Section 2706 of the Public Health Service Act (PHSA), Women's Health and Cancer Rights, added to PHSA by the 1998 Omnibus Budget Bill, the following services complementing medical and surgical benefits for mastectomies, in a manner determined in consultation with the attending Physician and the patient are considered Covered Expense and subject to all Plan provisions:

- (a) Reconstruction of the breast on which the mastectomy was performed;
- (b) Surgery or reconstruction of the other breast to produce a symmetrical appearance;
- (c) Prostheses and physical complications with all stages of the mastectomy, including lymphedemas.

D) Skilled nursing facility during a covered confinement for other than Custodial Care, benefits are paid at 100% for the first 10 days and 80% thereafter to a maximum of 60 days per calendar year. The Deductible does not apply to these benefits.

E) Diagnostic x-rays and laboratory tests are a Covered Expense as noted if ordered by a Physician, licensed technician or clinic for diagnosis of a sickness or injury being treated. If the inpatient stay is authorized, Plan benefits are paid at 80% of Covered Expense for inpatient services by a Participating Provider and 60% of Covered Expense for inpatient services by a Non-Participating Provider. If the inpatient stay is not authorized, Plan benefits are paid at 60% of Covered Expense for inpatient services by a Participating Provider and 50% of Covered Expense for inpatient services by a Non-Participating Provider. Plan benefits are paid at 80% of Covered Expense for outpatient services billed by a Participating Provider and 60% of Covered Expense for outpatient services by a Non-Participating Provider. Prior Authorization is required on all outpatient MRI's and CAT Scans or payable benefits are reduced to 50% of Covered Expense.

F) Cobalt or chemotherapy, blood transfusions, oxygen, dressings and surgical supplies are a Covered Expense as noted if ordered by a Physician, licensed technician or clinic for diagnosis of a sickness or injury being treated. Plan benefits are paid at 80% of Covered Expense.

G) A nurse for professional services provided the services require the specialized training of an R.N., L.V.N., or L.P.N. and are not primarily for housekeeping, personal hygiene or Custodial Care are a Covered Expense as noted if ordered by a Physician, licensed technician or clinic for the diagnosis of a sickness or injury being treated. Plan benefits are paid at 80% of Covered Expense.

H) Home health care must include services consistent with your injury or illness and provided the services require the specialized training of an R.N., L.V.N., L.P.N. or home health aide and are not primarily for housekeeping, personal hygiene or Custodial Care are a Covered Expense as noted if ordered by a Physician, licensed technician or clinic for the diagnosis of a sickness or injury being treated. Plan benefits are paid at 100% of Covered Expense for the first 15 visits and then 80% thereafter not subject to the deductible. A visit equals four hours or less.

I) A licensed physical therapist for treatment of a condition requiring physical therapy to restore an impaired bodily function are a Covered Expense as noted if ordered by a Physician, licensed technician or clinic for diagnosis of a sickness or injury being treated. Plan benefits are paid at 80% of Covered Expense.

J) A licensed medical or surgical supply house for rental of oxygen equipment, wheelchairs, crutches or other durable therapeutic equipment are a Covered Expense as noted if ordered by a Physician, licensed technician or clinic for diagnosis of a sickness or injury being treated. Plan benefits are paid at 80% of Covered Expense. (payment of rental fees shall not exceed the actual cost of equipment; also includes purchase of certain non-rentable medical equipment and post-surgical supplies not obtainable in a regular drug or department store that are usable only for the medical care of the patient).

K) Licensed professional ambulance service for necessary transportation to or from the nearest Hospital where appropriate care can be obtained is payable at 80%.

L) Provider of the initial prosthesis for (1) replacement of a natural part of the body removed while the patient was eligible under the Plan; (2) needed to correct a congenital deformity of a child covered under the Plan at birth; (3) or repair of such prosthetic device are a Covered Expense as noted if ordered by a Physician, licensed technician or clinic. Benefits are payable at 80% of Covered Expense.

M) Chiropractic care visits are a Covered Expense and are limited to a maximum of 10 visits per month up to 24 visits per Calendar Year. X-rays for chiropractic care are limited to \$100 per Calendar Year and are payable at 100%. Chiropractic care means services for correction by normal or mechanical means of structure unbalance or subluxation in the human body for purposes of removing nerve interference and the effects thereof, where such interference is the result of or related to distortion, misalignment or subluxation in the vertebral column. The Plan has contracted with Optum Health Care, a network of Participating Providers for chiropractic care services. The maximum benefit payable per visit is \$30 after a \$15 co-payment for a OHC chiropractor and the deductible does not apply. For non OHC chiropractors, benefits are payable at 80% of contracted rate up to a maximum of \$30 per visit and the deductible applies.

N) Hospice care is a Covered Expense and benefits are payable at 100% not subject to the deductible. The setting must be approved by the National Hospice Organization and PCMI. The patient must be diagnosed as terminally ill with a life expectancy of six months or less. It is necessary to seek Case Management with the Utilization Review Center prior to receiving this benefit.

O) Services for transplants will only be considered Covered Expense if the patient submits to Case Management by the Utilization Review Center. Although the patient does not have to abide by the decisions of the case manager, the Plan will not consider any treatment for this condition as a Covered Expense unless the process of Case Management is performed.

P) Routine newborn nursery care is a Covered Expense while in the Hospital and will be paid as any other claim.

Q) Maternity benefits will be paid as any other claim for the eligible employee or eligible dependent spouse. For an eligible dependent daughter, Covered Expense will be for only tubal pregnancy, complications resulting in a cesarean section, eclampsia, and other conditions directly caused by pregnancy which are generally considered complications; this does not include elective abortion, false labor, occasional spotting, morning sickness, Physician prescribed rest or normal delivery.

NEWBORNS AND MOTHERS HEALTH PROTECTION ACT OF 1996:

Health plans offering group health coverage generally may not, under federal law, restrict benefits for any hospital length of stay in connection with child birth for the mother or newborn child to less than 48 hours following a normal, vaginal delivery or less than 96 hours following a cesarean section, or require that a Provider obtain authorization from the Plan for prescribing a length of stay not in excess of the above period. Maternity stays in excess of 48 or 96 hours, as applicable, must be pre-certified under the Plan.

R) You must receive your **outpatient prescription drugs** from a Participating pharmacy or the mail order prescription program - available for maintenance drugs. A Copayment must be made by you for each medication and is not reimbursable. For a list of Participating pharmacies or for a mail order program envelope, please contact Caremark / AdvancePCS Health Systems at (888) 665-6759.

	<u>Participating Pharmacy</u>	<u>Mail Order (Up to a 90 day supply)</u>
Preferred Generic drugs:	\$ 5	\$ 5
Preferred Name Brand drugs:	20% \$ 20 minimum \$35 maximum	20% \$ 30 minimum \$45 maximum
Non-Preferred drug list:	20% \$ 35 minimum \$60 maximum	20% \$ 45 minimum \$70 maximum

Outpatient prescription drugs are provided through Caremark / AdvancePCS Health Systems, which offer both their retail pharmacy drug card for immediate prescription needs, and their mail order service program for maintenance medications. Under this program, you must use a Participating pharmacy, or obtain your medications from the mail order program. Outpatient prescription drugs are not subject to the Calendar Year deductible.

Covered medications include: a) drugs for which a prescription is required by state or federal law; b) injectable Insulin and Insulin syringes; c) legend oral contraceptives.; d) Imitrex limited to three prescriptions per month. All additional prescriptions must be pre-authorized.

Non Covered medications include: a) drugs that do not require a prescription (except insulin); b) drugs intended for use in a physician's office or another setting other than home use; c) investigational or experimental drugs, including compounded medications for non-FDA approved use; d) prescriptions which an eligible person is entitled to receive without charge from any Workers' Compensation Laws, or any municipal, state or federal program; e) therapeutic devices or appliances, support garments and other non-medical substances; f) drugs for which no charge is made or for which you would not be required to pay in the absence of this Plan; g) drugs prescribed in connection with medical or dental services which are not covered under this Plan; h) drugs which are not Medically Necessary.

Specialty Medications

Caremark Specialty Pharmacy Services will be your exclusive provider for specialty medications including specialty injectables, Infuseables along with certain oral medications. Under this program, you must obtain your medications through Caremark. Covered specialty medications are paid through the medical plan at 80% after your annual deductible has been applied.

S) Substance Abuse Treatment benefits are payable if you or your eligible dependents obtain authorization from the Utilization Review Center, this applies to both inpatient and outpatient treatment.

1. Inpatient treatment: When you use a Participating Provider, charges will be allowed at the negotiated contract rate and payable at 80% of Covered Expense. When you use a Non-Participating Provider charges will be allowed at the Usual, Customary and Reasonable for the geographic area and payable at 60% of Covered Expense.
2. Outpatient hospital treatment: Payable at 80% of Covered Expense for Participating Provider, 60% for non-

participating provider, after deductible is met.

3. Outpatient Physician Visit: An outpatient Physician visit is paid at 100% of Covered Expense after a \$15 co-payment with no deductible for a Participating PCP Provider and a PCP authorized Physician visit, and 80% of the contracted rate or Usual, Customary and Reasonable, whichever is less, after your deductible for PCP authorized Non-Participating Providers. A non-authorized Participating Physician visit and all related charges are paid at 60% of Usual, Customary and Reasonable after your deductible is satisfied.

T) Mental health care benefits are payable after you receive authorization from the Utilization Review Center. .

1. Inpatient treatment: When you use a Participating Provider, charges will be allowed at the negotiated contract rate for all inpatient treatment of mental illness and functional nervous disorders and payable at 80% of Covered Expense. When you use a Non-Participating Provider, benefits are payable at 60% of Usual, Customary and Reasonable.

2. Outpatient hospital treatment: Payable at 80% of Covered Expense for Participating Provider, 60% for non-participating provider, after deductible is met.

3. Outpatient Physician Visit: An outpatient Physician visit is paid at 100% of Covered Expense after a \$15 co-payment with no deductible for a Participating PCP Provider and a PCP authorized Physician visit, and 80% of the contracted rate or Usual, Customary and Reasonable, whichever is less, after your deductible for PCP authorized Non-Participating Providers. A non-authorized Participating Physician visit and all related charges are paid at 60% of Usual, Customary and Reasonable after your deductible is satisfied.

U) Accident benefits are payable at 80% of Covered Expense for charges after a \$50 copayment incurred within 90 days of any one Accident.

V) Elective sterilization for the employee or dependent Spouse are a Covered Expense and benefits will be paid as any other claim subject to the limits indicated within the Plan. Reversal of sterilization is not a Covered Expense.

W) Adult Preventive Care is a covered expense for all eligible adults (18 years and over) and include any routine examinations, related laboratory and x-ray services as follows:

1. Routine Physical Exams - 18 years and over

Participating Provider
100% every Calendar Year
not subject to the deductible.

Non-Participating Provider
80% of Usual, Customary and Reasonable
per Calendar Year after deductible.

The female examination may include one or more of the following procedures: Pap smear, mammogram, rectal exam, lab panel and urinalysis. The male examination includes one or more of the following procedures: urinalysis, lab panel, prostate and rectal exam.

Mammograms are a Covered Expense as follows: One baseline mammogram for women age 35 to 40, one mammogram every two years for women 40 to 50, one mammogram every year for women age 50 and over,

2. Adult immunizations are covered and include but are not limited to, influenza and rubella. (18 years and over). Benefits are payable at 100% and at 80% after the deductible for Non-Participating Providers.

3. Diabetic day-care self-management education is a Covered Expense.

4. Immunizations, examinations or reports required for obtaining or continuing employment, insurance purposes, government licensing, or travel is not a Covered Expense.

X) Well Child Care is a Covered Expense up to age 18 and includes any routine examinations and immunizations as follows:

Birth to age 18: Participating Provider
100% every Calendar Year

Non-Participating Provider
80% of Usual, Customary and Reasonable

not subject to the deductible.

per Calendar Year after deductible.

Related laboratory and x-ray services for well child care is a Covered Expense up to the following maximums:		
	<u>Participating Provider</u>	<u>Non-Participating Provider</u>
Birth to age 18:	100% every Calendar Year not subject to the deductible.	80% of Usual, Customary and Reasonable per Calendar Year after deductible.

Immunizations, examinations or reports required for obtaining or continuing employment, insurance purposes, government licensing, or travel is not a Covered Expense.

Y) Smoking Cessation programs Participating Provider 80% Non-Participating Provider 60% after annual deductible has been met to a maximum benefit of \$750 per year. Cessation drugs are payable under the outpatient prescription drug services.

Z) Acupuncture/Acupressure Benefits will be paid as any other claim for the eligible employee or eligible dependent spouse. In order for Acupuncture benefits to be considered for payment, treatment must be rendered by a licensed Acupuncturist. Benefit is limited to 80% of covered expense in network and 60% of covered expense out of network. Benefit is payable after annual deductible has been met and has an annual maximum benefit of \$500 per calendar year.

AA) Hearing Aides will be covered at 50% with a maximum benefit of \$1500 every 3 years. Evaluation by a State Certified Audiologist is required and prior authorization will be necessary before covered Employee or Dependent will be eligible for benefit.

BB) Weight Management programs designed to provide assistance to those deemed "Morbidly Obese" will be covered as any other illness. Those identified with extreme Obesity will be offered a 12 month program designed to help the insured lose weight. At the completion of the 12 month program if satisfactory weight-loss is not achieved, participant will then be considered eligible for appropriate weight loss procedure(s) as approved by AMA (American Medical Association) guidelines. Approved benefits will be covered as follows: Bariatric procedures including Lap Banding after an evaluation and Weight Management program has been completed.

Bariatric Surgery Services Maximum payable benefits per year of \$25,000 per lifetime In-Network. Not covered out of network.

All Bariatric surgery Services must be prior authorized, in writing, from the Utilization Management Medical Director. Prior authorization is required for all Persons. (Bariatric surgery Services must be provided by a Participating Bariatric Surgery Network Provider).

Benefits are provided for Hospital and professional services in connection with Medically Necessary bariatric surgery to treat morbid or clinically severe obesity as described below.

Morbid or clinically severe obesity is a result of persistent and uncontrollable weight gain that constitutes a present or potential threat to life. There are a variety of surgical procedures intended for the treatment of clinically severe obesity.

Gastric bypass with a Roux Y procedure up to 150 cm, laparoscopic adjustable gastric banding (the Lap-Band® System), vertical banded gastroplasty, or biliopancreatic bypass with duodenal switch as a single surgery, is considered medically necessary for the treatment of clinically severe obesity for selected adults (18 years and older) who meet the following criteria:

- a. BMI of 40 or greater, or BMI of 35 or greater with co-morbid conditions including, but not limited to, life threatening cardio-pulmonary problems (severe sleep apnea, Pickwickian syndrome and obesity related cardiomyopathy), severe diabetes mellitus, cardiovascular disease or hypertension.

Note: Individuals considering the laparoscopic adjustable gastric banding (Lap-Band®) procedure must meet the above minimum BMI requirement and, in addition, have a maximum BMI of less than 50.

- b. The patient must have actively participated in non-surgical methods of weight reduction; these efforts must be fully appraised by the physician requesting authorization for surgery.
- c. The physician requesting authorization for the surgery must confirm the following:

The patient's psychiatric profile is such that the patient is able to understand, tolerate and comply with all phases of care and is committed to long-term follow-up requirements; The patient's post-operative expectations have been addressed; The patient has undergone a preoperative medical consultation and is felt to be an acceptable surgical candidate; The patient has undergone a preoperative mental health assessment and is felt to be an acceptable candidate; The patient has received a thorough explanation of the risks, benefits, and uncertainties of the procedure; The patient's treatment plan includes pre- and post-operative dietary evaluations; The patient's treatment plan includes counseling regarding exercise, psychological issues and the availability of supportive resources when needed.

For revision of a gastric restrictive procedure for clinically severe obesity, there must be documentation of a failure secondary to a surgical complication such as fistula, obstruction or disruption of a suture/staple line, and is subject to the same criteria listed above.

All bariatric surgery services must be prior authorized, in writing, from the Plan's Medical Director through Anthem Blue Cross of California. Prior Authorization is required for all Participants, regardless of where you live.

For Participants who reside in California, the Plan will provide benefits for certain Medically Necessary services at a Participating Bariatric Surgery Network Hospital and Physician who agree to participate in the Bariatric Case Management program. For Participants who reside outside of California, the Plan will provide benefits for certain Medically Necessary services at a Participating Provider only, if Bariatric Case Management is in place. Benefits are payable as indicated above.

The Bariatric Case Management program is a beneficial component to the Bariatric Surgery Network which provides support and follow-up pre and post surgery. Services include, but are not limited to the following:

Pre-surgery: Up to 12 month enrollment and assessment period

Two-day post surgery: inpatient review and discharge planning

Three day to 11 weeks post surgery: monitoring for complications

Three to 11 months post surgery: review and management of weight loss, lifestyle and behavioral changes. There are no payable benefits for services performed at a Non-Participating Bariatric Surgery Network provider within California or at a Non-Participating Provider for services performed outside of California. No benefits are available for services performed outside of the United States of America.

Lifetime benefit for the Weight Management program, including surgery, will be limited to \$25,000 and must be completed at an approved center of excellence. Prior authorization is required. Contact Pinnacle Claims Management for a listing of approved providers and facilities.

CC) Voluntary Second Surgical Opinion is a Covered Expense for services associated with obtaining a second opinion from a Physician regarding the Medical Necessity of a surgery or treatment. The Physician rendering an additional opinion must: a) be qualified by license or experience to offer such an opinion; and b) not be financially related to the Physician rendering the initial opinion. Covered Expense for the office visit is payable, after a \$15 Co-payment, at 100% of Negotiated Fee Rate for Participating Providers, no Deductible applies. Non-Participating Provider benefits are payable at 80% of Usual, Customary and Reasonable, after your annual Deductible.

EXCLUSIONS AND LIMITATIONS

General limitations, exclusions and provisions, which apply to all Plan benefits, are as follows:

A) **Pre-Existing conditions**, or Disability or complications that are related are not Covered Expense unless you have been covered under the Plan for 12 months or provide proof of creditable coverage from prior carrier. A pre-existing condition is a sickness or injury for which medical advice, diagnosis, care, treatment or services, were recommended or received, or for which you had taken prescribed drugs or medicines six months prior to your effective date. **Not applicable to dependent children 19 and younger.**

In determining whether a pre-existing condition provision or a waiting period applies, the Plan will credit the time you (or, if applicable, your dependent) were covered under any individual or group health coverage, including nonprofit hospital service plans, health care service plans, fraternal benefit society, and self-insured employer plans or any other group health plan, except for supplemental coverage.

Qualifying prior coverage does not include accident only, credit, disability income, Medicare supplement, long-term care insurance, dental, vision, supplements to liability insurance, or no-fault insurance. The Plan will not take into account qualifying prior coverage where there has been a break in coverage of 63 days or more. You must provide the Plan Administrator with a written certificate of coverage from your prior carrier or Employer in order for qualifying coverage to be applied against a preexisting condition exclusion period.

B) PCMI or FCEOC is not responsible for the providing for, or the quality of, any type of Hospital, medical or similar care.

C) Benefits provided under this Plan do not regulate the amounts charged by Providers of medical care.

D) When the amount paid by the Plan exceeds the amount for which the Plan is liable for, FCEOC has the right to recover the excess amount. This amount may be recovered from the Participant, the person to whom payment was made or any other Plan.

E) This Plan in no way interferes with the right of any person entitled to Hospital benefits to select any Hospital. That person may choose any Physician who is a member of, or acceptable to, the attending staff and Board of Directors of the Hospital where services are received. However, that person's choice may affect the benefits payable according to the terms of the Plan.

F) The fact that a procedure or level of care is prescribed by a Physician does not mean that it is Covered Expense under the Plan and shall not bind FCEOC in determining the liability under the Plan. Services which are not reasonable and necessary shall include, but are not limited to, (1) procedures that are experimental, of unproven value or of questionable current usefulness; (2) procedures that tend to be redundant when performed in combination with other procedures; (3) procedures that are unlikely to provide a Physician with additional information when they are used repeatedly; (4) procedures that can be performed with equal efficiency at a lower level of care.

G) In addition to limitations and exclusions written elsewhere in this Plan Document, regardless of prescription, application, cause or purpose, the following are not covered:

1. Treatment that is not generally accepted practice in the United States;
2. Charges that would otherwise not be required if the patient did not have these Plan benefits, or charges by a Provider who accepts Plan benefits as "Payment in Full";
3. Expenses incurred when the patient was not eligible under the terms of the Plan;
4. Charges for treatment of any illness or injury that is covered by a Workers' Compensation law or legislation, or sustained in the course of any occupation for wages or profit except for the owner or partner who has expressly been excluded from the Workers' Compensation policy;

5. Charges incurred while in military service or for treatment of any illness or injury caused by an act of war, declared or undeclared;
6. Charges for treatment of any illness or injury resulting from the patient's commission of a felony;
7. Payments prohibited by law;
8. Charges for telephone consultations;
9. Charges for treatment of illness or injury where the patient fails to reasonably cooperate in providing information for coordinating or subrogating benefits;
10. Custodial care, maintenance therapy, educational training or services, nutritional counseling, diet management, weight control programs, commercial exercise programs, gym, and spa or health club memberships;
11. Vitamins, food or dietary supplements or other over-the-counter preparations that can legally be purchased without a Physician's written prescription, whether or not a Physician provides such written prescription, with the exception of prescriptive pre-natal vitamins.
12. Transportation costs for travel by scheduled airline, railroad, bus, taxi or other commercial carrier, regardless of destination or purpose;
13. Cosmetic surgery, which is surgical excision or reformation of any sagging skin on any part of the body including, but not limited to, face, neck, abdomen, arms, legs, or buttocks, or any services performed in connection with the enlargement, reduction or change in appearance of a portion of the body including, but not limited to, breasts, lips, jaw, chin, nose, ears or genitals, or hair transplantation, chemical face peels, or abrasion of the skin, or electrolysis epilation; except for repair or correction from illness, or injury sustained in an Accident which occurred while the person was eligible under the Plan;
14. Home exercise equipment, Jacuzzi, sauna or home air-conditioning unit;
15. Hearing aids will be covered after pre-authorization and evaluation by a State Certified Audiologist and will be limited to 50% to a maximum benefit of \$1500 every three years.
16. Orthoptics or visual motor training or other eye exercises, except when performed in lieu of surgery to correct an eye muscle disorder;
17. Charges for a missed appointment or completion of a claim form;
18. Charges for experimental or investigatory treatment, as determined by Medicare, unless such treatment is approved;
19. Bariatric procedures including Lap Banding until an evaluation and Weight Management program has been completed. Lifetime benefit for Weight Management surgery will be limited to \$25,000 and must be completed at an approved center of excellence. Prior authorization through PCMI is required. See additional requirements and restrictions listed above under Covered Expense, Weight Management Program.
20. In vitro fertilization and gamete intra fallopian transfer (GIFT), artificial insemination, infertility treatment or any charges associated with the direct inducement of pregnancy;
21. Sterilization reversal;
22. Eye refractions, eyeglasses or the fitting thereof including surgical correction of refractive errors, such as radial keratotomy and Lasik Surgery;
23. Services of a dentist or Physician for care and treatment of teeth and gums, including supplies in connection with treatment, unless charges are incurred for damages caused by accidental injuries sustained while covered under this Plan and dental implants; See Delta Dental Evidence of Coverage for Covered Dental Benefits

24. Charges for admission kits, TV, telephone, guest trays, guest cots, personal toiletries, stationary and other personal items not essential for medical treatment of the illness or injury;
25. Occupational therapy, unless such therapy is a Medically Necessary form of physical therapy for treatment of the injury or illness, and not solely for the entertainment of the patient;
26. Speech therapy, unless performed to assist in the restoration of normal speech which has been interrupted by injury or illness;
27. Items that is usable for other than medical purposes, or convenience items or attachments to standard equipment, including but not limited to orthopedic shoes (except when joined to braces), shoe inserts, air purifiers, humidifiers, supplies for comfort, hygiene or beautification;
28. Home or automobile modification to facilitate wheelchairs or other equipment;
29. Procedures or treatments to change characteristics of the body to those of the opposite sex;
30. Hyperkinetic syndromes and/or attention deficit disorders, learning disabilities, behavior problems, mental retardation or autistic disease of childhood; including medications necessary to treat these conditions.
31. Treatment for caffeine addiction;
32. Claims not submitted within 12 months after expenses were incurred, except in the absence of legal capacity;
33. Services rendered outside the United States, unless such services would have been covered if provided in the United States;
34. Any treatment, services, appliances or surgery related to treatment of temporomandibular joint pain or syndrome (the temporomandibular joint is the joint between the temple and the jaw), as either a medical or dental expense;
35. Services, supplies or medications associated with sex transformations and resulting complications;
36. Penile implants unless required as a result of injury or an organic disorder;
37. Myofunctional therapy;
38. Illness or injury resulting from the performance of any activity for pay or profit;
39. Confinement in a Hospital owned or operated by the federal government, except Usual, Reasonable and Customary charges otherwise payable and incurred at a Veteran's Administrative Facility or by a covered person as an armed services retiree (or such person's dependent) for services or supplies unrelated to military service;
40. Biofeedback, Hypnosis, or services related to pain management centers.
41. Misstatement of Non-tobacco status. Effective 01-01-09, claims processed for payment for tobacco related conditions will be reversed and considered ineligible for payment should it be determined the insured misstated his/her non-tobacco status. If any relevant facts pertaining to any person's eligibility for non-tobacco premium discount under this Plan are found to be misstated, an equitable adjustment of any premium discounts paid will be made. If such misstatement affects the existence of coverage, the true facts will be used in determining whether coverage is in force under the terms of this Plan, and in what amounts.

The above is not an all inclusive list and does not impede FCEOC from changing, altering, modifying, adding or eliminating exclusions and limitations to the Plan.

DENTAL PLAN

Refer to Delta Dental Evidence of Coverage for Dental Benefits

VISION CARE PLAN

The following vision care benefits are provided through Medical Eye Services, Inc. (MES).

PLAN FACTORS

PARTICIPATING PROVIDER BENEFITS:

Annual Deductible:

- Comprehensive Examination \$ 25 per employee or dependent
- Regular Lenses & Standard Frames \$ 25 per employee or dependent

Vision Examination:

- once every calendar year

Lenses:

- once every calendar year

Frames:

- once every calendar year

Contact Lenses:

- If approved in advance by MES (a) following cataract surgery; (b) to correct extreme visual acuity problems that cannot be corrected to 20/70 in the better eye except by their use; (c) certain conditions of Anisometropia; or (d) Keratoconus.
- When patients chose contact lenses for other reasons, MES will make an allowance of \$125 toward their cost in lieu of other benefits (lenses and frame) for that eligibility period.

When you select a doctor from the MES list, the vision benefits described above (examination, professional services, lenses and frames) will be provided. Any additional care, service and/or materials not covered by this Plan may be arranged between you and your doctor.

How to Use the Plan

- Take a Medical Eye Service claim form to the eye care Provider of your choice. If you do not bring your claim form with you at the time of your visit, you may be required to pay in full for the services. If services are received from a Non-Participating Provider, reimbursement will be made to the Participant up to the Schedule of Allowances. You or the Provider, should submit an itemized billing and a copy of your prescription with the claim form to Medical Eye Services.
- If you have any questions about the plan, please contact the Medical Eye Services, Inc. offices at:
P O Box 92917
Los Angeles, CA 90009
(800) 877-6372

Limitations - No Benefits will be Paid When:

- Lenses or frames that are furnished under the Plan and which have been lost, stolen or broken will not be replaced, except when benefits are otherwise available.

- Eyewear, when there is no prescription change, except when benefits are otherwise available.
- No-line (blended type) bifocal lenses, coated lenses, tints, or over-sized lenses will be limited to the Plan benefits. Contact lenses will be limited to the Plan benefits.

Exclusions

- Conditions covered by Workers' Compensation
- Services that begin prior to the insured's effective date or after benefits have terminated.
- Services and material in connection with special procedures such as: orthoptics or vision training and subnormal vision aids.
- Non-prescription (plano) eyewear.
- Medical or surgical treatment of the eyes.
- Charges for which the Participant is not required to pay.
- Eye examinations required by an employer as a condition of employment.
- Any services or material provided by another vision plan.

NON-PARTICIPATING PROVIDER BENEFITS:

Schedule of Allowances

	<u>Plan Pays up to</u>
▪ Vision Examination	\$ 40
▪ Single Vision lenses	\$ 30
▪ Bifocal lenses	\$ 50
▪ Trifocal lenses	\$ 65
▪ Lenticular lenses	\$125
▪ Frames	\$ 45
▪ Tint	\$ 5
▪ Contact Lenses - Medically Necessary*	\$250
▪ Contact Lenses - Cosmetic	\$125
▪ Determination of "necessary" versus "cosmetic" contact lenses under the non-Participating Provider reimbursement schedule will be consistent with Participating Provider services. Cosmetic contact lens services are in lieu of examination, lens, and frame service.	

The above lens allowances are for two lenses; if one lens is needed, the allowance will be one-half the pair allowance. The amount shown are maximums in the schedule of services, the amount charged or the amount usually charged by the Provider of such services to his or her private patients as determined by Medical Eye Services, whichever is the lesser amount.

SCHEDULE OF LIFE INSURANCE

For active full-time employees enrolled in the medical plan, the amount of Life Insurance is equal to your basic annual earnings rounded to the next highest \$1,000 and multiplied by two, to a maximum of \$350,000. For part-time regular employees or full-time regular employees not enrolled in the medical plan, the amount of Life Insurance is \$10,000.

Employee Life insurance reduces by 35% at age 65, 70 and 75, by 25% at age 80, 85, 90 and 95.

Effective Date

Coverage is effective the first of the policy month following full-time date of employment..

Life Benefit

The amount of group insurance is payable in the event of death at any time and from any cause, subject to the terms of the group insurance policy.

Beneficiary

The insured names the beneficiary and elects the manner in which proceeds are paid based on the most recent beneficiary form on file with FCEOC or Group Life Carrier.

Settlement Option

The amount may be paid in one sum, part in cash and the balance in installments, or entirely in installments. If the insured has not elected an option, the beneficiary can do so at the death of the insured.

Waiver Of Premium

If an insured becomes totally disabled before reaching age 60 and is not able to work for nine (9) months, the amount of Life Insurance protection will be continued without further premium payments as long as the disability meets the requirements of the Group Insurance Policy. Total disability, as defined in the Group Policy, means an Insured's complete inability to engage in any type of work for wage or profit for which he/she is suited by education, training or experience.

Conversion

The conversion privilege gives an Insured the right under certain conditions, to continue Life Insurance protection under an individual policy. No medical examination or evidence of insurability is required regardless of age or state of health as long as application is made and the first premium paid within 31 days of termination.

ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

Benefit:

The amount shown in the schedule is payable for loss of: Life, Both Hands, Both Feet, Sight of Both Eyes, One Hand and Sight of One Eye, One Foot and Sight of One Eye, or Speech and Hearing; One-half the amount in the Schedule of Benefits is payable for loss of; One Hand, One Foot, Sight of One Eye, Speech or Hearing. This benefit is payable in addition to all other benefits provided by the Plan, subject to the terms of the Group Insurance Policy.

Effective Date

Coverage is effective the first of the following month after full-time employment

Beneficiary:

In case of dismemberment, the benefit is payable to the insured. In the event of accidental death, the benefit is paid to the beneficiary named by the insured. These benefits are payable provided the death or dismemberment results from the bodily injury caused solely by an accident, and loss occurs within 365 days of the accident. Only one benefit (the larger) will be paid for more than one loss resulting from any one accident. Benefits will not be paid for loss resulting from self-inflicted injury, War, sickness, or disease.

BUSINESS TRAVEL ACCIDENT INSURANCE

This describes the Group Travel Accident Insurance Plan provided to employees who are traveling on business for FCEOC.

While this booklet describes the Group Travel Accident Plan arranged for your benefit, it is not considered as the contract of insurance. For simplicity, this coverage has been described in a general and brief manner in this booklet. The complete terms of the group travel accident coverage are set forth in the Policy issued to FCEOC.

In order to fully understand the extent of your coverage under this Business Travel Accident Plan, you should be familiar with the following terms.

BUSINESS TRIP - Your coverage for a business trip begins when you leave your residence or place of regular employment, whichever is later, and concludes upon your return to your place of employment or residence, whichever is earlier.

BUSINESS TRAVEL - Business Travel means travel for the purpose of furthering the business of FCEOC. Injuries sustained during the course of everyday travel to and from work, leaves of absence or vacations are not, for the purpose of the insurance, regarded as injuries sustained during business travel.

WHAT THE PLAN COVERS - The Group Travel Accident Insurance Plan provides all-risk accident protection against most types of accidents while you are traveling on business, including when you are flying as a passenger (but not as a pilot or crew member) in any civilian aircraft.

ELIGIBILITY AND BENEFITS - All Commission and Committee Members, Senior Management employee and all other full-time employees are eligible for coverage under the Group Travel Accident Plan when they are traveling on business for FCEOC.

ACCIDENTAL DEATH and DISMEMBERMENT BENEFIT

In the event you sustain a loss, as described below, due to an accident occurring while traveling on business, the Business Travel Accident Policy will pay the percent of your Principal Sum applicable to the loss. The injury must be sustained while the Policy is in force and the loss must occur within 365 days of the date of the accident. If you should sustain more than one loss in the same accident, only one of the amounts shown, the largest, will be paid.

The amount shown in the schedule is payable at: a) 100% for loss of: Life, Both Hands, Both Feet, Sight of Both Eyes, One Hand and Sight of One Eye, One Foot and Sight of One Eye, or Speech and Hearing of both ears; b) 60% for either One Hand or One Foot; c) 50% for Sight of One Eye, Speech or Hearing of both ears; d) 25% for Hearing of One Ear, Thumb and Index Finger of same Hand; e) Maximum payable for all losses is 100%.

Loss Means:

(i) loss of a hand by total severance at or above the wrist; (ii) loss of a foot by total severance at or above the ankle; (iii) complete and total loss to the sight of an eye; (iv) complete and total loss of speech; (v) complete and total loss of hearing; or (vi) loss of thumb and index finger by total severance at or above the knuckles.

Injury Means:

Accidental bodily injury which: (i) is direct and independent of any other cause; and (1) requires treatment by a legally qualified physician or surgeon.

BENEFIT AMOUNT

CLASSIFICATION	PRINCIPAL SUM
Commission and Committee Members	\$100,000
Senior Management	\$250,000
All Other Employees	\$100,000

THE PLANS LIMITATIONS

The maximum aggregate amount payable on account of several employees being injured in the same accident is \$1,000,000. In the event the total benefits otherwise payable to the injured employees or beneficiaries exceed this figure, each injured employee or beneficiary will be paid a proportionate share of the loss rather than the other normal benefit.

THE PLAN'S EXCLUSIONS

Benefits are not paid for any loss caused by or resulting from: (a) suicide or self-inflicted injury; (b) bacterial infection, except those occurring with a cut or wound at the time of the accident; (c) any kind of disease; (d) medical or surgical treatment; (e) war or any act of war; (f) injury sustained while in any of the armed forces; (g) injury sustained while riding as a pilot or crew member of any aircraft; or (h) injury sustained while riding in any aircraft operated by FCEOC.

PAYMENT OF BENEFITS

The Dismemberment Benefit is payable to you The Benefit for loss of life will be paid as follows: to the beneficiary

or beneficiaries designated in writing for the Group Travel Accident Insurance Plan, otherwise; to the beneficiary or beneficiaries designated under the group life insurance policy issued to FCEOC, otherwise; to your surviving spouse, otherwise; to your surviving child or children, equally, otherwise; to your surviving parents, equally, otherwise; to your surviving brothers and sisters, equally, otherwise; to your estate.

HOW TO FILE A CLAIM

If you should suffer a loss covered by the policy, either you or your beneficiary should contact the Human Resources Office to obtain claim forms. Read the instructions on these forms carefully and be sure that all the questions are answered. Remember to include any required attachments when you return the completed forms. After your claim has been processed you will be notified in writing if any information is required or if any benefits are denied in whole or in part.

ELIGIBILITY PROVISIONS

EMPLOYEE

Active full-time employees who regularly work at least 30 hours per week are eligible for medical, prescription drug, dental, vision, life insurance and accidental death and dismemberment (AD&D) coverage on the first day of the month following your date of employment. **Your effective date** will be the first day of the calendar month following such waiting period. (You must enroll in the Plan within 31 days of employment).

Open Enrollment -An annual open enrollment of 30 days will be conducted each year for eligible employees and their dependents who have not been previously enrolled in the group health plan. Employees who did not enroll during the time periods mentioned above have an opportunity to enroll during this open enrollment period. The effective date of coverage will be January 1, following submission and approval of an enrollment form. Additionally, enrollment will be allowed for any individual who becomes a dependent because of marriage, birth, adoption or placement for adoption. Coverage will begin on the first of the following month. . If you are absent from work due to sickness or injury on the date your Life Insurance/AD&D would have become effective, your effective date will be deferred until you return to active full-time work.

Late Enrollee - A "Late Enrollee" means an eligible employee or dependent that has declined health coverage at the time of the initial enrollment period or open special enrollment and subsequently requests enrollment. A maximum preexisting exclusion period of 18 months can be applied to Late Enrollees.

All Late Enrollees who do not enroll with the original group may be required to submit satisfactory evidence of insurability, (health evidence) regardless of when the application is received, before coverage can become effective.

Special Enrollment - You will not be considered a Late Enrollee if you meet the following conditions: 1) You were covered under another employer health benefit plan at the time you became eligible to enroll in the Plan; 2) You have lost coverage under another employer health benefit plan as a result of termination of employment or change in employment status; 3) Your Employer ceases to make contributions; 4) Your COBRA coverage terminates; 5) Your dependent will not be considered a Late Enrollee when he or she will be without coverage due to the above reasons or loss of coverage due to your death or divorce or coverage required according to a court order or addition to coverage due to marriage, birth, adoption or placement for adoption.

For any of the above reasons you must request enrollment within 31 days from date enrollment status is changed.

Non Participant, Life & AD&D - Active full-time employees enrolled in the medical plan have an eligibility waiting period of 30 days for Life Insurance/AD&D. Active full-time employees not enrolled in the medical plan and active regular part-time employees are eligible for Life Insurance/AD&D only after completing 90 days of employment. A regular part-time employee is someone who works at least 30 hours biweekly.

Voluntary Benefits – Supplemental Life and AD&D are a voluntary benefit offered by FCEOC. If an employee requests to enroll after 31 days of becoming eligible for coverage, Evidence of Insurability will be required. These benefits may change from time to time and are not part of FCEOC employer provided benefits.

DEPENDENTS: Your Spouse and Dependent Children up to age 26

Eligible dependents include your Spouse, your or your Spouse's natural children, legally adopted children and children under legal guardianship as a result of an order by a State or Federal Court. You are allowed to cover all eligible dependents under the age of 26. Your dependents are eligible for the same benefits as you are, except Life Insurance and AD&D. Your Child may be married, not living at home, working, not in school and living in another geographic area. Your dependent, under age 26, is eligible for coverage until he/she is eligible for other group coverage whether that coverage has been accepted or not. Plan Administrator may require verification.

For dependent children under age 19 to be eligible under guardianship, the child must: 1) live with you full time, 2) be financially supported by you for the past six months, and 3) qualify for coverage subject to standard underwriting procedures such as Preexisting and health evidence. The Plan Administrator must approve in advance any dependent child by guardianship relationship.

Eligibility based on a qualified Medical Child Support Order: If you and your Spouse are involved in a marital dissolution that results in a Medical Child Support Order, the Medical Child Support Order must be properly served and you must provide in writing to PCMI each of the following items: 1) The Participant's name, Social Security number and last known address; 2) The name and address of each child who is entitled to enrollment in the Plan; 3) The name and address of any representative of the children who should receive payment and/or communications from the Plan; 4) A reasonable description of the type of coverage ordered by the court, or the manner in which such coverage is to be determined; 5) The period for which coverage must be provided; and 6) Each plan or type of benefits to which the order applies.

Once PCMI receives a Medical Child Support Order from the court, the Participant and each child, (or the child's representative) will be notified of the receipt of the order and be provided a copy of the Plan's procedures for determining if the order is qualified. All parties will be notified of the Plan Administrator's determination.

Your dependents normally have the same **effective date** as you. Eligible dependents acquired after your Effective Date will be qualified on the date of marriage, birth, adoption or legal placement. You must advise PCMI and the Human Resources Office within 31 days that you have a new dependent. If you want to drop coverage for an existing dependent that would otherwise remain covered under the Plan, you may do so only during the annual enrollment period or a special enrollment period. If you want to add coverage for an existing dependent not currently covered under the Plan, you must wait for the annual open enrollment period or a special enrollment period.

TERMINATION AND CONTINUATION OF COVERAGE

TERMINATION

Your medical, prescription drug, dental and vision coverage will end on the earliest of the following dates, according to the Plan's records: 1) the last day of the calendar month for which you have made the required contributions; 2) the date you reach the maximum benefits under the Plan; 3) the date you no longer are employed by the Plan Sponsor; 4) the day the Plan is terminated. The only exception to that is a special enrollment (page 27)".

If you cover dependents, their coverage will automatically terminate when yours does. Coverage for any one dependent will cease on the earliest of the following dates: 1) for a Spouse, on the last day of the month in which a dissolution of marriage occurs; 2) for a child dependent, on the last day of the month in which the child dependent ceases to meet the definition of eligible dependent; 3) the date dependent coverage is discontinued under the Plan.

Certificate of Coverage - A certificate stating when you were covered under the Plan will be provided to you when you lose coverage under the Plan.

Your Life Insurance and Accidental Death & Dismemberment Insurance will terminate on the earliest of: 1) the date the policy terminates; 2) the date premium is due for you but not paid by the Plan; 3) the last day of

the period for which you make any required premium contribution, if you fail to make any further required contribution; 4) the date you enter active full-time duty, other than active duty training purposes for 2 months or less, in the armed forces (land, water or air) of any country or international authority; 5) the date your employment terminates. This means that you have ceased Active full-time or regular part-time work in an eligible class.

CONTINUATION OF COVERAGE UNDER COBRA

LAYOFF, LEAVE OF ABSENCE OR DISABILITY –

Continuation of coverage due to Disability

If an Employee or one of an Employee's Eligible Dependents is confined in a Hospital or similar facility on the date of termination, the Employee or such Eligible Dependent will be entitled to receive benefits during the uninterrupted continuation of such confinement until a) the patient is discharged from the Hospital or facility; or b) the patient exhausts his/her eligible days.

Eligibility for Coverage under COBRA -

You have a right to choose this continuation coverage if you lose your group health coverage under this Plan because of a "Qualifying Event" and the Participant was covered under the Plan on the day before the Qualifying Event, the Plan will offer the Participant and any covered eligible spouse, or eligible dependents the opportunity to continue coverage as a "Qualified Beneficiary" in compliance with the Consolidated Omnibus Budget Reconciliation Act of 1985 as amended (COBRA)

A "Qualified Beneficiary" is an Employee, Spouse and/or Dependent Child who was/were covered under this Plan on the day before a Qualifying Event, and who loses coverage as a result of the Qualifying Event. A Child who is born to the covered Employee, or who is placed for adoption with the covered Employee, during a period of COBRA continuation coverage is also a Qualified Beneficiary. The Employee's Qualifying event date and resultant continuation coverage period also apply to the child.

A "Qualifying Event" for a Participant is any of the following that results in a loss of coverage for that Participant (and you are not covered by another group plan):

- (1) Reduction in your hours of employment to the extent that the Employee is no longer eligible to participate in the Plan. Reduction of an Employee's hours of employment to non-eligible status. A Qualifying Event can occur whether or not the Employee actually works and may include but not limited to absence from work due to a disability, temporary lay-off or leave of absence (LOA), where Plan coverage terminates but termination of employment does not occur. If a covered Employee is on FMLA unpaid leave, a Qualifying Event occur at the time the Employee fails to return to work at the termination of the leave. Also to include if the Employee fails to pay their portion of the cost of the Plan coverage during said FMLA unpaid leave.
- (2) Termination (voluntary or involuntary) of your employment for reasons other than gross misconduct on your part.
- (3) The Employee's death.
- (4) Divorce or legal separation of the Employee from the Employee's Spouse.
- (5) The Employee's Spouse or eligible dependent(s) when the Employee becomes entitled to Medicare benefits under Title XVIII of the Social Security Act. For COBRA purposes, entitlement is described as the Medicare enrollment process has been completed with the Social Security Administration and the Employee has been notified that their Medicare coverage is in effect.
- (6) A Dependent Child no longer satisfies the Plan's definition of "Dependent Child".

If any of the events listed in (1) through (6) immediately above results in an increase in contribution which a Participant must pay to remain covered under the Plan, that increase in contribution will also be considered a Qualifying Event and a loss of coverage.

Coverage under COBRA will be identical to coverage offered under the Plan to similarly situated Employees, as such coverage under the Plan may change from time to time. Each qualified beneficiary under COBRA shall have all of the rights of an Employee under the Plan, including the right to enroll dependents, if such right is given to Employees; however other than a child born to the Employee or placed for adoption with the Employee during a period of COBRA continuation coverage, any such dependent so enrolled, who was not covered under the Plan

on the day prior to the initial Qualifying Event, although eligible for coverage under COBRA, shall not have the status of Qualified Beneficiary.

Initial Notification

Under the law, if the Qualifying Event is a divorce, legal separation, or a Child losing dependent status under the Plan, the Qualified Beneficiary eligible for COBRA as a result of such Qualifying Event must notify the Contracted Plan Administrator (PCMI), in writing, within sixty (60) days of the date of the later of the event or the date that coverage would end under the Plan because of the event. If the Plan Administrator is not so notified, the Qualified Beneficiary may not enroll in COBRA.

Employer has the responsibility to notify PCMI of the employee's death, termination, and reduction in hours of employment or Medicare entitlement within thirty (30) days of such event. Similar rights may apply to certain retirees, spouses, and dependent children if your Employer commences a bankruptcy proceeding and these individuals lose coverage.

When PCMI is notified that one of these events has happened, you will be notified that you have the right to choose continuation of coverage within fourteen (14) days following the thirty (30) day period specified in the above paragraph. If you do not choose continuation of coverage your group health coverage will end.

Electing COBRA

If a Qualified Beneficiary elects to enroll in COBRA, he must so notify the Plan Administrator, in writing, within sixty (60) days of the date the Plan Administrator mails written notification of the right to continue coverage, except that if the loss of coverage occurs after the date of the Qualifying Event, the sixty (60) days shall be counted from the date coverage is lost. An election is considered to be made on the date it is mailed to the Plan Administrator. Failure to elect COBRA within the 60-day period will result in the inability to elect COBRA continuation coverage.

Each Qualified Beneficiary may make his own independent election to receive or not receive COBRA coverage. However each Qualified Beneficiary may be listed on one (1) COBRA Election form. If an Employee or a Spouse of an Employee elects COBRA and does not specify his election is self-only, the election will be deemed to include election of COBRA for all Qualified Beneficiaries with respect to that Qualifying Event. An election on behalf of a minor child may be made by the child's parent or legal guardian. An election on behalf of Qualified Beneficiary who is incapacitated or deceased may be made by the legal representative or the estate of the Qualified Beneficiary as determined under applicable state law, or by the Spouse of the Qualified Beneficiary.

If notice of election is not sent to the Plan Administrator within the period specified in the paragraph immediately above, the Qualified Beneficiary may not enroll in COBRA.

A Qualified Beneficiary who waives his right to COBRA during the initial 60 day period discussed in the first paragraph of this section "Electing Cobra" may, at any time during such 60 day period, revoke his waiver and enroll in COBRA; however, coverage under COBRA will be effective as of the date the revocation of the waiver is sent to the Plan Administrator, and will not be made retroactive to the date coverage would have been in effect had the waiver not been made. This right to revoke a waiver expires at the end of the initial 60-day period.

Open Enrollment rights that are allowed to active Employees to choose among available coverage options are also available to COBRA participants. "Special enrollment rights", of the health Insurance Portability and Accountability Act (HIPAA) extend to COBRA participants. However, if a former Qualified Beneficiary DID NOT elect COBRA during their initial election period, they do not have special enrollment rights even though active Employees not participating in the Plan have such rights under HIPAA.

Effective Date of Coverage

COBRA continuation coverage, if elected within the period allowed for such election will be retroactively effective to the date coverage would otherwise have terminated due to a Qualifying Event. The Qualified Beneficiary will be charged for coverage within the retroactive period to current.

Length of COBRA Coverage

(1) For Covered Employees, Spouses and Dependent Children

If the Qualifying Event is an Employee's termination of employment for reasons other than gross misconduct,

or reduction in hours worked to the extent that the Employee is no longer eligible for coverage under the Plan, COBRA may be continued for up to eighteen (18) months for all Participants who become Qualified Beneficiaries as a result of such event.

If a Qualified Beneficiary is disabled on the day of either Qualifying Event discussed in the paragraph immediately above, or become disabled during the first sixty (60) days of COBRA coverage, COBRA coverage for all Qualified Beneficiaries in the disabled Qualified Beneficiary's family may be continued for an additional eleven (11) months beyond the original eighteen (18) months, regardless of whether or not the disabled individual himself elects the 11-month extension. As used herein, "disabled" means the Qualified Beneficiary has been determined under Title 2 or Title 16 of the Social Security Act to be disabled. The "first sixty (60) days of COBRA coverage" is counted from the date of the Qualifying Event or the date coverage would actually be lost, whichever is later.

For the 11-month extension to apply, the Qualified Beneficiary must notify the Plan Administrator, in writing, of the determination of disability, such notification to be within the initial 18-month period of COBRA, and not more than sixty (60) days after the date on which the determination was made by the Social Security Administration. If the disabled Qualified Beneficiary is later determined by the Social Security Administration to no longer be disabled, he must so notify the Plan Administrator, in writing, within thirty (30) days of such redetermination. If the redetermination occurs during the initial eighteen (18) months of COBRA, coverage may continue until the end of the eighteen (18) months. If the redetermination occurs during the 11-month extension, coverage will cease for all Qualified Beneficiaries as of the month that begins more than thirty (30) days after the date of the redetermination.

If a Qualified Beneficiary first becomes disabled more than sixty (60) days after COBRA has begun, or fails to notify the Plan Administrator as explained above within the 18-month period, the 11-month extension does not apply.

(2) For Spouses and Dependent Children

If the Qualifying Event is other than the two specified in (1) directly above, COBRA coverage may be continued for up to thirty-six (36) months for any Spouse or Dependent Child who become Qualified Beneficiaries as a result of such Qualifying Event.

(3) Multiple Qualifying Events

If a second qualifying event occurs during COBRA coverage, in no event will coverage under COBRA be extended beyond a maximum of thirty-six (36) months from the date of the initial Qualifying Event. Termination of employment following the Qualifying Event or reduction in hours is not a second Qualifying Event.

Payment for COBRA

The cost to a qualified beneficiary for COBRA coverage shall be no more than 102% of the Employer's cost, or 150% of the Employer's cost during an 11-month extension for disability, for such coverage. Continuation of coverage is fixed for a 12 month period of time.

A qualified beneficiary's first payment for COBRA is due forty-five (45) days after the date of his election. *If payment is not made within the 45 day period, the COBRA election is null and void. The initial premium payment must cover the period of coverage from the date the COBRA election retroactive to the date of loss of coverage due to the Qualifying Event (or the date a COBRA waiver was revoked).* All subsequent payments are due on the first (1st), of the month thereafter or within thirty (30) days of the first day of coverage such payment represents, or within the period of time allowed under the Plan for covered Employees, whichever is later. Payment is considered to be made on the date on which it is sent to the Plan and may be paid on a monthly, quarterly, semi-annual or annual basis. The Plan is not obligated to send monthly payment notices.

Failure to pay any contributions due within the time frames specified in this section will result in cancellation of COBRA coverage, such cancellation to be effective as of the end of the last day for which coverage has been paid. COBRA does not require that the Qualified Beneficiary be notified in the event that cancellation of COBRA coverage has occurred.

Payment of Claims

No claims and/or pharmacy benefits will be payable under the Plan until PCMI receives the applicable monthly contribution by, or on behalf of, the Qualified Beneficiary. Such receipt will not be considered complete until the check by which such payment is made is cleared by the bank on which it is drawn.

Termination of COBRA Coverage

However, your continuation coverage may be cut short for any of the following reasons:

- (1) Employer no longer provides group health coverage to any of its employees; or
- (2) The Qualified Beneficiary does not pay his contributions for COBRA within the time frames specified herein (COBRA will terminate on the last day of the period for which contributions have been made); or
- (3) The Qualified Beneficiary becomes covered under another group health plan that does not contain any exclusion or limitation with respect to any preexisting condition you may have (COBRA will terminate on the date coverage under the other plan becomes effective); or
- (4) You become entitled to Medicare; or
- (5) You extended coverage for up to 29 months due to your disability and there has been a final determination that you are no longer disabled.
- (6) The last day of the applicable maximum coverage period (18, 29, or 36 months)
- (7) Termination for cause the coverage of any Qualified Beneficiary on the same basis that the Plan may terminate the coverage of similarly situated non-COBRA beneficiaries for cause (for example: submission of fraudulent information to obtain benefits and/or claims.)
- (8) If an individual is receiving COBRA continuation coverage solely because of the person's relationship to the Qualified Beneficiary (for example: Spouse acquired during Employee's COBRA coverage period, etc..)

Under the law, you will have to pay the contribution for your continuation of coverage. There is a grace period of 30 days for payment of the regularly scheduled contribution.

When coverage for COBRA has terminated, PCMI will automatically provide a certificate of coverage. This document will be required in order for an Employee to waive any period of exclusion for a pre-existing condition with their new health plan if any.

If you have any questions about COBRA please contact PCMI. Also, if you have changed marital status (for example: divorce or legal separation), addition of a newborn or legally adopted eligible dependent, or you or your spouse have changed your address, please notify PCMI.

TOTAL DISABILITY

Medical Benefits

If you, or any eligible dependent, are Totally Disabled due to injury or sickness at the time medical benefits would otherwise terminate, such benefits will be continued for the Disabling condition only, through the earliest of the following dates: (1) the date your Physician certifies Total Disability ends; (2) the date maximum Plan benefits have been paid for the Disability; (3) one year from the date major medical coverage terminated; (4) the date your former employer ceases to provide coverage to your class of employees; (5) the date you or your dependent become effective with another group health plan.

You will be considered Totally Disabled when your attending Physician certifies that you are unable to perform the duties of any gainful employment for wages or profit, for which you are reasonably qualified by training and education. Your eligible dependent will be considered Totally Disabled when an attending Physician certifies that he or she is unable to engage in the normal activities of a person of the same age and sex due to injury or sickness.

COORDINATION OF BENEFITS AND SUBROGATION

COORDINATION OF BENEFITS

Benefits payable under the Plan will be coordinated with any other plan (including any medical policy provided by your auto insurer) you or your dependents may have that also pay you benefits. Coordination means that benefits are paid so that no more than 100% of the Usual, Customary and Reasonable expenses or the negotiated fee, whichever is less, will be covered under the combined benefits of all plans for which you or your dependents are eligible.

PCMI's order of payment for Coordination purposes is:

1. The Plan that covers the patient as the individual will be the primary payor. If the patient is eligible as the individual under two or more plans, the plan having the earliest effective date will be primary. Coordination of benefits does not apply to dependent children over the age of 19. If the dependent child has other group coverage, he/she would no longer be eligible for benefits under the FCEOC Health and Welfare Plan.
2. In the case of dependent children, the plan of the parent whose birthday comes earliest in the year will be primary.
3. When the natural parents are divorced, the primary payor will be the plan of the custodial parent. The secondary payor will be the plan of any stepparent living with the child in a parental relationship. The non-custodial parent's plan will be next.
4. The Plan Sponsor will coordinate as secondary to any Plan that is in excess over the Plan.

For the purpose of Coordination of Benefits, PCMI: (1) may release to or obtain from any individual or organization any claim information which PCMI may require; (2) has the right, if an overpayment is made under the Plan because of failure to report or consider other coverage, to recover the overpayment from any individual or individuals to whom it was made; (3) has the right to reimburse any other organization an amount PCMI determines to be warranted, if payments which should have been made under the Plan were made by that organization.

If any charges are covered under two or more parts of your plan, benefits will be coordinated so that the total payment will not exceed 100% of the actual charges.

If both husband and wife are eligible as an employee under the Plan and cover each other as dependents, benefits will be processed under both coverage's, except under the Prescription Drug Card Program.

Benefits under this Plan will be integrated with any benefits payable under the federal Medicare program. If you are eligible for Medicare coverage, but do not apply, benefits will be integrated up to the amount estimated by PCMI to be the benefits that would have been payable by Medicare.

SUBROGATION

The Plan will not pay for your benefits because of any illness, injury, disease or other condition for which another person might be responsible or legally liable by reason of his wrongful act against you. The Plan will advance benefits to you or your dependents if another person is responsible for your condition, if you agree in writing: (1) To reimburse the Plan to the extent of benefits the Plan has provided to you as soon as you or your heirs, parents or legal guardians, collect damages from the other person who was responsible for your illness, injury or disease. (2) To provide the Plan with a lien (a promise to pay) to the extent of your benefits provided by the Plan. The lien may be filed with the other person whose act caused your injuries, his agent, insurer, the Court, or administrative agency. When you request benefits, you must notify the Plan immediately if you believe that you are injured or ill because of the act of another person. You must supply additional information if requested by the Plan. If you learn after you request benefits that another person may be responsible for your injury or illness, you must notify the Plan of this fact within 90 days of any claim or legal action you take against another person if the Plan paid benefits to you as a result of that other person's actions.

HIPAA: NOTICE FOR SUBMISSION OF HIPAA HEALTH PRIVACY COMPLAINTS **Effective April 14, 2004**

A Participant who believes that the Plan Administrator / Covered Entity is not complying with the Privacy Rule or Privacy Provision requirements may file a complaint with the Secretary of Health and Human Services. The Privacy Provisions are outlined under the Administration section of this Plan Document.

How to File a Complaint

A complaint to the Secretary of Health and Human Services must:

- Be filed in writing, either on paper or electronically;
- Name the Plan Administrator / Covered Entity that is the subject of the complaint and describe the nature of the alleged violation applicable to the Privacy Rules;
- File within 180 days of when the person filing the complaint knew or should have known when the complaint occurred. This time limit may be waived by the Office of Civil Rights if good cause is shown.

Where to File a Complaint

Privacy Rule complaints to the Secretary of Health and Human Services should be addressed to the Office for Civil Rights (OCR) regional office that is responsible for matters relating to the Privacy Rule arising in the state or jurisdiction where the Plan Administrator / Covered Entity is located. Complaints may also be filed by email to OCRComplaint@hhs.gov. The OCR regional office that applies to FCEOC is as follows:

REGION IX:

Office for Civil Rights

U.S. Dept of Health and Human Services

50 United Nations Plaza – Room 332

San Francisco, CA 94102

PRIVACY PRACTICES **Effective April 14, 2004**

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

Introduction

FCEOC is committed to treating and using protected health information about Participants responsibly. This Notice of Health Information Practices describes the personal information we collect, and how and when we use or disclose that information. It also describes your rights as they relate to your protected health information. This Notice is effective *April 14, 2004*, and applies to all protected health information as defined by federal regulations.

Understanding Your Health Record/Information

Each time you visit Provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a:

- Basis for planning your care and treatment,
- Means of communication among the many health professionals who contribute to your care,
- Legal document describing the care you received,
- Means by which you or a third-party payer can verify that services billed were actually provided,
- A tool in educating health professionals,
- A source of data for medical research,
- A source of information for public health officials charged with improving the health of this state and the nation,

- A source of data for our planning and marketing,
- A tool with which we can assess and continually work to improve the care we render and the outcomes we achieve.

Understanding what is in your record and how your health information is used helps you to: ensure its accuracy, better understand who, what, when, where, and why others may access your health information, and make more informed decisions when authorizing disclosure to others.

Your Health Information Rights

Although your health record is the physical property of the Provider, the information belongs to you. You have the right to:

- Obtain a paper copy of this notice of information practices upon request,
- Inspect and copy your health record as provided for in 45 CFR 164.524,
- Amend your health record as provided in 45 CFR 164.528,
- Obtain an accounting of disclosures of your health information as provided in 45 CFR 164.528,
- Request communications of your health information by alternative means or at alternative locations,
- Request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522, and
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken.

Our Responsibilities

FCEOC is required to:

- Maintain the privacy of your health information,
- Provide you with this notice as to our legal duties and privacy practices with respect to information we collect and maintain about you,
- Abide by the terms of this notice,
- Notify you if we are unable to agree to a requested restriction, and
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will mail a revised notice to the address you've supplied us, or if you agree, we will email the revised notice to you.

We will not use or disclose your health information without your authorization, except as described in this notice. We will also discontinue to use or disclose your health information after we have received a written revocation of the authorization according to the procedures included in the authorization.

For More Information or to Report a Problem

If have questions and would like additional information, you may contact FCEOC's Privacy Officer at Human Resources at (559) 263-1070.

If you believe your privacy rights have been violated, you can file a complaint with the practice's Privacy Officer or with the Office for Civil Rights, U.S. Department of Health and Human Services. There will be no retaliation for filing a complaint with either the Privacy Officer or the Office for Civil Rights. The address for the OCR is listed below:

*Office for Civil Rights
 REGION IX:
 Office for Civil Rights
 U.S. Dept of Health and Human Services
 50 United Nations Plaza – Room 332
 San Francisco, CA 94102*

Examples of Disclosures for Treatment, Payment and Health Operations

We will use your health information for payment.

For example: A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used.

We will use your health information for regular health operations.

For example: The information provided to your Provider will be used to determine if benefits are payable under the Plan.

Business associates: There are some services provided in our organization through contacts with business associates. Examples include physician services in the emergency department and radiology, certain laboratory tests, and a copy service we use when making copies of your health record. When these services are contracted, we may disclose your health information to our business associate so that they can perform the job we've asked them to do and bill you or your third-party payer for services rendered. To protect your health information, however, we require the business associate to appropriately safeguard your information.

Any legal action where you or your Provider is a party will result in providing identifying health information. The retaining of legal counsel will include a confidentiality of this information.

Notification: We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location, and general condition.

Communication with family: Health professionals, using their best judgment, may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care.

Workers compensation: We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

Law enforcement: We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.

You will be asked to sign an enrollment form authorizing any insurance company, physician, hospital, clinic or health care provider to give PCMI or its designated agent any and all records pertaining to any medical history, services or treatment provided to anyone listed on the PCMI enrollment form for purpose of review, investigation or evaluation.

PRIVACY RULE / PROVISION

FCEOC, who is the sponsor of this Plan, will receive protected health information. The information may be identified to the individual in some cases. FCEOC is limited in how it may use this information. Its uses and disclosures must be necessary to carry out Plan functions. The plan functions must relate to payment or health care operations. It may also use or disclose the information as required by law.

Prior to receiving any protected health information FCEOC must certify to the Plan that it agrees to:

1. Not use or disclose the information, except as stated above;
2. Require that any agent or subcontractor of FCEOC agree to the same limits that apply to FCEOC prior to giving the information to them;
3. Not use or disclose the information for employment related decisions or actions;
4. Not use or disclose the information in connection with other benefit plans FCEOC may sponsor;
5. Report to the Plan any use or disclosure that does not comply with this General Privacy provision;
6. Make the information available for review by the person that it relates to;
7. Make the information available for amendment and include any amendments with it;
8. Provide the necessary information to give an accounting of disclosures;
9. Make its internal practices, books and records in relation to the information open for review by the Secretary

of Health and Human Services;

10. Return or destroy all information when it is no longer needed. If that is not possible, limit any future use or disclosure to the reason it was not possible to return or destroy it;
11. Maintain adequate separation between the Plan and itself. Access to the information will be limited to members of FCEOC's Human Resource department, and Finance department that work with the Plan. These individuals will receive the minimum necessary information to carry out the Plan functions they perform.
12. Provide an effective process to address non-compliance by FCEOC or its agents or subcontractors.

CLAIMS FILING PROVISIONS

To File a Claim

To file a claim you will need to give the Provider your name, your Employer's name, unique health care ID number from you ID card or your Social Security Number, sex, and birth date as reported on your enrollment form. If the claim is for a Dependent, the Dependent's name, sex, birth date, and relationship to you must be included. The use of a claim form is not necessary. You must sign the Authorization to Release Information and the Provider will take all itemized bills and mail it to Pinnacle Claims Management, Inc. P O Box 2220, Newport Beach, CA 92658. Itemized bills must include name, address, Tax Identification Number, and phone number of the treating Provider, each date of service, the diagnosis, a complete description of the services performed, the patient's full name, sex, date of birth, Employee's unique health care ID number or Social Security Number, the charges incurred, and Accident details if applicable. The Plan may require additional evidence to establish whether or not any claim should be paid, and may require supplementary documentation in order to adjudicate a claim. If the patient fails to cooperate with such requests, the claim may be denied.

Notice of Claim / Filing Limits

You should file your claims within 90 days after the expenses were incurred. Claims will still be considered for payment when it is not possible to provide notification within 90 days, but you should always file your claims as soon as possible. In no event will claims be paid if they are submitted more than 12 months after the expense was incurred, except in the absence of legal capacity. ***Claim forms are not necessary. PCMI will accept most bill forms from the Provider, as long as the information indicated in the preceding paragraph is contained on the billing form.***

Processing of Claims

You will receive a check and/or Explanation of Benefits (EOB) as soon as possible (usually within thirty (30) days after receipt of claim) after all necessary information has been received. You will be notified of the payment with an EOB at the time the Provider's check is mailed. Please keep copies of all EOB's sent to you, as PCMI will not reissue EOB's. It is important to note that PCMI is required to pay the Provider when you use a Participating Provider. ***If you chose to pay the Provider, other than the co-payment and/or Deductible, you will need to obtain a refund from the Provider. This is a contractual requirement for all Participating Providers.***

CLAIMS TIME LIMITS AND ALLOWANCES

The chart below sets forth the time limits and allowances that apply to the Plan and a Claimant with respect to claims filings, administration and benefit determinations (i.e., how quickly the Plan must respond to claims notices, filings and claims appeals and how much time is allowed for Claimants to respond, etc.). If there is any variance between the following information and the intended requirements of the law, the law will prevail.

Important: These claims procedures address the periods within which claims determinations must be decided, not paid. Benefit payments must be made within reasonable periods of time following Plan approval as governed by state statutes.

"PRE-SERVICE" CLAIM ACTIVITY	TIME LIMIT OR ALLOWANCE
Urgent Claim - defined below Claimant Makes Initial <u>Incomplete</u> Claim Request	Within not more than 24 hours (and as soon as possible considering the urgency of the medical situation), Plan notifies Claimant of information needed to complete the claim request. Notification may be oral unless Claimant requests a written notice.
Plan Receives <u>Completing</u> Information	Plan notifies Claimant, in writing or electronically, of its benefit determination as soon as possible and not later than 48 hours after the earlier of: (1) receipt of the completing information, or (2) the period of time Claimant was allowed to provide the completing information.
Claimant Makes Initial <u>Complete</u> Claim Request	Within not more than 72 hours (and as soon as possible considering the urgency of the medical situation), Plan

"POST-SERVICE" CLAIM ACTIVITY	TIME LIMIT OR ALLOWANCE
Claimant Appeals	See "Appeal Procedures" subsection.
Plan Responds to Appeal	Within 60 days after receipt of appeal
<p>"Full notice" means that notice is provided to the Claimant describing the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. Such extension must be necessary due to matters beyond the control of the Plan and notification to Claimant must occur prior to the expiration of the initial 15-day period.</p>	
Claimant Makes Initial <u>Incomplete</u> Claim Request	Within 30 days (and sooner if reasonably possible), Plan advises Claimant of information needed to complete the claim request.
Plan Receives <u>Completing</u> Information	Within 30 days, Plan approves or denies claim. 15 additional days may be allowed with full notice to Claimant - see definition of "full notice" below.
Claimant Makes Initial <u>Complete</u> Claim Request	Within 30 days of receiving the claim, Plan approves or denies claim. 15 additional days may be allowed with full notice to Claimant - see definition of "full notice" below.
Claimant Appeals	See "Appeals Procedures" subsection.
Plan Responds to Appeal	Within 60 days after receipt of appeal
<p>"Full notice" means that notice is provided to the Claimant describing the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. Such extension must be necessary due to matters beyond the control of the Plan and notification to Claimant must occur prior to the expiration of the initial 30-day or 60-day period.</p>	

Authorized Representative May Act for Claimant

Any of the above actions that can be done by the Claimant can also be done by an authorized representative acting on the Claimant's behalf. The Claimant may be required to provide reasonable proof of such authorization. For an urgent claim, a health care professional, with knowledge of a Claimant's medical condition, will be permitted to act as the authorized representative of the Claimant. "Health care professional" means a physician or other health care professional licensed, accredited, or certified to perform specified health services consistent with state law.

Written or Electronic Notices

The Plan shall provide a Claimant with written or electronic notification of any benefit reduction or denial. Written or electronic notice of an approved benefit must be provided only for Pre-Service benefit determinations.

RIGHTS OF EMPLOYEES PARTICIPATING IN THE PLAN

Assignment of Benefits

A Participant will have the right to assign the payment of benefits for which he/she is eligible under this Plan to any eligible Provider of services. If a Provider makes a representation to the Third Party Administrator (TPA) that a person covered under this Plan has made an assignment of benefit payments to the Provider, the TPA will make payment to the Provider based on that representation. ***If you utilize a Participating Provider the benefits will be paid directly to the Provider of services. This is a contractual requirement for all Participating Providers.*** The TPA will have the right to examine any claim to determine Covered Expense under this Plan whether assigned or unassigned.

Non-Discrimination

In connection with the administration of this Plan, the Plan Administrator or representatives of the Plan Administrator will not discriminate unfairly between individuals in comparison to similar situations at the time of such action.

Choice of Providers

The persons covered under this Plan have the sole right to select their own Providers of health care. PCMI or FCEOC is not responsible for the providing for, or the quality of, any type of Hospital, medical or similar care. Benefits provided under this Plan do not regulate the amounts charged by Providers of medical care.

This Plan in no way interferes with the right of any person entitled to Hospital benefits to select any Hospital. That person may choose any Physician who is a member of, or acceptable to, the attending staff and Board of Directors of the Hospital where services are received. However, that person's choice may affect the benefits payable according to the terms of the Plan.

AMENDMENT AND TERMINATION OF THE PLAN

Amending the Plan

While it is FCEOC's goal to provide Employees and their families with comprehensive benefits, FCEOC reserves the right to reduce, change or eliminate benefits at its discretion, provided such changes are provided to you in a written notice within 60 days after the change, explaining the change and the effective date of the change. Any such amendment shall be binding upon all Participants (including those Participants on continuation coverage). You may also be sent amendments to this Plan Document. Be sure to read and save all Plan communications.

No change in this Plan will be valid unless it is approved by the Plan Administrator or the duly authorized representative of the Plan Administrator and received in writing by the TPA. Any such amendment must be endorsed by the Plan Administrator or the duly authorized representative of the Plan Administrator and attached to this Plan Document.

Retroactive Amendments

An amendment to the Plan may be retroactively effective up to a maximum of six (6) months. Incurred, but not processed claims will be adjusted according to the amendment.

Miscellaneous Provisions

When the amount paid by the Plan exceeds the amount for which the Plan is liable for, FCEOC has the right to recover the excess amount. This amount may be recovered from the Participant, the person to whom payment was made or any other Plan.

Right to Terminate or Merge the Plan

Notwithstanding that the Plan is established with the intention that it be maintained indefinitely, the Employer reserves the unlimited right to terminate or merge the Plan at any time without prior written notice to any Participant. The date of the merger or termination will be the date specified in the enabling resolution. Termination of the Plan shall apply to all Participants including those on continuation coverage. Additionally, the Employer reserves the right to determine from time to time the level of contribution required from Participants for Plan coverage.

Misstatement of Facts

No agent or representative of the Plan will have the authority to legally change this document or waive any of its provisions, either purposely or inadvertently. Any change must be made as stated above. If any relevant facts pertaining to any person's eligibility for benefits under this Plan are found to be misstated, an equitable adjustment of any benefits paid will be made. If such misstatement affects the existence of coverage, the true facts will be used in determining whether coverage is in force under the terms of this Plan, and in what amounts.

Notice of Material Reduction of Benefits

This Plan shall furnish a summary of a material reduction in Covered Expenses or benefits to covered Participants within 60 days after the change has been adopted.

Entire Contract

The Plan Document, together with any Amendments to it, constitutes the entire contract. Any statement made by the Plan Administrator, the Claims Administrator, or any Employee will, in the absence of fraud, be considered a representation and not a warranty. No such statement will void coverage or reduce benefits, or be used in defense of a claim unless it is in writing.

MISCELLANEOUS

Identification (ID) Card

You will receive one (1) ID card if you are the only person covered or two (2) ID cards if two or more people are covered under the Plan. If you need additional ID cards for covered Dependents who live away from home, please contact PCMI's Customer Service department to request one. If your ID card is lost or stolen, or if any of the information on your card is incorrect, please notify our Customer Service department immediately.

If an Eligible Employee or Dependent permits a person who is not a covered member of the family unit to use their identification card, the Plan Sponsor will immediately terminate each eligible person. Additionally, the Plan will seek reimbursement for any improperly paid claim.

Legal Action

No Eligible Employee or Dependent will have any right or claims to benefits from the Plan, except as specified herein.

No legal action may be brought against the Plan earlier than 60 days after the Plan has been furnished with proof of a loss. In addition, no legal action can be brought against the Plan more than two (2) years from the date proof of loss was provided to the Plan.

State Law

This Plan shall be interpreted; construed and administered in accordance with applicable state or local laws to the extent such laws are not preempted by federal law.

Termination for Fraud

An individual's coverage or eligibility for coverage may be terminated if:

- The individual submits a claim that contains false or fraudulent information under State or Federal laws;
- A civil or criminal court finds that the individual has submitted claims that contained false or fraudulent information under State or Federal laws.

Word Usage

Whenever words are used in this document in the singular or masculine form, they shall, where appropriate, be construed so as to include the plural, feminine, or neutral form.

ERISA INFORMATION AND CLAIMS APPEAL PROCEDURES

ERISA INFORMATION

As a Participant in this Plan you are entitled to certain rights and protection under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan Participants shall be entitled to:

1. Examine, without charge, at the FCEOC's Human Resources Office and at other specified locations, all Plan documents, including insurance contracts, collective bargaining agreements and copies of all documents filed by the Plan with the U.S. Department of Labor, such as detailed annual reports and Plan documents;
2. Obtain copies of all Plan documents and other Plan information upon written request to FCEOC. PCMI may make a reasonable charge for the copies; and,
3. Receive a summary of the Plan's annual financial report if the Plan covers 100 or more Participants. The Plan Administrator is required by law to furnish each Participant with a copy of this summary financial report.

In addition to creating rights for Plan Participants, ERISA imposes duties upon the people who are responsible for the operation of your employee benefit Plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan Participants. No one, including your Employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA. If your claim for a welfare benefit is denied in whole or in part you may receive a written explanation of the reason for the denial. You have the right to have PCMI review and reconsider your claim.

Under ERISA there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case the court may require FCEOC to provide the materials and pay you up to \$100 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of FCEOC.

If you have a claim for benefits, which is denied or ignored, in whole or in part, you must first file an appeal with PCMI. Filing an appeal with PCMI is the only way to protect your appeal rights.

Please see Claims Appeal Procedures, for further information. If it should happen that Plan fiduciaries misuse the Plan's money or if you are discriminated against for asserting your rights you may seek assistance from the U.S. Department of Labor or you may file a suit in federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay those costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim frivolous.

If you have any questions about your Plan you should contact PCMI. If you have any questions about this statement or about your rights under ERISA you should contact the nearest office of the U.S. Labor-Management Services Administration, Department of Labor.

CLAIM APPEAL PROCEDURES

If a claim is denied, you may request a review by writing to PCMI, giving the reasons you disagree with the denial of the claim. ***This written appeal must be made within 180 days of the date the notice of denial was mailed to you as indicated on the postmarked envelope.*** Otherwise, the initial decision shall be the final decision of the Plan. You may request a "Claim Appeal Form" from PCMI or the Human Resource department or you may submit a letter to PCMI containing your name, address, Social Security number, the claim number assigned by PCMI, the date services were provided, a brief explanation of the reasons for the appeal and any additional information you feel might apply. Upon receiving your request your claim will be reviewed as follows:

The Appeal Committee will make a full and fair review and may require additional information it deems necessary. ***The Plan Administrator may make a reasonable charge for the copies.*** An Employee, or his/her authorized representative, may examine all pertinent documents which the Third Party Administrator may have and submit an opinion in writing of the issues and his/her comments.

Decision and Review:

Decision by the Third Party Administrator will be made within 30 days after receipt of the Employee's request for review. This decision will also be delivered to the Employee in writing, setting forth specific reasons for the decision and specific references to the pertinent Plan Provisions upon which the decision is based.

If you do not agree with the action taken by the Third Party Administrator, you may request a review by the Plan Administrator. This written appeal must be filed within 180 days from the date the notice of denial was mailed to you as indicated on the postmarked envelope.

Within 5 days of the conclusion of the review you will be mailed written findings of fact and determination of the Plan Administrator. This written determination will be your final administrative appeal. Should you decide to pursue remedy through the courts your suit must be filed with the court within ninety (90) days from the date of the written determination.

The Plan Sponsor has the authority to control and manage the operation and administration of the Plan. The Plan Sponsor may make whatever rules, interpretations, and computations, and take any other actions to administer the Plan that the Plan Sponsor considers appropriate, as long as the Plan Sponsor does not abuse its authority to act arbitrarily or capriciously.

SUMMARY OF PLAN INFORMATION

EMPLOYER IDENTIFICATION NUMBER (E.I.N.) - 94-1606519

PLAN SPONSOR - The Plan is sponsored and administered by Fresno County Economic Opportunities Commission

THIRD PARTY ADMINISTRATOR: Pinnacle Claims Management, Inc.

NAME, ADDRESS AND TELEPHONE NUMBER OF THE PLAN ADMINISTRATOR:

Fresno County Economic Opportunities Commission
1920 Mariposa Mall
Fresno, CA 93721
Phone: (559) 263-1030

NAME AND ADDRESS OF THE PERSON DESIGNATED TO ACT AS AGENT FOR SERVICE OF LEGAL PROCESS:

Fresno County Economic Opportunities Commission
Dawn Cagle, Associate Executive Director
1920 Mariposa Mall
Fresno, CA 93721

SOURCE OF PLAN CONTRIBUTIONS: The benefits described herein are funded by Employer and employee contributions.

FUNDING MEDIUM THROUGH WHICH BENEFITS ARE PROVIDED:

Benefits described herein are funded by Employer and employee contributions to the re-insurance stop-loss limit. Amounts above stop-loss limit are submitted to a named re-insurer for reimbursement.

DATES OF THE END OF THE PLAN YEAR:

FCEOC's Plan year ends on December 31st of any year.

FOR CLAIMS APPEAL PURPOSES CONTACT:

Pinnacle Claims Management, Inc.
17620 Fitch Street
Irvine, California 92614

DEPARTMENT OF LABOR:

Pension Welfare Benefit Administrator
770 E. Shaw Ave.
Fresno, CA 93710

Benefits described in this book are not insured and there is no liability on the part of the FCEOC Benefit Plan or any individual or entity to provide these benefits in excess of the available assets of the Plan. In addition, the Plan Sponsor reserves the right to modify, amend or rescind altogether any benefit or benefits as the financial condition of FCEOC Employee Benefit Plan and its fiduciary responsibility may require.

GLOSSARY/DEFINITIONS

ACCIDENT: An unexpected event which occurs without the patient's intent of injury, involving some unusual outside force or object. An Accident does not include an injury or illness which is intentionally self-inflicted or results from: (1) a fight in which the patient is intentionally involved; (2) a family quarrel; (3) an act of war; (4) disease or mental disorder; (5) medical, dental or surgical treatment.

COVERED EXPENSE: Includes only charges for services described, which are Medically Necessary and for which you are eligible up to any limits under your Plan. In the case of a Participating Provider, Covered Expense will be the negotiated fee. In the case of a non-Participating Provider, Covered Expense will be limited to the Usual, Customary & Reasonable fee.

CALENDAR YEAR: means the period of time that begins on January first of each year and ends on December thirty-first of the same year.

CONTRIBUTORY: means coverage for which an eligible employee must enroll and make any necessary cost contribution.

CUSTODIAL CARE: Care provided primarily to meet the personal needs of the Participant. This includes help in walking, bathing, dressing, 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.

DISABILITY: Any illness or injury resulting from the same cause or related causes, including complications. Unrelated illnesses, which are being treated concurrently by one Physician, shall be considered one Disability. The time period for a Disability shall be: (1) for an active employee a Disability shall begin on the day the condition is first diagnosed or treated, or the Accident occurs, and shall end when the employee returns to work for one full day, or remains treatment free for six consecutive months; (2) for a dependent or eligible Retiree, a Disability will begin on the day the condition is first diagnosed or treated, or the Accident occurs, and shall end when the person remains treatment free for six consecutive months.

EARNINGS: an eligible employee's salary or wages, commissions or bonuses; excluding overtime pay or additional compensation.

EMERGENCY: A time when you or your dependent need immediate medical attention because a delay in the treatment would result in your or your dependent's death, serious Disability or significant jeopardy to your or your dependent's condition.

EMPLOYER: The Employer is Fresno County Economic Opportunities Commission. The Employer is also the Plan Sponsor and Plan Administrator.

HOSPITAL: Any Provider which meets all the following requirements: (1) maintains permanent facilities for care of resident patients; (2) has a licensed Physician on duty; (3) has a facility for major surgery; (4) provides 24 hours a day nursing by registered graduate nurses; (5) operates lawfully in the area which it is located and is Joint Commission of Hospitals accredited; (6) primarily provides diagnostic and therapeutic medical care on a basis other than a rest home, nursing home, convalescent hospital, home for the aged, or treatment of alcoholism or drug addiction.

MEDICALLY NECESSARY: The benefits of this Plan are provided only for services that are Medically Necessary as determined by PCMI. The services must be ordered by the attending Physician for the direct care and treatment of a covered illness, injury or condition. The services must be standard medical practice where received for the illness, injury or condition being treated and must be legal in the United States.

MENTAL ILLNESS: a nervous condition, psychosis or neurosis.

PARTICIPANT: A participant is the employee of the Employer or his or her eligible dependent.

PARTICIPATING PROVIDER: Any Provider who has an agreement with the Plan to accept a negotiated fee rate.

PINNACLE CLAIMS MANAGEMENT, INC. (PCMI): A Third Party Administrator who has contracted with your Employer to process your group benefits.

PHYSICIAN: A Provider, who is not a member of your immediate family or your eligible Spouse's immediate family, who is practicing within the scope of his or her license as a Doctor of Medicine or Osteopathy; or, to the extent that specific benefits are provided, a Doctor of Dentistry, Podiatry, Optometry, or Chiropractic. A licensed Optician or Psychologist is included if performing services that are covered by the Plan.

PLAN: The Plan is the description of benefits and limitations contained within this document.

PREADMISSION HOSPITAL CERTIFICATION: the authorization for inpatient hospitalization stays by the Utilization Review Center prior to admission.

PRIMARY CARE PHYSICIANS: A Physician who is designated to practice medicine in the following areas: General Practitioners, Family Practitioners, Internists, Obstetricians, Gynecologists and Pediatricians.

PROVIDER: Any individual or organization, licensed by the state or appropriate governing body, which dispenses, supplies or performs the necessary care and treatment for an injury or sickness within the scope of its required licensing.

SUBSTANCE ABUSE: means alcoholism or narcotism.

SPOUSE: A Participant's Spouse is one that is under a legally valid marriage between persons of the opposite sex. The Plan does not recognize common-law marriages as valid.

THIRD PARTY ADMINISTRATOR (TPA): The Third Party Administrator is Pinnacle Claims Management, Inc. (PCMI)

USUAL, CUSTOMARY AND REASONABLE: Charges made for Medically Necessary services or supplies essential to the care of the patient, if they are the amount normally charged by the Provider for similar services in the geographic area where the services or supplies were furnished, as determined by the Plan. PCMI reserves the right to make this initial determination as well as any subsequent evaluations or modifications of the Usual, Customary and Reasonable fee standard.

The previous pages constitute the Plan Document for the FRESNO COUNTY ECONOMIC OPPORTUNITIES COMMISSION (FCEOC) Employee Benefit Plan that is designated as:

Health and Welfare Plan

This Plan Document defines and describes the rights, responsibilities, liabilities and limitations affecting the Participants of this Plan pursuant to the authority of FCEOC. Participation in this designated Plan shall be limited to qualified Employees of FCEOC, as defined in this Plan Document, who enroll on or after the date shown below.

Nothing shall abridge the right of FCEOC to amend the Plan Document subsequent to the date shown below.

PLAN EFFECTIVE DATE: January 1, 2011
Revised January 01, 2012

Signed by:

Brian Angus
Executive Director
Fresno County Economic Opportunities Commission