TUSD Medical Plan

Summary Plan Description

Effective: October 1, 2006

Administered by

Pinnacle Claims Management, Inc.

COBRA NOTIFICATION PROCEDURES

It is a Plan participant's responsibility to provide the following Notices as they relate to COBRA Continuation Coverage:

Notice of Divorce or Separation - Notice of the occurrence of a Qualifying Event that is a divorce or legal separation of a covered Employee from his or her spouse.

Notice of Child's Loss of Dependent Status - Notice of a Qualifying Event that is a child's loss of Dependent status under the Plan (e.g., a Dependent child reaching the maximum age limit).

Notice of a Second Qualifying Event - Notice of the occurrence of a second Qualifying Event after a Qualified Beneficiary has become entitled to COBRA Continuation Coverage with a maximum duration of 18 (or 29) months.

Notice Regarding Disability - Notice that: (a) a Qualified Beneficiary entitled to receive COBRA Continuation Coverage with a maximum duration of 18 months has been determined by the Social Security Administration to be disabled at any time during the first 60 days of continuation coverage, or (b) a Qualified Beneficiary as described in "(a)" has subsequently been determined by the Social Security Administration to no longer be disabled.

Notification must be made in accordance with the following procedures. Any individual who is either the covered Employee, a Qualified Beneficiary with respect to the Qualifying Event, or any representative acting on behalf of the covered Employee or Qualified Beneficiary may provide the Notice. Notice by one individual shall satisfy any responsibility to provide Notice on behalf of all related Qualified Beneficiaries with respect to the Qualifying Event.

Notification & Delivery - Notification of the Qualifying Event must be provided to the Employer's Human Resources department. Notification should be made in writing.

Content - Notification should include evidence that a Qualifying Event or other event extending coverage has occurred (e.g., copy of divorce decree, copy of child's birth certificate, copy of the Social Security Administration's disability determination letter).

Time Requirements for Notification - Should an event occur (as described in **NOTICE RESPONSIBILITIES** above), the Employee, other Qualified Beneficiary, or a representative acting on behalf of any such person) must provide Notice to the designated recipient within a certain time frame.

In the case of a divorce, legal separation or a child losing dependent status, Notice must be delivered within 60 days from the later of: (1) the date of the Qualifying Event, (2) the date health plan coverage is lost due to the event, or (3) the date the Qualified Beneficiary is notified of the obligation to provide Notice through the Summary Plan Description or the Plan Sponsor's General COBRA Notice. If Notice is not received within the 60-day period, **COBRA Continuation Coverage** will not be available, except in the case of a loss of coverage due to foreign competition where a second COBRA election period may be available – see "Effect of the Trade Act" in the **COBRA Continuation Coverage** section of the Plan's Summary Plan Description or Benefit Document.

If an Employee or Qualified Beneficiary is determined to be disabled under the Social Security Act, Notice must be delivered within 60 days from the later of: (1) the date of the determination, (2) the date of the Qualifying event, (3) the date coverage is lost as a result of the Qualifying Event, or (4) the date the covered Employee or Qualified Beneficiary is advised of the Notice obligation through the SPD or the Plan Sponsor's General COBRA Notice. Also, Notice must be provided within the 18-month COBRA coverage period.

The Plan will not reject an incomplete Notice as long as the Notice identifies the Plan, the covered Employee and Qualified Beneficiary(ies), the Qualifying Event/disability determination and the date on which it occurred. However, the Plan is not prevented from rejecting an incomplete Notice if the Qualified Beneficiary does not comply with a request by the Plan for more complete information within a reasonable period of time following the request.

TABLE OF CONTENTS

The following pages constitute the Plan Document for Torrance Unified School District Group Health Benefit Plan that is designated as:

Torrance Unified School District Self Funded Medical Plan

This Plan Document defines and describes the rights, responsibilities, liabilities and limitations affecting the Participants of this Plan pursuant to the authority of Torrance Unified School District. Participation in this designated Plan shall be limited to qualified Employees and their Eligible Dependents as defined in this Plan Document, who enrolls on or after the date shown below. Each covered person will be issued a copy of the Benefit Summary and this Plan Document. The Plan will not recognize benefits for any Employee as a result of statements made or not made in the Benefit Summary.

The Plan Document contained herein has been prepared by Pinnacle Claims Management, Inc. and reviewed and approved by Torrance Unified School District as a true and accurate description of its Self-Funded Medical Plan. Pinnacle Claims Management Inc. is not liable for any inaccurate or incomplete description contained herein.

Nothing shall abridge the right of Torrance Unified School District (TUSD) to amend the Plan Document subsequent to the date shown below.

PLAN EFFECTIVE DATE: October 1, 2006

Signed by:

_____

Plan Administrator or
Authorized Representative of the Plan Administrator

_____

Date

IMPORTANT PHONE NUMBERS & CONTACT SHEET

***CLAIMS ADMINISTRATOR**:*

- Medical benefits & claim questions
- Participating Provider questions

Pinnacle Claims Management, Inc. 800.649.9121
E-mail: CustomerService@pinnacletpa.com Fax: 949.863.9028
Website: www.pinnacletpa.com
Mailing Address:
P O Box 2220
Newport Beach, CA 92658

PARTICIPATING PROVIDER NETWORK -- Medical Services

California: Blue Cross PPO Prudent Buyer Plan 800.649.9121
Website: www.bluecrossca.com
Arizona: Blue Cross Blue Shield of Arizona 800.649.9121
Website: www.bcbsaz.com
All other States: Community Care Network (CCN) / First Health 888.685.7774
Website: www.ccnusa.com

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

Blue Cross of California Prudent Buyer 800.274.7767

***OUTPATIENT PRESCRIPTION DRUG SERVICES**:*

NMHC 800.777.0074 www.mynmhcrx.com
Mail Order Pharmacy – MYNMHC 800.777.0074 www.mynmhc.com
NMHC Ascend - Specialty Pharmacy Program 800.850.9122
Fax: 800.218.3221

Torrance Unified School District
SELF-FUNDED MEDICAL PLAN DOCUMENT

This Plan Document is intended to give you a working knowledge of the benefits sponsored by Torrance Unified School District (TUSD) and administered by Pinnacle Claims Management, Inc. (Pinnacle). It is maintained solely for the exclusive benefits for Employees, Retirees and their Eligible Dependents of TUSD in the event of Illness or Injury and for preventive care. 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, and avoid walk-in clinics and Hospital Emergency rooms. Review your health care bills carefully for any possible errors.

Your plan benefits are better 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 department, a Pinnacle office, or the Internet at www.pinnacletpa.com.

It is important that you notify the Human Resource/Benefits Department immediately of any changes in your status, such as new Dependents or change of address. Information supplied to the Human Resource/Benefits Department will be used to pay claims for you and your Eligible Dependents. 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 amount.

NOTICE OF FOREIGN LANGUAGE ASSISTANCE
SOLICITUD DE INFORMACION EN ESPAÑOL
(Spanish Language offer of Assistance)

Este documento está escrito en ingles y contiene un resumen de los derechos y beneficios de su plan de seguro. Si Ud. tiene dificultad en comprendar cualquier parte de este documento, comuniquese con los adminstradores de la:

Pinnacle Claims Management Inc.
P O Box 2220
Newport Beach, CA 92658

El horario de la oficina es: las siete de la mañana hasta las cinco de la tarde, lunes a jueves y las nueve de la mañana hasta cinco de la tarde, viernes. Ud. tambien puede llamar a la oficina del administrador del plan de seguro a estos teléfonos: 800-649-9121 para pedir ayuda.

CLAIMS FILING PROVISIONS

To File a Claim

To file a claim you will need to give the Provider your name, your Employer's name, your unique health care ID number from your ID card or your Social Security Number, sex, and birth date as reported on your enrollment card. 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***. Although, if you do use a claim form, you must sign the Authorization to Release Information and the Provider will take all itemized bills and mail it to Pinnacle at P O Box 2220, Newport Beach, CA 92658. Itemized bills from the Provider 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, including the recognized procedure code for that service, 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 until this documentation is received.

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 end of the plan year that the expenses are incurred. ***Claim forms are not necessary***. ***Pinnacle 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 your 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 Pinnacle will not reissue EOB's. It is important to note that Pinnacle 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 Participating Provider. This is a contractual requirement for all Participating Providers.***

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 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. An individual will not be prevented from becoming covered under the Plan due to a health status related factor. A "health status related factor" means any of the following:

- A medical condition (whether physical or mental and including conditions arising out of acts of domestic violence).
- Claims Experience
- Receipt of healthcare
- Medical history
- Evidence of insurability
- Disability
- Genetic Information

Choice of Providers

The persons covered under this Plan have the sole right to select their own Providers of health care. Pinnacle or Torrance Unified School District 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.

SUMMARY OF BENEFITS

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

BENEFIT SUMMARY – TUSD Medical Plan

A. GENERAL FEATURES	
Lifetime Maximum Benefit	**$ 2,500,000**
Participating Provider Network (EPO)	**California:** Blue Cross Prudent Buyer Plan PPO Network **Arizona:** Blue Cross Blue Shield of Arizona or First Health **Outside Calif & Arizona:** First Health (previously known as CCN)
Maternity Coverage	Participant , Spouse or Dependent Child
Plan Year Deductible: Individual and Family	 None
Out of Pocket Maximum Individual Maximum Family Maximum	 $500 $1,500

Except as noted, a Covered Person will not be required to pay more than **$500 as an Individual** or **$1,500 as a Family** in any Plan Year toward his share of Eligible Expenses which are not paid by the Plan. Once a Covered Person has met their out-of-pocket maximum, Eligible Expenses will be paid at 100% of the Negotiated Fee or Usual and Customary rates for the remainder of the Plan Year.

The following will <u>not</u> be applied to the Out-of-Pocket Maximum:

- Amounts applied to or paid to satisfy any Co-payments
- Non-covered Expense
- Non-compliance penalties for non-precertification
- Inpatient Physician Services billed separately from Hospital
- Amounts paid at 100%
- Ambulance Services
- Orthotics / Prosthetics
- TMJ & Jaw Problems
- Durable Medical Equipment / Medical Supplies
- Infertility Services – not billed by Hospital
- Contraceptive Devices or Medications
- Sleep Disorders – Treatment & Testing
- Substance Abuse / Alcoholism Care

	EPO PROVIDERS
Percentage Payable – The percentage that the Plan pays. Except as otherwise noted below	90% of Covered Expense after applicable co-payments
Covered Expense	Covered Expense is limited to the Negotiated Fee Rate.

This is an Exclusive Provider Option (EPO) plan, and as such coverage is only provided when services are obtained by Participating Providers. The exception to this provision is for an Emergency. If you have a true Emergency, as defined below, the following coverage is provided:

- **Emergency Room with Admission to Hospital or within 48 hrs of an accident – paid at 100% of Covered Expense by Plan**
- **Emergency Room – Sudden & Serious – $100 Co-pay per use, balance paid at 100% of Covered Expense by Plan**
- **Emergency Room – Physician Services Covered only in the case of an Emergency at 100% less a $25 Co-pay**
- **Ambulance services – benefits paid at 90% of Covered Expense by Plan**
- **Anesthesia services – benefits paid at 90% of Covered Expense by Plan**

MEDICAL PLAN BENEFIT SUMMARY (cont'd)

Emergency

Sudden & Serious Illness

A Sudden & Serious Illness is any condition that begins suddenly and is considered out of the ordinary. A Sudden & Serious Illness usually includes:

- Temperature above 102° (oral) or 103° (rectal)
- Chest pain with sudden onset
- Profuse Hemorrhage
- Severe abdominal pain of sudden onset
- Acute respiratory distress
- Obvious severe mental distress
- Life-threatening situations
- Visits to the Emergency room requiring Emergency Hospital admission

Life-Threatening Condition

A Life-Threatening Condition is defined as a sudden and unexpected onset of a medical condition requiring medical or surgical care. Life-Threatening Conditions usually include:

- Severe chest pain
- Profuse hemorrhaging (bleeding)
- Difficulty in breathing
- Sudden onset of weakness or paralysis of a body part
- Unconsciousness
- Convulsions
- Severe burns
- Multiple injuries or trauma
- Partial or complete severing of a limb
- Ingestions of a poisonous substance

B. PAID HOSPITAL EXPENSES	PLAN PAYS EPO PROVIDERS	EMPLOYEE PAYS
Inpatient Care (Includes Room & Board, Ancillary Charges, Intensive Care) **Requires Pre-Certification**	90% of Covered Expense	10% of Covered Expense
Outpatient Care: - *Emergency Room with Admission to Hospital or within 48 hrs of an accident	100% of Covered Expense	$-0-
- *Emergency Room – Sudden & Serious	100%, after a $100 Co-pay per use	$100 Co-pay per use
- *Emergency Room – Non Emergency	100%, after a $100 Co-pay per use	$100 Co-pay per use
- *Emergency Room – Physician Services	100%, after a $25 Co-pay per visit	$ 25 Co-pay per visit
- Ambulatory Surgery Center **Requires Pre-Certification**	90% of Covered Expense	10% of Covered Expense
- Outpatient Surgery at Hospital	90% of Covered Expense	10% of Covered Expense
- All Other Outpatient Hospital Services	90% of Covered Expense	10% of Covered Expense
- Birthing Center / Midwife	90% of Covered Expense	10% of Covered Expense
- Preadmission Testing	90% of Covered Expense	10% of Covered Expense
C. COVERED EXPENSES	**PLAN PAYS EPO PROVIDERS**	**EMPLOYEE PAYS**
*Acupuncture Services Limited to 26 visits per Plan Year combined with Chiropractic Care	100%, after a $30 Co-pay per visit	$ 30 Co-pay per visit
*Allergy Injections / Treatment Co-pay is only taken if an Office Visit is billed with Injection *Allergy Testing	100%, after a $25 Co-pay per visit 100% of Covered Expense	$ 25 Co-pay per visit $-0-
*Ambulance	90% of Covered Expense	10% of Covered Expense
Anesthesia	90% of Covered Expense	10% of Covered Expense
Blood or Blood Products	90% of Covered Expense	10% of Covered Expense
Chemotherapy	90% of Covered Expense	10% of Covered Expense
*Chiropractic type Care Limited to 26 visits per Plan Year combined with Acupuncture Care - *X-rays billed as part of Chiropractic Type Care	100%, after a $30 Co-pay per visit 100% of Covered Expense	$ 30 Co-pay per visit $-0-
*Contraceptive Management - Office Visit - Contraceptive Injections Co-pay is only taken if an Office Visit is billed with Injection - *Contraceptive Medications & Devices	- 100%, after a $25 Co-pay per visit - 100% of Covered Expense - 100%, after Rx Card Co-pays	- $25 Co-pay per visit - $-0- - Rx Card Co-pays
*Diabetic Nutritional Counseling	100%, after a $25 Co-pay per visit	$ 25 Co-pay per visit
Diagnostic X-Ray & Lab – *office, clinic or free-standing facility – hospital, including professional fees	- 100% of Covered Expense - 90% of Covered Expense	- $-0- - 10% of Covered Expense

*** = these items do not apply to your Out of Pocket maximum**

MEDICAL PLAN BENEFIT SUMMARY (cont'd)

C. COVERED EXPENSES cont'd	PLAN PAYS EPO PROVIDERS	EMPLOYEE PAYS
Dialysis Services	90% of Covered Expense	10% of Covered Expense
*Durable Medical Equipment	90% of Covered Expense	10% of Covered Expense
*Hearing Exams & Hearing Aids	Not a Covered Expense	100% of Billed Charges
Home Health Care Limited to 100 visits per Plan Year	90% of Covered Expense	10% of Covered Expense
Home Infusion Therapy / Home Injectable Services	90% of Covered Expense	10% of Covered Expense
Hospice Care, Patient Care - *Bereavement Counseling, per visit Limited to 8 visits for members of immediate family during the 6 months following the death of the Covered Person	90% of Covered Expense - 100%, after a $25 Co-pay per visit	10% of Covered Expense $25 Co-pay per visit
*Infertility Services - Maximum of $10,000 per Lifetime - Includes Physician services & medications - Surgical / Diagnostic procedures for diagnosis of infertility *Storage of Embryo or Cord Blood	 - 80% of Covered Expense - 80% of Covered Expense - 90% of Covered Expense Not a Covered Expense	 - 20% of Covered Expense - 20% of Covered Expense - 10% of Covered Expense 100% of Billed Charges
*Medical Supplies	90% of Covered Expense	10% of Covered Expense
Mental Health Care - Inpatient Care - Outpatient Care Inpatient Care is limited to 30 days per Plan Year. Partial Hospitalization will count as Inpatient care at a 2-for-1 ratio Outpatient Care is limited to 40 visits per Plan Year	 - 90% of Covered Expense - 100%, after $25 Co-pay per visit	 - 10% of Covered Expense - $25 Co-pay per visit
*MRI, Cat Scan, Ultrasound & Nuclear Medicine	100% of Covered Expense	$ -0-
*Occupational Therapy Coverage is limited to services to restore physical function	100%, after a $30 Co-pay per visit	$30 Co-pay per visit
*Orthotics Covered only when Medically Necessary & are custom made for the feet.	90% of Covered Expense	10% of Covered Expense
*Physical Therapy Limited to 26 visits per Plan Year	100%, after $30 Co-pay per visit	$30 Co-pay per visit
*Physician Services - *Visit (Office/Home) - *Services in the office (lab, X-ray, injections, supplies, etc) - *In office Surgery Maximum of 1 co-pay per day if multiple services are billed in conjunction with the office visit - *Hospital Visit – Inpatient - *Hospital Visit – Inpatient Billed by Hospital - *Emergency Room Visit	 - 100%, after a $25 Co-pay per visit - 100% of Covered Expense - 100% of Covered Expense - 90% of Covered Expense - 90% of Covered Expense - 100%, after a $25 Co-pay per visit	 - $25 Co-pay per visit - $ -0- - $ -0- - 10% of Covered Expense - 10% of Covered Expense - $25 Co-pay per visit

* = these items do not apply to your Out of Pocket maximum

MEDICAL PLAN BENEFIT SUMMARY (cont'd)

C. COVERED EXPENSES (cont'd)	PLAN PAYS EPO PROVIDERS	EMPLOYEE PAYS
Pregnancy & Maternity Care - *Office Visit – initial visit & any diagnostic visits outside the Global Fee for the delivery - *All other visits associated with the Global Fee for the delivery - Normal Delivery, cesarean section and complications of pregnancy prior to birth or to the mother - *Inpatient Physician Services & Hospital Services - *Elective Abortion - *Circumcision for Newborn Services for newborn healthy baby are payable as part of the Mothers benefits for first 31 days only Services for newborn sick baby are payable under the Baby's benefits Baby MUST be enrolled within 31 days – complete an enrollment form from Human Resources	- 100%, after $25 Co-pay - 100% of Covered Expense - 90% of Covered Expense - 90% of Covered Expense - 100%, after $150 Co-pay - 90% of Covered Expense	- $25 Co-pay per visit $ - 0 – - 10% of Covered Expense - 10% of Covered Expense - $150 Co-pay - 10% of Covered Expense
*Preventive Care: Adult - Age 18 & over - *routine annual physical exam - *routine immunizations - *travel immunizations - *routine lab, x-rays, colonoscopies**+** & prostate tests - *routine pap smear - annually - *routine mammogram - annually **Mammogram Provisions**: One baseline mammogram for women age 35 to 40 One mammogram every year for women age 40 or older **+ - includes anesthesia & these benefits apply regardless of the place of service**	- 100%, after $25 Co-pay - 100% of Covered Expense - 100% after $25 Co-pay - 100% of Covered Expense - 100% of Covered Expense - 100% of Covered Expense	- $25 Co-pay per visit - $-0- - $25 Co-pay - $-0- - $-0- - $-0-
Well Child Care - up to Age 18 - *routine office visits (including annual physicals), lab & x-rays - *routine immunizations - *travel immunizations	- 100%, after $25 Co-pay per visit - 100% of Covered Expense - 100%, after $25 Co-pay per visit	- $25 Co-pay per visit - $-0- - $-0-
*Prosthetics	90% of Covered Expense	10% of Covered Expense
Radiation Therapy	90% of Covered Expense	10% of Covered Expense
Respiratory Therapy	90% of Covered Expense	10% of Covered Expense
*Second Surgical Opinion	100%, after a $25 Co-pay per visit	$25 Co-pay per visit
*Sleep Disorders – Treatment & Testing	90% of Covered Expense	10% of Covered Expense
*Speech Therapy *Covered only when used to restore or rehabilitate speech loss caused by Injury or Sickness*	100%, after a $25 Co-pay per visit	$25 Co-pay per visit
Skilled Nursing Limited to 100 days per Plan Year and Pre-Certification is required	90% of Covered Expense	10% of Covered Expense
*Sterilization Procedures - *Tubal Ligation - *Vasectomy	- 100%, after a $150 Co-pay - 100%, after a $150 Co-pay	- $150 Co-pay - $150 Co-pay
*Substance Abuse / Alcoholism Care - *Inpatient Care – limited to 30 days per Plan Year and payable up to $20,000 per Plan Year - *Outpatient Care/Visits – limited to 26 visits per Plan Year Partial Hospitalization will be covered as Inpatient care at a 2-for-1 ratio	- 90% of Covered Expense - 100%, after a $25 Co-pay per visit	- 10% of Covered Expense - $25 Co-pay per visit

* = these items do not apply to your Out of Pocket maximum

MEDICAL PLAN BENEFIT SUMMARY (cont'd)

C. COVERED EXPENSES (cont'd)	PLAN PAYS EPO PROVIDERS	EMPLOYEE PAYS
Surgeon, Assistant Surgeon	90% of Covered Expense	10% of Covered Expense
*TMJ / Jaw Joint Treatment Limited to $3,000 in benefits per Plan Year	90% of Covered Expense	10% of Covered Expense
Transplants – Organ & Tissue **Requires pre-certification**	90% of Covered Expense	10% of Covered Expense
*Urgent Care Facility – per visit (Co-pay is waived if admitted to the Hospital directly from Urgent Care) - *Physician Visit billed separately from Urgent Care	- 100%, after a $50 Co-pay per visit - 100%, after a $25 Co-pay per visit	- $50 Co-pay per visit - $25 Co-pay per visit

D. UTILIZATION MANAGEMENT - PRE-CERTIFICATION Blue Cross of California (800) 274-7767	
Inpatient Admissions ***Non-compliance penalties will not apply to the Out of Pocket Maximum***	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 a reduction in payable benefits to 50%.
Outpatient Surgery at Surgery Center ***Non-compliance penalties will not apply to the Out of Pocket Maximum***	Requires prior certification or payable benefits are reduced to 50%.

OUTPATIENT PRESCRIPTION DRUG SERVICES

Participating NMHC Pharmacy

Type of Medication	30-Day Retail Option Co-pays	90 Day Mail Service Option thru NMHC www.mynmhc.com Co-pays
Generic – Tier 1	**$10**	**$10**
Preferred Brand – Tier II	**$25**	**$25**
Non-preferred Brand – Tier III	**$40**	**$40**
If a Covered Person requests brand when there is an FDA approved generic alternative and the MD has not indicated that a brand name drug is necessary, the Covered Person will be responsible for the applicable co-pay plus the cost difference between the brand-name drug and its generic equivalent.		

MEDICAL PLAN

UTILIZATION MANAGEMETN / PRE-CERTIFICATION AND CASE MANAGEMENT

Utilization Management / Pre-Certification – Torrance Unified School District has appointed a Utilization Review Organization to administer the Utilization Management/Pre-certification and Case Management programs. To get the most out of your benefit plan, and avoid any unpleasant surprises, you must understand the Utilization Management / Pre-Certification requirements. If you have any questions or are in doubt about whether Utilization Management / Pre-Certification 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 Management / Pre-Certification program. If you receive any such service, and do not follow the procedures set forth in this section, your benefits will be reduced. If you do not receive the certified service within 60 days of the certification, or if the nature of the services changes, a new pre-service review must be obtained. If the Review Center determines that the proposed service is not Medically Necessary, your Physician will be notified immediately. Written notice will be sent to you and Provider of the service. ***If you do not receive a written notice authorizing the proposed services, than you must contact the Utilization Review Center at 1-800-274-7767 immediately.***

The Utilization Management / Pre-Certification program evaluates the Medical Necessity of care and setting in which care is provided. The program advises you and your Physician if it has been determined that services can be safely provided in an outpatient setting, or if an inpatient stay is recommended. Services that are Medically Necessary are certified by the Claims Administrator for an appropriate period and monitored so that you know when it is no longer Medically Necessary to continue those services.

These reviews and certifications are performed by a Review Center. The Review Center is staffed by Physicians and other health care professionals, and may be either the Claims Administrator's own Utilization Management / Pre-Certification team or an independent third party, chosen at the sole and absolute discretion of the Plan Administrator. The telephone number to call for Utilization Management / Pre-Certification is listed above and shown on your Plan identification card.

Utilization Management / Pre-Certification Requirements

This plan requires Utilization Management / Pre-Certification by the Review Center when the following services are received:

Inpatient Hospital Admission - Authorization must be given by the Utilization Review Center for all Non-Emergency Hospital confinements at least three (3) 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. Failure to follow the above specified notification procedures or when authorization is not obtained, will result in a reduction in payable benefits to 50%. Additional costs paid by the Participant due to this reduction in benefits will not apply to the accumulation of the medical Out of Pocket maximum.

Inpatient Mental and Emotional Admission – Authorization must be given by the Utilization Review Center at least three (3) working days prior to admission. Failure to follow the above specified notification procedures or when authorization is not obtained, will result in a reduction in payable benefits to 50%. Additional costs paid by the Participant due to this reduction in benefits will not apply to the accumulation of the medical Out of Pocket maximum.

Inpatient Skilled Nursing Admission - Authorization must be given by the Utilization Review Center at least three (3) working days prior to admission. Failure to follow the above specified notification procedures or when authorization is not obtained, will result in a reduction in payable benefits to 50%. Additional costs paid by the Participant due to this reduction in benefits will not apply to the accumulation of the medical Out of Pocket maximum.

Outpatient Surgery at an ambulatory surgical center – Authorization must be given to the facility where the services will be performed by the Utilization Review Center at least three (3) working days prior to surgery. Failure to follow the above specified notification procedures or when authorization is not obtained, will result in a reduction in payable benefits to 50%. Additional costs paid by the Participant due to this reduction in benefits will not apply to the accumulation of the Out of Pocket maximum.

There are three states of Utilization Management / Pre-Certification:

1. **Pre-service review** determines the Medical Necessity of scheduled, non-Emergency hospital admissions and ambulatory surgical center services.

2. **Concurrent review** determines whether services continue to be Medically Necessary. There are two types of concurrent review:
   a. **Service review** evaluates the Medical Necessity of services when pre-service review is not required or has not been performed as required.
   b. **Continued Service review** is performed after pre-service or with a service review to determine the Medical Necessity of ongoing treatment.

3. **Retrospective review** is performed when the Review Center has not been notified and therefore has been unable to perform the appropriate pre-service or concurrent review.

Extraordinary Circumstances

In determining "extraordinary circumstances", the Claims Administrator may take into account whether or not your condition was severe enough to prevent you from notifying the Claims Administrator, or whether or not a member of your family was available to notify the Claims Administrator for you. You may have to prove that such "extraordinary circumstances" were present at the time of the Emergency.

If the Claims Administrator approves the "extraordinary circumstances" then the services will be reviewed on a retrospective review basis to determine Medically Necessary services and there will be no reduction in benefits.

CASE MANAGEMENT

The personal case management program enables you to obtain medically appropriate care in a more economical, cost effective and coordinated manner during prolonged periods of intensive medical care. Potentially large dollar claims and/or long-term treatment claims are monitored under Case Management and through the cooperation of the patient, the Physician and the Case Manager; alternate health care may be considered a Covered Expense, to the benefit of all concerned. The Plan Administrator does not have any obligation to provide personal case management. These services are provided at the Plan Administrator's sole and absolute discretion.

How Personal Case Management Works
You may be identified for possible personal case management through the Plan's Utilization Management / Pre-Certification procedures, by the attending Physician, Hospital, staff, or the Claims Administrator's claim reports. You or your family may also call the Claims Administrator if:

1. You require extensive, long-term treatment;
2. The Claims Administrator anticipates that such treatment utilizing services or supplies covered under this Plan will result in considerable cost;
3. A cost benefit analysis determines that the benefits payable under this Plan for the alternative plan of treatment can be provided at a lower overall cost than the benefits you would otherwise receive under this Plan; and
4. You (or your legal guardian) and your Physician agree, in a letter of agreement, with the Case Manager's recommended substitution of benefits and with the specific terms and conditions under which alternative benefits are to be provided.

Alternative Treatment Plan
If a case manager determines that your needs could be met more efficiently, an alternative treatment plan may be recommended. This may include providing benefits not otherwise covered under this Plan. A Case Manager will review the medical records and discuss your treatment with the attending Physician, you and your family.

The Claims Administrator, Case Manager or Review Center makes treatment recommendations only; any decision regarding treatment belongs to you and your Physician. The Plan will, in no way, compromise your freedom to make such decisions.

Effect on Benefits
Any alternate health care benefits are accumulated toward the Lifetime Maximum and are provided on a case-by-case basis only. The Plan has absolute discretion in deciding whether or not to substitute benefits for any Participant, which alternate benefits may be offered and the terms of the offer. The substitution of benefits in a particular case in no way commits the Plan to do so in another case or for another Participant. The personal Case Management program does not prevent us from strictly applying the expressed benefits, exclusions and limitations of the Plan at any other time or for any other Participant.

NOTE: We reserve the right to use the services of one or more third parties in the performance of the services outlined in the letter of agreement. No other assignment of any rights or delegation of any duties is valid without the prior written consent of the other party.

Human organ and tissue transplant services also require the use of Case Management. Authorization will be provided if the services are Medically Necessary and the Physicians on the surgical team and facility in which the transplant is to take place are approved by the Review Center for the transplant requested. Failure to comply with Case Management services may result in a denial of benefits.

OTHER PROVISIONS

Authorization Program

The authorization program provides prior authorization for authorized referrals from a Participating Provider to a non-Participating Provider, and for certain "special services".

Required prior authorizations may be provided by the Review Center. The Review Center is staffed by Physicians and other health care professionals, and may be either the Claims Administrator's own Utilization Management / Pre-Certification team or an independent third party, chosen at the sole and absolute discretion of the Plan Administrator. The telephone number to call for prior authorization is shown on your Plan identification card.

It is your responsibility to obtain authorization from the Review Center before you receive any service subject to the authorization program. If you receive any such service, and do not follow the procedures set forth in this section, your benefits will be reduced or denied.

In order for the maximum benefits of this Plan to be payable, advance authorization is required for services received from non-Participating Providers. When the appropriate authorization is obtained, these services are called authorized referral services.

Special Services

- Organ and Tissue transplants
- Authorized referrals to non-Participating Providers

Effect on benefits

For services requiring authorized referral:

1. The co-payment / co-insurance for Participating Providers will apply for Medically Necessary **authorized** referral services received from a non-Participating Provider.
2. There are no payable benefits for non-Participating Providers that have not been authorized in advance, unless these services qualify as a true Emergency, are services of an anesthesiologist, or for ambulance services.

For Special Services: Benefits for special services subject to prior authorization will be provided as stated in this Plan for the specific service only when authorization has been obtained as required. No benefits are payable for unauthorized special services, nor for experimental or investigative transplants.

Special Services

1) Organ and Tissue Transplants - Authorization for organ and tissue transplants will be provided as follows:

a. For kidney, bone, skin or cornea transplants only if both of the following criteria are met:
   i. The services are Medically Necessary and appropriate; and
   ii. The Physicians on the surgical team and the facility in which the transplant is to take place are approved by the Utilization Review Center for the transplant requested.

b. For transplantation of liver, heart, heart-lung, lung, kidney-pancreas or bone marrow, including autologous bone marrow transplant, peripheral stem cell replacement and similar procedures, only if all of the following criteria are met:
   i. The services are Medically Necessary and appropriate; and
   ii. The Providers or related preoperative and postoperative services are approved by the Utilization Review Center; and
   iii. The transplant will be performed at a Center of Excellence.

c. If a TUSD Employee donates organ or tissue for a transplant to a non-TUSD patient, then the Plan limits the Donor reimbursement benefits to a maximum of $5,000 per transplant.

Services Subject to Authorization Program

In order for benefits of this Plan to be payable, advance authorization is required for services received from non-Participating Providers. When the appropriate authorization is obtained, these services are called authorized referral services. Please refer to "Effect on Benefits" below to determine how Plan benefits are payable in this situation.

NOTE: Authorized referrals are required for the services of Physicians of a type not available with the Prudent Buyer Plan network to obtain payable benefits under this Plan. A Physician's written referral is required, in order for the services of some Physicians to be covered under this Plan.

Effect on benefits

For services requiring authorized referral:

1. The Plan percentage payable for Participating Providers will apply for Medically Necessary authorized referral services received from a non-Participating Provider.
2. Benefits for Special Services subject to prior authorization will be provided as stated in this Plan for the specific service only when authorization has been obtained as required. No benefits are payable for unauthorized Special Services, nor for experimental or investigative transplants. Benefits for organs and tissue transplants

will result in a denial of benefits if prior authorization is not obtained.

When Authorization will be Provided

Authorized referrals to non-Participating Providers will be authorized only when all of the following criteria are met:

1. There is no Participating Provider who practices the appropriate specialty or provides the required services or has the necessary facilities within a 30 mile radius of your residence for Providers and a 50 mile radius for Hospitals;
2. You are referred to the non-Participating Provider by a Physician who is a Participating Provider; **and**
3. The services are authorized by the Review Center **before** services are received.

Admissions to a Non-Participating Hospital as a result of an Emergency

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 the Plan). 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, the Plan reverts to the non-Participating Provider benefit, which will result in a denial of payable benefits from that point forward until discharge.

DISAGREEMENTS WITH COST CONTAINMENT DECISIONS

PRE-CERTIFICATION APPEAL PROCESS:

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.

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 Review Center that made the determination. 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.

If you, your representative, or your Physician acting on your behalf, find the reconsidered decision still unsatisfactory, a request for an appeal of a reconsidered decision may be submitted in writing to the Plan Administrator. Please refer to the Claims Appeal Procedures section for additional information.

PARTICIPATING PROVIDER ORGANIZATION (PPO/EPO)

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/or Hospital. There are no payable benefits when a non-Participating Provider is utilized except in the following circumstances:

If you have a true Emergency, as defined below, the following coverage is provided:

- **Emergency Room with Admission to Hospital or within 48 hrs of an accident – paid at 100% of Covered Expense by Plan**
- **Emergency Room – Sudden & Serious – $100 Co-pay per use, balance paid at 100% of Covered Expense by Plan**
- **Emergency Room – Physician Services Covered only in the case of an Emergency at 100% less a $25 Co-pay**
- **Ambulance services – benefits paid at 90% of Covered Expense by Plan**
- **Anesthesia services – benefits paid at 90% of Covered Expense by Plan**

Emergency :

Sudden & Serious Illness

A Sudden & Serious Illness is any condition that begins suddenly and is considered out of the ordinary. A Sudden & Serious Illness usually includes:

- Temperature above 102° (oral) or 103° (rectal)
- Chest pain with sudden onset
- Profuse Hemorrhage
- Severe abdominal pain of sudden onset
- Acute respiratory distress
- Obvious severe mental distress
- Life-threatening situations
- Visits to the Emergency room requiring Emergency Hospital admission

Life-Threatening Condition

A Life-Threatening Condition is defined as a sudden and unexpected onset of a medical condition requiring medical or surgical care. Life-Threatening Conditions usually include:

- Severe chest pain
- Profuse hemorrhaging (bleeding)
- Difficulty in breathing
- Sudden onset of weakness or paralysis of a body part
- Unconsciousness
- Convulsions
- Severe burns
- Multiple injuries or trauma
- Partial or complete severing of a limb
- Ingestions of a poisonous substance

Participating Providers are made up of many Hospitals, doctors and medical clinics throughout California, Arizona and the United States 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 Pinnacle or Torrance Unified School District.

CHOICE OF PROVIDERS

WARNING: THIS PLAN PROVIDES COVERGE ONLY WHEN CERTAIN PROVIDERS ARE USED. PLEASE READ THE FOLLOWING INFORMATION TO KNOW FROM WHOM OR WHAT GROUP OF PROVIDERS HEALTHCARE MAY BE OBTAINED. A LIST OF COVERED PROVIDERS WILL BE PROVIDED TO COVERED PERSONS WITHOUT CHARGE.

In order to receive the benefits of the Plan - except in certain limited situations, which are identified below or within this Plan Document – ALL HEALTHCARE must be provided or authorized by Providers participating in the networks identified below. A list of Participating Providers is available to Covered Participants without charge. Also, outpatient prescription drugs must be purchased at pharmacies participating in the NMHC drug program.

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 Physician from the Blue Cross of California Prudent Buyer Plan (PPO) Participating Provider Directory and make an appointment. If you or your Eligible Dependent needs to receive care in Arizona, your Participating Provider network is through Blue Cross Blue Shield of Arizona. For any other states your Participating Provider network is through CCN/First Health. You may obtain a list of Participating Physicians from any of these networks by contacting Pinnacle's Customer Service department at 1-800-649-9121, or you may use the Internet. The internet sites for each of these networks are as follows:
   Blue Cross of California: www.bluecrossca.com
   Blue Cross Blue Shield of Arizona: www.bcbsaz.com
   CCN/FirstHealth: www.ccnusa.com

2. Be sure to inform the Physician's office that your health plan is administered by Pinnacle, and bring your Plan 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**. Your benefits will be denied if you utilize a non-Participating Provider, even if the directory shows the Provider as a Participating Provider. Directories are published every 3 to 6 months and may be out of date at the time you receive treatment. Please remember to re-verify the Provider's Participating status with your Provider prior to any treatment.

3. If required, you will need to make a small payment to the Physician's office. This would be the amount listed on your ID card, and it will be either the partial or full amount you would normally be responsible for under your plan benefits.

4. The Physician will send the bill to Pinnacle and you should make no additional payment until you receive an explanation of benefits (EOB) from Pinnacle's claim office. Participating Providers have agreed not to charge

you more than the Negotiated Fee Rate and, you will not be responsible for any amount in excess of the Negotiated Fee Rate for the Covered Expenses of a Participating Provider.

5. Participating Providers require automatic assignment to the Provider. This means that it is mandatory that Pinnacle issue all payments to the Provider. An EOB will be sent to you to notify you that the claim was processed. This EOB will indicate the "Amount you Owe" to the Provider of service. Please subtract any amounts you have previously paid this Provider and remit the balance to the Provider. **Please keep all EOB's sent to you, as copies of your EOB are not available.**

6. Should you have questions regarding the program, please call Pinnacle's Customer Service department at (800) 649-9121 or use their website at www.pinnacletpa.com.

PROVISIONS FOR PARTICIPATING PROVIDERS

It is your responsibility, both personally and financially, to verify Participating Provider status for your care at or from:

- **the Provider you select or are referred to at the specified location, because some Providers participate at one location, but not at others;**
- **the Physician who will be providing care to you;**
- **the Hospital or other facility.**

If a Participating Surgeon refers you to a non-Participating Anesthesiologist your Covered Expense will be processed at the Participating Provider Percentage Payable of Usual, Customary and Reasonable. Please note that this may not always be identified as part of the claim when submitted by the Provider. If this situation occurs, please notify the Customer Service department for appropriate handling.

If there are no Participating Providers (other than Hospitals) within 30 miles of you, then you should request coverage under the Out of Area Plan by contacting Pinnacle's Customer Service department and if approved your charges will be processed according to the benefits outlined in the Out of Area Plan. If you follow the appropriate procedures your Covered Expense will be processed at the Out of Area Percentage Payable of Usual, Customary and Reasonable.

If services are as a result of an Accident or medical Emergency your Covered Expense will be processed at the Participating Provider Percentage Payable of Usual, Customary and Reasonable.

DETERMINATION OF PAID MEDICAL PLAN BENEFITS

Determination Of Covered Expenses and Medical Necessity

Subject to the exclusions, conditions and limitations stated in this Plan Document, the Plan will pay benefits to, or on behalf of, a Participant for covered Medical Expenses up to the maximums specified within this Plan Document. The Plan will pay benefits for the Usual, Customary and Reasonable charges for services and supplies, which are ordered by a Physician. Services and supplies must be furnished by an eligible Provider and be Medically Necessary. All payments made under this Plan for allowable charges will be limited to Usual, Customary and Reasonable charges and / or Negotiated Fee Rate.

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 Torrance Unified School District 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.

Approval of a claim is subject to the determination of the Medical Necessity of provided services. Medical Necessity is a broadly accepted professional term meaning services were essential to treatment of the Illness or Injury. Treatment determined to be Medically Necessary will follow guidelines where such treatment:

- is consistent with symptoms or diagnosis and treatment of the condition, disease, ailment or Injury
- is appropriate with regard to standards of good medical practice

- is not primarily for the conveniences of the patient, the Physician or other Provider
- is the most appropriate supply or level of services that can safely be provided to the patient. When applied to an inpatient, it means the patient's medical symptoms or condition require services or supplies which cannot be safely provided to the patient as an outpatient.

Please refer to the definitions section of this Plan Document for a complete definition of Medical Necessity or Medically Necessary.

The obligation of the Plan shall be fully satisfied by the payment of allowable expenses in accordance with this Plan Document. Benefits will be paid for the reimbursement of Medical Expense incurred by the Participant if all provisions mentioned in this Plan Document are satisfied.

The fact that a Physician may prescribe, order, recommend, or approve a service or supply does not, in itself, make it Medically Necessary or make the charge an allowable expense, even though it is not specifically listed as an exclusion.

Your benefits are paid by taking the amount of Covered Expense for all Medically Necessary services, subtracting any applicable Deductible and paying the remaining at the Percentage Payable, less any applicable co-payments, up to the Plan Maximum. If you use a non-Participating Provider there are no payable benefits except in the case of an Emergency. If it is as a result of an Emergency than the Covered Expense will be no more than the Usual, Customary and Reasonable charges as determined by the Plan. Covered Expense is subject to the exclusions, conditions and limitations stated within this Plan Document. Services and supplies must be ordered by a Physician and be furnished by an eligible Provider and be Medically Necessary.

PLAN FACTORS

Your Plan includes one of each of the following factors:

A) Calendar Year or Plan Year Deductible: NONE There is no Calendar Year or Plan Year Deductible for this Plan.

B) Lifetime Plan Maximum: Your lifetime Plan Maximum is $2,500,000. This amount of Covered Expense is the aggregate or total of benefits payable during each Participant's lifetime.

C) Maximum Benefits: The maximum benefit is the maximum amount of payable benefits for Covered Expense incurred by each Participant. Other maximum benefits are specified in the applicable sections of this Plan Document.

LIFETIME MAXIMUM BENEFIT LIMITS:

• Infertility Benefits	Maximum of $10,000 per Lifetime
• Maximum of all Plan benefits	Maximum of $2,500,000 per Lifetime

PLAN YEAR MAXIMUM BENEFIT LIMITS:

• Acupuncture Care	Maximum of 26 visits per Plan Year combined with Chiropractic Care
• Chiropractic Care	Maximum of 26 visits per Plan Year combined with Acupuncture services
• Home Health Care	Maximum of 100 visits per Plan Year
• Hospice Care - Bereavement Counseling	Limited to 8 visits following death of Participant within 6 months of the death of the Covered Person
• Inpatient / Partial Care treatment for Mental and Nervous	Maximum of 30 days per Plan Year
• Outpatient treatment for Mental and Nervous	Maximum of 40 visits per Plan Year
• Physical Therapy	Maximum of 26 visits per Plan Year

• Skilled Nursing	Limited to 100 visits per Plan Year
• Substance Abuse / Alcoholism Care	Inpatient care limited to 30 days per Plan Year up to $20,000 in payable benefits per Plan Year and Outpatient care limited to 26 visits per Plan Year
• TMJ / Jaw Joint Treatment	Limited to $3,000 in payable benefits per Plan Year

D) Percentage Payable: Your Percentage Payable is 90% when you use a Participating Provider. When you use a non-Participating Provider there are no payable benefits under this Plan, unless otherwise noted within the Plan. Percentage Payable is the percentage of Covered Expense that is paid by the Plan up to the Plan maximums stated throughout this Plan.

E) Co-payments: A Co-payment will apply to each visit or service as indicated within this Plan. The Co-payment amounts are your responsibility and are not reimbursable, except in the case of Coordination of Benefits (COB), Rx Co-payments are excluded from COB reimbursements. **Co-payments will not apply to the Out-of-pocket Maximum and will continue to be your responsibility even after your Out-of-pocket Maximum has been met.** Please refer to each section within this Document for additional information concerning these benefits. When a claim is submitted for payment, Pinnacle will process that claim and subtract the Co-payment from the payable benefits. The Explanation of Benefits that is sent to your home will indicate that the Co-payment is your responsibility even though you may have paid that to the Provider at the time of service.

F) Out of Pocket Maximum: Your Out of Pocket Maximum is $500 per eligible Individual Participant per Plan Year. The Family Out of Pocket Maximum is $1,500 per Plan Year. A family means an Eligible Employee and their Eligible Dependents.

The Out of Pocket Maximum is the point at which the Covered Expense is payable at 100% for each Covered Person or Covered Family during any and each Plan Year. Covered Expenses in excess of the Out of Pocket Maximum are payable at 100% by the Plan. Your Out of Pocket Maximum must be satisfied for each person covered or per Family for each Plan Year. The Co-payments, pre-certification non-compliance penalties, amounts in excess of Usual, Customary and Reasonable, Prescription Drug Card services, Benefits paid at 100%, Ambulance services, Inpatient Physician services billed separately from the Hospital invoice, orthotics, prosthetics, services related to TMJ and Jaw problems, durable medical equipment, medical supplies, Infertility services billed separately from the Hospital invoice, Contraceptive devices or medications, treatment and testing for sleep disorders, Substance Abuse / Alcoholism care and treatment, and non-Covered Expenses are not included in calculating the Out of Pocket Maximum, nor paid in full once the Out of Pocket Maximum is reached.

COVERED EXPENSE

Note: This Plan only covers services by a Participating Provider unless otherwise indicated below. There are no payable benefits for a non-Participating Provider.

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

A) Abortion is a Covered Expense for elective or non-elective abortion procedures and any complications arising out of an abortion. Benefits for these services apply to a covered Participant, their covered Spouse, and their covered dependent child. Benefits are payable at 90% of the Negotiated Rate for a non-elective abortion and at 100%, less a $150 copayment when services performed are for an elective abortion. Benefits will not apply to your Out-of-Pocket Maximum for elective abortions.

B) Acupuncture services are a Covered Expense for pain management when rendered by a licensed Physician or acupuncturist. Benefits are payable up to a maximum of 26 visits per Plan Year combined with Chiropractic care at 100% of the Negotiated Rate, less a $30 copayment for a Participating Provider only. **These benefits do not apply to your Out-of-Pocket Maximum.**

C) Allergy Injections / Treatment is a Covered Expense for those Medically Necessary services, including the antigen, rendered in a Physician's office for the treatment of allergies. Benefits are payable at 100% of the

Negotiated Rate, less a $25 copayment for a Participating Provider only. The copayment is only taken if an office visit is billed. **These benefits do not apply to your Out-of-Pocket Maximum.**

D) Allergy Testing is a Covered Expense for those Medically Necessary services to test for or diagnose allergies. Benefits are payable at 100% of Negotiated Rate for a Participating Provider only. The copayment is only taken if an office visit is billed. **These benefits do not apply to your Out-of-Pocket Maximum.**

E) Ambulance services are a Covered Expense for necessary professional ground and Medically Necessary air ambulance transportation in an Emergency to or from the nearest Hospital where appropriate care can be obtained or from the Hospital to the Participant's home or to a Skilled Nursing Facility when there is documentation the patient required ambulance transportation. Benefits are payable at 90% of Negotiated Rate for Participating Providers and at 90% of Usual, Customary and Reasonable for non-Participating Providers. **These benefits do not apply to your Out-of-Pocket Maximum.**

F) Ambulatory Surgery Center/ Outpatient Surgery at Hospital is a Covered Expense for surgical procedures and associated Physician services and supplies that can be safely and adequately performed in an Outpatient department of a Hospital or in a freestanding ambulatory unit. **Pre-authorization is required when services are performed at a freestanding ambulatory unit.** Failure to pre-authorize these services will result in a reduction in benefits to 50% of Covered Expense. Covered Expense is payable at 90% of the Negotiated Rate for Participating Providers only. Surgical procedures qualified for outpatient surgery are not expected to result in extensive blood loss; require major or prolonged invasion of a body cavity; or involve any major blood vessels.

G) Anesthesia services are a Covered Expense for the administration of regional or general anesthesia to a Participant by a qualified anesthesiologist or certified registered nurse anesthetist (C.R.N.A.) in connection with a covered surgical service and not administered by the operating surgeon or assistant surgeon. Covered Expense is payable at 90% of the Negotiated Rate for a Participating Provider and for services provided by a non-Participating Provider, benefits are payable at 90% of Usual, Customary and Reasonable. The administration of local or topical anesthesia is not a Covered Expense, except in maternity cases.

H) Attention Deficit Disorders (ADD & ADHD) are a Covered Expense for testing and treatment of ADD or ADHD. Regular Plan benefits will be paid for these services and treatment. Please refer to the appropriate sections of the Plan based upon the services recommended to determine specific payable benefits.

I) Birthing Center / Midwife services are a Covered Expense for Medically Necessary services and supplies. Covered Expense is payable at 90% of the Negotiated Rate for a Participating Provider only. Services must be performed by a licensed Midwife at a licensed and accredited Birthing Center.

J) Blood transfusions, blood, blood plasma, are a Covered Expense as noted if ordered by a Physician, licensed technician or clinic for diagnosis of a Illness or Injury being treated, including blood, blood plasma, and plasma extenders, when not available to the Participant without charge. Plan benefits are paid at 90% of Negotiated Rate for a Participating Provider only.

K) Chemotherapy and Radiation Therapy - Outpatient is a Covered Expense for chemotherapy and radiation therapy performed in an Outpatient department of a Hospital or an outpatient clinic or Physician's office as well as the associated Physician services. Covered Expense is payable at 90% of the Negotiated Rate for a Participating Provider only.

L) Chiropractic care is a Covered Expense for diagnostic evaluations and treatments by manipulation and other modalities, including x-rays. All payable benefits are limited to Participating Providers only and are payable at 100%, less a $30 copayment up to a maximum of 26 visits per Plan Year combined with Acupuncture services**.** Benefits for X-rays are payable at 100% of Covered Expense. **These benefits do not apply to your Out-of-Pocket Maximum and Massage Therapy is not covered.**

M) Circumcision is a Covered Expense and benefits are payable at 90% of the Negotiated Rate for a Participating Provider only. **These benefits do not apply to your Out-of-Pocket Maximum.**

N) Contraceptive Management, Drugs and Devices are a Covered Expense when prescribed by a Physician and include: Oral contraceptive drugs, intradermal contraceptive devices (i.e., Norplant), Depo-Provera injections, and insertion and/or removal of intradermal contraceptive devices. Benefits for contraceptive management visits are payable at 100% of the Negotiated Rate, less a $25 copayment for Participating Providers only. Benefits for contraceptive injections are payable at 100% of the Negotiated Fee for

Participating Providers only. The copayment is only applied if an office visit is billed with the injection. Oral contraceptive drugs and contraceptive devices are available under the Prescription Drug Card benefit. **These benefits do not apply to your Out-of-Pocket Maximum.**

O) **Cosmetic surgery** for services complementing medical and surgical benefits for mastectomies, in a manner determined in consultation with the attending Physician and the patient are a Covered Expense as follows:

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

All relevant Plan provisions regarding annual deductibles, coinsurance and co-payments apply to these additional services.

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.

P) Expenses incurred for Hospitalization in connection with **dental or oral surgery** will be considered Covered Expense if the confinement is certified in writing by a Physician as Medically Necessary to safeguard the life of the patient. Hospital confinement means confinement as a registered bed patient for 24 hours or more. For Pre-Certified services, Covered Expense is payable at 90% of the Negotiated Rate for Participating Hospitals only. For non Pre-Certified services, Covered Expense is payable at 50% of the Negotiated Rate for Participating Hospitals only.

Dental Care for Accidental Injury is a Covered Expense for treatment of Accidental injuries to the jaw, mouth or natural teeth and regular Plan benefits will be paid for treatment received within six (6) months of the Accident and provided the date of the Accident is after the effective date of coverage. Benefits are payable, at 90% of Negotiated Rate for Participating Provider and at 90% of Usual, Customary and Reasonable for services provided by a non-Participating Provider.

Q) **Diabetic Daycare Self-Management Education Programs and related Nutritional Counseling** is a Covered Expense and benefits are payable at 100% of Negotiated Rate for a Participating Provider only, less a $25 copayment per visit. Covered Expense includes the charges of a diabetic day care center and for the services of a Physician or other professionals who are knowledgeable about the treatment of diabetics (such as a registered nurse, registered pharmacist, registered dietician or nutritionist) for the purposes of enabling diabetics and their families to understand and practice daily management of diabetes. Coverage will also include visual aids (but not eyeglasses) to assist with proper dosing of insulin and other Medically Necessary equipment and supplies. **These benefits do not apply to your Out-of-Pocket Maximum.**

R) **Diagnostic x-rays and laboratory tests** are a Covered Expense as noted if ordered by a Physician, licensed technician or clinic for the diagnosis of an Illness or Injury being treated. Benefits for services obtained within the Physician's office, a clinic or a free standing facility are payable at 100% of Negotiated Rate for Participating Providers only and do not apply to your Out-of-Pocket Maximum. Benefits for services obtained at the Hospital in an outpatient place of service are payable at 90% of Negotiated Rate for Participating Providers only and Covered Expense includes a Physician's interpretation of covered diagnostic tests and studies, pathology and radiology services. Covered Expense shall also include electrocardiograms, electroencephalograms, pneumoencephalograms, basal metabolism tests or similar diagnostic tests. See "Pre-Admission Testing" for additional information. Routine laboratory and x-ray services are payable under Preventive or Well Child Care.

Note: Unless expressly listed elsewhere, eligible diagnostic services do not include: 1) audiometric testing when performed to determine the need for a hearing aid, 2) eye refractions, or 3) dental X-rays unless related to the diagnosis or treatment of a medical condition or resulting from an Accidental injury.

S) **Dialysis Services and Treatment** are a Covered Expense including the training of a person to assist the patient with home dialysis, when provided by a Hospital, free standing dialysis center or other appropriate

covered Provider. Benefits are payable at 90% of Negotiated Rate for Participating Providers only.

T) Durable Medical Equipment is a Covered Expense for the rental or initial purchase; whichever is less expensive and subject to approval by the TPA. Utilization Management / Pre-Certification is not required but is recommended. Payment of rental fees shall not exceed the actual cost of equipment and includes the 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 as well as oxygen & respiration equipment; Hospital beds; non-powered wheelchairs; braces; crutches; traction apparatus; head halters; cervical collars; insulin pumps; and dialysis equipment. Plan benefits are paid for Medically Necessary durable medical equipment at 90% of Negotiated Rate for Participating Providers only. **These benefits do not apply to your Out-of-Pocket Maximum.**

U) Emergency Room Care for Sudden & Serious Illness / Life Threatening Condition the Plan pays for covered Hospital charges and associated Physician services. The treatment for a Life Threatening Condition or Sudden & Serious Illness must begin within 24 hours of onset. If treatment is received in a Hospital Emergency room for a condition more than 24 hours in duration, it will be considered a non-Emergency and benefits for a Sudden & Serious Illness or a Life Threatening Condition will not apply. Final determination of a Sudden & Serious Illness or a Life Threatening Condition will be the TPA's responsibility based on information in the patient's medical records requested from the Hospital or on the submitted claim information.

Sudden & Serious Illness

A Sudden & Serious Illness is any condition that begins suddenly and is considered out of the ordinary. A Sudden & Serious Illness usually includes:

- Temperature above 102° (oral) or 103° (rectal)
- Chest pain with sudden onset
- Profuse Hemorrhage
- Severe abdominal paid of sudden onset
- Acute respiratory distress
- Obvious severe mental distress
- Life-threatening situations
- Visits to the Emergency room requiring Emergency Hospital admission

Life-Threatening Condition

A Life-Threatening Condition is defined as a sudden and unexpected onset of a medical condition requiring medical or surgical care. Life-Threatening Conditions usually include:

- Severe chest pain
- Profuse hemorrhaging (bleeding)
- Difficulty in breathing
- Sudden onset of weakness or paralysis of a body part
- Unconsciousness
- Convulsions
- Severe burns
- Multiple injuries or trauma
- Partial or complete severing of a limb
- Ingestions of a poisonous substance

Covered Expense is payable at 100% of the Negotiated Rate for Participating Providers and 100% of Usual, Customary and Reasonable for Emergency services at a non-Participating Hospital. A $100 copayment per use applies, unless you are admitted to the Hospital or services are within 48 hours of an Accident. Please refer to the Inpatient Hospital benefits section for your benefits in the event you are admitted to the Hospital. Physician services billed separately from the facility will be payable at 100% of Covered Expense, less a $25 copayment per visit. **These benefits do not apply to your Out-of-Pocket Maximum.**

Emergency Room Treatment of a non-Emergency Illness Covered Expense is payable at 100% of the Negotiated Rate, less a $100 copayment per use for Participating Providers only. Please refer to Inpatient Hospital section for additional information on your benefits in the event you are admitted to the Hospital. Physician services billed separately from the facility will be payable at 100% of Covered Expense, less a $25 copayment per visit. **These benefits do not apply to your Out-of-Pocket Maximum.**

V) Family Planning Services are payable at 100% of the Negotiated Rate, less a $150 copayment for services

performed at a Participating Provider only. Covered Expense includes elective or voluntary sterilization procedures, such as a Tubal Ligation and/or a Vasectomy. Elective abortion procedures and any complications arising out of an abortion for the Employee, eligible Spouse, and Dependent Child are also a Covered Expense and benefits are payable at 100% of the Negotiated Fee, less a $150 copayment, for Participating Providers only. **These benefits do not apply to your Out-of-Pocket Maximum.**

W) Foot Care is a Covered Expense for the treatment of mycotic toenails and removal of nail matrix or root. The treatment of routine foot care and removal of corns, calluses, toenails, or subcutaneous tissue when care is prescribed by a Physician treating metabolic or peripheral vascular disease, is also a Covered Expense. Benefits are payable at 100% of the Negotiated Rate, less a $25 copayment per visit for services performed by a Participating Provider only. Please see "Orthotics" for additional information.

X) Home health care is a Covered Expense if services are consistent with your Injury or Illness and provided, the services are under a Home Health Care plan which require the specialized training of an R.N., L.V.N., L.P.N., home health aide, physical, occupational or speech therapist and are not primarily for housekeeping, personal hygiene or Custodial Care. These services must be ordered by a Physician, licensed technician or clinic, for the diagnosis of an Illness or Injury being treated and do not include services of an individual who usually lives with the patient or is a member of the patient's family or for transportation. A single home health care visit is defined as a visit of four hours or less. Covered Expense also includes medical supplies, drugs, and medicines prescribed by a Physician, laboratory services, and home uterine activity monitoring including all monitors and Terbutaline. Plan benefits are paid at 90% of Negotiated Rate for a Participating Provider only and are limited to 100 visits per Plan Year. Utilization Management / Pre-Certification is not required but is recommended to ensure appropriate and Medically Necessary services are obtained.

Y) Home Infusion Therapy / Home Injectable Therapy is a Covered Expense if services are consistent with your Injury or Illness and, provided the services are Medically Necessary. These services must be ordered by a Physician, licensed technician or clinic, for the diagnosis of an Illness or Injury being treated and include administration of drugs by intravenous (into a vein), intramuscular (into a muscle), subcutaneous (under the skin), and intrathecal (into the spinal canal) routes. Plan benefits are payable at 90% of Negotiated Rate for a Participating Provider only. Utilization Management / Pre-Certification is not required but is recommended to ensure appropriate and Medically Necessary services are obtained. This benefit is separate from your Specialty Rx injectable program available through the NMHC Ascend program.

Z) Hospice care is a Covered Expense and consists of Inpatient services, outpatient services and home health care, as delineated within this Plan Document, delivered to a Terminally Ill Participant by medical personnel and home health care providers under a licensed Hospice administration. Plan benefits are payable at 90% of Negotiated Rate for a Participating Provider only. The setting must be approved by the National Hospice Organization and Pinnacle and services must be case managed. The patient must be diagnosed as Terminally Ill with a life expectancy of six months or less. Covered Expense includes bereavement counseling up to 8 visits at a 100% less a $25 copayment per visit for members of the immediate family during the 6 months following the death of the Covered Person, provided the patient's family members remain covered under the Plan following the patient's death. Covered Expense does **Not** include: pastoral, financial or legal counseling; funeral arrangements; homemaker, caretaker or transportation services for the family; housecleaning and house maintenance expenses.

AA) Hospital Services – Please see "Inpatient Hospital Services" and/or "Outpatient Hospital Services" for additional information.

BB) Infertility services are a Covered Expense and are payable at 80% of Negotiated Rate for Participating Providers only. These services are payable up to a Lifetime maximum of $10,000 per Participant. Covered Expense includes Physician services and all related medications. Surgical services and diagnostic procedures for the purpose of diagnosing infertility are payable at 90% of Negotiated Fee for Participating Providers only. Oral medications are available through the Prescription Drug card program at the appropriate copayment. If the medication is in an injectable form, you will be required to pay for the medication up front and submit the receipt for reimbursement according to the provisions outlined above. **These benefits do not apply to your Out-of-Pocket Maximum and the storage of embryo or cord blood is not a Covered Expense.**

CC) Immunizations are a Covered Expense, please refer to "Preventive Care" for payable benefits for routine (preventive) immunizations. For non-routine immunizations, benefits are payable for Medically Necessary services at 100% of the Negotiated Rate for a Participating Provider only. **These benefits do not apply to your Out-of-Pocket Maximum.**

DD) Injectables are a Covered Expense and include medicines, which are dispensed using a hypodermic syringe and/or needle for Medically Necessary conditions ordered by a Physician in a medical clinic, or a Physicians office. Benefits are payable at 90% of the Negotiated Rate for a Participating Provider only.

For injectables dispensed in the Physicians office which are in the following categories:

- Antibiotics, Pain Medications and Medically Necessary steroidals; or
- Non-routine immunizations (not for Well Child Care or Preventive Care).

Benefits in these circumstances are payable at a 100% of Covered Expense for Participating Providers only. **These benefits do not apply to your Out-of-Pocket Maximum.**

EE) Inpatient 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, not to include services, drugs or supplies which are dispensed but not used in the Hospital, i.e. take home medications are not a Covered Expense. For Pre-Certified services, Covered Expense is payable at 90% of the Negotiated Rate for Participating Hospitals only. For non Pre-Certified services, Covered Expense is payable at 50% of the Negotiated Rate for Participating Hospitals only.

FF) Inpatient Physician services are a Covered Expense for the treatment of an illness or Injury and include: a) surgery; b) second surgical opinion; c) Assistant Surgery; d) anesthesia; e) Radiology – interpretation fees; f) Pathology – interpretation fees; g) Inpatient medical visits; h) consultations. Covered services from a Participating Provider are payable at 90% of the Negotiated Rate. For Emergency Room Physician services billed separately from the Hospital, benefits are payable at 100% of Negotiate Rate, less a $25 co-payment per visit for Participating Providers only.

It is important to note that not all Physicians based at a Participating Hospital or facility are Participating Providers. You are responsible to request and verify that ALL Physician services be performed by a Participating Provider. This includes (but is not limited to) the Emergency rooms, lab/X-rays, pharmacy, Hospitalists, other Departments or Floors that may not be a Participating Provider even though they are located in a Participating Hospital.

GG) Insulin Pump – Please see "Durable Medical Equipment" for additional information.

HH) 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 payable at 90% of the Negotiated Rate for Participating Hospitals only. For non Pre-Certified services, Covered Expense is payable at 50% of the Negotiated Rate for Participating Hospitals only.

II) Marriage and Family Counseling – Please see "Mental and Nervous Health Care – Outpatient" for additional information.

JJ) Maternity & Pregnancy benefits will be payable for maternity related services as any other Illness or Injury under this Plan for a covered Employee, covered Dependent Spouse, or covered Dependent Child. Coverage is allowed for routine maternity services and complications of pregnancy and include the following services:

- Pre-natal visits and routine pre-natal and post-partum care
- Expenses associated with a normal or cesarean delivery as well as any expenses associated with complications of pregnancy;
- Genetic testing or amniocentesis when deemed Medically Necessary by a Physician

Covered Expense includes both inpatient and outpatient services and benefits for a Normal Delivery, cesarean section or complications of pregnancy are payable at 90% of the Negotiated Rate for a Participating Provider only. Benefits for the initial visit & any diagnostic visits outside the Global Fee for the delivery are payable at 100%, after a $25 copayment. All other visits associated with the Global Fee for the delivery are payable at 100% of Negotiated Rate for Participating Providers only. Inpatient Physician Services & Hospital Services are payable at 90% of the Negotiated Rate for Participating Providers only. Benefits are payable for circumcision of a newborn baby under the Baby's benefits at 90% of Negotiated Rate for Participating Providers only, provided the baby is enrolled .

Services for a newborn healthy baby are payable as part of the Mothers benefits for the first 31 days only (excluding circumcision services) and services for a newborn sick baby are payable under the Baby's benefits

from the day of birth, provided that the Baby is enrolled within 31 days of birth. If the newborn healthy Baby is to be covered after the 31st day of birth, the Baby MUST be enrolled within 31 days of their date of birth. Please contact the Human Resource department for the appropriate forms to enroll your baby. Please note that your baby will not be enrolled automatically and neither the TPA nor the Hospital can initiate enrollment on your behalf.

For payable benefits that apply to a newborn sick baby, please see "Newborn Care – Sick Baby" for additional information.

NOTE: Maternity / Pregnancy care will not include: 1) Lamaze and other charges for education related to pre-natal care and birthing procedures; 2) adoption expense; or 3) expenses of a surrogate mother who is not a covered Employee or covered Spouse.

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.

KK) Medical and surgical supplies are a Covered Expense as noted if ordered by a Physician, licensed technician or clinic for diagnosis of an Illness or Injury being treated. Covered Services include disposable supplies such as: surgical dressings, casts, splints, trusses, syringes, colostomy bags and related supplies, and catheters. Diabetic supplies such as chemstrips and blood lancets necessary for testing the blood sugar level of diabetics, and accucheck monitor (blood/glucose monitor) are payable under your Prescription Drug Card benefits. Plan benefits are paid, after your Deductible, at 90% of Negotiated Rate for a Participating Provider only. **These benefits do not apply to your Out-of-Pocket maximum.**

LL) Mental and Nervous health care are a Covered Expense for the treatment of Mental and Emotional Disorders. Benefits are payable as indicated below. Pre-Certification is required for all Inpatient admissions.

1**.** Inpatient and Partial Hospitalization treatment: Benefits are limited to 30 days per Plan Year. Pre-Certified services, are payable at 90% of the Negotiated Rate for Participating Providers only. For non Pre-Certified services, Covered Expense is payable at 50% of the Negotiated Rate for a Participating Provider only. Partial Hospitalization will count as inpatient care at a 2-for-1 exchange ratio.

2. Outpatient treatment**:** Benefits are payable at 100% of the Negotiated Rate, less a $25 copayment per visit, for a Participating Provider only. Benefits are limited to 40 visits per Plan Year.

MM) Midwife – Please see "Birthing Center/Midwife Services" for additional information.

NN) MRI, Cat Scan, Ultrasound & Nuclear Medicine services are a Covered Expense if ordered by a Physician, licensed technician or clinic for the diagnosis of an illness or Injury being treated. Covered services include Magnetic Resonance Imaging (MRI's), Cat Scans, Magnetic Resonance Angiography (MRA's), Positron Emission Tomography (PET) scans, Bone Density testing; and any cardiac diagnostic procedure utilizing nuclear medicine. Benefits are payable at 100% of the Negotiate Rate for a Participating Provider only. **These benefits do not apply to your Out-of-Pocket maximum.**

OO) Newborn care – Sick Baby is a Covered Expense for Medically Necessary services and supplies while in the Hospital and for Physician services and supplies, provided the proper enrollments have been completed within 31 days of birth. These expenses will be a separate and distinct claim from the mothers' expenses. Covered Expense is payable at 90% of the Negotiated Rate for Participating Hospitals and Participating Physicians only.

PP) Nurse and/or Nurse Practitioners 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 an Illness or Injury being treated. Private Duty Nursing expenses are not a Covered Expense under the Plan. Plan benefits for Medically Necessary Covered Expenses are payable at 90% of Negotiated Rate for a Participating Provider only. If services are provided in the home, the Home Health Care benefit limit of 100 visits per Plan Year will apply.

QQ) Occupational Therapy or an occupational therapist for treatment of a condition requiring therapy is a Covered Expense as noted if ordered by a Physician, licensed technician or clinic for diagnosis or treatment of an Illness or Injury. Occupational therapy is limited to services to restore physical function. Plan benefits are payable for a Participating Provider at 100% of the Negotiated Rate, less a $30 copayment per visit. **These benefits do not apply to your Out-of-Pocket maximum.**

RR) Orthotics is a Covered Expense for Medically Necessary services and includes a durable brace made for and fitted to the patient; orthopedic shoes when an integral part of a brace; orthotics or orthopedic appliances used to treat a condition requiring more than a supportive device of the foot; or orthotics or orthopedic devices not primarily used for the support or comfort of the foot. Plan benefits are payable for a Participating Provider only at 90% of the Negotiated Rate. **These benefits do not apply to your Out-of-Pocket maximum.**

SS) Other Outpatient Hospital Services are those Medically Necessary services rendered in an Outpatient department of a Hospital and include (but are not limited to) a) laboratory tests and x-rays; c) respiratory therapy. Covered Expense is payable at 90% of the Negotiated Rate for a Participating Provider only.

TT) Pap Smear – Please see "Diagnostic Lab & X-ray Services" (when Illness related) or "Preventive Care-Adult" for additional information.

UU) Physical Exams – Please see "Preventive Care-Adult" or "Well Child Care" for additional information.

VV) Physical Therapy services by a licensed physical therapist for treatment of a condition requiring physical therapy to repair an impaired bodily function are a Covered Expense as noted if ordered by a Physician, licensed technician or clinic for treatment of an Illness or Injury. Utilization Management / Pre-Certification is not required but is recommended for any extended treatment plans. Plan benefits are limited to 26 visits per Plan Year and are payable at 100% of the Negotiated Rate, less a $30 copayment per visit for a Participating Provider only. **These benefits do not apply to your Out-of-Pocket maximum.**

WW) A Physician is covered for professional, medical, surgical, diagnostic or anesthetic services.

An **Outpatient Physician visit in the office or home for the** exam and same day related services, including but not limited to, allergy injections and injections that are billed by that Provider. Benefits for the visit are payable at 100% of the Negotiated Rate, after a $25 copayment and all other services are payable at 100% for Participating Providers. There is a maximum of one copayment per day if multiple services are billed in conjunction with the office visit. **These benefits do not apply to your Out-of-Pocket maximum.**

An **Inpatient Physician visit** or consultation is payable at 90% of the Negotiated Rate for a Participating Provider only. **If these services are billed separately from the Hospital bill, then Plan benefits will not apply to your Out-of-Pocket maximum.**

In Office Surgery at a Physician's office are a Covered Expense for Medically Necessary services and benefits are payable at 100% of Negotiated Rate for a Participating Provider only. **These benefits do not apply to your Out-of-Pocket maximum.**

Emergency Room Physician Services is a Covered Expense and benefits for a Participating Provider are payable at 100% of Negotiated Rate, less a $25 copayment per visit, when services are billed separately from the Hospital invoice. **These benefits do not apply to your Out-of-Pocket maximum.**

XX) Pre-admission Testing is a Covered Expense for those diagnostic tests related to the scheduled admission and performed within 72 hours prior to a scheduled Hospital admission. Covered Expense is payable at 90% of the Negotiated Rate for a Participating Provider, provided that the admission is considered a Covered Expense. Tests must be done while the person is Not confined as an inpatient in a Hospital and test results must appear in the Participants medical record kept by the Hospital where the patient is admitted.

YY) Pregnancy Care – Please see "Maternity and Pregnancy benefits" for additional information.

ZZ) Prescription Drug Card Program - Outpatient prescription drugs are provided through a program administered by NMHC (National Medical Health Cards) offered by your Plan Sponsor, which requires that you receive your outpatient Prescription Drugs through a Participating NMHC Pharmacy, which is a national network of Participating Pharmacies, and/or MyNMHC for the mail order program for maintenance medications. For all covered medications, you are responsible to pay the Rx Co-payment based upon the type of drug

dispensed for a Participating pharmacy, or the mail-order program, and the Plan will pay the remainder of the Covered Expense. **These benefits do not apply to your Out-of-Pocket maximum.**

The Rx Co-payment amounts are listed below and on your Identification Card. Co-payments apply to each new and refill prescription drug. Co-payments are not reimbursable and do not apply to your medical plan Out-of-Pocket maximum and are not eligible for coordination of benefits. Outpatient prescription drugs are limited to a quantity not to exceed a 30-day supply for retail pharmacies and up to a 90-day supply for maintenance medications through the mail order program.

The Rx Co-payment amounts:	**NMHC Group: 200000**	
	Retail	**NMHC**
	Participating Pharmacy	**Mail Order**
Non-Preferred Brand – Tier III drugs:	$40.00 up to 30 day supply	$40.00 up to 90 day supply
Preferred Brand – Tier II drugs:	$25.00 up to 30 day supply	$25.00 up to 90 day supply
Generic - Tier 1 drugs:	$10.00 up to 30 day supply	$10.00 up to 90 day supply

The pharmacist will collect the Co-payment at the time the drugs are obtained. A generic medication will be substituted for a brand-name prescription whenever a generic form of the drug is available. If a Participant requests or elects a Brand Name Drug when there is an FDA approved Generic Drug alternative and the Physician has not indicated that a Brand Name Drug is necessary, the co-payment will equal the applicable co-pay plus the cost difference between the brand-name drug and its generic equivalent.

For a list of Participating pharmacies in any U.S. state or a mail order program envelope, please contact NMHC at (800) 777-0074 or use the NMHC website at www.nmhc.com. Prescriptions may be refilled at your local pharmacy after 75% of the medication has been used. Prescriptions being refilled through the mail order program may occur after 65% of the medication has been used.

Drug Coverage is based on the use of the Plan's Preferred Drug Formulary through NMHC which is updated on an ongoing basis by NMHC's Formulary Committee. Non-Preferred brand drugs may be covered subject to higher co-payments. Selected drugs and drug dosages may require prior authorization by NMHC for Medical Necessity and appropriateness of therapy. A complete list of Preferred brand drugs can be obtained from their website at www.nmhc.com by clicking on the formulary tab or by calling NMHC at 1-800-777-0074.

Please refer to the prescription mail-order form and brochure for additional information and an explanation on how to use the mail-order option. Mail-order brochures and forms can be obtained from NMHC by contacting them at 1-800-777-0074 or via the internet at www.mynmhc.com.

If a Participant needs to have a prescription order filled but they have not received their identification card or it has been lost or it is not in their possession, the Participant must pay for the prescription at the time it is dispensed and submit a claim for reimbursement to NMHC. The reimbursement will be reduced by the applicable copayment and any unallowable costs.

Covered prescriptions dispensed by non-Participating (non-NMHC) pharmacies located outside of the Plan's service area will be covered when dispensed in conjunction with, and immediately following, an event requiring Emergency care where the Participant is unable to use a Participating (NMHC) pharmacy. In such circumstances, the Participant must pay for the prescriptions at the time they are dispensed and submit a claim for reimbursement to NMHC. The reimbursement will be reduced by the applicable copayment and any unallowable costs.

a) **Covered medications include**: a) drugs that are Medically Necessary listed in NMHC's drug formulary for which a prescription is required by state or federal law with a prescription order of a duly licensed Participating Physician and is dispensed by a licensed pharmacist; b) Insulin for the treatment of diabetes and diabetic test strips; c) any required hypodermic syringes and/or needles; dispensed for use with self-injectable drugs or medications; d) contraceptive drugs or devices prescribed for birth control; e) prescription vitamins, including pre-natal vitamins; f) prescription inhalers which are Medically Necessary; g) prescription Nicotine patches and Zyban for Nicotine addiction; h) drugs used for erectile dysfunction, including Viagra.

Non Covered prescription and drug expenses include:

b) drugs that do not require a prescription (except insulin or diabetic test strips);
c) drugs intended for use in a physician's office or another setting other than home use;

d) investigational or experimental drugs that are prescribed for experimental purposes or indications not approved by the United States Food and Drug Administration, except that off-label use of an FDA-approved drug for the treatment of a life threatening condition is covered, subject to the following requirements:
    - the drug must be recognized for treatment of the health condition by one of the following: 1) the American Association Drug Evaluations, 2) the American Hospital Formulary Service Drug Information, 3) the United States Pharmacopoeia Dispensing Information, volume 1 "Drug Information for the Health Care Professional", or 4) Two articles from major peer reviewed medical journals that present data supporting the proposed off-label use or uses as generally safe and effective unless there is clear and convincing contradictory evidence presented in a major peer reviewed medical journal.
    - the prescribing Physician must submit documentation supporting compliance with the requirement stated above if required by the Claim Administrator.
    - for the purpose of this benefit, "life threatening," means either or both of the following: 1) disease or conditions where the likelihood of death is high unless the course of the disease is interrupted, or 2) diseases or conditions with potentially fatal outcomes, where the end point of clinical intervention is survival.
e) prescriptions which an eligible person is entitled to receive without charge from any Workers' Compensation Laws, or any municipal, state or federal program;
f) drugs used for cosmetic purposes (e.g. Retin A (wrinkle prevention) for an Eligible Participant under age 40 and Rogaine for hair growth) Retin-A will be covered for an Eligible Participant under age 40 for a diagnosis of Acne Vulgaras or skin cancer only;
g) cosmetics, health or beauty aids, dietary supplements, anorectics (i.e. appetite suppressants) or any other diet medications;
h) any medication dispensed in connection with any health condition which is not covered under the terms of the medical benefits of the Plan;
i) drugs for which no charge is made or for which you would not be required to pay in the absence of this Plan;
j) drugs which are not Medically Necessary;
k) hypodermic syringes and/or needles, except when dispensed for use with insulin or other self-injectable drugs or medications.

Specialty Pharmacy program – The Specialty Pharmacy program covers all specialty pharmaceutical medications. Specialty pharmaceutical medications are those medications typically used to treat chronic conditions and are often injectable medications. Many of the new biotech and oncology medications are considered specialty medications. The Specialty Pharmacy program for TUSD is managed through NMHC Ascend. It is required that all specialty medications are obtained through NMHC Ascend. Your Plan does not cover these specialty medications through your local pharmacy or the Physician's office. You must contact NMHC Ascend at 1-800-850-9122 to obtain all of your specialty pharmacy medications. The NMHC Ascend program will send a 90-day supply of the medications directly to your home or your designated location. You will be required to pay a single Non-Preferred Brand Co-pay for each 90-day supply. There is no extra cost for shipping and most specialty medications will be sent either UPS or FedEx. NMHC Ascend hours of operation are: Monday thru Friday 9am-6pm EST.

Drug Utilization Review – The Prescription Drug Card Program includes Utilization Management / Pre-Certification of prescription drug usage for health and safety reasons. If NMHC or the Claim Administrator detects patterns of over-utilization or misuse of drugs, the Plan will notify the Eligible Participant's Physician and pharmacist. The Plan Administrator reserves the right to limit benefits to prevent over-utilization of drugs.

Drug Prior Authorization Categories

Androgens (eg testosterone, danazol, fluoxymeterone)
Antifungals (eg terbinagine)
Anti-obesity agents (eg orlistat)
Anti-emetics (eg aprepritant)
Vitamins (eg Vitamin B complex)
Cox-II inhibitors (eg celecoxib)
Antineoplastics (eg Tarceva, Iressa, Gleevac)
Dermatologic creams (eg hyroquinone, pimecrolimus, tacrolimus)
Pulmonary Arterial Hypertension agents (eg iloprost)
Antivirals (eg ribavirin)
Anti-diabetic agents (eg Symlin, Byetta)

Quantity Limit Categories
Oral Antifungal (fluconazole)
Contraceptives (oral, devices)
Anti-Cholesterol
Erectile Dysfunction
Anti-Migraine
Psychiatry (fluoxetine delayed release 90mg)
Pain (oxycodone, butorphanol)
Anticoagulation (low molecular weight heparins)
Anti-diabetic ulcers
Diabetes (Supplies, Test agents)

Contingent Therapy or Step Therapy Medications
Antihistamines
Aprepitant
Ribavirin
Celbrex

Age Restrictions
Pediatric vitamins (up to age 16)
Tretinoin Products (eg Retin-A) (up to age 34)
Prenatal vitamins (up to age 50)

AAA) Preventive Care - Adult is a Covered Expense as follows: Routine annual physical exam/GYN exam, routine immunizations, travel immunizations, routine lab & x-ray, prostate exams and tests, routine sigmoidoscopy and routine colonoscopy, routine annual cervical cancer screening test (pap smear), and routine Mammograms with limitations as follows:

Mammogram Provisions:

One baseline mammogram for women age 35 to 40;
One mammogram every year for women age 40 and over.

Participating Provider - Benefits are payable at 100% of the Negotiated Rate for routine immunizations, routine lab & x-ray services, routine sigmoidoscopy† or routine colonoscopy†, routine mammograms and routine pap smears. Payable benefits for all annual routine physical exams and/or travel immunizations are at 100% of the Negotiated Rate after a $25 copayment per service.

† coverage for all routine colonoscopies and/or routine sigmoidoscopies are payable at 100% regardless of the place of service and includes Physician, facility and anesthesia charges.

Non-Participating Provider – No Benefits are payable.

Adult Preventive benefits are for all Eligible Participants age 18 or older covered under the Plan. Please refer to "Well Child Care" for payable benefits that pertain to children under age 18.

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

BBB) Prosthetic services for the purchase of the first prosthetic appliance to replace all or part of any internal body organ or external body part lost or impaired and for their repair and/or replacement if required because of wear or damage if Medically Necessary and if ordered by a Physician. Benefits are payable at 90% of Negotiated Rate for a Participating Provider only. Covered Expense includes artificial arm, shoulder, leg, hip, knee or eye; after a mastectomy, a breast implant, an external breast prosthesis and the first bra made solely for use with the prosthesis; a cardiac pacemaker; ostomy supplies; or a wig if it is related to radiation/chemotherapy treatment (limited to two (2) per Plan Year). **These benefits do not apply to your Out-of-Pocket maximum.**

CCC) Radiation Therapy – Please see "Chemotherapy/Radiation Therapy" for additional information.

DDD) Respiratory Therapy – Please see "Other Outpatient Hospital Services" for additional information.

EEE) Second (Third) Surgical Opinion - Voluntary 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 is payable at 100% of the Negotiated Rate, after a $25 copayment for Participating Providers only. **These benefits do not apply to your Out-of-Pocket maximum.**

FFF) Skilled Nursing Facility/Extended Care Facility during a covered confinement for other than Custodial Care is a Covered Expense. Benefits are limited to a maximum of 100 days per Plan Year and are payable at 90% of the Negotiated Rate for a Participating Provider only. All services require pre-authorization prior to admission. If pre-authorization is not obtained benefits are reduced to 50% of the Negotiated Rate.

GGG) Sleep Disorders – Treatment and Testing is a Covered Expense for the diagnosis and treatment of sleeping disorders or sleep apnea. Treatment may include purchase of an "airway dilator", whether a fixed type or adjustable type, but does not include adjustments made to an "airway dilator" once placed, or the purchase of a "night guard", which are not a Covered Expense. Benefits are payable at 90% of the Negotiated Rate for a Participating Provider only. **These benefits do not apply to your Out-of-Pocket maximum.**

HHH) Speech Therapy services are a Covered Expense for Medically Necessary and/or physiologically necessary services when ordered by a Physician or dully licensed speech therapist to restore or rehabilitate speech loss caused by Injury or Illness. Excluded are services to correct non-organic articulatory disorders and services that are otherwise provided by the public schools or other agencies such as Crippled Children's program. Plan benefits are payable at 100% of Negotiated Rate, after a $25 copayment for a Participating Provider only. **These benefits do not apply to your Out-of-Pocket maximum.**

III) Sterilization – Elective is a Covered Expense for the Employee, eligible Spouse, or eligible Dependent and benefits will be paid regardless of Medical Necessity. Benefits are payable at 100% of the Negotiated Rate after a $150 copayment per service for a Participating Provider only. Reversal of sterilization or a repeat vasectomy/tubal ligation are not a Covered Expense. **These benefits do not apply to your Out-of-Pocket maximum.**

JJJ) Substance Abuse / Alcoholism Care is a Covered Expense for physical and/or emotional dependence on drugs, narcotics, alcohol or other addictive substances to a debilitating degree. It does not include tobacco dependence or dependence on ordinary drinks containing caffeine. Benefits are payable as indicated below and Pre-Certification is required for all Inpatient admissions.

1. Inpatient and Partial Hospitalization treatment: Benefits are limited to 30 days per Plan Year and payable up to $20,000 per Plan Year. Pre-Certified services, are payable at 90% of the Negotiated Rate for Participating Providers only. For non Pre-Certified services, Covered Expense is payable at 50% of the Negotiated Rate for a Participating Provider only. Partial Hospitalization will count as inpatient care at a 2-for-1 exchange ratio. **These benefits do not apply to your Out-of-Pocket maximum.**

2. Outpatient treatment**:** Benefits are payable at 100% of the Negotiated Rate, less a $25 copayment per visit, for a Participating Provider only. Benefits are limited to 26 visits per Plan Year. **These benefits do not apply to your Out-of-Pocket maximum.**

KKK) Surgical Services (including Surgeon, and Assistant Surgeon) is a Covered Expense and benefits are payable for a Participating Provider at 90% of the Negotiated Rate.

A Physician who performs services as an assistant surgeon will be allowed at 25% of the surgeon's charge and payable at 90% of the Negotiated Rate for a Participating Provider. No benefits are payable for surgical assistance rendered by an intern, resident, or Hospital staff member.

- Multiple Surgical Procedures performed by one (1) or more Physicians during the same operative session will be considered Covered Expense according to the following:
  1. The lesser of the actual charges, the Negotiated Rate, or Usual, Customary and Reasonable will be allowed for the primary surgical procedure.
  2. Fifty percent of the lesser of the actual charges, the Negotiated Rate, or Usual, Customary and Reasonable for the secondary surgical procedure.
  3. Twenty-five percent of the lesser of the actual charges, the Negotiated Rate, or Usual, Customary and

Reasonable for the third and all other procedures billed.

- Bilateral Surgical Procedures performed by one (1) or more Physicians during the same operative session will be considered Covered Expense according to the following:
  1. The lesser of the actual charges, the Negotiated Rate, or Usual, Customary and Reasonable will be allowed for the primary surgical procedure.
  2. Fifty percent of the lesser of the actual charges, the Negotiated Rate, or Usual, Customary and Reasonable for the secondary or bilateral surgical procedure.

- Multiple Traumatic Injuries performed by one (1) or more Physicians during the same operative session will be considered Covered Expense according to the following:
  1. The lesser of the actual charges, the Negotiated Rate, or Usual, Customary and Reasonable will be allowed for each procedure performed on a separate bodily area or system.
  2. The lesser of the actual charges, the Negotiated Rate, or Usual, Customary and Reasonable will be allowed for the primary procedure performed on the same bodily area or system.
  3. Fifty percent of the lesser of the actual charges, the Negotiated Rate, or Usual, Customary and Reasonable for the secondary surgical procedure.

- Co-Surgeons for Medically Necessary and approved surgical procedures requiring two (2) or more Physicians for the same operative procedure, where each Physician is the primary surgeon will be considered Covered Expense according to the following:
  1. The lesser of the actual charges, the Negotiated Rate, or Usual, Customary and Reasonable will be allowed for each Physician.

- Dental Surgery for the treatment of a fractured jaw or an Injury to sound natural teeth sustained while covered under this Plan, provided that treatment is rendered within six (6) months after the Accident's occurrence.

LLL) TMJ/Jaw Joint Treatment is a Covered Expense and benefits are payable at 90% of the Negotiated Rate for a Participating Provider only up to a maximum of $3,000 in payable benefits per Plan year. **These benefits do not apply to your Out-of-Pocket maximum.**

MMM) Transplant Services for non-experimental human organs/tissue transplants will only be considered Covered Expense if the recipient is covered by this Plan and the donor is not covered by this Plan or any other source of benefits for medical expenses, than the donor and recipient charges are covered. If a TUSD Employee donates organ or tissue for a transplant to a non-TUSD patient, then the Plan limits the Donor reimbursement benefits to a maximum of $5,000 per transplant. Case Management and pre-certification by the Utilization Review Center is required. 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. Plan benefits are payable at 90% of the Negotiated Rate if the above conditions are met. Covered Expense includes acquisition costs and drugs, unless specifically excluded under Exclusions and Limitations.

NNN) Services while traveling outside the United States for normally covered and Medically Necessary services is a Covered Expense only if the Eligible Participant did NOT travel to such a location for the sole purpose of obtaining such services, drugs or supplies. Payable benefits will not be assigned to Providers outside of the United States and are payable based upon the type of benefits provided as delineated within this Plan.

OOO) Urgent Care Facility services are a Covered Expense for Medically Necessary services, as long as the facility meets the definition of an Urgent Care Facility. Benefits are payable at 100% of the Negotiated Rate after a $50 copayment for a Participating Provider only. All ancillary services billed in conjunction with the Facility Fee, when it is a Participating Provider, will be paid at 100% of the Negotiated Rate. For the Physician visit that is billed separately from the Facility, benefits are payable at 100% of Negotiated Rate after a $25 copayment for a Participating Provider. The Copayment is waived if the patient is admitted to the Hospital directly from the Urgent Care Facility. **These benefits do not apply to your Out-of-Pocket maximum.**

PPP) Well Baby or Routine Newborn Nursery care – Inpatient is a Covered Expense for Medically Necessary services and supplies while in the Hospital for the initial confinement and for Physician services for the initial examination and also for circumcision of male infants. Benefits will be payable as part of the mother's claim for the first 31 days. Covered Expense is payable at 90% of the Negotiated Rate for Participating Hospitals and Participating Physicians only. Circumcision services and those Physician services billed separately from the Hospital bill will not apply to your Out-of-Pocket maximum. If the mother is not an eligible Dependent under this

Plan, then benefits will be payable under the employee for the first 31 days. **These benefits do not apply to your Out-of-Pocket maximum.**

QQQ) Well Baby & Well Child Care – **Outpatient** is a Covered Expense to age 18 and includes routine office visits (including annual physicals), routine lab and x-ray, routine immunizations and travel immunizations as follows:

Participating Providers - Benefits are payable at 100% of the Negotiated Rate, after a $25 copayment for routine exams and travel immunizations. All related routine lab work and x-rays and routine immunizations will be payable at 100% of the Negotiated Rate. **These benefits do not apply to your Out-of-Pocket maximum.**

Non-Participating Providers – There are no payable benefits for a non-Participating Provider.

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

EXCLUSIONS AND LIMITATIONS

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

1) Services which are **not Usual, Customary and Reasonable and not Medically Necessary** shall include, but are not limited to, (1) procedures that are an elective service or supply, or experimental, or still under clinical investigation by health professionals, or of unproven value or of questionable current usefulness, including any complications resulting from this exclusion; (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; (5) charges that are in excess of the Usual, Customary and Reasonable charges.

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

2) Treatment that is **not generally accepted practice in the United States;**

3) 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**";

4) Expenses incurred when the **patient was not eligible** under the terms of the Plan or charges incurred prior to an Individual's effective date of coverage under the Plan or after coverage is terminated;

5) 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;

6) Charges incurred in **connection with full-time active military service** in the armed forces of any country or international authority; or for treatment of any illness or injury caused by war or act of war, declared or undeclared.

7) Charges for treatment of any illness or injury received during the **commission of, or attempt to commit, a felony**; Expenses for services or supplies received while incarcerated in a penal institution or in legal custody; or, injuries sustained while engaging in an illegal occupation. However, this exclusion does not apply where medical expenses result from a medical condition (physical or mental), including a medical condition resulting from domestic violence (e.g. depression);

8) Payments **prohibited by law**;

9) Charges for **telephone consultations**;

10) Charges for treatment of illness or injury where the patient **fails to reasonably cooperate** in providing information for coordinating or subrogating benefits. Any expense caused by any third party when payment for such expenses has been paid (or will be paid) by the third party or the third party's insurance company. See section entitled "Subrogation" for further information;

11) Charges for **Custodial care** and/**or maintenance therapy**, including care or confinement primarily for the

purpose of meeting personal needs which could be rendered at home or by persons without professional skills or training. Any type of maintenance care which is not reasonably expected to improve the patient's condition, except as may be included as part of a formal Hospice care program. Services or supplies that cannot reasonably be expected to lessen the patient's disability and to enable him to live outside of an institution, including rest cures, sanitarium or **convalescent care**;

12) Charges for **educational training** and/or vocational testing or job training, whether or not given in a facility providing medical or psychiatric care;

13) Charges for **nutritional counseling** and/or diet management, except as expressly stated within this Plan;

14) Charges for **weight control programs**, commercial exercise programs, gym, spa or health club memberships;

15) **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, except pre-natal vitamins;

16) **Transportation costs, mileage costs, or travel** charges for travel by scheduled airline, railroad, bus, taxi or other commercial carrier, regardless of destination or purpose, except for ambulance charges as listed in Covered Expense. Charges for accommodations or hotel, whether or not recommended by a Physician;

17) Plastic, reconstructive or **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;
- improvement of the function of a body part, other than the teeth or structures supporting the teeth, that are malformed;
- improvement of the function of a body part malformed as a result of a severe birth defect, such as harelip or webbed fingers or toes; or
- compliance with the provisions of this Plan associated with mastectomies.

18) **Home exercise equipment, Jacuzzi, sauna, home air-conditioning unit, air purification units, humidifiers, and electric heating units**;

19) Charges for a **missed appointment or completion of a claim form**;

20) Charges for **experimental or investigatory treatment**, as determined by Medicare, unless such treatment is approved. Medicines or drugs which are in the Food and Drug Administration (FDA) Phases I, II or III testing, drugs which are not commercially available for purchase or are not approved by the FDA for general use;

21) Treatment for **obesity**, except as specifically stated otherwise, no benefits will be payable for any medical or surgical treatment for obesity, weight control, weight reduction, weight loss or dietary control, whether or not it is in any case, part of the treatment plan for any other disease process. These treatments include, but are not limited to medical management with or without medication, or surgical interventions including but not limited to gastric bypass, gastric stapling, insertion of a gastric bubble, or stomach banding. In addition, any complications resulting from the above mentioned exclusion would not be coverable under the policy provisions.

22) **Sterilization reversal** or reconstruction of prior elective sterilization, including repeat sterilization procedures (i.e. a Vasectomy for a male or a Tubal Ligation for a female);

23) **Eye refractions and examinations** for the purposes of prescribing corrective lenses, eye glasses, or contact lenses or the fitting thereof, orthoptics, vision therapy, visual motor training, or other special vision procedures, including procedures whose purpose is the surgical correction of refractive errors, such as **radial keratotomy.** NOTE: This exclusion will not apply to the initial purchase of glasses or lenses following cataract surgery covered under this Plan when no intraocular lens has been implanted;

24) Services of a dentist or Physician for **care and treatment of teeth and gums**, dental implants, routine dental exams including supplies in connection with treatment, unless charges are incurred for damages caused by Accidental injuries to natural sound teeth sustained while covered under this Plan, unless as indicated under

Covered Expense or for the following:

- Treatment of tumors of the gum; and
- Reduction of fractures of the jaw or facial bones;
- Surgical correction of harelip, cleft palate or protruding mandible;
- Removal of stones from salivary ducts;
- Removal of bony cysts of the jaw, torus palatinus, leukoplakia, or malignant tissues;
- Freeing of muscle attachments; or
- The repair of alleviation of damage to sound natural teeth caused solely by Accidental Injury and then only for expenses which are incurred within 90 days of the accident;

NOTE: The Plan will also provide coverage for anesthesia and facility charges related to a dental procedure if a Participant is: (1) less than seven years of age, (2) developmentally disabled, regardless of age, or (3) has compromised health. The use of general anesthesia must be Medically Necessary, regardless of age.

25) Charges for **luxury items** such as admission kits, TV, telephone, guest trays, guest cots, personal toiletries, stationery and other personal items not essential for medical treatment of the illness or injury;

26) Items that are usable for other than medical purposes, or **convenience items** or attachments to standard equipment, including but not limited to air purifiers, humidifiers, food liquidizers, supplies for comfort, wigs (except as indicated under Chemotherapy/Radiation therapy), hygiene or beautification;

27) **Structural changes** to a house or vehicle;

28) **Transsexual procedures** or treatments to change characteristics of the body to those of the opposite sex, including services, therapy, supplies or medications associated with sex transformations, sexual dysfunctions or inadequacies and resulting complications;

29) Treatment for **caffeine addiction or smoking cessation,** including Physician visits, medications and programs for behavioral modification or other support groups, except as specifically covered under the Prescription Drug Card benefits;

30) Claims submission **exceeding the filing limit** and not submitted within twelve (12) months after expenses were incurred, except in the absence of legal capacity;

31) **Services rendered outside the United States** if the Participant traveled to such a location for the sole purpose of obtaining such services, drugs or supplies;

32) **Penile implants** unless required as a result of injury or an organic disorder;

33) Myofunctional or **massage therapy**, except when Medically Necessary and prescribed in writing by the attending Physician or surgeon specifically as to duration and type;

34) **Court-ordered care, confinement, services** or supplies furnished, paid for or for which benefits are provided or required under any law of a government. This does not include a plan established by a government for its own employees or their dependents;

35) Services for or related to these types of treatments:

- **Hypnosis or Hypnotherapy**
- **Psychodrama**
- **Biofeedback**
- **Mega-vitamin therapy**
- **Dance or Art Therapy**
- **Scientology**

36) **Holistic or Homeopathic Medicine**, including certain non-organic therapies as follows: Bioenergetics Therapy; Confrontation Therapy; Crystal Healing Therapy; Education Remediation; Erhard Seminar Training; Guided Imagery; Marathon Training; Primal Therapy; Rolfing; Sensitivity Training; Training Analysis (Tutorial, Orthodox); Transcendental Meditation;

37) Charges for any **prescription refills in excess of the number specified by the Physician**, or any refill dispensed after one (1) year from the Physician's original order;

38) Charges for a Physician or other Provider acting **outside the scope of his license**;

39) Charges under one (1) coverage of this Plan to the extent that benefits are payable for the same **charges under**

another coverage provided under this Plan, or services or supplies for which a Eligible Participant is entitled (or could have been entitled if proper application had been made) to have reimbursed by or furnished by any plan, authority or law of any government, governmental agency (Federal or State, Dominion or Province or any political subdivision thereof). However, this provision does not apply to Medicare Secondary Payer or Medicaid Priority rules;

40) Charges for any service, supply or **treatment not recommended, approved or provided by or under the direct supervision of a Physician,** including any period of Hospital confinement which were/are not recommended, approved and certified as necessary and reasonable by a Physician, other than those specifically provided herein;

41) Charges made for **public services or supplies** which can be paid for by any government agency, even if the Participant waives his rights to those services or supplies;

42) Charges for **Sales Tax** or other tax imposed by law, or for any postage, shipping or handling charges which may occur in the transmittal of information to the Claim Administrator, or for interest or financing charges;

43) **Prior Coverage** or services or supplies for which the Eligible Participant is eligible for benefits under the Plan which this Plan replaces;

44) Charges for **Ecological or Environmental Medicine**, such as **chelation therapy**, orthomolecular substances, use of substances of animal, vegetable, chemical or mineral origin which are not specifically approved by the FDA as effective for treatment;

45) Charges for **hearing aids** and examinations for them;

46) Charges for **unnecessary Hospital services** not consistent with and not required in the management and treatment of a Sickness or Injury for which a person is admitted, or charges for **confinement in a Hospital for diagnostic purposes only** when such diagnostic services could be performed in an Outpatient setting;

47) Charges for **speech therapy** to correct a non-organic speech defect;

48) Charges for **non-covered/excessive services** other than those specifically provided herein, or for any services, which exceed the limitations, stated in this document;

49) Charges for Provider services or supplies rendered or provided by an **immediate relative** of the Employee, Spouse or patient, or an individual who resides in the Employee's household, including services of an L.P.N., R.N. or C.R.N.A;

50) Charges for **occupational therapy** when it is rendered for other than correction of a physical impairment caused by disease, Injury or congenital deformity;

51) Expense related to **self-inflicted injury**, including intentional ingestion or inhalation of any gas, fumes, narcotic or hallucinogenic drug not ordered by a licensed Doctor acting within the scope of his license and which is not Medically Necessary for the treatment of an Injury, Illness or condition, except where such self-inflicted injury results from a medical condition (physical or mental), including a medical condition resulting from domestic violence (e.g. depression)**;**

52) **Preventive or Routine services,** including exams, physicals and supplies not ordered by a Physician or not Medically Necessary for treatment of Illness, Injury or pregnancy, except as may be specifically included in the list of Covered Expense;

53) All services and supplies primarily for treatment of and/or in connection with orthognathic, prognathic and **maxillofacial surgery**, except as previously stated in this Plan;

54) Services or items any **school system** is required to provide under public law;

55) Services of a **resident physician or intern** rendered in that capacity or charges for **technical medical assistance** or standby Physician services;

56) Drugs, medications, or supplies for topical application in the **treatment of hair loss or alopecia (baldness)**, including replacement of nonproductive hair follicles with productive follicles from another area of the scalp or

body, or any other surgeries or treatments for baldness;

57) Programs to **manage stress**;

58) Expenses incurred in connection with the pregnancy of a **surrogate mother** who conceives, carries to term and delivers a newborn on behalf of an Eligible Participant;

59) Services for or in connection with the following counseling services:
- **Pastoral**
- **Financial**
- **Spiritual**
- **Death or bereavement,** except as expressly covered as part of a program of Hospice care

60) The following Providers:
- **Naturopaths**
- **Rolfers**
- **Hypnotists**

61) **Orthotics or orthopedic devices** primarily used for the support or comfort of the feet or to treat a condition requiring more than a supportive device of the foot;

62) **Routine foot care** and removal of corns, calluses, toenails or subcutaneous tissue, except when care is prescribed by a physician treating metabolic or peripheral vascular disease;

63) **R.N. or L.P.N. furnished to an inpatient in a health care facility** unless such nursing services could not have been safely and adequately furnished by the general nursing staff, if such facility was fully staffed;

64) **Private Duty nursing services** except when Medically Necessary and prescribed in writing by the attending Physician or surgeon specifically as to duration and type;

65) Counseling or testing concerning **inherited (genetic) disorders.** This limitation does not apply when such services are determined by a Physician to be Medically Necessary during the course of a pregnancy which is covered by the Plan or for the purpose of diagnosis and treatment of a Genetic disease;

66) **Behavioral Disorders –** Except as noted, testing or treatment for behavioral disorders, mental retardation or autism;

67) **Any services, care or supplies not specifically listed in the Summary Plan Description** as Covered Expense are not covered under the Plan.

ELIGIBILITY PROVISIONS

EMPLOYEE

Annual Open Enrollment & Choice of Coverage

During Annual Open Enrollment (each September) you can elect coverage for you and your Dependents, even if you previously declined it. At that time, you may also drop or decline coverage for you and your Dependents' coverage under the Plan. All changes made during Open Enrollment will be effective October 1st. The Employee will be responsible for making timely payments of any required contributions to the Plan.

Eligibility Requirements – Employees

To participate in the Plan coverages, which are described herein, an Employee must be:

A Permanent Full-time, a Part-time (20 hours or more per week) Employee, and a Certificated Adult Education Teacher, under the definitions below are eligible to apply their TUSD paid fringe benefits towards the cost of their health package. These Employees may be required to contribute to the cost of their health package if their health elections exceed the amount of the TUSD paid fringe contribution. A Part-time Employee (less than 20 hours per week) is eligible for benefits as defined below, and is required to pay for the cost of their health package, as there are no TUSD paid fringe contributions for this class of employees. Dependent coverage is available to all qualified Dependents at the Employee's expense. Additionally, the Employee must meet the District's standard minimum eligibility requirements for fringe benefits due to either contractual language or District policy and submit an enrollment application on behalf of himself/herself.

Permanent & Full-time Employee: All permanent and full-time employees are eligible for a TUSD contribution towards fringe benefits.

Permanent & Part-time (20 hours or more per week) Employees: All classified permanent and part-time employees who work 20 hours or more per week in one classification, or certified (excluding Adult Education, see below) permanent and part-time employees who have a signed contract for at least 50% are eligible for TUSD contribution towards fringe benefits at a pro-rated amount based on the number of hours worked.

Certificated Adult Education Teachers: Adult Education Teachers qualify for a TUSD contribution towards fringe benefits when they work in a regularly scheduled assignment for 14 hours or more per week. Full-time for Adult Education Teachers is 28 hours per week. TUSD fringe benefits are pro-rated on the number of hours worked for employees who work less than Full-time, but at least 14 hours per week.

Part-time Employees (less than 20 hours per week): Part-time employees (less than 20 hours per week) who work at least 10 hours per week are eligible to enroll in medical insurance only. **The Part-time employee (less than 20 hours per week) pays all premiums.** Enrollment for medical insurance is open for a period of 3 weeks starting from the date you are first employed by TUSD. There is also an Open Enrollment period each year during the month of September.

A Part-time Employee (less than 20 hours per week) must complete the Enrollment Form for the Plan of their choice and a Benefit Selection Form and submit these forms to Human Resources Department - Benefits. Upon receipt of these forms, the Human Resource Benefits Department will hold your forms for 60 days. At the end of 60 days, your hours will be verified and if you are working at least 10 hours per week (not an average), you will be eligible to participate in the medical plan that you chose. Your coverage effective date will be first of the following month. The Human Resource Benefits Department will send you a letter in writing informing you of the effective date. If you do not qualify with the minimum of 10 hours per week, a letter will be sent to you informing you that you will not be able to participate in the medical plan.

All medical insurance premiums are to be paid entirely by the Employee. Premiums are due monthly and checks should be made payable to TUSD and mailed to: TUSD 2335 Plaza del Amo, Torrance, CA 90509, and are due on the 1st of each month. **If a payment is missed, your medical insurance will be canceled.**

Substitute employees: No coverage is available.

Contact your Employer for enrollment information and forms.

See Extension of Coverage section(s) for instances when these eligibility requirements may be waived or modified. Eligibility for Medicaid or the receipt of Medicaid benefits will not be taken into account in determining eligibility.

Standard Enrollment Period / Effective Date

An Eligible Employee's coverage is effective, subject to timely enrollment, upon completion of the following period: for employees hired in the months of July or August, health coverage begins October 1, with the exception of new hires who work 12 calendar months; benefits will begin the first of the month following month of hire. Employees hired after the month of September, the effective date is the first of the following month of hire.

If an Employee fails to enroll within 31 days after completion of the waiting period, his coverage can become effective only in accordance with the "Open Enrollment" or "Special Enrollment Rights" provisions below.

DEPENDENTS

Eligible Dependents of an Employee is:

- A legally married Spouse of the opposite sex. The marriage must meet all requirements of a valid marriage contract in the Employee's state of residence, but will not include a common law spouse. The Employee must notify the District immediately in the event of a divorce and submit a copy of the final decree of divorce;

- A Domestic partner, any Employee may enroll their qualified Domestic Partner provided they have filed a Declaration of Domestic Partnership with the California Secretary of State (available form the Secretary of State's website at http://www.ss.ca.gov) and returned the California State Affidavit for Domestic Partner to the District office within 30 days of the approval from the State of California. Otherwise your Domestic Partner cannot be added until the "annual open enrollment" period;

- An unmarried Child under age until the end of the month in which he attains age 19, who is primarily dependent upon the Employee for support and maintenance as defined by the Internal Revenue Service. For these purposes a "Child" will include
  - A natural child;
  - a stepchild who is in the custody of the Employee;
  - a grandchild born to the Employee's unmarried child under age 19, but only if the grandchild can be claimed as a dependent by the Employee under the Internal Revenue Code;
  - a child who is adopted by the Employee or placed with him for adoption prior to age 18. Placed for adoption means the assumption and retention by the Employee of a legal obligation for total or partial support of the child in anticipation of adoption of the child. The child must be available for adoption and the legal process must have begun. Placement ends when the legal support obligation ends;
  - notwithstanding any residency or main support and care requirements, a child for whom Plan coverage is required due to a Medical Child Support Order (MCSO) which the Plan Sponsor determines to be a Qualified Medical Child Support Order (QMSCO) in accordance with its written procedure (which are incorporated herein by reference and which can be obtained without charge). A QMSCO will also include a judgment, decree or order issued by a court of competent jurisdiction or through an administrative process established under state law and having the force and effect of law under state law and which satisfies the QMSCO requirements of ERISA (section 609 (a));

- an unmarried student until the end of the month in which he attains age 25, if such child meets the requirements of the preceding paragraph, except age, and is in Full-time school attendance at a qualified educational institution.

  As used herein, the term "qualified educational institution" will mean high schools, junior colleges or other two-year colleges granting two-year degrees; universities or colleges granting four-year degrees or post-graduate degrees; proprietary schools such as business colleges, professional schools and trade and technical schools – which are established as other than evening schools exclusively.

  Full-time school attendance means 12 units or more per semester in all of the above except for proprietary schools. In a proprietary school, Full-time school attendance will mean a minimum of 25 hours of classroom attendance per week on a five-day week schedule.

  Cessation of Full-time school attendance will terminate Dependent status with respect to the student

EXCEPT that: 1) if cessation is due to school vacation, Dependent status will terminate on the date the school reconvenes if attendance does not resume, or 2) if cessation is due to graduation, Dependent status will terminate at the end of the month of graduation; or 3) if cessation is due to disability which prevents Full-time school attendance, Dependent status will terminate on the first day of the school's next regular session which follows the date established by a Physician's written statement to the Contract Administrator that the student is capable of full-time school attendance if attendance does not resume.

Student Status verification needs to be received no later than March 1st for the Spring semester and no later than October 1st for the Fall semester. If verification is not received by the above indicated dates, the dependent will be terminated off of the policy. The dependent may be added back to the policy during the next Open Enrollment period, provided that they are a full-time student. If the Participant feels that the Dependent was terminated in error, the Participant may send a written appeal to PCMI. To maintain uninterrupted eligibility for a student, it is the Employee's responsibility to supply the TPA with the required documentation in a timely manner each semester.

The Plan Administrator or Contract Administrator has the right to request information needed to determine an individual's eligibility for benefits under the Plan.

An Eligible Dependent does Not include:

- a Spouse following legal separation or a final decree of dissolution or divorce;
- any person who is on active duty in a military service, to the extent permitted by law;
- any Souse who is eligible and has enrolled as an Employee under the Plan;

See **Extension of Coverage** section(s) for instances when these eligibility requirements may be waived or modified. Eligibility for Medicaid or the receipt of Medicaid benefits will not be taken into account in determining a Dependent's eligibility.

Effective Date - Dependents

A Dependent who is eligible and enrolled when the Employee enrolls, will have coverage effective on the same date as the Employee. A Dependent acquired later may become covered only if the Employee makes written application for coverage for the Dependent. If application is made:

1. On, before or within thirty-one (31) days of their eligibility date, the Dependent's coverage will be effective on the date of eligibility; or
2. After 31 days beyond the date of eligibility, the Dependent's coverage will be effective only in accordance with the "Open Enrollment" or "Special Enrollment Rights" provisions.

A Dependent's coverage will not become effective prior to the Employee's effective date.

Newborn and Adoptive Children – Limited Automatic 31 Day Benefit Period

If a Dependent child is born to an Employee or covered Dependent Spouse, benefits will be available for Covered Expenses of the child which are incurred within the first 31-days after birth. Benefits for such child will be available for the 31-day period only. After the 31-day period, coverage for the child will be available only if, within the 31-days after the child's birth, the Employee has notified the Plan Sponsor or the Claim Administrator of the birth, has enrolled the child, and has agreed to make any required contributions for coverage from the moment of birth.

The above 31-day benefit period will also apply to an adoptive newborn that is placed with the Employee or Dependent Spouse within 31 days of birth (i.e. the child will have a 31-day benefit period beginning on the date of birth). Any other adoptive child will also be eligible for a 31 day benefit period, beginning with: (1) the date the child is placed with the Employee or Dependent Spouse for adoption, or (2) the date the adoption is final.

NOTE: During the limited 31-day benefit period, a newborn or adoptive child is NOT a Covered Person. Any extended coverage periods or coverage continuation options which are available to Covered Persons WILL NOT APPLY to a child who is provided with these 31 days of limited benefits and who is not enrolled within such 31-day period.

If an individual wishes to re-enroll in the Plan after coverage has terminated due to Employee's failure to make the required contributions for such coverage, he may apply for such re-enrollment only during the Open Enrollment period.

In no event will Dependent coverage become effective at a time when the Employee is not covered for the

corresponding Employee coverage.

Special Enrollment Rights Due to Loss of Other Coverage

An Employee or Dependent who loses other coverage may request enrollment into the TUSD plan if the following conditions are met:

Employee or Dependent declined coverage. The Employee or Dependent declined TUSD coverage when it became available because he or she had other coveage.

The declination of other coverage was in writing. The declination of coverage is stated in writing.

Loss of coverage. The Employee or Dependent must have lost coverage under one of three circumstances:

- the end of COBRA continuation coverage,
- loss of eligibility, or
- the end of employer contributions toward your other plan coverage.

Individuals eligible for enrollment. Employees, their Spouses, or Dependents who satisfy the loss of coverage requirements and are otherwise eligible to enroll in a plan must be offered an opportunity to enroll. In addition, if an Employee alone meets these conditions, all family members (spouses and dependents) are entitled to enrollment.

Special Enrollment Rights for Newly-acquired Dependents

Newly acquired Dependents may be added to TUSD coverage if the following conditions are met.

Employee eligible for or already covered. The Employee must be either participating in the Plan or eligible to enroll in it

New Dependent status. The Dependent, as determined by the Plan's terms, must have become the Employee's dependent through marriage, birth, adoption, or placement for adoption.

Individuals eligible for special enrollment. Acquiring a new Dependent also grants special enrollment rights to a current Employee, his or her Spouse, or both, even if they previously declined coverage. However, enrollment is not available for other dependents who previously declined coverage or for dependents who are newly acquired for reasons other than marriage, birth, adoption or placement for adoption.

Special Enrollment Period – Court Ordered Coverage

If an Employee or Spouse is required to provide coverage for a child under Medical Child Support Order and such order is determined to be a QMSCO, the child shall be covered subject to the terms of the order. A request to enroll the child may be made by the Employee or Spouse, by the child's other parent, or by a State Agency on the child's behalf.

The Special Enrollment Period is thirty-one (31) days from the date of the marriage, birth, adoption, or placement for adoption. Failure to request enrollment during the Special Enrollment Period shall result in the waiver of the opportunity to enroll in the Plan until another enrollment period, if any, becomes available.

The effective date of enrollment under this Special Enrollment Period section is: a) the date of the marriage; b) the date of the birth; c) the date of the adoption or the placement for adoption.

NOTE: Under no circumstances will coverage for a Dependent become effective prior to an Employee's coverage.

Employee Responsibilities

Employees who meet the above qualifications, must make a written request for enrollment within 31 days of the date of qualification. This request must be submitted to the Human Resources Benefits Department to the attention of the Human Resource Analyst, and include any documents that can substantiate your request (e.g. notice from employer canceling medical coverage, copy of birth certificate or marriage certificate).

It is the Employee's responsibility to contact the Human Resources Benefits Department in a timely manner for the necessary forms, and if required, pay the additional premiums. If eligible, coverage will become effective on the first day of the following month of qualification of coverage. The Employee is responsible for paying all additional costs

of coverage for addition of Dependents.

Annual Re-Election
Each Plan Year, during the month of September, Employees and their Dependents may transfer between the available coverage options offered by the Plan Sponsor. The newly-elected coverage(s) will be effective on October 1st following the end of the Annual Re-Election period.

Reinstatement / Rehire
If an Employee returns to active employment and eligible status following an approved leave of absence in accordance with the Employer's guidelines and the Family and Medical Leave Act (FMLA), and during the leave Employee discontinued paying his share of the cost of coverage causing coverage to terminate, such Employee may not have coverage reinstated as if there had been no lapse (for himself and any Dependents who were covered at the point contributions ceased), but coverage will be reinstated upon his date of return, subject to the eligibility provisions of the Plan.

In accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), certain Employees who return to active employment following active duty service as a member of the United States armed forces, will be reinstated to coverage under the Plan immediately upon returning from military service. Additional information concerning the USERRA can be obtained from the Plan Sponsor.

NOTES: Except in the above instances, any terminated Employee who is rehired will be treated as a new hire and will be required to satisfy all eligibility and enrollment requirements.

Transfer of Coverage
If a husband and wife are both Employees and are covered as Employees under this Plan and one of them terminates, the terminating spouse and any of his eligible and enrolled Dependents will be permitted to immediately enroll under the remaining Employee's coverage. Such new coverage will be deemed a continuation of prior coverage and will not operate to reduce or increase any coverage to which the person was entitled while enrolled as the Employee or the Dependent of the terminated Employee.

If a Covered Person changes status from Employee to Dependent or vice versa, and the person remains eligible and covered without interruption, then Plan benefits will not be affected by the person's change in status.

Dual Coverage
When a husband and wife are both enrolled for coverage as Employees under this Plan, each has the option to enroll eligible Dependents for coverage hereunder. If both Spouses are employed with TUSD and are eligible for TUSD fringe benefits, you have the option of combining both of your fringe benefit contributions together and apply for family coverage. The combined maximum contractual benefits to which both Employees are entitled hereunder will not exceed the aggregate of 100 percent of the Usual, Customary and Reasonable charge(s) for the Covered Expense(s). See Coordination of Benefits section for claims handling procedures.

Adjustments for Prior Plan Administrator Coverage
This document is a restatement of prior coverage(s) offered by the Plan Administrator and is intended to replace the prior coverage(s). Except to the extent that benefits are expressly modified, it is not intended that benefits will be reduced or increased for an Eligible Participant who was covered under the prior coverage(s) on the day of discontinuance and who is eligible as an active enrollee or a COBRA enrollee under the Summary Plan Description on its effective date. Any deductibles satisfied or benefits paid with respect to such covered persons under the prior coverage(s) will be deemed to be Deductibles satisfied or benefits paid under the Summary Plan Description. Any contiguous periods an Eligible Participant was covered under a prior coverage(s) of the Plan Administrator will be deemed to be time covered under the Summary Plan Description.

Allowance for Prior "Creditable Coverage"
An individual (Employee or Dependent) who transfers to this Plan from another plan of "creditable coverage" within 63 days (i.e. with not more than 62 days of non-coverage, not counting any days applied toward waiting period requirements), has a right to demonstrate "creditable coverage" and to request a certificate of creditable coverage from the prior health plan(s). This Plan will help any such individual in obtaining such certificate(s).

An individual also has the right to demonstrate creditable coverage through the presentation of documentation or other means where a certificate of creditable coverage cannot be obtained from the prior health plan(s).

If the prior coverage is determined to be "creditable coverage", the Plan enrollee will be credited with time covered

under such prior plan(s) toward any time-covered requirements that may apply to Plan coverage's, including the eligibility-waiting period.

"Creditable Coverage" includes those coverage's identified in H.R. 3103, such as coverage under a group health plan (including a governmental or church plan), individual health insurance coverage, Medicare (other than coverage solely under Sec 1928), Medicaid, military sponsored healthcare, a program of the Indian Health Services, a State health benefits risk pool, the Federal Employees Health Benefits Program, a public health plan as defined in regulations and any health benefit plan of the Peace Corps Act.

TERMINATION OF COVERAGE

Employee Coverage Termination

Except as noted, an Employee's coverage under the Plan will terminate upon the earliest of the following:

- termination of the Plan;
- termination of participation in the Plan by the Employee;
- the end of the month which includes the date the Employee is no longer in a class of employees eligible for coverage hereunder;
- the date Employee exhausts his maximum benefits;
- the date the Employee begins active duty service in the armed forces of any country or organization, except for reserve duty of less than thirty-one (31) days. See the **Extension of Coverage During U.S. Military Service** in the **Extensions of Coverage** section for more information;
- the end of the period for which Employee last made the required contribution, if the coverage is provided on a contributory basis (i.e. Employee shares in the cost);
- at midnight on the last day of the month in which the covered Employee leaves or is dismissed from the employment of the Employer, ceases to be eligible, or ceases to be engaged in active employment for the required number of hours as specified in **Eligibility and Effective Dates** section - except when coverage is extended under the terms of any **Extensions of Coverage** provisions;
- the date the Employee dies.

An Employee otherwise eligible and validly enrolled under the Plan shall not be terminated from the Plan solely due to his health status or need for health services.

Dependent Coverage Termination

Except as noted, a Dependent's coverage under the Plan will terminate upon the earliest of the following:

- termination of the Plan or discontinuance of Dependent coverage under the Plan;
- Dependent's exhaustion of his/her Maximum Plan Benefits;
- termination of the coverage of the Employee, except when Employee's coverage terminates solely due to Employee's exhaustion of his/her Maximum Plan Benefit;
- at midnight on the last day of the month in which the Dependent ceases to meet the eligibility requirements of the Plan, except when coverage is extended under the **Extensions of Coverage** section. An Employee's adoptive child ceases to be eligible on the date on which the petition for adoption is dismissed or denied or the date on which the placement is disrupted prior to legal adoption and the child is removed from placement with the Employee;
- the end of the month which includes the date the Employee received written notice from the Plan Sponsor that the Employee's medical identification card has been misused. See the Misuse of Identification Card

provision in the Administrative Procedures;

- the end of the period for which the Employee last made the required contribution for such coverage, if Dependent's coverage is provided on a contributory basis (i.e., Employee shares in the cost). However, in the case of a child covered due to a Qualified Medical Child Support Order (QMCSO), the Employee must provide proof that the child support order is no longer in effect or that the Dependent has replacement coverage that will take effect immediately upon termination;

- the date the Dependent enters the armed forces of any foreign country or international organization or the date "Continuation Coverage', as set forth in the Uniformed Services Employment and Reemployment Rights Act (USERRA), terminates, if the Dependent was on duty in the Uniformed Services for more than 31 days and elected such Continuation Coverage.

NOTE: A Dependent otherwise eligible and validly enrolled under the Plan shall not be terminated from the Plan solely due to his health status or need for health services.

Certificate of "Creditable Coverage"
An individual (Employee or Dependent) who terminates his/her plan or employment has the right to demonstrate "creditable coverage" to a new employer by requesting a Certificate of Creditable Coverage from Pinnacle Claims Management, Inc. This Plan will help any such individual in obtaining such certificate(s). Please contact Pinnacle Claims Management, Inc at 1-800-649-9121.

*- (See **COBRA Continuation Coverage**) -*

EXTENSIONS OF COVERAGE

Coverage may be continued beyond the **Termination of Coverage** date in the circumstances identified below. Unless expressly stated otherwise, however, coverage will not extend: (1) beyond the date the Plan is terminated, and (2) for a Dependent, beyond the date the Employee's coverage ceases.

Extension of Coverage for Developmentally Disabled or Handicapped Dependent Children
If an already covered Dependent child attains age 19, which would otherwise terminate his status as a "Dependent," and:

- if on the day immediately prior to the attainment of such age the child was a covered Dependent under the Plan; and
- at the time of attainment of such age the child is incapable of self-sustaining employment by reason of mental retardation, cerebral palsy, epilepsy, other neurological disorder, physical handicap, or disability due to injury, accident, congenital defect or sickness; and
- the child's condition has been diagnosed by a Physician as a permanent or long-term dysfunction or condition; and
- such child is primarily dependent upon the Employee for support and maintenance;

then such child's status as a "Dependent" will not terminate solely by reason of his having attained age 19 and he will continue to be considered a covered Dependent under the Plan so long as he remains in such condition, and otherwise conforms to the definition of "Dependent."

The Employee must submit proof of the child's incapacity to the Contract Administrator within thirty-one (31) days of the child's attainment of the limiting age, and thereafter as may be required, but not more frequently than once a year after the two year period following the child's attainment of such age.

Extensions of Coverage During Absence From Work
If an Employee fails to continue in eligible active status but is not terminated from employment (e.g., he is absent due to an approved leave, a temporary layoff, etc.), he may be permitted to continue health care coverage's for himself and his Dependents though he could be required to pay the full cost of coverage during such absence. Any such extended coverage allowances will be provided on a non-discriminatory basis.

Except as noted, any coverage that is extended under the terms of this provision will automatically and immediately cease on the earliest of the following dates:

- on the date coverage terminates as specified in the Employer's personnel policies or other Employer communications, if any. Such documents are incorporated into the Plan by reference;
- the end of the period for which the last contribution was paid, if such contribution is required;
- the date of termination of this Plan.

NOTE: To the extent that the Employer is subject to the Family and Medical Leave Act of 1993 (FMLA), it intends to comply with the Act. The Employer is subject to FMLA if it is engaged in commerce or in any industry or activity affecting commerce and employs fifty (50) or more employees for each working day during each of twenty (20) or more calendar workweeks in the current or preceding Calendar Year.

In accordance with the FMLA, an Employee is entitled to continued coverage if he: (1) has worked for the Employer for at least twelve months, (2) has worked at least 1,250 hours in the year preceding the start of the leave, and (3) is employed at a worksite where the Employer employs at least fifty employees within a 75-mile radius.

Continued coverage under the FMLA is allowed during up to 12 workweeks of unpaid leave in any 12-month period. Such leave must be for one or more of the following reasons:

- the birth of an Employee's child and in order to care for the child;

- the placement of a child with the Employee for adoption or foster care;
- to care for a spouse, child or parent of the Employee where such relative has a serious health condition; or
- Employee's own serious health condition that makes him unable to perform the functions of his or her job.

Plan benefits may be maintained during an FMLA leave at the levels and under the conditions that would have been present if employment was continuous. The above is a summary of FMLA requirements. An Employee can obtain a more complete description of his FMLA rights from the Plan Sponsor's Human Resources or Personnel department. Any Plan provisions that are found to conflict with the FMLA are modified to comply with at least the minimum requirements of the Act.

Extension of Coverage During U.S. Military Service
Regardless of an Employer's established termination or leave of absence policies, the Plan will at all times comply with the regulations of the Uniformed Services Employment and Reemployment Rights Act (USERRA) for an Employee entering military service.

USERRA provides for the continuation of health benefits for Employees who are on military leave. If an Employee was covered under the Plan immediately prior to being ordered to active military duty, coverage may continue for up to 18 months or the duration of active military service, whichever is shorter. The Employee must pay the cost of coverage if the leave duration is over 30 days. The premium may not exceed 102% of the actual cost of coverage.

Regardless of whether an Employee elects continuation coverage under USERRA, coverage will be reinstated on the first day the Employee returns to active employment if the Employee was released under honorable conditions.

The Employee must return to employment:

- on the first full business day following completion of military service for military leave of 30 days or less; or
- within 14 days of completion of military service for military leave of 31-180 days; or
- within 90 days of completion of military service for military leave of more than 180 days.

When coverage under the Plan is reinstated, all provisions and limitations of the Plan will apply to the extent that they would have applied if the Employee had not taken military leave and coverage had been continuous. No waiting period or pre-existing condition exclusion can be imposed on a returning Employee or Dependents if these exclusions would have been satisfied had the coverage not been terminated due to the order to active military service.

The Employee who is ordered to active military service (and that Employee's eligible Dependent(s)) is considered to have experienced a COBRA qualifying event. The affected persons have the right to elect continuation of coverage under either USERRA or COBRA. Under either option, the Employee retains the right to re-enroll in the Plan in accordance with the above stipulations.

*- (See **COBRA Continuation Coverage**) -*

EXTENSION OF BENEFITS DURING TOTAL DISABILITY

If, on the date coverage terminates (as determined by the **Termination of Coverage** section), an Employee or Dependent is Totally Disabled, benefits will be extended but only for the condition causing such Total Disability and only during the uninterrupted continuance of that disability. Extended benefits under the terms of this provision will terminate on the earlier of the following:

1. upon termination of the Total Disability;

2. twelve (12) months following the date coverage terminated; or

3. upon the individual's eligibility for coverage in any other group plan, self-insured plan, prepayment plan, HMO or government plan that does not limit coverage for the disabling condition;

4. upon termination of the Plan;

5. the end of the period for which any required contributions for extended benefits has not been paid.

With reference to an Employee, "Total Disability" or "Totally Disabled " means a disability resulting solely from a sickness, injury or pregnancy that prevents the Employee from performing every duty pertaining to his or her occupation or engaging in any other type of work for remuneration. For a Dependent, it is disability that prevents Dependent from engaging in substantially all the normal activities of a person in good health of like age and sex.

A Physician (MD or DO) must certify an Employee or Dependent as Totally Disabled. Also, the individual must be under the care of a Physician (MD or DO) in order to be Totally Disabled for Plan purposes.

NOTE: If a Covered Person is eligible for and elects COBRA continuation coverage under the terms of the section entitled **COBRA Continuation Coverage**, coverage will be provided for ALL CONDITIONS and not just the disabling condition. However, this Extension of Benefits will run concurrently with such COBRA coverage and WILL NOT operate to extend the COBRA maximum period.

*- (See **COBRA Continuation Coverage**) -*

COBRA CONTINUATION COVERAGE

In order to comply with the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), the Plan includes a continuation of coverage option, that is available to certain Covered Persons whose health care coverage(s) under the Plan would otherwise terminate. This provision is intended to comply with that law but it is only a summary of the major features of the law. In any individual situation, the law and its clarifications and intent will prevail over this summary.

Definitions - When capitalized in this COBRA section, the following items will have the meanings shown below:

Qualified Beneficiary - An individual who, on the day before a Qualifying Event, is covered under the Plan by virtue of being either a covered Employee, or the covered Dependent spouse or child of a covered Employee.

Any child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage. Such child has the right to immediately elect, under the COBRA continuation coverage's the covered Employee has at the time of the child's birth or placement for adoption, the same coverage that a Dependent child of an active Employee would receive. The Employee's Qualifying Event date and resultant continuation coverage period also apply to the child.

An individual who is not covered under the Plan on the day before a Qualifying Event because he was denied Plan coverage or was not offered Plan coverage and such denial or failure to offer constitutes a violation of applicable law. The individual will be considered to have had the Plan coverage and will be a "Qualified Beneficiary" if that individual experiences a Qualifying Event.

Exception: An individual is not a Qualified Beneficiary if the individual's status as a covered Employee is attributable to a period in which he was a nonresident alien who received no earned income from the Employer that constituted income from sources within the United States. If such an Employee is not a Qualified Beneficiary, then a spouse or Dependent child of the Employee is not a Qualified Beneficiary by virtue of the relationship to the Employee.

Qualifying Event - Any of the following events that would result in the loss of health coverage under the Plan in the absence of COBRA continuation coverage:

voluntary or involuntary termination of Employee's employment for any reason other than Employee's gross misconduct;

reduction in an Employee's hours of employment to non-eligible status. In this regard, a Qualifying Event occurs whether or not Employee actually works and may include absence from work due to a disability, temporary layoff or leave of absence where Plan coverage terminates but termination of employment does not occur. If a covered Employee is on FMLA unpaid leave, a Qualifying Event occurs at the time the Employee fails to return to work at the expiration of the leave, even if the Employee fails to pay his portion of the cost of Plan coverage during the FMLA leave;

for an Employee's spouse or child, Employee's entitlement to Medicare. For COBRA purposes, "entitlement" means that the Medicare enrollment process has been completed with the Social Security Administration and the Employee has been notified that his or her Medicare coverage is in effect;

for an Employee's spouse or child, the divorce or legal separation of the Employee and spouse;

for an Employee's spouse or child, the death of the covered Employee;

for an Employee's child, the child's loss of Dependent status (e.g., a Dependent child reaching the maximum age limit).

NonCOBRA Beneficiary - An individual who is covered under the Plan on an "active" basis (i.e., an individual to whom a Qualifying Event has not occurred).

Notification – If the Employer is the Plan Administrator and if the Qualifying Event is Employee's termination/reduction in hours, death, or Medicare entitlement, then the Plan Administrator must provide Qualified Beneficiaries with notification of their COBRA continuation coverage rights within 44 days of the event. If the Employer is not the Plan Administrator, then the Employer's notification to the Plan Administrator must occur within 30 days of the Qualifying Event and the Plan Administrator must provide Qualified Beneficiaries with their COBRA

rights notice within 14 days thereafter. Notice to Qualified Beneficiaries must be provided in person or by first-class mail.

Each Qualified Beneficiary, including a child who is born to or placed for adoption with an Employee during a period of COBRA continuation coverage, has a separate right to receive a written election notice when a Qualifying Event has occurred that permits him to exercise coverage continuation rights under COBRA. However, where more than one Qualified Beneficiary resides at the same address, the notification requirement will be met with regard to all such Qualified Beneficiaries if one election notice is sent to that address, by first-class mail, with clear identification of those beneficiaries who have separate and independent rights to COBRA continuation coverage.

An Employee or Qualified Beneficiary is responsible for notifying the Plan of a Qualifying Event that is a Dependent child's ceasing to be eligible under the requirements of the Plan, or the divorce or legal separation of the Employee from his/her spouse. A Qualified Beneficiary is also responsible for other notifications. See the **COBRA Notification Procedures** as included in the Plan's Summary Plan Description (and the Employer's "COBRA General Notice" or "Initial Notice") for further details and time limits imposed on such notifications. Upon receipt of a notice, the Plan Administrator must notify the Qualified Beneficiary(ies) of their continuation rights within 14 days.

Election and Election Period - COBRA continuation coverage may be elected during the period beginning on the date Plan coverage would otherwise terminate due to a Qualifying Event and ending on the later of the following: (1) 60 days after coverage ends due to a Qualifying Event, or (2) 60 days after the notice of the COBRA continuation coverage rights is provided to the Qualified Beneficiary. Failure to make a COBRA election within the 60-day period will result in the inability to elect COBRA continuation coverage. See NOTE.

If the COBRA election of a covered Employee or spouse does not specify "self-only" coverage, the election is deemed to include an election on behalf of all other Qualified Beneficiaries with respect to the Qualifying Event. However, each Qualified Beneficiary who would otherwise lose coverage is entitled to choose COBRA continuation coverage, even if others in the same family have declined. A parent or legal guardian may elect or decline for minor Dependent children.

An election of an incapacitated or deceased Qualified Beneficiary can be made by the legal representative of the Qualifying Beneficiary or the Qualified Beneficiary's estate, as determined under applicable state law, or by the spouse of the Qualified Beneficiary.

If, during the election period, a Qualified Beneficiary waives COBRA continuation coverage rights, the waiver can be revoked at any time before the end of the election period. Revocation of the waiver will be an election of COBRA continuation coverage. However, if a waiver is revoked, coverage need not be provided retroactively (that is, from the date of the loss of coverage until the waiver is revoked). Waivers and revocations of waivers are considered to be made on the date they are sent to the Employer or Plan Administrator.

Open enrollment rights that allow NonCOBRA Beneficiaries to choose among any available coverage options are also applicable to each Qualified Beneficiary. Similarly, the "special enrollment rights" of the Health Insurance Portability and Accountability Act (HIPAA) extend to Qualified Beneficiaries. However, if a former Qualified Beneficiary did not elect COBRA, he does not have special enrollment rights, even though active Employees not participating in the Plan have such rights under HIPAA.

The Plan is required to make a complete response to any inquiry from a healthcare provider regarding a Qualified Beneficiary's right to coverage during the election period.

NOTE: See the "Effect of the Trade Act" provision for information regarding a second 60-day election period allowance.

Effective Date of Coverage - COBRA continuation coverage, if elected within the period allowed for such election, is effective retroactively to the date coverage would otherwise have terminated due to the Qualifying Event, and the Qualified Beneficiary will be charged for coverage in this retroactive period.

See "Election and Election Period" for an exception to the above when a Qualified Beneficiary initially waives COBRA continuation coverage and then revokes his waiver. In that instance, COBRA continuation coverage is effective on the date the waiver is revoked.

Level of Benefits - COBRA continuation coverage will be equivalent to coverage provided to similarly situated NonCOBRA Beneficiaries to whom a Qualifying Event has not occurred. If coverage is modified for similarly situated NonCOBRA Beneficiaries, the same modification will apply to Qualified Beneficiaries.

If the Plan includes a deductible requirement, a Qualified Beneficiary's deductible amount at the beginning of the COBRA continuation period must be equal to his deductible amount immediately before that date. If the deductible is computed on a family basis, only the expenses of those family members electing COBRA continuation coverage are carried forward to the COBRA continuation coverage. If more than one family unit results from a Qualifying Event, the family deductibles are computed separately based on the members in each unit. Other Plan limits are treated in the same manner as deductibles.

If a Qualified Beneficiary is participating in a region-specific health plan that will not be available if the Qualified Beneficiary relocates, any other coverage that the Plan Sponsor makes available to active Employees and that provides service in the relocation area must be offered to the Qualified Beneficiary.

Cost of Continuation Coverage - The cost of COBRA continuation coverage is fixed in advance for a 12-month determination period and will not exceed 102% of the Plan's full cost of coverage during the period for similarly situated NonCOBRA Beneficiaries to whom a Qualifying Event has not occurred. The "full cost" includes any part of the cost that is paid by the Employer for NonCOBRA Beneficiaries. Qualified Beneficiaries will be charged 150% of the full cost for the 11-month disability extension period if the disabled person is among those extending coverage.

The initial "premium" (cost of coverage) payment must be made within 45 days after the date of the COBRA election by the Qualified Beneficiary. If payment is not made within such time period, the COBRA election is null and void. The initial premium payment must cover the period of coverage from the date of the COBRA election retroactive to the date of loss of coverage due to the Qualifying Event (or the date a COBRA waiver was revoked, if applicable). Contributions for successive periods of coverage are due on the first of each month thereafter, with a 30-day grace period allowed for payment. Payment is considered to be made on the date it is sent to the Plan or Plan Sponsor.

The Plan must allow the payment for COBRA continuation coverage to be made in monthly installments but the Plan is also permitted to allow for payment at other intervals. The Plan is not obligated to send monthly premium notices.

The cost of COBRA continuation coverage can only increase during the Plan's 12-month determination period if:

the cost previously charged was less than the maximum permitted by law;

the increase occurs due to a disability extension (i.e., the 11-month disability extension) and does not exceed the maximum permitted by law which is 150% of the Plan's full cost of coverage if the disabled person is among those extending coverage; or

the Qualified Beneficiary changes his coverage option(s) which results in a different coverage cost.

Timely payments that are less than the required amount but are not significantly less (an "insignificant shortfall") will be deemed to satisfy the Plan's payment requirement. The Plan may notify the Qualified Beneficiary of the deficiency but must grant a reasonable period of time (at least 30 days) to make full payment. A payment will be considered an "insignificant shortfall" if it is not greater than $50 or 10% of the required amount, whichever is less.

If premiums are not paid by the first day of the period of coverage, the Plan has the option to cancel coverage until payment is received and then reinstate the coverage retroactively to the beginning of the period of coverage.

NOTES: For Qualified Beneficiaries who reside in a state with a health insurance premium payment program, the State may pay the cost of COBRA coverage for a Qualified Beneficiary who is eligible for health care benefits from the State through a program for the medically-indigent or due to a certain disability. The Employer's personnel offices should be contacted for additional information.

See the "Effect of the Trade Act" provision for additional cost of coverage information.

Maximum Coverage Periods - The maximum coverage periods for COBRA continuation coverage are based on the type of Qualifying Event and the status of the Qualified Beneficiary and are as follows:

if the Qualifying Event is a termination of employment or reduction of hours of employment, the maximum coverage period is 18 months after the Qualifying Event. With a disability extension (see "Disability Extension" information below), the 18 months is extended to 29 months;

if the Qualifying Event occurs to a Dependent due to Employee's enrollment in the Medicare program before the Employee himself experiences a Qualifying Event, the maximum coverage period for the Dependent is 36 months from the date the Employee is enrolled in Medicare;

for any other Qualifying Event, the maximum coverage period ends 36 months after the Qualifying Event.

If a Qualifying Event occurs that provides an 18-month or 29-month maximum coverage period and is followed by a second Qualifying Event that allows a 36-month maximum coverage period, the original period will be expanded to 36 months, but only for individuals who are Qualified Beneficiaries at the time of both Qualifying Events. Thus, a termination of employment following a Qualifying Event that is a reduction of hours of employment will not expand the maximum COBRA continuation period. In no circumstance can the COBRA maximum coverage period be more than 36 months after the date of the first Qualifying Event.

COBRA entitlement runs concurrently with continuation of coverage under The Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) - USERRA does not extend the maximum period of COBRA coverage. If coverage is continued under USERRA, the equivalent number of months of COBRA entitlement will be exhausted.

Disability Extension - An 11-month disability extension (an extension from a maximum 18 months of COBRA continuation coverage to a maximum 29 months) will be granted if a Qualified Beneficiary is determined under Title II or XVI of the Social Security Act to have been disabled at the time of the Qualifying Event or at any time during the first 60 days of COBRA continuation coverage. To qualify for the disability extension, the Plan Administrator must be provided with notice of the Social Security Administration's disability determination date that falls within the allowable periods described. The notice must be provided within 60 days of the disability determination and prior to expiration of the initial 18-month COBRA continuation coverage period. The disabled Qualified Beneficiary or any Qualified Beneficiaries in his or her family may notify the Plan Administrator of the determination. The Plan must also be notified if the Qualified Beneficiary is later determined by Social Security to be no longer disabled.

If an individual who is eligible for the 11-month disability extension also has family members who are entitled to COBRA continuation coverage, those family members are also entitled to the 29-month COBRA continuation coverage period. This applies even if the disabled person does not elect the extension himself.

Termination of Continuation Coverage - Except for an initial interruption of Plan coverage in connection with a waiver (see "Election and Election Period" above), COBRA continuation coverage that has been elected by or for a Qualified Beneficiary will extend for the period beginning on the date of the Qualifying Event and ending on the earliest of the following dates:

the last day of the applicable maximum coverage period - see "Maximum Coverage Periods" above;

the date on which the Employer ceases to provide any group health plan to any Employee;

the date, after the date of the COBRA election, that the Qualified Beneficiary first becomes covered under any other plan that does not contain any exclusion or limitation with respect to any preexisting condition that would reduce or exclude benefits for such condition in the Qualified Beneficiary;

the date, after the date of the COBRA election, that the Qualified Beneficiary becomes entitled to Medicare benefits. For COBRA purposes, "entitled" means that the Medicare enrollment process has been completed with the Social Security Administration and the individual has been notified that his or her Medicare coverage is in effect;

in the case of a Qualified Beneficiary entitled to a disability extension, the later of:

29 months after the date of the Qualifying Event, or the first day of the month that is more than 30 days after the date of a final determination under Title II or XVI of the Social Security Act that the disabled Qualified Beneficiary whose disability resulted in the Qualified Beneficiary's entitlement to the disability extension is no longer disabled, whichever is earlier; or

the end of the maximum coverage period that applies to the Qualified Beneficiary without regard to the disability extension;

the end of the last period for which the cost of continuation coverage is paid, if payment is not received in a timely manner (i.e., coverage may be terminated if the Qualified Beneficiary is more than 30 days delinquent in paying the applicable premium). The Plan is required to make a complete response to any inquiry from a healthcare provider regarding a Qualified Beneficiary's right to coverage during any period the Plan has not received payment.

The Plan Sponsor can terminate, for cause, the coverage of any Qualified Beneficiary on the same basis that the Plan may terminate the coverage of similarly situated NonCOBRA Beneficiaries for cause (e.g., for the submission of a fraudulent claim).

If an individual is receiving COBRA continuation coverage solely because of the person's relationship to a Qualified Beneficiary (i.e., a newborn or adopted child acquired during an Employee's COBRA coverage period), the Plan's obligation to make COBRA continuation coverage available will cease when the Plan is no longer obligated to make COBRA continuation coverage available to the Qualified Beneficiary.

Effect of the Trade Act - In response to Public Law 107-210, referred to as the Trade Act of 2002 ("TAA"), the Plan is deemed to be "Qualified Health Insurance" pursuant to TAA, the Plan provides COBRA continuation of coverage in the manner required of the Plan by TAA for individuals who suffer loss of their medical benefits under the Plan due to foreign trade competition or shifts of production to other countries, as determined by the U.S. International Trade Commission and the Department of Labor pursuant to the Trade Act of 1974, as amended.

Eligible Individuals - The Plan Administrator shall recognize those individuals who are deemed eligible for federal income tax credit of their health insurance cost or who receive a benefit from the Pension Benefit Guaranty Corporation ("PBGC"), pursuant to TAA as of or after November 4, 2002. The Plan Administrator shall require documentation evidencing eligibility of TAA benefits, including but not limited to, a government certificate of TAA eligibility, a PBGC benefit statement, federal income tax filings, etc. The Plan need not require every available document to establish evidence of TAA eligibility. The burden for evidencing TAA eligibility is that of the individual applying for coverage under the Plan. The Plan shall not be required to assist such individual in gathering such evidence.

Temporary Extension of COBRA Election Period

Definitions:

Nonelecting TAA-Eligible Individual – A TAA-Eligible Individual who has a TAA related loss of coverage and did not elect COBRA continuation coverage during the TAA-Related Election Period.

TAA-Eligible Individual – An eligible TAA recipient and an eligible alternative TAA recipient.

TAA-Related Election Period – with respect to a TAA-related loss of coverage, the 60-day period that begins on the first day of the month in which the individual becomes a TAA-Eligible Individual.

TAA-Related Loss of Coverage – means, with respect to an individual whose separation from employment gives rise to being a TAA-Eligible Individual, the loss of health benefits coverage associated with such separation.

In the case of an otherwise COBRA Qualified Beneficiary who is a Nonelecting TAA-Eligible Individual, such individual may elect COBRA continuation of coverage during the TAA-Related Election Period, but only if such election is made not later than 6 months after the date of the TAA-Related Loss of Coverage.

Any continuation of coverage elected by a TAA-Eligible Individual shall commence at the beginning of the TAA-Related Election Period, and shall not include any period prior to such individual's TAA-Related Election Period.

HIPAA Creditable Coverage Credit
With respect to any TAA-Eligible Individual who elects COBRA continuation of coverage as a Nonelecting TAA Individual, the period beginning on the date the TAA-Related Loss of Coverage, and ending on the first day of the TAA-Related Election Period shall be disregarded for purposes of determining the 63-day break-in-coverage period pursuant to HIPAA rules regarding determination of prior creditable coverage for application to the Plan's preexisting condition exclusion provision.

Applicable Cost of Coverage Payments
Payments of any portion of the applicable COBRA cost of coverage by the federal government on behalf of a TAA-Eligible Individual pursuant to TAA shall be treated as a payment to the Plan. Where the balance of any contribution owed the Plan by such individual is determined to be significantly less than the required applicable cost of coverage, as explained in IRS regulations 54.4980B-8, A-5(d), the Plan will notify such individual of the deficient payment and allow thirty (30) days to make full payment. Otherwise the Plan shall return such deficient payment to the individual and coverage will terminate as of the original cost of coverage due date.

REINSTATEMENT

COBRA Participants
An Employee who has elected COBRA continuation of coverage will be considered to have had no lapse of coverage, provided that the coverage is in effect on the day before the Employee returns to eligible employment.

Following A Military Leave of Absence – USERRA
Regardless of an Employer's established termination or leave of absence policies, the Plan will always comply with the regulations of Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) for an Employee entering service in the "uniformed services".

In order for the Employee to be entitled to USERRA rights, the following conditions must be met:

- The Employee's absence must be for service in the uniformed services;
- If possible, the Employee (or appropriate officer of the military) must give the Plan Sponsor advance notice of the Employee's absence from work;
- The Employee's absence from work must not exceed five (5) years (subject to certain exceptions); and
- The Employee was released from military service under honorable conditions.

USERRA provides for the continuation of health benefits for Employees who are on military leave. If an Employee was covered under the Plan immediately prior to being ordered to active military duty, coverage may continue for up to 18 months, or the duration of active military service, whichever is shorter. The Employee must pay the entire cost of the coverage if the leave duration is over 30 days. The premium may not exceed 102% of the actual cost of the coverage.

Regardless of whether an Employee elects continuation coverage under USERRA, the coverage will be reinstated on the first day the Employee returns to active employment if the Employee was released under honorable conditions subject to the following:

- The Employee must return to employment on the first full business day following completion of military service for military leave of 30 days or less.
- The Employee must submit an application for employment.
    - Within 14 days of completion of military service for leaves of 31-180 days; or
    - Within 90 days of completion of military service for leaves of more than 180 days.

When coverage under the Plan is reinstated, all provisions and limitations of the Plan will apply to the extent that they would have applied if the Employee had not taken military leave and coverage had been continuous. The Employee and any Eligible Dependents will not be subject to a Waiting Period or Pre-Existing condition.

An Employee who is ordered to active military service is considered to have experienced a COBRA qualifying event along with any of their Eligible Dependents. The affected persons have the right to elect continuation of coverage under either USERRA or COBRA. Under either option, the Employee retains the right to re-enroll in the Plan in accordance with the above stipulations.

Any Deductible or coinsurance satisfied prior to the leave of absence will be credited if reinstatement takes place within the same Calendar Year.

COORDINATION OF BENEFITS

Benefits payable under the Plan will be coordinated with any other Benefit 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.

Benefit Plan – The term Benefit Plan includes this Plan or any of the following plans:

1. Group or group-type plans, including franchise or blanket benefit plans;
2. Blue Cross and Blue Shield group plans;
3. Group practice and other group prepayment plans;
4. Federal government plans or programs, including Medicare;
5. Other plans required or provided by law. This does not include Medicaid or any benefit plan which, by its terms, does not allow coordination; or
6. No Fault Auto Insurance, by whatever name it is called, when not prohibited by law.

Automobile limitations – When medical payments are available under an auto insurance policy, this Plan shall pay excess benefits only, without reimbursement for auto policy deductibles. This Plan shall always be considered the secondary payer regardless of the individual's election under Personal Injury Protection (PIP) coverage with the auto insurance company.

Pinnacle's order of payment for Coordination purposes is:

1. The plan with no rules for coordination with other benefits will be deemed to pay its benefits before a plan that contains such rules.

2. The Plan that covers the patient as the individual will be the primary payer. If the patient is eligible as the individual under two or more plans, the plan having the earliest effective date will be primary.

3. In the case of Dependent children:
   a) the plan of the parent whose birthday comes earliest in the year will be primary.
   b) If both parents have the same birthday, the plan having the earliest effective date will be primary.
   c) If the specific terms of a court decree state that one (1) of the parents is responsible for the Child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. If the parent with financial responsibility has no coverage for the Child's health care services or expenses, but that parent's Spouse does, the Spouse's plan is primary. This subparagraph shall not apply with respect to any claim determination period during which benefits are paid or provided before the entity has actual knowledge.
   d) If the parents are not married or are separated or are divorced and there is no court decree allocating responsibility for the Child's health care services or expenses, the order of benefit determination among the plans of the parents and the parents Spouse's is:
      1.) the plan of the custodial parent;
      2.) the plan of the Spouse of the custodial parent;
      3.) the plan of the non-custodial parent's plan; and
      4.) the plan of the Spouse of the non-custodial parent.

4. In the case of an active or inactive Employee, the plan that covers a person as an Employee who is neither laid off or retired (or as that Employee's Dependent) is primary. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored. Coverage provided an individual as a retired worker and as a dependent of that individual's Spouse as an active worker will be determined under rule 1) stated above.

5. If a person whose coverage is provided under a right of continuation (COBRA) pursuant to federal or state law is also covered under another plan, the plan covering the person as an Employee, member, subscriber, or retiree (or as that person's Dependent) is primary and the continuation coverage is secondary. If the other plan does not have this rule and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

6. Benefits under this Plan will integrate with any benefits payable under the federal Medicare program. In most instances, the Employers Group Plan takes a primary payer position to Medicare. A Participant and/or a dependent Spouse who is a Medicare beneficiary, and, as a result of the provisions of Title XVIII of the Social Security Act and implementing regulations, Medicare is:
   a) secondary for Active Employees and Spouses of Active Employees
   b) secondary for expenses incurred on or after January 1, 1987 by active Employee's, or Dependents of Active Employee's, who are eligible for Medicare because of disability other than for End Stage Renal

Disease, and

c) secondary for the first 30 months after an individual under age 65 begins treatment for End Stage Renal Disease.
d) Primary the 31st month after an individual under age 65 begins treatment for End Stage Renal Disease.
e) Primary the date the Employee terminates group coverage, terminates employment, retires or ceases to be in an eligible class for group coverage.

For purposes of this Plan, Medicare coverage will be assumed if you are eligible, whether or not you have actually enrolled in Part A or Part B.

If according to the above, a person is eligible for Medicare and if Medicare is the Primary payer, regular benefits under this Plan may be reduced by benefits paid by Medicare if the total of the benefits payable under both plans would exceed 100% of the covered allowable expense. In no event will this Plan pay more than the regular benefits payable in the absence of other coverage.

The Plan Sponsor will coordinate as secondary to any Plan that is in excess over the Plan.

For the purpose of Coordination of Benefits, Pinnacle:

(1) may release to or obtain from any individual or organization any claim information which Pinnacle 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 Pinnacle determines to be warranted, if payments that 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 or Registered Domestic Partners are eligible as Employees under TUSD and cover each other as dependents, benefits will be processed under both coverages, except under the Prescription Drug card program.

SUBROGATION AND REIMBURSEMENT, THIRD PARTY RECOVERY

Benefits Subject to This Provision
This provision shall apply to all benefits provided under any section of this Plan.

When This Provision Applies
A Covered Person may incur medical or other charges related to injuries or illness caused by the act or omission of another person; or Another Party may be liable or legally responsible for payment of charges incurred in connection with the injuries or illness. If so, the Covered Person may have a claim against that other person or Another Party for payment of medical or other charges. In that event, the Plan will be secondary, not primary, and the Plan will be Subrogated to all rights the Covered Person may have against that other person or Another Party and will be entitled to Reimbursement. In addition, the Plan shall have the first lien against any Recovery to the extent of benefits paid or to be paid and expenses incurred by the Plan in enforcing this provision. The Plan's first lien supersedes any right that the Covered Person may have to be "made whole." In other words, the Plan is entitled to the right of first Reimbursement out of any Recovery the Covered Person procures or may be entitled to procure regardless of whether the Covered Person has received compensation for any of his damages or expenses, including any of his attorneys' fees or costs. Additionally, the Plan's right of first Reimbursement will not be reduced for any reason, including attorneys' fees, costs, comparative negligence, limits of collectability or responsibility, or otherwise. As a condition to receiving benefits under the Plan, the Covered Person agrees that acceptance of benefits is constructive notice of this provision.

The Covered Person must:

execute and deliver a Subrogation and Reimbursement Agreement;

authorize the Plan to sue, compromise and settle in the Covered Person's name to the extent of the amount of medical or other benefits paid;

immediately reimburse the Plan, out of any Recovery made from Another Party, 100% of the amount of medical or other benefits paid for the injuries or illness under the Plan and expenses (including attorneys' fees and costs of suit, regardless of an action's outcome) incurred by the Plan in collecting this amount (without reduction for attorneys' fees, costs, comparative negligence, limits of collectability or responsibility, or otherwise);

notify the Plan in writing of any proposed settlement and obtain the Plan's written consent before signing any release or agreeing to any settlement; and

cooperate fully with the Plan in its exercise of its rights under this provision, do nothing that would interfere with or diminish those rights and furnish any information required by the Plan.

When a right of recovery exists, and as a condition to any payment by the Plan (including payment of future benefits for other illnesses or injuries), the Covered Person will execute and deliver all required instruments and papers, including a Subrogation and Reimbursement Agreement provided by the Plan as well as doing and providing whatever else is needed to secure the Plan's rights of Subrogation and Reimbursement, before any medical or other benefits will be paid by the Plan for the injuries or illness. However, failure or refusal on the Covered Person's part to execute such agreements or furnish information does not preclude the Plan from exercising its right to Subrogation or obtaining full reimbursement. In addition, the Covered Person will do nothing to prejudice the Plan's right to Subrogation and Reimbursement and acknowledges that the Plan precludes operation of the made-whole and common-fund doctrines.

The Plan Administrator has maximum discretion to interpret the terms of this provision and to make changes, as it deems necessary.

Amount Subject to Subrogation or Reimbursement
Any amounts recovered will be subject to Subrogation or Reimbursement. In no case will the amount subject to Subrogation or Reimbursement exceed the amount of medical or other benefits paid for the injuries or illness under the Plan and the expenses incurred by the Plan in collecting this amount. The Plan has a right to recover in full, without reduction for attorneys' fees, costs, comparative negligence, limits of collectability or responsibility, or otherwise, even if the Covered Person does not receive full compensation for all of his charges and expenses.

When a Covered Person Retains an Attorney
The Covered Person agrees not to retain an attorney who does not recognize and consent to the fact that the Plan precludes the operation of the "made-whole'' and "common fund" doctrines, and as such, will not assert either doctrine against the Plan's lien. The Plan will neither pay the Covered Person's attorneys' fees and costs associated with the recovery of funds, nor reduce its reimbursement pro rata for the payment of the Covered Person's attorneys' fees and costs. Attorneys' fees will be payable from the Recovery only after the Plan has received full Reimbursement.

A Covered Person who receives any Recovery (whether by judgment, settlement, compromise, or otherwise) has an absolute obligation to immediately tender the Recovery to the Plan under the terms of this provision. Furthermore, a Covered Person agrees to direct his or her attorney who receives any Recovery (whether by judgment, settlement, compromise, or otherwise) that he or she has an absolute obligation to immediately tender the Recovery to the Plan under the terms of this provision. A Covered Person or his attorney who receives any such Recovery and does not immediately tender the Recovery to the Plan will be deemed to hold the Recovery in constructive trust for the Plan, because the Covered Person or his or her attorney is not the rightful owner of the Recovery and should not be in possession of the Recovery until the Plan has been fully reimbursed.

When the Covered Person is a Minor or is Deceased
These provisions apply to the parents, trustee, guardian or other representative of a minor Covered Person and to the heir or personal representative of the estate of a deceased Covered Person, regardless of applicable law and whether or not the minor's representative has access or control of the Recovery.

When a Covered Person Does Not Comply
When a Covered Person does not comply with the provisions of this section, the Plan Administrator shall have the authority, in its sole discretion, to deny payment of any claims for benefits by the Covered Person and to deny or reduce future benefits payable (including payment of future benefits for other injuries or illnesses) under the Plan by the amount due as Reimbursement to the Plan. The Plan Administrator may also, in its sole discretion, deny or reduce future benefits (including future benefits for other injuries or illnesses) under any other group benefits plan maintained by the Plan Sponsor. The reductions will equal the amount of the required Reimbursement. If the Plan must bring an action against a Covered Person to enforce this provision, then that Covered Person agrees to pay the Plan's attorneys' fees and costs, regardless of the action's outcome.

Defined Terms for Subrogation:

Another Party **-** Any individual or organization, other than the Plan, who is liable or legally responsible to pay expenses, compensation or damages in connection with a Covered Person's injuries or illness.

Another Party shall include the party or parties who caused the injuries or illness; the insurer, guarantor or other indemnifier of the party or parties who caused the injuries or illness; a Covered Person's own insurer, such as uninsured, underinsured, medical payments, no-fault, homeowner's, renter's or any other liability insurer; a workers' compensation insurer; and any other individual or organization that is liable or legally responsible for payment in connection with the injuries or illness.

Covered Person **-** Anyone covered under the Plan, including minor Dependents.

Recovery **-** Any and all monies paid to the Covered Person by way of judgment, settlement or otherwise (no matter how those monies may be characterized, designated or allocated) to compensate for any losses caused by, or in connection with, the injuries or illness. Any Recovery shall be deemed to apply, first, for Reimbursement.

Reimbursement **-** Repayment to the Plan for medical or other benefits that it has paid toward care and treatment of the injury or illness and for the expenses incurred by the Plan in collecting this benefit amount.

Subrogation - The Plan's right to pursue the Covered Person's claims for medical or other charges paid by the Plan against Another Party.

CLAIMS PROCEDURES

It is the intent of the Plan Administrator that the following claims procedures comply with the United States

Department of Labor ("DOL") regulation, 29 CFR § 2560.503-1.

SUBMITTING A CLAIM

A claim is a request for a benefit determination that is made, in accordance with the Plan's procedures, by a Claimant or his authorized representative. A claim must name the Plan, a specific Claimant, a specific health condition or symptom or diagnostic code, and a specific treatment, service or supply (or procedure/revenue codes) for which a benefit or benefit determination is requested, the date of service, the amount of charges, the address (location) where services are received, and provider name, address, phone number and tax identification number.

There are two types of health claims: (1) Pre-Service Claims, and (2) Post-Service Claims:

1) **A Pre-Service Claim** is where the terms of the Plan condition benefits, in whole or in part, on prior approval of the proposed care. See the Utilization Management Program section for that information.

   Important: A Pre-Service Claim is only for the purposes of assessing the Medical Necessity and appropriateness of care and delivery setting. A determination on a Pre-Service Claim is not a guarantee of benefits from the Plan. Plan benefit payments are subject to review upon submission of a claim to the Plan after medical services have been received, and are subject to all related Plan provisions, including exclusions and limitations.

2) **A Post-Service Claim** is a written request for benefit determination after a service has been rendered and expense has been incurred. A Post-Service Claim should be submitted to the claims office ninety (90) days after expenses are incurred. Failure to furnish complete proof of loss within the time required will not invalidate or reduce any claim if it can be shown that it was not reasonably possible to give proof within such time, provided proof of loss is furnished as soon as reasonably possible and, unless the Claimant is legally incapacitated, within twelve (12) months from the date on which the covered charges were incurred.

   A Post-Service Claim should be submitted to:

   Pinnacle Claims Management, Inc.
   P. O. Box 2220
   Newport Beach, CA 92658

   NOTE: In accordance with federal law, the Centers for Medicare and Medicaid Services (CMS) have three (3) years to submit claims when CMS has paid as the primary plan and the Plan should have been primary.

ASSIGNMENTS TO PROVIDERS

All Eligible Expenses reimbursable under the Plan will be paid to the covered Employee except that: (1) assignments of benefits to Hospitals, Physicians or other providers of service will be honored, (2) the Plan may pay benefits directly to providers of service unless the Covered Person requests otherwise, in writing, within the time limits for filing proof of loss, and (3) the Plan may make benefit payments for a child covered by a Qualified Medical Child Support Order (a QMCSO) directly to the custodial parent or legal guardian of such child.

Benefits due to any Network provider will be considered "assigned" to such provider and will be paid directly to such provider, whether or not a written assignment of benefits was executed. Notwithstanding any assignment or non-assignment of benefits to the contrary, upon payment of the benefits due under the Plan, the Plan is deemed to have fulfilled its obligations with respect to such benefits, whether or not payment is made in accordance with any assignment or request.

No covered Employee or Dependent may, at any time, either while covered under the Plan or following termination of coverage, assign his right to sue to recover benefits under the Plan, or enforce rights due under the Plan or any other causes of action that he may have against the Plan or its fiduciaries.

NOTE: Benefit payments on behalf of a Covered Person who is also covered by a state's Medicaid program will be subject to the state's right to reimbursement for benefits it has paid on behalf of the Covered Person, as created by an assignment of rights made by the Covered Person or his beneficiary as may be required by the state Medicaid plan. Furthermore, the Plan will honor any subrogation rights that a state may have gained from a Medicaid-eligible beneficiary due to the state's having paid Medicaid benefits that were payable under the Plan.

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 DOL.

"PRE-SERVICE" CLAIM ACTIVITY	**TIME LIMIT OR ALLOWANCE**
Urgent Claim - defined below	
Claimant Makes Initial Incomplete 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 Completing 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 Complete Claim Request	Within not more than 72 hours (and as soon as possible considering the urgency of the medical situation), plan responds with written or electronic benefit determination.
Claimant Appeals	See "appeal procedures" subsection. An appeal for an urgent claim may be made orally or in writing.
Plan Responds to Appeal	Within not more than 72 hours (and as soon as possible considering the urgency of the medical situation), after receipt of claimant's appeal.
An "urgent claim" is an oral or written request for benefit determination where the decision would result in either of the following if decided within the time frames for non-urgent claims: (1) serious jeopardy to the Claimant's life or health, or the ability to regain maximum function, or (2) in the judgment of a Physician knowledgeable about the Claimant's condition, severe pain that could not be adequately managed without the care or treatment being claimed. Where the "Time Limit or Allowance" stated above reflects "or sooner if possible," this phrase means that an earlier response may be required, considering the urgency of the medical situation.	
Concurrent Care Claim - defined below	
Plan Wants to Reduce or Terminate Already Approved Care	Plan notifies Claimant of intent to reduce or deny benefits before any reduction or termination of benefits is made and provides enough time to allow the Claimant to appeal and obtain a response to the appeal before the benefit is reduced or terminated. Any decision with the potential of causing disruption to ongoing care that is Medically Necessary is subject to the urgent claim rules.
"PRE-SERVICE" CLAIM ACTIVITY	**TIME LIMIT OR ALLOWANCE**
Claimant Requests Extension for Urgent Care	Plan notifies Claimant of its benefit determination within 24 hours after receipt of the request (and as soon as possible considering the urgency of the medical situation), provided the Claimant requests to extend the course of treatment at least 24 hours prior to the expiration of the previously-approved period of time or treatment. Otherwise, the Plan's notification must be made in accordance with the time allowances for appeal of an urgent, pre-service or post-service claim, as appropriate.
A "concurrent care claim" is a Claimant's request to extend a previously-approved and ongoing course of treatment beyond the approved period of time or number of treatments. A decision to reduce or terminate benefits already approved does not include a benefit reduction or denial due to Plan amendment or termination.	
Non-Urgent Claim	

Claimant Makes Initial Incomplete Claim Request	Within 5 days of receipt of the incomplete claim request, plan notifies claimant, orally or in writing, of information needed to complete the claim request. Claimant may request a written notification.
Plan Receives Completing Information	Within 15 days, plan responds with written or electronic benefit determination. 15 additional days may be allowed with full notice to claimant - see definition of "full notice" below.
Claimant Makes Initial Complete Claim Request	Within 15 days, plan responds with written or electronic benefit determination. 15 additional days may be allowed with full notice to claimant - see definition of "full notice" below.
Claimant Appeals	See "appeal procedures" subsection.
Plan Responds to Appeal	Within 30 days after receipt of appeal (or where plan requires 2 mandatory levels of appeal, within 15 days for each appeal).
"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.	

"POST-SERVICE" CLAIM ACTIVITY	**TIME LIMIT OR ALLOWANCE**
Claimant Makes Initial Incomplete Claim Request	Within 30 days (and sooner if reasonably possible), Plan advises Claimant of information needed to complete the claim request.
Plan Receives Completing 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 Complete 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 (or within 30 days for each appeal if Plan provides for two appeal levels).
"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.	

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.

CLAIMS DENIALS

If a claim is wholly or partially denied (see NOTE), the Claimant will be given written or electronic notification of such denial within the time frames required by law - see "Claims Time Limits and Allowances." The notice will include the following and will be provided in a manner intended to be understood by the Claimant:

- the specific reason(s) for the decision to reduce or deny benefits:
- specific reference to the Plan provision(s) on which the denial is based as well as identification of and access to any guidelines, rules, and protocols that were relied upon in making the decision;
- a statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records or other information relevant to the Claimant's claim for benefits;
- the identity of any medical or vocational experts consulted in connection with the claim, even if the Plan did not rely upon their advice, or a statement that the identity of the expert(s) will be provided upon request;
- a description of any additional information needed to change the decision and an explanation of why it is needed;
- a description of the Plan's procedures and time limits for appealed claims.

CLAIM APPEAL PROCEDURES

Review Procedures:

A Covered Person, or the Covered Person's representative may request a review of the claim denial by making a written request to the Third Party Administrator ***within 180 days of receipt of the notice of denial***. You may request a "Claim Appeal Form" from Pinnacle or your Human Resources office or you may submit a letter to Pinnacle containing your name, address, your unique health care ID number, the claim number assigned by Pinnacle, the date services were provided. Written notice for review should:

1. State the reasons the Covered Person feels the claim should not have been denied; and
2. Include any additional documentation that the Covered Person believes supports the claim.

On receipt of written request for review of a claim, the Third Party Administrator will review the claim and furnish copies of all documents and all reasons and facts relative to the decision. ***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.

RIGHTS OF THE PLAN ADMINISTRATOR

EXAMINATION OF CLAIM AND /OR CLAIMANT
The Plan Administrator or any duly authorized representative of the Plan Administrator will have the right to examine any claim for benefit determination under this Plan, whether assigned or unassigned. The Plan Administrator, at the Plan's expense, have the right to have the person whose Illness or Injury is the basis for a claim examined as often as reasonably required during the time a claim is pending under the Plan.

GLOSSARY/DEFINITIONS

ABORTION: Shall mean induced termination of a pregnancy at the election of the Participant. A therapeutic Abortion is the induced termination of a pregnancy by any acceptable means medically indicated by a diagnosis affecting the mental or physical health of the mother.

ACCIDENT: An unexpected event that occurs without the patient's intent of injury, usually 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; and /or (6) commission of a felony.

AMBULATORY SURGICAL CENTER: A public or private outpatient facility other than a medical or dental office, whose main function is performing surgical procedures on an Outpatient basis. It must be licensed as a Surgery Center according to state and local laws and must meet all requirements of an Outpatient Surgery Center providing surgical services. The facility must have an organized staff of Physicians with permanent facilities, which are equipped to and operated primarily for the purpose of performing surgical procedures. The Physician and nursing care services must be continuous whenever a patient is in the facility and it does not typically provide for overnight stays other than for one (1) night.

AMENDMENT: A formal document that changes the provisions of the Plan Document as approved by the Plan Sponsor and TPA, duly signed by the authorized person(s) designated by the Plan Administrator.

BIRTHING CENTER: Shall mean a licensed outpatient facility, which provides childbirth facilities for low-risk maternity patients. The Birthing Center must meet fully every one (1) of the following tests: 1) has an organized staff of certified midwives, physicians and other trained personnel; 2) has necessary medical equipment; 3) has a backup of Physicians; 4) has a written agreement to transfer to a Hospital if necessary; 5) is in compliance with any applicable state or local regulations; and 6) home birthing with the use of a licensed midwife or physician does not meet the requirements of a birthing center nor is it a Covered Expense.

CHILD: Shall mean only an unmarried Dependent of the Employee, provided the following conditions are met:
1) the Child is not eligible for group health coverage sponsored by his employer; and
2) the Child depends on the Employee for support within the meaning of Section 152 of the Code and is one (1) of the following:
    a) A natural son or daughter of the Employee/Spouse
    b) A stepchild whose primary place of residence is with the Employee
    c) A legally adopted Child or a Child to whom a court of competent jurisdiction has entered an interlocutory order of adoption
    d) Any other Child, who is related to the Employee, is mainly dependent upon the Employee for care and support, is living with the Employee in a parent-child relationship, and legally qualifies under guardianship as a dependent.

Or
The Employee is required to provide health care coverage for the Child under a qualified medical support order.

CLAIMS ADMINISTRATOR / CONTRACT ADMINISTRATOR: Shall mean Pinnacle Claims Management, Inc. A company that performs all functions reasonably related to the general management, supervision and administration of one or more benefits of the Plan in accordance with the terms and conditions of an administration agreement between the Contract Administrator and the Plan Sponsor.

The Contract Administrator is not a fiduciary of the Plan and does not exercise any discretionary authority with regard to the Plan. The Contract Administrator is not an insurer of Plan benefits, is not responsible for Plan financing and does not guarantee the availability of benefits under the Plan.

CODE: Shall mean the United States Internal Revenue Code of 1986, as amended.

CONVALESCENT HOSPITAL: See "Skilled Nursing Facility"

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.

CREDITABLE COVERAGE: Shall mean health care coverage which may be used to reduce a Participant's pre-existing condition exclusion period as of the Enrollment Date. Creditable Coverage shall only include individual or group health insurance coverage and other health care coverage specifically set forth in HIPAA, including Medicaid and Medicare. Creditable Coverage shall not include coverage consisting of excepted benefits as defined by HIPAA.

CUSTODIAL CARE: Care provided primarily to meet the personal needs of the Participant. This includes help in walking, getting in or out of bed, 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. Such care is Custodial regardless of who recommends, provides, or directs the care; where the care is provided; and whether or not the patient can be trained to care for himself.

DEPENDENT: Shall mean:

a) The Spouse of an Employee who is not divorced from the Employee or whose marriage to the Employee has not been otherwise legally terminated
b) Each unmarried Child of an Employee up to age 19.
c) Each unmarried Child of an Employee from age 19 through the day on which he ceases to be a Full-Time Student (as defined in this Plan Document) at an accredited institution of higher learning, but in no event beyond his 25th birthday.
d) Each unmarried Child of an Employee who has attained his 19th birthday who is mentally retarded or physically handicapped and who is incapable of engaging in self-sustaining employment due to such incapacity and is dependent upon the Employee for support and maintenance and is reported as a dependent on the Employee's current Internal Revenue Service Tax statement. Application of such continuation of Dependent status must be made with the Claims Administrator within thirty-one (31) days of the Child's 19th birthday. The Plan Sponsor has the right to require proof of the continuation of such incapacity upon attainment of age 19 or anytime thereafter as deemed necessary by the Plan Sponsor.

DISABILITY / TOTAL DISABILITY: Any Illness or Injury resulting from the same cause or related causes, including complications, which prevent an injured person form continuously performing every duty pertaining to his or her occupation or engaging in any other type of work for remuneration. Unrelated illnesses that 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, 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.

ELIGIBLE DEPENDENT: Shall mean a Dependent of an Eligible Employee.

ELIGIBLE EMPLOYEE: Shall mean an active Full-time Employee of Torrance Unified School District, who regularly works the required number of hours or more per pay period as described in the employee/personnel handbook to meet the Employer's definition of a Full-time Employee.

ELIGIBLE EXPENSES: See "Covered Expenses"

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.

EMERGENCY CARE: The first treatment given in a Hospital's Emergency room right after either: a) the sudden and unexpected onset of symptoms; b) an Accident causing injuries severe enough to require immediate hospital

level care. Hospital level care will be deemed to be required only if: a) care could not adequately have been provided other than in a Hospital; b) adequate care was not available elsewhere in the area at the time and place it was given.

EMPLOYEE: Shall mean an individual whom the Employer compensates for personal services performed on a regular and continuous basis, and for whom the Employer pays employment taxes as required by the Code.

EMPLOYER: The Employer is Torrance Unified School District. The Employer is also the Plan Sponsor, the Fiduciary and the Plan Administrator.

ENROLLMENT DATE: Shall mean the first day of coverage or, if there is a Waiting Period, the first day of the month following the Waiting Period.

FIDUCIARY: Any entity having binding power to make decisions regarding Plan policies, interpretations, practices or procedures.

FULL-TIME STUDENT: Shall mean a student at an accredited institution of higher learning who is enrolled for at least twelve (12) credit hours per school term, or who otherwise meets the definition of "full-time" student as established by the institution which he is attending. If the Dependent attends a proprietary school, full time is 25 hours per week on a five (5) days per week schedule.

HIPAA: Shall mean the Health Insurance Portability and Accountability Act of 1996, as presently enacted and as it may be amended from time to time, together with its related rules and regulations. References to any section of HIPAA shall include any successor provision.

HOME HEALTH CARE AGENCY: An agency or organization that: a) is primarily engaged in and duly licensed, if such licensing is required by the appropriate licensing authority, to provide skilled nursing services and other therapeutic services; b) has policies established by a professional group associated with the agency or organization that includes at least one registered nurse (RN) to govern the services provided; c) provides for full-time supervision of its services by a Physician or by a registered nurse; d) maintains a complete medical record on each patient; e) has a full-time administrator.

In rural areas where there are no agencies that meet the above requirements or areas in which the available agencies do not meet the needs of the community, the services of visiting nurses may be substituted for the services of an agency.

HOME HEALTH CARE PLAN: A plan providing for continued care and treatment after discharge from a Hospital. The care and treatment must be: a) for the same or related condition requiring hospitalization; b) an alternative to staying in the Hospital; c) prescribed in writing by the attending Physician and commencing within seven (7) days of discharge from the Hospital.

HOSPICE or **HOSPICE AGENCY:** An entity providing a coordinated set of services rendered at home, in Outpatient settings or in institutional settings for Covered Persons suffering from a condition that has a terminal prognosis. A Hospice must have an interdisciplinary group of personnel that includes at least one Physician and one registered nurse, and must maintain central clinical records on all patients. A Hospice must meet the standards of the National Hospice Organization (NHO) and applicable state licensing requirements.

HOSPITAL: An institution 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) maintains facilities for diagnosis of Injury or disease;
(6) maintains a daily medical record for each patient;
(7) operates lawfully in the area which it is located and is Joint Commission of Hospitals accredited;
(8) 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.

ILLNESS: Shall mean physical disease or sickness, including pregnancy.

IMMEDIATE FAMILY: Shall mean a Spouse, parent, grandparent, Child, grandchild, brother or sister of a Participant.

INJURY: Shall mean physical harm received by an individual as the result of any one (1) Accident.

INPATIENT: Shall mean the classification of a Participant when that person is admitted to a Hospital, hospice facility or Extended Care Facility for treatment, and charges are made for room and board to the Participant as the result of such treatment and to which the person has been assigned on a 24-hour-a-day basis without being issued passes to leave the premises. After twenty-three (23) observation hours, a confinement will be considered an Inpatient confinement.

INTENSIVE CARE UNIT: (ICU), Coronary Care Unit (CCU), Burn Unit, or Intermediate Care Unit - A Hospital area or accommodation exclusively reserved for critically and seriously ill patients requiring constant observation as prescribed by the attending Physician, that provides room and board, specialized registered professional nursing and other nursing care and special equipment and supplies on a stand-by basis and that is separated from the rest of the Hospital's facilities.

LIFETIME: All periods an individual is covered under the Plan, including any prior statements of the Plan. It does not mean a Participant's entire lifetime.

MEDICAL NECESSITY / MEDICALLY NECESSARY: The benefits of this Plan are provided only for services that are Medically Necessary as determined by Pinnacle. The services must be ordered by the attending Physician for the diagnosis, 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. It must be effective, appropriate and essential based upon recognized standards of the health care specialty. In no event will the following be deemed necessary:

- services rendered by a health care Provider not requiring the technical skills of such a Provider;
- services and supplies furnished primarily for the personal comfort or convenience of the person, or any person who cares for him/her, or any person who is part of his her family;
- services rendered to a person solely because he/she is an inpatient on any day in which the person's physical or mental condition could safely and adequately be diagnosed or treated while not confined;
- part of the cost which exceeds any other service or supply sufficient to safely and adequately diagnose or treat the person's physical or mental condition.

MEDICARE: Health Insurance for the Aged and Disabled as established by Title I of Public Law 89-98 including parts A, B and D and Title XVIII of the Social Security Act, and as amended from time to time.

MENTAL ILLNESS / MENTAL OR EMOTIONAL DISORDER: A nervous condition, psychosis or neurosis.

MENTAL NERVOUS DISORDER TREATMENT FACILITY: An institution that primarily provides a program for the diagnosis, evaluation and effective treatment of Mental Disorder and which is not primarily a school or a custodial, recreational or training institution. It must be supervised full-time by a psychiatrist responsible for patient care that is there regularly and is staffed by psychiatric Physicians involved in care and treatment. It should provide infirmary-level medical services and provide or arrange with a Hospital in the area for any other required medical service. A written plan of treatment for each patient based on medical, psychological and social needs, which is supervised by a psychiatric Physician, is required. The facility must meet standard licensing requirements for the state.

MULTIPLE SURGICAL PROCEDURES: Shall mean surgical procedures which are performed during the same operative session and which are not incidental or secondary to one (1) primary procedure for which the operative session is undertaken. An "incidental procedure" is a procedure that is not Medically Necessary at the time it is performed. A "secondary procedure" is a procedure that is not part of the primary procedure for which the operative session is undertaken.

NEGOTIATED FEE RATE: Shall mean the negotiated fee rate determined for a Participating Provider that represents an amount less than or equal to the Provider's normal charges. A Participant is not responsible for the difference between the Providers billed charges and the Negotiated Fee Rate.

OPEN ENROLLMENT: Shall mean the period of 30 to 60 days prior to the Plan's effective date on an annual basis. This is the period of time when those Employees who missed the Standard Enrollment Period, and did not have a Qualifying Event that made them eligible for the Special Enrollment Period, may enroll within the Plan. This

is also the time when those Employee's who had previously declined coverage, for themselves or their Dependents, may now elect coverage under the Eligibility provisions of the Plan. You may also be able to drop your Dependents' coverage under the Plan. All changes made during Open Enrollment will be effective the next October 1.

OUTPATIENT: Shall refer to a person receiving medical care other than as an Inpatient or shall refer to Covered Expense other than those associated with a Hospital confinement.

PARTICIPANT: A participant is the Employee of TUSD or his or her Eligible Dependent that satisfies the eligibility and participation requirements specified in this Plan Document.

PARTICIPATING PROVIDER/ PARTICIPATING BLUE CROSS PPO PROVIDER: Any Provider who has an agreement with the Plan to accept a Negotiated Fee Rate.

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, Chiropractic, Acupuncture, Optometry. A licensed Optician, licensed midwife, Marriage, family and child counselor, Psychologist, Physical Therapy, Occupational Therapy, Audiologist, Speech Pathology, Registered Nurse, Licensed Vocational Nurse, Licensed Practical Nurse, Clinical Social Worker is included if performing services that are covered by the Plan.

PINNACLE CLAIMS MANAGEMENT, INC.: A Third Party Administrator who has contracted with TUSD to administer and process your group benefits.

PLAN: Is the Health Plan for Employees of Torrance Unified School District.

PLAN ADMINISTRATOR: See "Plan Sponsor"

PLAN SPONSOR: Shall mean Torrance Unified School District.

PLAN YEAR: Shall mean the period of time that begins on October first of each year and ends on September thirtieth of the next year.

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

PREFERRED PROVIDER: Any Provider or Hospital who has an agreement with the Plan to accept a Negotiated Fee Rate.

PROVIDER: Any individual or organization, licensed by the state or appropriate governing body or regulatory agency, which dispenses, supplies or performs the necessary care and treatment for an injury or sickness within the scope of its required licensing to include: Medical Doctor; Doctor of Osteopathy; Acupuncturist; Dentist; Optometrist; Chiropractor; Podiatrist; Chiropodist; Licensed Psychologist; Clinical Social Worker; Registered Nurse; Licensed Vocational Nurse; Licensed Practical Nurse; Psychiatric Mental Health Nurse; Respiratory Care Practitioner; Occupational Therapist; Audiologist; Speech Pathologist; Marriage, family and child counselor; Physical Therapist.

NOTE: The term "Provider" will not include the Participant himself, his relatives or interns, residents or fellows or others enrolled in graduate medical education program.

SEMI-PRIVATE ROOM CHARGE: The standard charge by a facility for semi-private room and board accommodations, or the average of such charges where the facility has more than one established level of such charges, or 90% of the lowest charge by the facility for single bed room and board accommodations where the facility does not provide any semi-private accommodations.

SICKNESS: Shall mean physical disease or illness (other than mental health conditions), including pregnancy. Also, a condition must be diagnosed by a Physician in order to be considered a Sickness by this Plan.

SKILLED NURSING FACILITY/EXTENDED CARE FACILITY: Shall mean an institution or distinct part of an institution that:

a) is primarily engaged in providing accommodations and skilled nursing care on a twenty-four (24) hour per day basis to Inpatients recovering from Sickness or Injury;
b) is under the full-time supervision of a Physician or Registered Nurse;
c) admits patients only upon the recommendation of a Physician and maintains adequate medical records;
d) has established methods and written procedures for the dispensing and administration of drugs;

e) is not, other than incidentally, a place of rest, a place for the aged, a nursing home, a hotel, a school or a similar institution, a place for drug addicts, a place for alcoholics, a place for the care of the mentally ill or persons with nervous disorders, or for the care of senile persons; and is licensed in accordance with all applicable federal, state and local laws and is approved by Medicare.

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.

SUBSTANCE ABUSE: Shall mean:

a) alcoholism – a condition diagnosed as falling within the category 303 of the International Classification of Diseases of the U.S. Department of Health, Education and Welfare, as amended; or
b) Drug Dependence (Chemical Dependence) - a condition diagnosed as falling within the category 304 of the International Classification of Diseases of the U.S. Department of Health, Education and Welfare, as amended.

SUDDEN & SERIOUS ILLNESS: Shall mean any condition that begins suddenly and is considered out of the ordinary. A Sudden & Serious Illness usually includes:

- Temperature above 102° (oral) or 103° (rectal)
- Chest pain with sudden onset
- Profuse Hemorrhage
- Severe abdominal paid of sudden onset
- Acute respiratory distress
- Obvious severe mental distress
- Life-threatening situations
- Visits to the Emergency room requiring Emergency Hospital admission

SUMMARY PLAN DESCRIPTION: A formal written document that describes the plan of benefits, provisions and limitations provided by the Employer to its covered Eligible Employees and their covered Eligible Dependents, including any Amendments.

TERMINALLY ILL: Shall mean having a life expectancy of six (6) months or less as certified in writing by the attending Physician.

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

URGENT CARE FACILITY: A facility which is engaged primarily in providing minor Emergency and episodic medical care and which has:

- A board certified Physician, a registered nurse (RN) and a registered X-ray technician in attendance at all times;
- X-ray and laboratory equipment and a life support system.

An Urgent Care Facility may include a clinic located at, operated in conjunction with, or which is part of a regular Hospital.

USUAL, CUSTOMARY AND REASONABLE: Medical and dental expenses are reimbursed according to dictated guidelines of Usual, Customary and Reasonable. Guidelines used to determine Usual, Customary and Reasonable are:

- The usual fees the Hospital, doctor, dentist or other medical Provider most frequently charges the majority of patients for a similar medical or dental service, as determined by the Plan;
- Fees will fall into the customary range of fees charged in the Provider's geographic area by most Hospitals, doctors, dentists or other medical Providers with similar training and experience for the performance of a similar medical service or procedure;
- Unusual circumstances or medical complications requiring additional time, skill and experience in connection with a particular medical or dental service or procedure;
- For Emergency services, services at an Outpatient surgery department, or during an Inpatient confinement at a Participating Hospital, where a Participant had no choice in Providers, the Usual, Customary and Reasonable will deemed to be the Provider's billed charges;
- Pinnacle reserves the right to make this initial determination as well as any subsequent evaluations or modifications of the Usual, Customary and Reasonable fee standard.

WAITING PERIOD: Shall mean any period of time imposed by the Plan between the first day of employment and the first day of eligibility for coverage under the Plan.

SUMMARY OF PLAN INFORMATION

EMPLOYER IDENTIFICATION NUMBER (E.I.N.) – 95-6003151

PLAN SPONSOR - The Plan is sponsored and administered by Torrance Unified School District

THIRD PARTY ADMINISTRATOR / CLAIMS ADMINISTRATOR:
For Medical Benefits: Pinnacle Claims Management, Inc.
17620 Fitch Street
Irvine, CA 92614

For Prescription Drug Benefits: NMHC (National Medical Health Cards)
9343 Tech Center Dr., Ste 200
Sacramento, CA 95826

PLAN ADMINISTRATOR:
Torrance Unified School District
2335 Plaza Del Amo
Torrance, CA 90509
(310) 972-6020

BENEFIT PLAN YEAR: October 1 of any year through September 30 of the next year

TYPE OF PLAN: Employee Welfare Plan

FOR CLAIMS APPEAL PURPOSES CONTACT:
For Medical Benefits: Pinnacle Claims Management, Inc.
17620 Fitch Street
Irvine, California 92614
800-649-9121

For Pharmacy Benefits: NMHC (National Medical Health Cards)
9343 Tech Center Dr., Ste 200
Sacramento, CA 95826
800-777-0074

AGENT FOR SERVICE OF LEGAL PROCESS:
Plan Administrator
Torrance Unified School District
2335 Plaza Del Amo
Torrance, CA 90509

SOURCE OF PLAN CONTRIBUTIONS: The Plan Administrator will from time to time, evaluate the costs of the Plan and determine the amount to be contributed by the Employer and the amount to be contributed (if any) by each Employee. The amounts determined each year will be distributed separately. Please refer to your "fringe benefits" packet.

FUNDING MEDIUM THROUGH WHICH BENEFITS ARE PROVIDED:
Employee Obligations – The coverages afforded to an Employee by this Plan will require an Employee contribution but will be at least partially funded by the Employer. If an Employee elects to enroll Dependents under the Plan, the Employee will be responsible for payment of all or a portion of the Dependent contributions suitable to cover such enrollment. For active Employees, the Employer will deduct such contributions on a regular basis from the Employee's wage or salary.

Employer Obligations – The Employer will make contributions to the Plan for the healthcare coverage(s) of Employees and may contribute to the cost of Dependent coverage.

Employer contributions and those paid by Employee, if any, will be placed in a special account or accounts administered by the Plan Administrator to provide the non-insured benefits under the Plan. Contributions for insured coverage's or ancillary coverage's will be paid directly to the Provider of such coverage.

Plan Funded Benefits – The contributions will be applied to provide the benefits under the Plan.

Administration Expenses – Contributions may also be used to pay: 1) administrative expenses of the Plan in accordance with the terms and conditions of any administrative agreement between the Plan Sponsor and Claim Administrator(s) and 2) other reasonable operating expenses of the Plan.

Taxes – Any premium or other taxes which may be imposed by any state or other taxing authority and which are applicable to the coverage's of the Plan will be paid by the Plan Sponsor.

To provide benefits, purchase insurance protection, pay administrative expenses and any other necessary taxes, the contributions which are paid by Employees will be used first and any remaining Plan obligations will be paid by Employer contributions. Should total Plan liabilities in a Plan Year be less than the total Employee contributions, any excess will be applied to reduce total Employee contribution requirements in the subsequent Plan Year or, at Plan Sponsor's discretion, may be used in any other manner which is consistent under applicable law.

Benefits described in this book are not insured and there is no liability on the part of Torrance Unified School District Benefit Plan or any individual or entity to provide these benefits in excess of the available assets of the Plan. Pinnacle Claims Management, Inc. is a contractual not a fiduciary administrator.

ADMINISTRATION

PLAN ADMINISTRATOR

The Plan Administrator shall have the authority and responsibility for:

1) Calling and attending the meetings at which this Plan's funding policy and method are established and reviewed;
2) Establishing the policies, interpretations, practices and procedures of this Plan and rendering final decisions on review of claims as described in this Plan Document;
3) Complying with all reporting and disclosure statements under applicable federal and state law;
4) Hiring all persons providing services to the Plan
5) Receiving all disclosures required of fiduciaries and other service providers under applicable federal or state law;
6) Acting as this Plan's agent for the service of legal process; and
7) Performing all other responsibilities allocated to the Plan Administrator in the instrument appointing the Plan Administrator.

The Plan Administrator will have the duty, power, and discretion to construe and interpret this Plan, to decide all questions or eligibility, and to determine the amount, manner, and time of payment of any benefits under this Plan. All interpretations under the Plan, and all determinations of fact made in good faith by the Plan Administrator, will be final and binding on the Participants and beneficiaries and all other interested parties.

CLAIM ADMINISTRATOR

The Claim Administrator shall have the authority and responsibility for:

1) Interpreting this Plan's provisions relating to coverage except where the Claims Administrator requests an interpretation or a claimant files an appeal with the Plan Administrator, in which case the Plan Administrator shall interpret the Plan and shall communicate in writing to the Claims Administrator the appropriate interpretation of the Plan;
2) Administering the Plan's claim procedures;
3) Processing checks for benefits in accordance with Plan provisions;
4) Filing claims with the insurance companies, if any, who issue stop loss insurance policies to the Employer;
5) Performing all other responsibilities delegated to the Claim Administrator in the instrument appointing the Claims Administrator.

ACTION BY EMPLOYER / PLAN SPONSOR

Any authority or responsibility allocated or reserved to the Employer under this Plan may be exercised by any duly authorized officer of the Employer.

ADVISORS TO FIDUCIARIES

A named fiduciary or his delegate may retain the services of actuaries, attorneys, accountants, brokers, employee benefit consultants, and other specialists to render advice concerning any responsibility such fiduciary has under this Plan.

MULTIPLE FIDUCIARY FUNCTIONS
Any named fiduciary may serve in more than one (1) fiduciary capacity with respect to the Plan.

CO-FIDUCIARY LIABILITY
A fiduciary shall not have liability for a breach of fiduciary duty of another fiduciary, unless he participates knowingly in such breach, knowingly undertakes to conceal such breach, has actual knowledge of such breach and fails to take action to remedy such breach, or, through his negligence in performing his own specific fiduciary responsibilities, enables such other fiduciary to commit a breach of the latter's fiduciary duty.

NOTICE OF APPOINTMENTS OR DELEGATIONS
A named fiduciary shall not recognize or take notice of the appointment of another named fiduciary, or the delegation of responsibilities or a named fiduciary, unless and until the Employer notifies the named fiduciary in writing of such appointment or delegation. The named fiduciaries may assume that an appointment or delegation continues in effect until the named fiduciary receives written notice to the contrary from the Employer.

PRIVACY RULE / PROVISION
TUSD, who is the sponsor of this Plan, will receive protected health information. The information may be identified to the individual in some cases. TUSD 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 TUSD 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 TUSD agree to the same limits that apply to TUSD 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 TUSD 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 the TUSD's Human Resource and Finance Departments 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 TUSD or its agents or subcontractors.

WRITTEN DIRECTIONS
Whenever a named fiduciary or delegate must or may act upon the written direction of another named fiduciary or delegate, the named fiduciary or delegate is not required to inquire into the propriety of such direction and shall follow the direction unless it is clear on its face that the actions to be taken under that direction would be prohibited by terms of this Plan. Moreover, such named fiduciary or delegate shall not be responsible for failure to act without written directions.

AMENDMENT AND TERMINATION OF THE PLAN

Amending the Plan

While it is Torrance Unified School District's goal to provide Employees, qualified Retirees and their families with comprehensive benefits, the Plan 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. Previously processed claims will be re-processed upon request.

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.

MISCELLANEOUS ADMINISTRATIVE PROVISIONS

Administration
Certain benefits of the Plan are administered by a Claim Administrator under the terms and conditions of administration agreement between the Plan Sponsor and Claim Administrator. The Claim Administrator is not an insurance company.

Alternative Care
In addition to the benefits specified herein, the Plan may elect to offer benefits for services furnished by any provider pursuant to an approved alternative treatment plan for an Eligible Participant. The Plan will provide such alternative benefits at the Plan Sponsor's sole discretion and only when and for so long as it determines that alternative services are Medically Necessary and cost-effective, and that the total benefits paid for such services do not exceed the total benefits to which the Claimant would otherwise be entitled under this Plan in the absence of alternative benefits.

If the Plan elects to provide alternative benefits for an Eligible Participant in one instance, it will not be obligated to provide the same or similar benefits for that person or other Eligible Participants in any other instance, nor will such election be construed as a waiver of the Plan Sponsor's right to administer the Plan thereafter in strict accordance with the provisions of the Summary Plan Description.

Anticipation, Alienation, Sale or Transfer
Except for assignments to providers of service, no benefits payable under the provisions of the Plan will be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance or charge, and any attempt so to anticipate, alienate, sell, transfer, assign, pledge, encumber, or charge will be void; nor will such benefit be in any manner liable for or subject to the debts, contracts, liabilities, engagements, or torts of, or claims against, any Employee, covered Dependent or beneficiary, including claims of creditors, claims for alimony or support, and any like or unlike claims.

Clerical Error
Clerical error by the Plan Sponsor will not invalidate coverage otherwise validly in-force nor continue coverage otherwise validly terminated.

Collective Bargaining Agreements
Any collective bargaining agreements pursuant to which benefits under This Plan are established or maintained are available for inspection in the offices of the Plan Sponsor.

Conflict of Provisions
With regard to any contract of insurance or reinsurance which is or becomes a part of the Plan, if any provision of such contract has been omitted from or is in conflict with the provisions of the Summary Plan Description, the appropriate insurance or reinsurance contract wording shall prevail.

Conversion Policy
A conversion policy for individual coverage purposes is not offered by the Plan Sponsor.

Discrepancies
In the event that there may be a discrepancy between the booklet(s) provided to Employees and the Summary Plan Description, the Summary Plan Description will prevail.

Discretionary Authority
The Plan Administrator has discretionary authority to interpret the Plan in order to make eligibility and benefit determinations as it may determine in its sole discretion. The Plan Administrator also has the discretionary authority to make factual determinations as to whether any individual is entitled to receive any benefits under the Plan.

Entire Contract
The Summary Plan Description, 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.

Facility of Payment
Every person receiving or claiming benefits under the Plan will be presumed to be mentally and physically competent and of age. However, in the event the Plan determines that the Employee is incompetent or incapable of executing a valid receipt and no guardian has been appointed, or in the event the Employee has not provided the Plan with an address at which he/she can be located for payment, the Plan may, during the lifetime of the Employee, pay any amount otherwise payable to the Employee, to the husband or wife or relative by blood of the Employee, or to any other person or institution determined by the Plan to be equitably entitled thereto; or in the case of the death of the Employee before all amounts payable have been paid, the Plan may pay any such amount to one or more of the following surviving relatives of the Employee: lawful Spouse, child or children, mother, father, brothers, or sisters, or the Employee's estate, as the Plan Sponsor in its sole discretion may designate. Any payment in accordance with this provision will discharge the obligation of the Plan.

Fee Forgiveness / No Out-of-Pocket
You are required by this Group Plan to pay any Deductible, co-payment and/or co-insurance amounts as specified within this Plan Document. This requirement cannot be waived by you or any Provider with the use of a "fee forgiveness" or "out-of-pocket expense" arrangement or agreement, whether written or verbal.

Fiduciaries
Fiduciaries will serve at the discretion of the Plan Sponsor and will serve without compensation, but they will be entitled to reimbursement of their expenses properly and actually incurred in an official capacity. The Plan Sponsor may at any time and from time to time remove any Fiduciary or appoint new Fiduciaries. Any Fiduciary may resign at any time upon 30 days' notice in writing delivered to the Plan Sponsor. Fiduciaries may act at a meeting or without a meeting, by a majority of the Fiduciaries at the time in office. The Fiduciaries may appoint a member as its secretary who will have such powers and responsibilities relating to the administration of benefits under the Plan as the Fiduciaries may delegate.

Fiduciary Responsibility, Authority and Discretion
Fiduciaries will discharge their duties under the Plan solely in the interest of the Employees and their beneficiaries and for the exclusive purpose of providing benefits to Employees and their beneficiaries and for the exclusive purpose of providing benefits to Employees and their beneficiaries and defraying the reasonable expenses of administering the Plan.

The Fiduciaries will administer the Plan and will have the authority to exercise the powers and discretion conferred on them by the Plan and will have such other powers and authorities necessary or proper for the administration of the Plan as may be determined from time to time by the Plan Sponsor.

In carrying out their responsibilities under the Plan, Fiduciaries will have discretionary authority to interpret the terms of the Plan and Summary Plan Description, even if the terms are found to be ambiguous, and to determine eligibility for and entitlement to plan benefits in accordance with the terms of the Plan. Any interpretation or determination made pursuant to such discretionary authority will be given full force and effect, unless it can be shown that the interpretation or determination was arbitrary and capricious.

The Fiduciaries may employ such agents, attorneys, accountants, investment advisors or other persons (who also may be employed by the Employer) or third parties (such as, but not limited to provider networks, or utilization management organizations) as in their opinion may be desirable for the administration of the Plan, and may pay any such person or third party reasonable compensation. The Fiduciaries may delegate to any agent, attorney, accountant, or other person or third party selected by them, any power or duty vested in, imposed upon or granted to them by the Plan. However, the Fiduciaries will not be liable for acts or omissions of any agent, attorney, accountant or other person or third party except to the extent that the appointing Fiduciaries violated their own general fiduciary duties in: 1) establishing or implementing the Plan procedures for allocation or delegation, 2) allocating or delegating the responsibility, or 3) continuing the allocation or delegation.

Force Majeure

Should the performance of any act required by the Plan be prevented or delayed by reason of any act of nature, strike, lockout, labor troubles, restrictive governmental laws or regulations, or any other cause beyond a party's control, the time for the performance of the act will be extended for a period equivalent to the period of delay, and non-performance of the act during the period of delay will be excused. In such an event, however, all parties will use reasonable efforts to perform their perspective obligations under the Plan.

Gender and Number

Except when otherwise indicated by the context, any masculine terminology will also include the feminine (and vice-versa) and any term in the singular will also include the plural (and vice-versa).

Identification (ID) Cards

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 Pinnacle'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 Pinnacle's Customer Service department immediately.

Illegality of Particular Provision

The illegality of any particular provision of the Summary Plan Description will not affect the other provisions, but the Summary Plan Description will be construed in all aspects as if such invalid provision were omitted.

Indemnifications

To the extent permitted by law, Employees of the Employer, the Fiduciaries, and all agents and representatives of the Fiduciaries will be indemnified by the Plan Sponsor and saved harmless against any claims and conduct relating to the administration of the Plan except claims arising from gross negligence, willful neglect, or willful misconduct. The Plan Sponsor reserves the right to select and approve counsel and also the right to take the lead in any action in which it may be liable as an indemnitor.

Legal Action

No Eligible Employee, Dependent, or other beneficiary will have any right or claim to benefits from the Plan, except as specified herein. Any dispute as to benefits under this Plan will be resolved by the Plan Sponsor under and pursuant to the Summary Plan Description.

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.

Loss of Benefits

To the extent permitted by law and the provisions of this Plan, the following circumstances may result in the ineligibility, denial, loss, forfeiture, offset or disqualification of benefits:

- An Eligible Employee's failure to contribute their share of the cost of coverage.
- A claim for benefits that is not filed within the time limits of the Plan.
- Any misrepresentations or misstatements pertaining to a person's eligibility or information contained in the filing of claims.

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 is 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.

If the age of an Eligible Participant has been misstated in an enrollment form and if the amount of the contribution required of an Employee with respect to such Eligible Participant is based on age, an adjustment of such contribution amount will be made based on the Eligible Participant's true age. Contributions so affected will be adjusted on the contribution due date next following the date of the discovery of such misstatement.

If age is a factor in determining eligibility or the amount of a benefit and there has been a misstatement of age of a Eligible Participant in an enrollment form or claims filing, his / her eligibility or amount of benefits, or both, will be adjusted in accordance with his/her true age. Upon the discovery of an Eligible Participant's misstatement of age, benefits affected by such misstatement will be adjusted immediately.

Any misstatement of age will neither continue coverage otherwise validly terminated, nor terminate coverage otherwise validly in force.

The Plan Administrator reserves the right to recover any and all benefits paid to, for or on behalf of any Eligible Participant, which result from any misstatement of age. Such recovery shall be made against the recipient of the benefits paid in reliance upon the misstatement of age.

Misuse of an Identification Card

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.

Non-Discrimination Due to Health Status

An individual will not be prevented from becoming covered under the Plan due to a health status-related factor. A "health status-related factor" means any of the following:

1. A medical condition (whether physical or mental and including conditions arising out of acts of domestic violence);
2. Claims experience;
3. Receipt of healthcare;
4. Medical history;
5. Evidence of insurability;
6. Disability; or
7. Genetic information

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.

Physical Examination and Autopsy

The Plan Administrator, at Plan expense, will have the right and opportunity to have a Physician of its choice examine the Eligible Participant when and as often as it may reasonably require during the pendency of any claim, and to make an autopsy in case of death, where it is not forbidden by law.

Purpose of the Plan

The purpose of the Plan is to provide certain healthcare benefits for eligible Employees of the Participating Employer and their eligible Dependents.

Reimbursements

Whenever any benefit payments which should have been made under the Plan have been made by another party, the Plan Sponsor and the Claim Administrator will be authorized to pay such benefits to the other party; provided, however, that the amounts so paid will be deemed to be benefit payments under the Plan, and the Plan will be fully discharged from liability for such payments to the full extent thereof.

Right of Recovery

When the amount paid by the Plan exceeds the amount for which the Plan is liable for, Torrance Unified School

District 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. The Employee or Dependent will make good faith attempt to assist the Claim Administrator in such recovery. The Plan Administrator shall be entitled to deduct the amount of any such overpayments from any future claims payable to the Employee or any of his Dependents.

The Plan Administrator may in its sole discretion, pay benefits for care or services pending a determination of whether or not such care or services are covered hereunder. Such payments will not affect or waive any exclusion, and to the extent benefits for such care or services have been provided, the Plan will be entitled to recoup and recover the amount paid therefore from the Eligible Participant or the Provider of service in the event it is determined that such care or services are not covered hereunder. The Eligible Participant (parent, if a minor) will execute and deliver to the Plan all assignments and other documents necessary or useful to the Plan Administrator or Claim Administrator for the purpose of enforcing the Plan's rights under this provision.

Rights Against the Plan Administrator or Employer

Neither the establishment of the Plan, nor any modifications thereof, nor any distributions hereunder, will be construed as giving to any Employee or any person any legal or equitable rights against the Plan.

Substitution

Employees will do nothing to prejudice such rights of the Plan Sponsor and further they agree to do all acts necessary to preserve and take advantage of such rights. If payment has been made by the Plan in such instances and if the adverse party reimburses the Employee directly, the Plan will have the right to recover such payment from an Employee.

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.

Titles or Headings

Where titles or headings precede explanatory text throughout the Summary Plan Description, such titles or headings are intended for reference only. They are not intended and will not be construed to be a substantive part of the Summary Plan Description and will not affect the validity, construction or effect of the Summary Plan Description.

Type of Plan

This Plan is a self-funded group health plan which is subject to the Health Insurance Portability and Accountability Act (HIPAA). Plan benefits are not guaranteed under a contract or policy of insurance.

Workers Compensation

The benefits provided by the Plan are not in lieu of and do not affect any requirement for coverage by Workers' Compensation Insurance laws or similar legislation.

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