



MONTEREY PENINSULA
C O L L E G E

**Self-Funded
Medical Plan**
Classified SPD

Effective July 1, 2010

TABLE OF CONTENTS

SUMMARY PLAN DESCRIPTION	3
YOUR BENEFITS AT A GLANCE	6
ELIGIBILITY AND PLAN PARTICIPATION	7
MEDICAL PLAN PROVISIONS	9
PRESCRIPTION DRUG PLAN	12
PRINCIPLE BENEFITS AND COVERAGES	15
EXCLUSIONS AND LIMITATIONS	24
COORDINATION OF BENEFITS	27
COBRA	28
THIRD PARTY LIABILITY	30
EXTENSION OF BENEFITS	31
FAMILY AND MEDICAL LEAVE	31
SUBMISSION OF CLAIMS	33
PROCEDURE FOR APPEAL OF DENIED CLAIMS	33
DEFINITIONS	35
GENERAL PROVISIONS	39
BRIDGEHEALTH AMENDMENT	40
HIPAA PRIVACY RULE REQUIREMENTS	41

SUMMARY PLAN DESCRIPTION

INTRODUCTION: This summary provides an overview of the benefits and limitations of your coverage through this Medical Plan. More detailed information regarding each benefit is contained within the specific benefit description section of this Plan Document.

MEDICAL PLAN: Comprehensive Medical coverage is subject in certain instances to required deductibles, percentage payable and benefit maximums.

Benefits include:

- ◆ Physician Services
- ◆ Inpatient Hospital Services
- ◆ Outpatient Hospital Services
- ◆ Skilled Nursing Facility
- ◆ Home Health Care
- ◆ Home Hospice/Facility Hospice
- ◆ Diagnostic Lab and X-Ray
- ◆ Ambulance Services
- ◆ Mental Health Benefit
- ◆ Substance Abuse Benefit
- ◆ Physical Therapy
- ◆ Durable Medical Equipment
- ◆ Preventative Care – Preventive Care
- ◆ Pregnancy and Maternity Care
- ◆ Organ Transplants
- ◆ Radiation Therapy
- ◆ Chemotherapy
- ◆ Hemodialysis
- ◆ Prosthetic Appliances
- ◆ Treatment to Natural Teeth
- ◆ Prescription Drugs

DEDUCTIBLE: Before the Plan begins to pay benefits in any calendar year, you are first required to pay an amount toward covered expenses. This amount is called the deductible. The calendar year deductible for each covered employee and dependent is \$250 In-Network and \$500 Out-of-Network. This deductible applies separately to each insured during each calendar year and can only be satisfied with expenses that are covered under the Plan. No more than \$750 In-Network and \$1,500 Out-of-Network is required of a family to satisfy the deductible for a calendar year. Any portion of the deductible that is met in the last three months of the calendar year will be carried over to help satisfy the deductible requirement for the next year.

SERVICES NOT SUBJECT TO DEDUCTIBLE: The deductible will not be applied to covered services described under Preventive Care. The deductible will not be applied to covered services described under Mental Disorder/Substance Abuse – Outpatient. The

deductible will not apply for services for office visits or for Emergency Room Treatment. These services will be subject to the applicable co-payment and co-insurance.

ACCIDENT BENEFIT: The deductible will not be applied to the first \$500 of covered services necessary as the result of accidental injury when expenses are incurred within 90 days of the accident.

BENEFIT MAXIMUM: This is the maximum lifetime amount of benefits that will be paid by this Plan for each eligible employee and each covered dependent. For any eligible employee or dependent, whether or not there has been an interruption in the continuity of his or her coverage, the overall lifetime Medical Benefit Maximum is \$1,000,000.

On each January 1, while you or your dependents are still covered by the plan, up to \$1,000 of the benefits paid in the prior calendar year will automatically be restored to your lifetime maximum. Also, when you receive more than \$1,000 in benefits in a calendar year, you may apply for restoration of your full lifetime maximum by submitting evidence of good health satisfactory to the Plan.

PERCENTAGE PAYABLE: The amount payable under this Plan depends upon the type of provider you choose. The Plan allows you the flexibility to select either a network provider or a non-network provider. However, the reimbursement and balance bill levels will vary depending upon the type of provider you choose. Also, the payment percentage will be 100% of a negotiated rate once the amount paid by an individual for the 5% of the negotiated rate not paid by the Plan totals \$2,500 per person or the amount paid by a family totals \$5,000. Charges for services that are not covered are not included in the total out-of-pocket calculations and may cause a participant's payment responsibility to exceed the maximum stated above.

- ◆ When you or your dependent use a network provider, the Plan will pay the network provider 95% of a negotiated rate, which, along with your payment of any applicable deductible or co-payment, they have agreed to accept as payment in full for covered expenses.
- ◆ When you use a non-network provider, the Plan will pay 70% of the customary and reasonable charge. You are responsible for the remaining 30% as well as any amount above the customary and reasonable charge.

In certain circumstances, non-network providers will be reimbursed at 100% of the customary and reasonable charge:

- ◆ All emergency services
- ◆ Anesthesiologist
- ◆ California residents who cannot reasonably access a network provider (no network provider within a 30 mile radius from residence)
- ◆ Individual temporarily residing or traveling outside of California
- ◆ Non-California residents

The payment percentage will also be 100% of customary and reasonable charges for non-network providers once the amount paid by an individual for the 30% of the customary and reasonable charge not paid by the Plan totals \$3,500 per person or the amount paid by a family totals \$7,000. Charges for services that are not covered and charges by non-network providers in excess of the customary and reasonable charge are not included in the total out-of-pocket calculations and may cause a participant's payment responsibility to exceed the maximum stated above.

The following amounts are not included in the calculation of the \$3,500 or \$7,000 maximum:

- ◆ Co-payments required under the Prescription Drug Plan
- ◆ Co-payments required under the Mental Disorder/Substance Abuse – Outpatient
- ◆ The annual Plan deductible
- ◆ Emergency Room and Office Visit Co-payments
- ◆ Amount over the Medicare Allowable, when Medicare is the Primary Payer.

PRE-SERVICE REVIEW: All hospitalizations and surgical procedures require review by Blue Cross of California prior to admission to the hospital or prior to the surgery being performed. Pre-Service Review determines the medical appropriateness of hospitalization in an acute care facility, the length of stay necessary and any requirement for a second surgical opinion. Please refer to the section entitled “Medical Plan Provisions” on **Page 9** of the Plan Document for more information on the Pre-Service Review Program. Blue Cross of California can be contacted regarding the Pre-Service Review Program by calling 1-800-274-7767.

EXCLUSIONS: Certain costs will not be covered by the Plan. Please refer to the sections in the Plan Document entitled “Principal Benefits and Coverages” for those services that are covered by the plan. Also, please refer to the section entitled “General Exclusions and Limitations” for those services that are not covered by the Plan.

If you have any questions regarding your coverage or the benefits as described in the Summary Plan Description or Plan Document, please contact:

Keenan HealthCare
P.O. Box 2744
Torrance, California 90509
1-877-853-3626

YOUR BENEFITS AT A GLANCE

DEDUCTIBLE:	<p>\$250 In-Network per person per Calendar year and \$500 Out-of-Network per person per Calendar year. Does not apply to out of pocket maximum.</p> <p>\$750 In-Network per family per Calendar year and \$1,500 Out-of-Network per family per Calendar year. Does not apply to out of pocket maximum.</p>
CO-PAYMENTS:	<p>\$25.00 for each physician's office visit \$100.00 for each Emergency Room visit (waived if admitted) Does not apply to out of pocket maximum or deductible.</p>
PRESCRIPTION DRUGS RETAIL:	<p>\$5.00 for each generic drug \$20.00 for each formulary brand-name drug \$35.00 for each non-formulary brand name drug 30 day supply Does not apply to out of pocket maximum or deductible.</p>
PRESCRIPTION DRUGS MAIL ORDER:	<p>\$10.00 for each generic drug \$40.00 for each formulary brand-name drug \$70.00 for each non-formulary brand name drug 90 day supply Does not apply to out of pocket maximum or deductible.</p>
PERCENTAGE PAYMENT:	<p>95% for In-Network Providers</p> <p>70% of the customary and reasonable charge for Non-Network Providers</p> <p>100% of the customary and reasonable charge after out of pocket maximum has been satisfied. (Applies to Non-Network Providers)</p>

OUT OF POCKET MAXIMUM: \$2,500 In-Network per person per calendar year and \$3,500 Out-of-Network per person per calendar year
(Does not apply to deductible Or copays)

\$5,000 In-Network per family per calendar year and \$7,000 Out-of-Network per family per calendar year

BENEFIT MAXIMUM: \$1,000,000.00
(Lifetime Maximum)

NOTE: Certain benefits contain specific maximums and co-payments. Please refer to “Principal Benefits and Coverages” on Page 14 of the Plan Document for detailed descriptions of these features.

ELIGIBILITY AND PLAN PARTICIPATION

ELIGIBILITY REQUIREMENTS: The employees defined as eligible by Monterey Peninsula College may enroll as subscribers to this Plan.

EFFECTIVE DATE OF EMPLOYEE COVERAGE: You will be eligible for benefits on the first day of the month following the date your eligible employment begins.

If an Employee requests enrollment more than thirty-one (31) days after the date of eligibility, the Late Entrant Application section will apply. For further details, please refer to the Late Entrant Application section.

DEPENDENT ELIGIBILITY: Dependent means (a) the covered employee’s spouse under a legally valid marriage between persons or an out-of-state same sex marriage as defined in SB 54 or domestic partner as defined in Family Code Section 297 with a legally executed Declaration of Domestic Partnership filed with the California Secretary of State; and (b) the covered employee’s unmarried children from birth, including step-children or legally adopted children to age twenty-five (25) if they continue to qualify as a dependent as defined by the Internal Revenue Code.

Proof of financial dependence will be required and may be requested annually. Failure to provide such proof will result in termination of coverage for the dependent.

Unmarried children enrolled before age 25 and who, after reaching age 25, depend on the subscriber for support and are unable to work due to mental retardation or physical disability, may continue coverage by providing proof of incapacity certified by a physician. This certification must be received by the Plan Administrator within 31 days of the child’s 25th birthday. After the child’s 27th birthday, the Plan may request proof of continuing dependency and disability, but not more often than annually.

DOMESTIC PARTNER OR SAME SEX MARRIAGE TAX IMPLICATIONS:

If your domestic partner or your partner's eligible dependents are not considered "tax dependents" under federal law, the fair market value of the health insurance coverage provided to your partner and partner's eligible dependents will be included in your gross income. This amount is considered "imputed income." This will increase both your taxable income and your tax liability. Under federal law, a domestic partner cannot qualify as your spouse for purposes of excluding employer-provided health benefits from your taxable income. Unless your domestic partner qualifies as a dependent under the Internal Revenue Code (IRC) §105(b), you will be taxed on the fair market value of the cost of coverage provided to your domestic partner. These same tax implications would apply to out-of-state same sex marriage.

DEPENDENT EFFECTIVE DATE: Coverage for your dependents will be in force under the same terms as your coverage. However, coverage for a newly acquired spouse or a child acquired through marriage will become effective on the first day of the month following the date of marriage. A newborn infant, adopted child or a child placed for adoption are effective from the date of birth or the date the Employee controls the health care of the child. In all cases of newly acquired dependents, an application to enroll the new dependent must be filed within thirty-one (31) days.

If enrollment for an eligible dependent is made more than thirty-one (31) days after the date of eligibility, the Late Entrant Application Section will apply. For further details, please refer to the Late Entrant Application section.

APPLICATION FOR ENROLLMENT: Every person eligible to enroll as a subscriber must file an applications with the employer within a time period ending 31 days after becoming eligible for coverage. This application must include any eligible family members for whom application is being filed.

LATE ENTRANT APPLICATION: An employee and/or dependents must be enrolled in the health benefit plan before or within 31 days of the date of eligibility. An employee and/or dependent who requests enrollment after 31 days from the date of eligibility will be considered a Late Enrollee, unless the person qualifies under one of the Late Enrollee Exceptions listed below.

Late Enrollees are subject to the following Late Enrollment limitation: The effective date of the person's coverage under the health benefit plan may be deferred for up to 12 months from the date of the Late Enrollee's request for enrollment.

Late Enrollee Exceptions:

1. Employees who decline coverage during their initial enrollment period or drop coverage because they have coverage under another employer's health benefit plan, will not be considered Late Enrollees if their coverage under the other employer's health benefit plan ends because of:
 - a. termination of employment or change of employment status (theirs or the person through whom they were covered),

- b. termination of the other employer's health benefit plan,
 - c. the employer stops paying for the person's coverage,
 - d. death of the person through whom they were covered, or,
 - e. divorce from the person through whom they were covered, AND these employees request enrollment within 31 days after termination of coverage under the other employer's health benefit plan.
2. A spouse or minor child who is enrolled within 31 days after issuance of a court order directing that coverage be provided for the person under a covered employee's health benefit plan will not be considered a Late Enrollee.
3. Employees who decline coverage during their initial enrollment period will not be considered late enrollees if enrolled within thirty-one (31) days after the Employee gains a new dependent by marriage, birth, adoption or placement for adoption. This enrollment period is available for the eligible Employee and persons who become the eligible Employee's dependents. If coverage is chosen during this time frame, it is effective on the following dates:
- a. for a marriage or domestic partnership, no later than the first day of the month beginning after the date the plan receives the completed request for the enrollment,
 - b. for a birth, the date of birth, or,
 - c. for an adoption or placement for adoption, the date of the adoption or placement.

TERMINATION OF BENEFITS: You and your dependents coverage under the Plan will cease on the earliest of the following dates: (a) the date your employer terminates the Group Plan; (b) the last day of the month in which you no longer meet the eligibility requirements established by your employer.

Please refer to the section entitled "COBRA Continuation Coverage" on **Page 28** of the Plan Document for information relating to continuation of benefits after termination of coverage under this Plan.

MEDICAL PLAN PROVISIONS

WHEN YOUR DOCTOR RECOMMENDS A HOSPITAL STAY: If your doctor recommends hospitalization, call Blue Cross of California's toll-free number right away. A Professional Services Coordinator, who is a registered nurse (R.N.), will review with you the requirements of your Second Opinion and Hospital Case Management Program. The nurse will also notify your doctor and the hospital for you of the authorizations given and discuss with your doctor and appropriate treatment plan.

WHILE YOU ARE HOSPITALIZED: During your hospital stay, the Blue Cross of California Professional Services Coordinator will check with the hospital on your progress and will assist with discharge planning when the time comes. If your treatment requires a

longer stay than authorized, your Coordinator will coordinate approval of any additional hospital days with your physician.

IN AN EMERGENCY: If you must be admitted to the hospital for emergency care or surgery, you, your physician, or another responsible party must notify Blue Cross of California within 48 hours of the admission. For such emergency admissions only, please call Blue Cross of California on weekends, evenings or holidays. Non-emergency admissions should always be reported in advance of your planned admission date and soon as your advised that hospitalization may be necessary. These non-emergency admissions should be called in to Blue Cross of California during normal business hours (6 a.m. – 5 p.m., Pacific Time, Monday through Friday).

WHEN YOUR DOCTOR RECOMMENDS SURGERY: If your doctor recommends surgery, call Blue Cross of California's toll-free number and a Professional Service Coordinator will advise you what is required by your medical plan. If a second surgical opinion is required, Blue Cross of California will make the arrangements for you. If a second opinion isn't required for your proposed treatment, Blue Cross of California will advise you when you call.

Having a second opinion will help you be better informed about whether the proposed treatment is really necessary. If the second opinion confirms that treatment is necessary, you'll feel more at ease about going ahead. But, if the second opinion differs from the first recommendation, the final decision on whether to proceed will still be yours.

WHEN YOUR DOCTOR RECOMMENDS AUTOLOGOUS BONE MARROW TRANSPLANTATION (ABMT). If your doctor recommends ABMT, call Blue Cross of California's toll-free number and a professional services coordinator will advise you what is required by your medical plan. Precertification of all ABMT requests prior to initiating any transplant or related treatment or testing is required.

PRE-SERVICE REVIEW IS NOT REQUIRED FOR INPATIENT HOSPITAL STAYS FOR MATERNITY CARE OF 48 HOURS OR LESS FOLLOWING A NORMAL DELIVERY OR 96 HOURS OR LESS FOLLOWING A CESAREAN SECTION.

Remember, you and your physician will always make the final decision concerning treatment. If you call 1-800-274-7767, Blue Cross of California can provide the information you and your doctor need to help you plan together appropriate, cost-effective care.

NECESSARY INFORMATION.

When calling Blue Cross of California, please have the following information ready:

- √ Employee's name, last four digits of the Social Security number, or assigned ID number
- √ Patient's name, date of birth, sex and contact telephone number
- √ Hospital's name, location and telephone number

- √ Date of admission
- √ Diagnosis and/or surgical procedure, if known
- √ Date of surgery, if available

PRE-EXISTING CONDITION LIMITATION: A pre-existing condition is a sickness manifested or a bodily injury sustained in the ninety (90) days prior to a Plan participant's effective date. No benefits will be payable under this Plan in connection with a pre-existing condition until the employee or dependent has been covered by the Plan for six (6) consecutive months.

An Employee is entitled to credit past health insurance coverage against the six (6) month Pre-existing Condition clause, provided the Employee's past coverage, including any extension of benefits pursuant to COBRA, has not lapsed for more than sixty-three (63) days. The Contract Administrator shall require and obtain proof of creditable coverage and after applying any creditable coverage shall notify the Employee of any period of time that may be subject to the Pre-existing Condition clause.

The Pre-existing Conditions clause shall not apply to any claims:

- ◆ a Covered Person incurs on or after six (6) consecutive months following the Covered Person's employment with the Employer;
- ◆ an otherwise eligible newborn Child incurs, provided the Dependent Child is fully enrolled in the Plan within thirty-one (31) days of his/her birth and provided any break in creditable coverage for the Dependent Child does not exceed 63 days;
- ◆ an otherwise eligible adopted Child incurs, provided the Dependent Child is fully enrolled in the Plan within thirty-one (31) days of his/her adoption or placement for adoption, and provided any break in creditable coverage for the Dependent Child does not exceed 63 days;
- ◆ arising from pregnancy, regardless of any break in creditable coverage; or
- ◆ a genetic disorder.

MEDICAL NECESSITY: The benefits of the Plan are provided only for services that are medically necessary. Because a physician or other provider may prescribe, order, recommend or approve a service or supply does not, in itself, make it medically necessary. Keenan Healthcare will review the medical necessity of a service based on whether the service: (a) is appropriate and necessary for the symptoms, diagnosis or treatment of the medical condition; (b) is provided for the diagnosis or direct care and treatment of the medical condition; (c) is within standards of good medical practice within the organized medical community and; (d) is not primarily for the convenience of the insured, the insured's physician or another provider.

KEENAN HEALTHCARE: Keenan Healthcare combines the advantages of traditional health insurance plans with a network of quality conscious and cost-effective Hospitals and Physicians/Providers in California through the Blue Cross Prudent Buyer PPO network.

Under this plan, you have a free choice of Physicians and Hospitals. If you use a Blue Cross Prudent Buyer Provider, however, a higher percentage of the Provider's charges for Medically Necessary services will be paid as they qualify as preferred benefits.

You may access provider listings by going online, www.anthem.com/ca, or requesting assistance from the customer service unit at Keenan 1-877-853-3626.

PRESCRIPTION DRUG PLAN

Benefits for prescription drugs are provided through a plan administered by Express Scripts.

A Walk-In Network Program is available as well as a Mail Order Program. The type of program selected and whether a brand name drug or a generic drug is selected determine the benefits.

WALK-IN NETWORK PROGRAM: Employees and dependents may obtain up to a 30-day supply of medication from participating pharmacies. Your MPC identification card identifies your Express Scripts Plan Number. Present your card to the pharmacist to obtain your prescriptions.

You are responsible for a \$5.00 co-payment for each generic drug or refill. You are responsible for a \$20.00 co-payment for each formulary brand name drug or refill. You are responsible for a \$35.00 co-payment for each non-formulary brand name drug or refill.

These co-payments do not count toward the individual or family maximum coinsurance amounts.

Participating pharmacies in the Walk-In Network Program:

There are more than 47,500 participating pharmacies throughout the United States. These include most major chain stores and many independent pharmacies. You can locate a pharmacy in your area by calling Express Scripts Customer Service at **1-800-447-9638**. The customer Service Call Center is available 24 hours a day, 7 days a week.

MAIL ORDER PROGRAM: Employees and dependents may obtain up to a 90-day supply of maintenance medication through the mail using the Express Scripts Mail Service Pharmacy.

You are responsible for \$10.00 co-payment for each generic drug or refill. You are responsible for a \$40.00 co-payment for each formulary brand name drug or refill. You are responsible for a \$70.00 co-payment for each non-formulary brand name drug or refill.

These co-payments do not count toward the individual or family maximum coinsurance amounts.

For new mail service prescriptions, you should follow these steps:

- ◆ If you need to start your medication right away, have your physician complete two prescriptions.
- ◆ Fill one prescription immediately at a retail pharmacy through Express Scripts.
- ◆ Complete a participant profile and mail it, along with the second prescription from your physician, to the Express Scripts mail service program.
- ◆ Participant profile forms and self-addressed envelopes for Express Scripts are available from the Human Resources Department or by calling Express Scripts Customer Service at **1-800-447-9638**.

For refill prescriptions:

When you receive your first prescription through the mail, you will receive a prescription refill slip, if applicable, and a prescription request card. Follow the refill instructions to order a refill. Remember to order your refill at least three weeks before your current supply runs out.

You are responsible for the co-payment for each Mail Order prescription filled. These co-payments do not count toward the individual or family maximum coinsurance amounts.

When available, lower cost generic medication will be automatically substituted for brands unless the doctor requests otherwise.

If you have any questions or problems concerning your prescription order, you can call toll-free to **1-800-447-9638**.

PHYSICIAN PREFERENCE PROGRAM: Your prescription drug plan includes a physician preference program that controls prescription costs by encouraging doctors to use less expensive alternate therapies that are therapeutically equivalent to name-brand drugs. The goal for Express Scripts is to keep your doctor informed of the difference in cost between therapeutically equivalent medicines as well as the differences in daily usage and side effects.

The physician preference program will not affect your doctor's care at all. When a prescription is dispensed to you, either at a retail pharmacy or through the mail, and Express Scripts identifies that a less costly drug might be appropriate, your doctor is contacted. If your doctor agrees to the change, a new prescription is provided to your pharmacy and the alternate medication will be dispensed upon refill. You will also get a letter with information and instructions for your new medication. Under no circumstances is medication changed without your doctor's approval.

IN AN EMERGENCY: In the event of an emergency and you need to purchase a prescription drug in a location where there is no Participating Pharmacy, you can submit a claim for reimbursement. You will be reimbursed the cost of the prescription less the applicable co-payment.

Claims should be sent to: **Express Scripts**
P.O. BOX 66773
St. Louis, MO 63166-6773
www.express-scripts.com

EXCLUSIONS AND LIMITATIONS FOR THE DRUG PLAN:

1. Diet Pills
2. Fertility Medication
3. Retin-A for treatment of non-acne only
4. Any drug which can be legally purchased without a prescription
5. Durable Medical Equipment
6. Any exclusion and limitation of the health plan

This drug plan only applies to prescriptions obtained from a Participating Pharmacy or through the Mail Order Program. Refer to Page 25 of the Plan Document for a description of the prescription drug benefits payable when prescriptions are not obtained through this drug plan.

PRINCIPLE BENEFITS AND COVERAGES

This section is designed to describe the principle benefits that are covered and the percentage of costs of those benefits, which will be paid for under this Plan. The services that are excluded from coverage are listed in the subsection entitled “General Exclusions and Limitations”.

All eligible charges are subject to the annual deductible unless otherwise stated.

All Out-of-Network payments are based on the customary and reasonable charge.

BENEFIT	IN-NETWORK PLAN PAYS	OUT-OF-NETWORK PLAN PAYS
PHYSICIAN SERVICES Medically necessary visits in the hospital, skilled nursing facility or at home; including services of a surgeon, assistant surgeon, pathologist, radiologist.	95%	70%
PHYSICIANS SERVICES – OFFICE VISITS Services received in a physician office visit setting	95% after \$25.00 co-payment (Deductible does not apply)	70% after \$25.00 co-payment (Deductible does not apply)
ANESTHESIOLOGIST	95%	95%
INPATIENT HOSPITAL Inpatient services for treatment of injury or illness including the hospital’s charges for room and board up to the semi-private room rate; intensive care; medically necessary services and supplies.	100% Tier 1 90% Tier 2 80% Tier 3	80%
OUTPATIENT HOSPITAL Hospital outpatient services for treatment of injury or illness are covered when medically necessary services are provided in the outpatient facility of a hospital, urgent care center or outpatient surgical facility.	95%	70%

ALL Out-of-Network payments are based on the customary and reasonable charge.

BENEFITS	IN-NETWORK PLAN PAYS	OUT-OF-NETWORK PLAN PAYS
<p>EMERGENCY ROOM SERVICES Services incurred in a Hospital Emergency Room.</p>	<p>95% after \$100.00 co-payment (Deductible does not apply)</p>	<p>70% after \$100.00 co-payment (Deductible does not apply)</p>
<p>SKILLED NURSING FACILITY Inpatient services including the charge for a semi-private room and medically necessary services and supplies when transfer is ordered by a physician immediately following a covered hospital stay. The patient must remain under the supervision of the physician treating the illness or injury for which the patient was confined.</p>	<p>95%</p>	<p>70%</p>
<p>HOME HEALTH CARE/HOME HOSPICE CARE Services of a home health care agency or hospice agency are covered when medically necessary, prescribed by the patient's physician and included in a written treatment plan. Benefits are provided only to a person who is homebound and would otherwise require hospitalization, and when care is provided by a licensed home health agency or visiting nurse association, And for services of a registered nurse, licensed vocational nurse, licensed physical therapist, occupational therapist, speech therapist or medical social service worker. Limited to a combined maximum of \$7,500 per calendar year.</p>	<p>95%</p>	<p>70%</p>
<p>FACILITY HOSPICE To be eligible, the patient must be in the latter stages of a terminal illness as determined by a physician's certification. Limited to six months maximum stay.</p>	<p>95%</p>	<p>95%</p>

All Out-of-Network payments are based on the customary and reasonable charge.

BENEFITS	IN-NETWORK PLAN PAYS	OUT-OF-NETWORK PLAN PAYS
<p>OUTPATIENT DIAGNOSTIC LAB AND X-RAY Diagnostic X-Ray services and clinical laboratory services when provided to diagnose illness or injury</p>	95%	70%
<p>AMBULANCE SERVICE Medically necessary ambulance services; including the base charge, mileage and supplies to transport a patient to and from the hospital. Air ambulance transportation must be from the place the patient is first disabled to the nearest hospital where appropriate care can be provided</p>	95%	95%
<p>PROSTHETIC APPLIANCES Surgical implants, artificial limbs or eyes and the first pair of eyeglasses or contact lenses when required as the result of eye surgery</p>	95%	95%
<p>CHIROPRACTIC CARE Chiropractic treatment for professional services which involve manual manipulation (with or without the application or treatment modalities such as, but not limited to diathermy, ultrasound, heat and cold) of the spinal skeletal system and/or surrounding tissue to restore proper articulation of joints, alignment of bones or nerve functions.</p>	95% after \$25.00 co-payment (Deductible does not apply)	70% after \$25.00 co-payment (Deductible does not apply)
<p>ACUPUNCTURE Acupuncture for Medically Necessary treatment of a diagnosis of intractable pain syndrome or pain not relieved by standard treatment. If Medically Necessary, acupuncture is approved for two (2) to three (3) times per week up to eight (8) visits per diagnosis or treatment cycle.</p>	95% after \$25.00 co-payment (Deductible does not apply)	95% after \$25.00 co-payment (Deductible does not apply)

All Out-of-Network payments are based on the customary and reasonable charge.

BENEFIT	IN-NETWORK PLAN PAYS	OUT-OF-NETWORK PLAN PAYS
<p>RECONSTRUCTIVE SURGERY The performance of a covered mastectomy and breast reconstruction in connection with a mastectomy, including reconstruction of the breast on which a mastectomy has been performed; surgery and reconstruction on the other breast to produce a symmetrical appearance; prostheses; and treatment for physical complications of all stages of mastectomy, including lymphademas.</p>	95%	70%
<p>MENTAL DISORDERS / SUBSTANCE ABUSE & COUNSELING</p> <p>INPATIENT The hospital's charge for room & board up to the semi-private room rate; medically necessary services and supplies.</p> <p>OUTPATIENT</p>	<p>95%</p> <p>95% after \$25.00 co-payment (Deductible does not apply)</p>	<p>70%</p> <p>70% after \$25.00 co-payment (Deductible does not apply)</p>
<p>PHYSICAL THERAPY When provided by a registered physical therapist and referred by an M.D. or D.O.</p>	95% after \$25.00 co-payment (Deductible does not apply)	70% after \$25.00 co-payment (Deductible does not apply)

All Out-of-Network payments are based on the customary and reasonable charge.

BENEFITS	IN-NETWORK PLAN PAYS	OUT-OF-NETWORK PLAN PAYS
<p>DURABLE MEDICAL EQUIPMENT Rental or purchase of medical equipment and supplies which are: ordered by a physician, usable only by the patient, not primarily for the patient's comfort or hygiene, not for environmental control, not primarily used for exercise and manufactured specifically for medical use. Rental charges that exceed the reasonable purchase price of the equipment are not covered.</p>	95%	95%
<p>PREVENTIVE CARE</p> <p>One routine physical exam every 24 months limited to a maximum benefit of \$500 for Covered Employee and Spouse or Domestic Partner regardless of medical necessity; Charges for the Covered Person's routine physical examination, including draw fees for laboratory work, charges for routine urinalysis and charges for wellness panel laboratory tests will be subject to the \$500 maximum benefit.</p> <p>A stool, occult blood test and an electrocardiogram shall each be covered and will be applied to the \$500 maximum benefit at the following interval: every five years under age 35, every three years at age 35 or more but less than age 40, and once per Calendar Year at age 40 or more.</p> <p>The following benefits are not subject to the \$500 maximum benefit</p> <p>(a) Charges for prostate cancer testing, but only in the following circumstances:</p>	<p>Deductible Waived</p> <p>95%</p> <p>95%</p>	<p>Deductible Waived</p> <p>70%</p> <p>70%</p>

All Out-of-Network payments are based on the customary and reasonable charge.

BENEFITS	IN-NETWORK PLAN PAYS	OUT-OF-NETWORK PLAN PAYS
<p>PREVENTIVE CARE CONT.</p> <ul style="list-style-type: none"> (i) The Covered Person either has an abnormal prostate examination and has not received prostate cancer testing during the past six (6) months; or (ii) Is age 50 or more and has not received prostate cancer testing during the past year. Repeat testing will not be a Covered Expense unless it is ordered by a Physician and is Medically Necessary; or (iii) As recommended by the US Preventative Service Task Force. <p>(b) Charges for the following colorectal screening procedures:</p> <ul style="list-style-type: none"> (i) Sigmoidoscopy for a Covered Person over age 40 who has not received a sigmoidoscopy for five years; or every twelve months, provided that the procedure is ordered by a Physician following a sigmoidoscopy which indicates that a repeat examination is necessary; and 	<p>95%</p>	<p>70%</p>

All Out-of-Network payments are based on the customary and reasonable charge.

BENEFIT	IN-NETWORK PLAN PAYS	OUT-OF-NETWORK PLAN PAYS
<p>PREVENTIVE CARE CONT.</p> <p>(ii) Colonoscopy for a Covered Person over age 30 whose mother, father, sister, or brother has had colon or rectal cancer, or, a repeat colonoscopy or sigmoidoscopy when ordered by a Physician and furnished at least 12 months after the initial colonoscopy; or</p> <p>(iii) Colonoscopy for a Covered Person age 50 or more as recommended by the National Cancer Institute.</p> <p>(c) Well-Woman Exams The charges for well-woman exams, Pap tests, and routine or diagnostic mammographies as follows:</p> <p>(i) A clinical breast examination, including mammogram for women ages 20 to 39 inclusive, every three years; A clinical breast examination, including a mammogram, every year, for women age 40 and over.</p> <p>(ii) Charges for annual Pap and ovarian cancer screening tests are limited to one every twelve (12) months, provided that such tests are ordered by a Physician.</p>	<p>95%</p>	<p>70%</p>

All Out-of-Network payments are based on the customary and reasonable charge.

BENEFITS	IN-NETWORK PLAN PAYS	OUT-OF-NETWORK PLAN PAYS
<p>PREVENTIVE CARE CONT.</p> <p>(d) Well Baby and Well Child Care The charges for a dependent child, from infant to 19 years of age and not subject to the \$500 maximum benefit, as follows:</p> <p>(i) A Physician's services for routine physical examinations (6 exams to age 1, 1 exam annually to age 6, 1 exam every 24 months from age 6 to 19), including radiology and laboratory services; and</p> <p>(ii) Immunizations in accordance with the recommendations of the Academy of Pediatricians.</p>	95%	70%
<p>PREGNANCY & MATERNITY CARE</p> <p>Medically necessary treatment and services for pregnancy and complications of pregnancy are covered the same as any other illness. Coverage applies to employee, spouse and dependent children. Includes hospital nursery care of a newborn child.</p> <p>Benefits may not be restricted for any hospital stay in connection with childbirth to less than forty-eight (48) hours following a vaginal delivery, or less than ninety-six hours (96) hours following a delivery by cesarean section. However, the attending provider, after consultation with the mother, may discharge the mother earlier.</p> <p>A physician or other health care provider is not required to obtain authorization for prescribing a length of stay of up to 48 or 96 hours.</p>	95%	70%

<p>ORGAN & TISSUE TRANSPLANT Services provided in connection with surgery for cornea, kidney, skin, heart, lung, heart-lung, liver, kidney and pancreas in combination, bone marrow. Coverage is provided for: a Plan participant who receives the organ or tissue, a Plan participant who donates the organ or tissue or an organ or tissue donor who is not a Plan participant, if the organ or tissue recipient is a Plan participant. The benefits paid would be reduced by any amounts paid or payable by the non-participant's own insurance coverage.</p>	95%	70%
<p>RADIATION THERAPY, CHEMOTHERAPY, HEMODIALYSIS</p>	95%	70%
<p>TREATMENT TO NATURAL TEETH Accidental Injury – for treatment within 6 months of injury if accident occurs while a member of this plan. Non Accident Treatment – hospital services only, limited to three days if surgery under general anesthetic is required. Does <u>not</u> provide surgical benefit.</p>	95%	70%
<p>BLOOD TRANSFUSIONS Including blood processing and the cost of unreplaced blood and blood products.</p>	95%	70%
<p>PRESCRIPTION DRUGS Benefit <u>only</u> applies if prescriptions are not immediately available through a participating pharmacy or the mail order program of the prescription drug plan. Applies to Take Home drugs provided by a hospital or prescription drugs dispensed by a physician in the office.</p>	95%	70%

EXCLUSIONS AND LIMITATIONS

The following charges will not be considered covered medical expenses under this plan:

- A. Services or supplies that are not Medically Necessary as defined.
- B. Services received prior to the date coverage is effective under this Plan. Services received after coverage ends, except as specifically stated under Extension of Benefits or Continuation of Coverage.
- C. Any amounts in excess of Customary and Reasonable charges.
- D. Services for which the Plan participant is not legally obligated to pay. Services for which no charge is made. Services for which no charge is made in the absence of insurance coverage, except services received at a non-governmental charitable research hospital.

Such a hospital must meet the following guidelines:

1. It must be internationally known as being devoted mainly to medical research, and
 2. At least 10 percent of its yearly budget must be spent on research not directly related to patient care, and
 3. At least one-third of its gross income must come from donations for grants other than gifts or payments for patient care, and
 4. It must accept patients who are unable to pay, and
 5. Two-thirds of its patients must have conditions directly related to the hospital's research.
- E. Work-related conditions if benefits are recovered or can be recovered, either by adjudication, settlement, or otherwise, under any Workers' Compensation, Employers Liability law or occupational disease law, even if the Plan participant does not claim those benefits.
 - F. Conditions caused by an act of war. Conditions caused by a release of nuclear energy, whether or not the result of war.
 - G. Any services provided by a local, state or federal government agency.
 - H. Any services in excess of the Medicare allowable to the extent that the Plan participant is entitled to receive Medicare benefits for those services, whether or not Medicare benefits are actually paid. Any services for which payment may be obtained from any other local, state or federal government agency (except Medi-Cal).
 - I. Professional services received from a person who lives in the Plan participant's home or who is related to the Plan participant by blood or marriage.

- J. Inpatient room and board charges in connection with a hospital stay primarily for environment change, physical therapy or treatment of chronic pain, Custodial Care or rest cures. Services provided by a Skilled Nursing or Residential Treatment Facilities, except as specifically stated under Skilled Nursing Facility.
- K. Hyperkinetic syndromes, learning disabilities, behavioral problems, mental retardation or autistic disease of childhood.
- L. Braces, other orthodontic appliances or orthodontic services.
- M. Dental plates, bridges, crowns, caps or other dental prostheses, dental services, extraction of teeth or treatment to the teeth or gums, except as specifically stated under Treatment to Natural Teeth. Cosmetic dental surgery or other services for beautification.
- N. Hearing aids and routine hearing tests.
- O. Optometric services, eye exercises, including orthoptics, routine eye exams and routine eye refractions. Eyeglasses or contact lenses, except as specifically stated under Prosthetic Appliances.
- P. Outpatient occupational therapy, except by a Home Health Agency or Visiting Nurse Associated as specifically stated in Home Health Care.
- Q. Outpatient speech therapy, except following surgery, injury or noncongenital organic disease.
- R. Cosmetic surgery or other services for beautification.
- S. Services primarily for weight reduction or treatment of obesity. This exclusion will not apply to surgical treatment of obesity if:
 - 1. Surgical treatment of obesity is necessary to treat another life-threatening condition involving obesity, and
 - 2. It has been documented that non-surgical treatments of the obesity have failed.
- T. Procedures or treatments to change characteristics of the body to those of the opposite sex.
- U. Sterilization reversal. Artificial insemination and in-vitro fertilization.
- V. Orthopedic shoes (except when joined to braces) or shoe inserts, air purifiers, air conditioners, humidifiers, exercise equipment and supplies for comfort, hygiene, or beautification. Educational services, nutrition counseling or food supplements. Telephone consultations.

- W. Routine physical exams or tests which do not directly treat an actual illness, injury or condition, including those required by employment or government authority, except as specifically stated under the Preventive Care section of the Plan.
- X. Charges for intentionally self-inflicted Injury or Illness in excess of the specific reinsurance retention level as stated in the reinsurance contract.
- Y. An eye surgery solely for the purpose of correcting refractive defects of the eye such as near-sightedness (myopia) and astigmatism.
- Z. Charges for a condition, injury or disability resulting from any involvement in an illegal occupation or attempt to commit an illegal act and any complication therefrom.
- AA. Charges for any illness, injury, disease or other condition for which a third party may be liable or legally responsible by reason of negligence, an intentional act or breach of any legal obligation on the part of such third party. Nevertheless, benefits will be advanced subject to compliance with provisions stated in the Plan Document.
- BB. Charge for services related to a pre-existing condition as described on **Page 11**.
- CC. Charges for any form of transportation, except as specified in the ambulance benefit.
- DD. Charges for the preparation of medical reports or itemized billings.
- EE. Charges for non-medical services or personal comfort items even if prescribed by a physician. This would include training, educational or instruction materials, air conditioners, purifiers, humidifiers, or dehumidifiers, corrective shoes, heating pads, whirlpools, hot tubs, waterbeds, hot water bottles and any other clothing or equipment whose sole purpose is not for the therapeutic treatment of a medical illness or injury.
- FF. Charges for treatment of Temporomandibular Joint Dysfunction (TMJ) except for necessary medical and/or surgical and arthroscopic treatment.
- GG. Charges for medical equipment, supplies, prescribed drugs, procedures, or treatments which are experimental or investigational in nature and have not been established safe or effective; or which are not in accordance with generally accepted professional standards to treat a specifically diagnosed illness or injury.
- HH. Charges for failure to keep a scheduled appointment with a physician or therapist.

COORDINATION OF BENEFITS

INTENT: The intent of coordination of benefits is to provide that the sum of benefits paid under this Plan plus benefits paid under all other group plans will not exceed the actual amount of covered expense for a treatment or service. Covered expense will be interpreted to be a necessary, reasonable and customary item that is covered under at least one of the plans involved.

ORDER OF BENEFITS DETERMINATION: If a person is covered under this Plan and under one or more other plans, the rules set forth below apply:

1. A plan, which does not provide for Coordination of Benefits, will pay its benefit first.
2. A plan covering the patient as an employee will provide its benefits before the plan covering the patient as a dependent.
3. The plan which covers the patient as a dependent child of a parent whose date of birth (excluding year of birth) occurs earlier in a calendar year will determine its benefits before a plan which covers that dependent child as a parent whose date of birth (excluding year) occurs later in a calendar year. If both parents have the same date of birth (excluding year of birth), the benefits of the plan, which covered the parent longer, and determined before the benefits of the plan, which covered the parent for a shorter time.

However, if the other plan does not have this rule, but instead has a rule based upon the gender of the parent and, if as a result, the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits.

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

Regardless of the above, if there is a court decree, which establishes a parent's financial responsibility for the child's health care expenses, a plan which covers the child as a dependent of that parent pays first.

5. If none of the above rules apply, the plan which has covered the person for the longer period of time will determine its benefits, first, except that the plan covering a person as a laid-off or retired employee will be secondary to a plan covering the person as an active employee.

COORDINATION WITH MEDICARE: Medicare is the primary payer for retirees age 65 and older. When Medicare is the primary payer, covered expense will be interpreted to be the Medicare allowable. By using a Medicare provider the out of pocket expense may be reduced because you will not be billed for the amount over Medicare allowable. This Plan is the primary payer for: (a) active employees over age 65; (b) active employees' spouses who are age 65 or older; (c) any employee or their dependent who is eligible for Medicare due to disability, regardless of age, *as long as* the employee has *current employment status*, as determined by Medicare rules; and (d) the first thirty (30) months of treatment for "end stage renal disease" for employees and their dependents under age 65.

EXCHANGE OF INFORMATION: Any Plan participant who claims primary benefits under this Plan must provide all information that is needed to coordinate benefits. In addition, all information that is needed to coordinate benefits may be exchanged with other companies, organizations, or person only for this express purpose.

FACILITY OF PAYMENT: The Plan may reimburse any other plan if benefits were paid by the other plan but should have been paid under this Plan in accordance with the detailed provisions of this section. In such instances, the reimbursement amounts will be considered benefits paid under this Plan and, to the extent of those amounts, will discharge this Plan from liability.

REASONABLE CASH VALUE: When another plan provided benefits in the form of services rather than cash payment, the reasonable cash value of any service provided will be considered to be a benefit paid. The reasonable cash value of any service provided to the covered individual by any service organization will be considered expense incurred by that individual, and the liability of the Plan will be reduced accordingly.

RIGHTS OF RECOVERY: Whenever payments for covered benefits have been made by the Plan and those payments are more than the maximum payment necessary to satisfy the intent of this provision, regardless of who was paid, the Plan has the right to recover the excess amount from any persons to or from whom those payments were made, or from any insurance company, service plan or any other organizations or persons.

COBRA CONTINUATION COVERAGE

In accordance with the Consolidated Omnibus Budget Reconciliation Act (COBRA), a person will be entitled to continue group coverage under this Plan if he or she would lose coverage otherwise because of a qualifying event that occurs while the employer is subject to the continuation of coverage provisions of COBRA. A qualifying event is defined as any of the following occurrences:

1. The death of an employee,
2. The employee's termination or separation from employment (other than by reason of the employee's gross misconduct), or the reduction in the employee's work hours to less than the number of hours required for eligibility.
3. The divorce or legal separation of the employee from his or her spouse.

4. The employee becomes entitled to benefits under Title XVIII of the Social Security Act (“Medicare”). (This qualifying event only applies to dependents of an employee already continuing coverage under COBRA).
5. A dependent child ceases to be a dependent under the eligibility requirements of the Plan.
6. The retiree’s employer files for reorganization under Title XI, United States Code, beginning on or after July 1, 1986. (This qualifying event is only applicable to retiree’s and their qualified beneficiaries).
7. And such other qualifying event as may be added to Title X of COBRA.
8. The birth of a child or placement of a child for adoption to a person while on COBRA qualifies the child to be covered and the beneficiary to extend coverage to family coverage.

If a qualifying event occurs, the person will receive notice of eligibility for the continuation of group coverage and other related information from Monterey Peninsula College within 44 days after a qualifying event becomes known. However, if qualifying event (3) or (5) above occurs, or the Social Security Administration determines that a qualified beneficiary was disabled at the time of the employee’s termination or reduction in hours, the person must first notify the employer within 60 days of the qualifying event, or, the Social Security Administration’s determination of disability.

An eligible person will be entitled to continue group coverage, provided an election is made within 60 days of the notice of eligibility and the required premiums are paid within 45 days of the election. The premiums for the person continuing coverage will not exceed 102% of the applicable group dues rate, except for an eligible person who continues group coverage up to 29 months because of entitlement to Social Security disability benefits, in which case, the premiums for months 19 through 29 will not exceed 150% of the applicable group premium rate.

The benefits under the continuation of group coverage will be identical to the benefits that would be provided to the person if the qualifying event had not occurred.

If qualifying event (2) above occurs on or after the effective date of this plan, an eligible employee and eligible dependents will be entitled to select to continue group coverage for a maximum period of 18 months unless the Social Security Administration determines that the eligible person or dependent became disabled within the first 60 days of COBRA coverage. The employee must inform the employer within 60 days of the determination and before the end of the 18-month period, in which case the eligible person and any eligible family members may extend coverage up to 29 months.

If a second qualifying event (other than qualifying events (4) and (6) above) occurs during the 18 months after the date of qualifying event (2), the original 18 months period may be extended to 36 months but only for those individuals who were covered under the plan at the time of the first qualifying event and were still covered under the plan at the time of the second qualifying event.

If qualifying event (1), (3) or (5) above occurs on or after the effective date of this plan, the eligible dependents may elect to continue group coverage for a maximum period of 36

months. If qualifying event (4) above occurs on or after the effective date of this Plan, the eligible dependents may elect to continue group coverage for a maximum period of 36 months from the date when the employee first became entitled to Medicare benefits. If qualifying event (6) above occurs on or after the effective date of this Plan, coverage will continue until the date of the retiree's death or in the case of a surviving spouse or dependent children of the retiree, 36 months after the date of the retiree's death, except if coverage is substantially reduced within a year before or after the occurrence of qualifying event (6), retirees and widows and widowers of retirees who died before the employer files for reorganization under Title XI, United States Code, are entitled to a lifetime continuation of coverage.

The continuation of group coverage will begin on the date the person's coverage under this plan would otherwise terminate and it will continue for up to the applicable period noted above. However, the group continuation of coverage will cease if any one of the following events occur prior to the expiration of the applicable period.

1. Discontinuance of all employer provided group health plans.
2. Nonpayment of required premiums.
3. The person becomes covered under another group health plan that does not include a pre-existing condition exclusion or limitation provision that applies to the person.
4. The person becomes entitled to Medicare benefits.

THIRD PARTY LIABILITY/REIMBURSEMENT

If an eligible employee or dependent is injured or becomes ill through the act or omission of another person, and if benefits are paid under the Plan due to such injury or illness, then to the extent medical expenses are reimbursed for the same injury or illness from a third party, the Plan shall be entitled to a refund of such benefits.

The Plan shall be relieved of any and all legal, equitable or contractual obligation contained in this Plan for any benefits paid for illness or injuries caused by a third party, unless the Insured agrees to accept and execute an assignment, form or document certifying the following:

1. That medical expenses in connection with an illness or injury caused by a third party will be included in any claim made against that third party.
2. That reimbursement will be made to the Plan for benefit payments made should a recovery settlement be received from a third party that exceeds the Insured's portion of the total loss.
3. That all information requested by the Plan in asserting its right to pursue recovery will be supplied and cooperation given in obtaining all forms and documents necessary for this purpose.

The Plan is also entitled to a refund from benefits available under uninsured motorist provision of automobile insurance policies.

Reimbursement shall not exceed (a) the amount received by the Plan participant for such expenses from the third party or (b) the amount paid by the Plan for such expenses.

EXTENSION OF BENEFITS

If a plan participant is totally disabled when coverage ends, and is under the treatment of a physician, the benefits of the Plan may continue to be provided for services treating the totally disabling illness or injury. No benefits are provided for services treating any other illness, injury or condition.

A Plan participant confined as an inpatient in a hospital or skilled nursing facility is considered totally disabled as long as the inpatient stay is medically necessary, and no written certification of the total disability is required.

A Plan participant not confined as an inpatient who wishes to apply for total disability benefits must submit written certification by a physician of the total disability. The Plan must receive this certification within 90 days of the date coverage ends under this Plan. At least once every 90 days while benefits are extended, the Plan must receive proof that the participant's total disability is continuing.

Benefits are provided until one of the following occurs:

1. The participant is no longer totally disabled, or
2. The maximum benefits of this Plan are paid, or
3. The participant becomes covered under another group health plan that provides coverage without limitation for the disabling illness or injury, or
4. 12:01 AM on the day following a period of twelve (12) months from the date coverage terminates.

This provision is separate and distinct from the Continuation of Coverage option under COBRA as described above. If you choose to continue coverage for a disability under the Extension of Benefits provision, you can elect COBRA coverage when the extension expires and the maximum COBRA period will be counted from the date coverage ended under the Plan by virtue of your termination of employment.

FAMILY AND MEDICAL LEAVE

THE FOLLOWING IS INTENDED TO COMPLY WITH FEDERALLY MANDATED LANGUAGE. IT IS ALSO INTENDED TO COORDINATE WITH THE FAMILY AND MEDICAL CARE LEAVE SECTIONS OF THE MONTEREY PENINSULA COLLEGE COLLECTIVE BARGAINING AGREEMENTS. IN THE EVENT OF A CONFLICT BETWEEN THE FOLLOWING LANGUAGE AND THE COLLECTIVE BARGAINING AGREEMENT THE APPROPRIATE COLLECTIVE BARGAINING AGREEMENT WILL PREVAIL.

FAMILY AND MEDICAL LEAVE: If you become eligible for a family or medical leave of absence in accordance with the Family and Medical Leave Act of 1993 (FMLA) (including any amendments of such Act) your insurance coverage may be continued on the same basis as if you were an actively-at-work employee for up to twelve (12) weeks during the twelve month period, as defined by your employer, for any of the following reasons:

1. to care for your child after the birth or placement of a child with you for adoption or foster care; so long as such leave is completed within 12 months after the birth of placement of the child;
2. to care for your spouse, child, foster child, adopted child, stepchild, or parent with has a serious health condition; or
3. for your own serious health condition.

In the event you or your spouse are both insured as employees of the District, the continued coverage under (1) may not exceed a combined total of 12 weeks. In addition, if the leave is taken to care for a parent with a serious health condition, the continued coverage may not exceed a combined total of 12 weeks.

CONDITIONS:

1. If, on the day your insurance is to begin, you are already on an FMLA leave of absence, you will be considered actively at work. Insurance for you and any eligible dependents will begin in accordance with the terms of the policy. However, if your leave of absence is due to your own or any eligible dependent's serious health condition, benefits for that condition will not be payable to the extent benefits are payable under any prior group plan.
2. You are eligible to continue coverage under FMLA if:
 - a) you have worked for your employer for at least one year;
 - b) you have worked at least 1,250 hours over the previous 12 months;
 - c) your employer employs at least 50 employees within 75 miles from your worksite.
3. If you decide not to return to your job at the end of the 12 weeks FMLA Leave, you Will be liable for payments at regular group rates for the benefits extended to you during your FMLA Leave.
4. You and your dependents are subject to all conditions and limitations of the policy during your leave, except that anything in conflict with the provisions of the FMLA will be construed in accordance with the FMLA.
5. If requested by the Plan, you must submit proof acceptable to the Plan that your leave is in accordance with FMLA.
6. This FMLA continuation is concurrent with any other continuation option except for COBRA, if applicable. You may be eligible to elect any COBRA continuation available under the policy following the day your FMLA continuation ends.
7. FMLA continuation ends on the earliest of:
 - a) the day you return to work;
 - b) the day you notify your employer that you are not returning to work;
 - c) the day your coverage would otherwise end under the policy; or
 - d) the day coverage has been continued for 12 weeks.

SUBMISSION OF CLAIMS

SUBMISSION OF CLAIMS: If you are obtaining services from a Network Provider, present your Monterey Peninsula College Medical Plan identification card to the provider and request that the claim be submitted directly to Keenan.

TIME LIMIT OF FILING CLAIMS: Completed claim forms and itemized billings should be submitted within ninety (90) days after the date services or treatment have been received or as soon as is reasonably possible, but in no event later than 24 months from the date of service. The Plan is not liable for benefits if claims are not filed within this time period.

Send all claims to:

**Keenan HealthCare
P.O. Box 2744
Torrance, California 90509**

If you have any questions regarding your benefits, a claim payment or the Network provider membership, please call 1-877-853-3626.

CLAIM PROCESSING: Claims are processed for payment or denial based only upon information submitted with the claim; therefore, to avoid unnecessary delay, it is very important that the claim is complete.

Payment will be determined after the claim is received and reviewed for eligibility, medical necessity and other exclusions and limitations. Payment or denials will be based on the Benefits, Coverage's, Limitations, and Exclusions as outlined in this Plan Document and will be subject to any applicable deductible, percentage payable and benefit maximums as set forth in this Medical Plan.

If any information is given to you over the telephone or in writing by any of the Claims Department staff or your Employer which is not in accordance with the language of this Plan Document, the provisions in this Plan Document supersede and will stand as your verification of benefit coverage.

PROCEDURE FOR APPEAL OF DENIED CLAIMS

Appeals

If you disagree with the processing or a decision made about your claim, you must request a review of the denied claim by filing written notice to Keenan. The request for review must be made no later than 90 days after the notice of denial was received. Send all notices to:

Keenan HealthCare
P.O. Box 2744
Torrance, California 90509

A written request for review must set forth all the grounds upon which it is based, together with any supporting facts and circumstances which you feel should be considered. You may review any pertinent documents of the Plan or insurance company in preparing a request for review.

Within a reasonable time (as determined in the administrative agreement with Keenan) after receipt of the request for review, you will be notified as to the date, time and place of the hearing by regular mail to the address shown on the request for review. You may be represented at such hearing by an attorney or any other representative of your choosing at their own expense.

A decision will be made promptly and within 60 days. In the event of special circumstances, the decision may require additional time, but a decision will be made no later than 120 days after receipt of the request for review. The decision on review will be in writing and will include specific reasons for the decision.

Arbitration

If you are not satisfied after following the appeal process outlined in the Appeals section, you must submit your claim and all other claims arising out of or related to your claim or the handling of that claim to binding arbitration.

Any dispute regarding a claim for damages that falls within the jurisdictional limits of small claims court must be submitted to the small claims court for resolution. Remember, Small Claims Court Findings will be final and binding upon both parties.

If the amount in dispute exceeds the jurisdictional limits of small claims court, the claims must be submitted for binding arbitration. The arbitration process begins when you make a written demand to the Plan for arbitration.

This arbitration will be held before a designated neutral arbitrator appointed by the County Medical Association or the American Arbitration Association.

Fees and Costs

A demand for arbitration shall not be effective unless a check for \$150, made payable to Group Health Plan, Arbitration Account, accompanies the demand. Only one check for \$150 is necessary per demand, regardless of the number of respondents served. The Plan shall deposit this \$150, plus \$150 from the Plan in a special account maintained by a financial institution as designated by the District. These deposits provide initial funds to pay the fees of the neutral arbitrator and the expenses incurred by the neutral arbitrator in conducting arbitration, which fees and expenses shall be borne equally by the parties. The accounts shall be replenished from time to time as directed by the neutral arbitrator.

The Arbitration Findings Will Be Final and Binding.

DEFINITIONS

Accidental Injury: Definite trauma resulting from a sudden, unexpected and unpleasant event, occurring by chance, caused by an independent external source.

Actively at Work: The active performance of all of an employee's normal job duties at the employer's usual place of business. An employee will be deemed actively at work on a day that is not one of the employer's scheduled workdays only if the employee was actively at work on the most recent preceding scheduled workday.

Calendar Year: The period of twelve (12) months from January 1 through December 31 of each year.

Coinsurance: The specified percentage payable that is the payment responsibility of the Plan participant for covered medical expenses.

Copayment: The specified dollar amount that is the payment responsibility of the Plan participant for certain types of covered medical expenses. Does not apply to coinsurance.

Cosmetic Procedure: Any surgery, service, drug or supply designed to improve the appearance of an individual by alteration of a physical characteristic which is within the broad range of normal but which is considered unpleasing or unsightly.

Custodial Care: Care furnished primarily to provide room and board (which may or may not include nursing care, training in personal hygiene and other forms of self care and/or supervisory care by a Physician) or care furnished to a person who is mentally or physically disabled, and

1. who is not under specific medical, surgical or psychiatric treatment to reduce the disability to the extent necessary to enable the patient to live outside an institution providing care; or
2. when, despite medical, surgical or psychiatric treatment, there is no reasonable likelihood that the disability will be so reduced.

Customary and Reasonable: A charge which falls within the common range of fees billed by a majority of physicians for a procedure in a given geographic region, or which is justified based on the complexity or severity of treatment for a specific case. Customary and Reasonable charges will be subject to review annually in order to provide subscribers with the best possible coverage under the Plan.

Deductible: Before the Plan begins to pay benefits in any calendar year, you are first required to pay an amount toward covered expenses. This amount is called the deductible. The calendar year deductible for each covered employee and dependent is \$250 In-Network and \$500 Out-of-Network. This deductible applies separately to each insured during each calendar year and can only be satisfied with expenses that are covered under the Plan. No more than \$750 In-Network and \$1,500 Out-of-Network is required of a family to satisfy the deductible for a calendar year. Any portion of the deductible that is met in the last three

months of the calendar year will be carried over to help satisfy the deductible requirement for the next year. Does not apply to coinsurance.

Emergency Services: Services provided for a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that the absence of immediate medical attention could reasonably be expected to result in any of the following:

1. placing the patient's health in serious jeopardy;
2. serious impairment to bodily function;
3. serious dysfunction of any bodily organ or part.

Experimental or Investigational: Any treatment, therapy, procedure, drug or drug usage, facility or facility usage, equipment or equipment usage, device or device usage, or supplies which are not recognized by generally accepted professional standards as being safe and effective for use in the treatment of the illness, injury or condition at issue. Services which require approval by any federal or state government agency before use and where approval has not been granted at the time the services were rendered, will be considered Experimental or Investigational. Any services which are not approved or recognized by accepted professional medical standards but nevertheless are authorized by law or by a government agency for use in testing, trials, or other studies on human patients, will be considered Experimental or Investigational in nature.

Home Health Care Agency: A hospital, agency, or other service that is recognized by Medicare and certified by the proper authority of the state in which it is located to provide home health care services of a Home Health Aide; Certified Nursing Aide, Licensed Vocational Nurse, or Registered Nurse.

Hospice Care: Care received under a program that is (1) designed to provide palliative and supportive care to individuals who have received a diagnosis of terminal illness; (2) supportive to the covered family members by providing certain services listed under the Home Hospice benefit; (3) licensed or certified in the jurisdiction where the program is established; (4) directed and coordinated by medical professionals.

Hospital: An institution that is (a) licensed as an acute care facility by the proper authority of the state in which it is located; (b) recognized as a hospital by the Joint Commission (c) a state licensed and Joint Commission-recognized mental health or psychiatric facility or an alcoholic or drug treatment facility, provided that these facilities are providing a treatment program for these specific diagnosed conditions and are operating within the scope of their license. A hospital does not include any institution, or part thereof, that is used primarily as a convalescent home, rest home, home for the aged, nursing home, custodial care facility, training center, residential care facility or half-way house.

Mental Disorders: Mental disorders are recognized primarily by symptoms or signs that appear as distortions of normal thinking, distortions of the way things are perceived (for example, seeing or hearing things that are not there), moodiness, sudden and/or extreme changes in mood, depression, and/or unusual behavior such as depressed behavior or highly agitated or manic behavior. Some mental or nervous disorders are: Schizophrenia, manic depressive and other conditions usually classified in the medical community as psychosis; drug, alcohol and other substance addiction or abuse; depressive, phobic, manic and anxiety

conditions (including panic disorders); hypochondria; personality disorders (including paranoid, schizoid, dependent, antisocial and borderline); dementia and delirious states; post traumatic stress disorder, adjustments reactions, reactions to stress; anorexia nervosa and bulimia.

Negotiated Rate: Those charges and fees agreed upon between network providers and Keenan Healthcare.

Network Providers: Those physicians, hospitals and other providers who have agreed to accept plan negotiated rates plus your payment of any applicable deductible and copayment, as payment in full for covered services.

Non-Network Providers: Those providers who do not have contractual relationships with Keenan Healthcare. These providers may bill you for any charges in excess of plan allowances.

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

Physicians:

1. A doctor of medicine (M.D.) or a doctor of osteopathy (D.O.) who is licensed to practice medicine or osteopathy where the care is provided, or
2. One of the following providers, but only when the provider is licensed to practice where the care is provided, is rendering a service within the scope of that license, is providing a service for which benefits are specified in this Plan and where benefits would be payable if the services were provided by a physician.
 - a) A dentist (D.D.S.)
 - b) An optometrist (O.D.)
 - c) A dispensing optician
 - d) A podiatrist or chiropodist (D.P.M., D.S.P. or D.S.C.)
 - e) A psychologist (Ph.D.)
 - f) A chiropractor (D.C.)
 - g) An acupuncturist
 - h) A clinical social worker (C.S.W. or L.C.S.E.)*
 - i) A marriage, family and child counselor (M.F.C.C.)
 - j) A physical therapist (P.T. or R.P.T.)*
 - k) A speech pathologist*
 - l) An audiologist*

Note: The providers indicated by an asterisk (*) are covered only by referral of a physician.

Physical Therapy: Treatment, under the direction of a Doctor of Medicine and provided by a registered physical therapist, or licensed doctor of podiatric medicine, utilizing physical agents such as ultrasound, heat and massage, to improve a patient's musculoskeletal, neuromuscular and respiratory systems.

Plan Participant: Any employee of Monterey Peninsula College who is eligible for coverage under this Medical Plan and who has enrolled in the Plan according to the requirement of Monterey Peninsula College. Plan participant is also used to refer to eligible dependents that have been enrolled in the Medical Plan.

Skilled Nursing Facility: A facility with a valid license issued by the California State Department of Health as a Skilled Nursing Facility or any similar institution licensed under the laws of any other state, territory, or foreign country.

Substance Abuse: Any diagnosed condition, confinement or treatment related to the chemical dependency on alcohol or drugs.

Summary Plan Description: Describes the benefits to which Plan participants are entitled. Monterey Peninsula College will provide the Summary Plan Description to each eligible employee upon request.

Terminal Illness: An illness in which it is medically probable that the patient has less than six (6) months to live. The patient's attending Doctor of Medicine must provide written certification.

Tiered Hospital Network: Hospitals that are within the network are grouped into 1 of 3 different tiers based on the cost or efficiency of care that they provide. Tier I network hospitals have a lower co-insurance than Tier II hospitals and Tier II hospitals have a lower co-insurance than Tier III hospitals.

Total Disability (or Totally Disabled):

- a) For an employee, a disability which prevents the individual from working with reasonable continuity in the individual's customary employment or in any other employment in which the individual might reasonably be expected to engage, in view of the individual's age, education, interests and physical and mental capacity.
- b) For a dependent, a disability which prevents the individual from engaging with normal or reasonable continuity in the individual's customary activities or in those in which the individual otherwise reasonably might be expected to engage, in view of the individual's age, education and interest.

GENERAL PROVISIONS

FORM OR CONTENT OF AGREEMENT: The entire agreement between the parties consists of:

- a) this Summary Plan Description/Plan Document and
- b) the individual applications of eligible persons.

Non-Fraudulent statements of the employer or of any eligible person that are not in written applications will not be used to deny a claim under this Agreement. No agent of the Plan may change this Agreement or waive any of its contents. No change in this Agreement is valid unless the change is by endorsement signed by the employer.

WORKERS' COMPENSATION INSURANCE: This Agreement does not affect any requirement for coverage by Workers' Compensation insurance. It does not replace that insurance.

PROTECTION OF COVERAGE: The plan does not have the right to cancel the coverage of any Plan Participant under this Agreement while the Agreement is still in effect, the participant is still eligible and the participant's premium charges are paid according to the terms of this Agreement.

CANCELLATION OF COVERAGE: The employer may cancel this Agreement by giving at least 60 days' prior written notice to the other parties. No written notice is sent to the Plan participant when coverage is canceled. A Plan participant's coverage is canceled under the provisions outlined under Termination of Benefits.

MAILING ADDRESSES: Any notice required of the Plan Administrator in this Agreement will be mailed to the Employer. Any notice required of the Employer in this Agreement must be mailed to Keenan HealthCare, P.O. Box 2744, Torrance, California 90509, the Plan Administrator.

CLERICAL ERRORS: Clerical errors do not deprive any participant of his or her coverage under this Agreement. Also, these errors do not create or continue coverage that would not otherwise be effective.

GROUP RECORDS: The employer is responsible for keeping employee/retiree eligibility records relating to this Agreement.

PROVIDING OF CARE: The Plan is not responsible for providing any type of hospital, medical or similar care. Also, the Plan is not responsible for the quality of any type of hospital, medical or similar care received.

NON-REGULATION OF PROVIDERS: Benefits provided under this Agreement do not regulate the amounts charged by providers of medical care.

BENEFITS NOT TRANSFERABLE: Only eligible participants are entitled to receive benefits under this Agreement. The right to benefits cannot be transferred.

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

EXPENSE IN EXCESS OF BENEFITS: The Plan is not liable for any expense the Plan participant incurs in excess of the benefits of this Agreement.

AREA OF SERVICE: The benefits of this Agreement are provided for covered services received anywhere in the United States, unless such services are furnished in connection with an emergency.

PAYMENT OF PROVIDERS: The Plan pays Network Providers directly for the benefits of this Agreement. Also, the Plan may pay Non-Network Providers of service directly when benefits are assigned. These payments fulfill the obligation of the Plan to the Plan participant for those services.

RIGHT OF RECOVERY: When the amount paid by the Plan exceeds the amount for which the Plan is liable under this Agreement, the Plan has the right to recover the excess amount. This amount may be recovered from the Plan participant, or the person to whom the payment was made or any other plan.

FREE CHOICE OF HOSPITAL AND PHYSICIAN: This agreement in no way interferes with the right of any person entitled to benefits to select a provider.

PREMIUM CHARGES: Premium charges, if any, will be determined by the employer. The employer will reimburse the Plan for claims paid plus any and all administrative charges. The employer is responsible for supplying up-to-date eligibility information. The Plan may rely upon the latest information received as correct without certification.

Amendment to Plan Document and Summary Plan Description For the BridgeHealth Network

The Health Plan is amended to include access to the travel network maintained by BridgeHealth (the “BridgeHealth Network”). The BridgeHealth Network will be available to each **Covered Person** when (a) the Covered Person’s treating physician recommends a **Covered Service** that is available through the BridgeHealth Network, and (b) the Covered Person elects to receive treatment from a provider participating in the BridgeHealth Network (a “Network Provider”).

In addition to paying for the Covered Services provided to a Covered Person, the Health Plan will pay for certain costs that are associated with accessing the BridgeHealth Network (the “Covered Network Costs”). The Covered Network Costs include: (a) the cost of all necessary Travel Services for the Covered Person and one companion, and (b) a Travel Benefit.

The term "Travel Services" shall mean (a) round trip transportation between the Covered Person's home location and the location of the treating Network Provider; (b) hotel accommodations near the Network Provider; and (c) local transportation among the airport, hotel, and Network Provider. All Travel Services must be reserved and scheduled through BridgeHealth. The term "Travel Benefit" shall mean a pre-determined flat payment amount paid to the Covered Person, which payment amount is intended to cover any incidental and "out-of-pocket" expenses incurred by the Covered Person in connection with his/her treatment. The Travel Benefit shall be payable upon completion of the travel associated with such treatment and may be reduced by any amount that is ordinarily payable by the Covered Person (such as a deductible).

The Covered Network Costs will be considered when determining a Covered Person's **Lifetime Maximum Benefit** or any similar limitation imposed under the Health Plan.

Any medical services performed by a person or entity that is not a Network Provider shall be subject to the general terms of the Health Plan, and shall not be subject to the terms otherwise applicable to treatment received through the BridgeHealth Network.

To the extent that a Network Provider performs services that are not Covered Services under the Health Plan, the Covered Person shall be responsible for paying the BridgeHealth Network for such services. The Covered Person shall be responsible for making any such payments in advance of his/her treatment by the Network Provider.

**Amendment to Plan Document and Summary Plan Description
to comply with the
Standards for Privacy of Individually Identifiable Health Information (the "Privacy
Standards")
issued pursuant to
The Health Insurance Portability and Accountability Act of 1996, as amended
("HIPAA")**

The Monterey Peninsula College Medical Plan (the "Plan") Plan Document and Summary Plan Description (the "Plan Documents") are hereby amended to comply with HIPAA's Privacy Standards, as follows:

1. Disclosure of Summary Health Information to the Plan Sponsor

In accordance with the Privacy Standards, the Plan may disclose Summary Health Information to the Plan Sponsor, if the Plan Sponsor requests the Summary Health Information for the purpose of (a) obtaining premium bids from health plans for providing health insurance coverage under this Plan or (b) modifying, amending or terminating the Plan.

"Summary Health Information" may be individually identifiable health information and it summarizes the claims history, claims expenses or the type of claims experienced by individuals in the plan, but it excludes all identifiers that must be removed for the information to be de-identified, except that it may contain geographic information to the extent that it is aggregated by five-digit zip code.

2. Disclosure of Protected Health Information (“PHI”) to the Plan Sponsor for Plan Administration Purposes

In order that the Plan Sponsor may receive and use PHI for Plan Administration purposes, the Plan Sponsor agrees to:

- a. Not use or further disclose PHI other than as permitted or required by the Plan Documents or as Required by Law (as defined in the Privacy Standards);
- b. Ensure that any agents, including a subcontractor, to whom the Plan Sponsor provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such PHI;
- c. Not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor, except pursuant to an authorization which meets the requirements of the Privacy Standards;
- d. Report to the Plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which the Plan Sponsor becomes aware;
- e. Make available PHI in accordance with Section 164.524 of the Privacy Standards (45 CFR 164.524);
- f. Make available PHI for amendment and incorporate any amendments to PHI in accordance with Section 164.526 of the Privacy Standards (45 CFR 164.526);
- g. Make available the information required to provide an accounting of disclosures in accordance with Section 164.528 of the Privacy Standards (45 CFR 164.528);
- h. Make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of the U.S. Department of Health and Human Services (“HHS”), or any other officer or employee of HHS to whom the authority involved has been delegated, for purposes of determining compliance by the Plan with Part 164, Subpart E, of the Privacy Standards (45 CFR 164.500 et seq);
- i. If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the PHI infeasible; and

- j. Ensure that adequate separation between the Plan and the Plan Sponsor, as required in Section 164.504(f)(2)(iii) of the Privacy Standards (45 CFR 164.504(f)(2)(iii)), is established as follows:
 - i. The following employees, or classes of employees, or other persons under control of the Plan Sponsor, shall be given access to the PHI to be disclosed:
 - Associate Dean of Human Resources
 - Staff as designated by Associate Dean of Human Resources
 - Vice President for Administrative Services
 - Staff as designated by Vice President for Administrative Services
 - Plan Auditor
 - ii. The access to and use of PHI by the individuals described in subsection (i) above shall be restricted to the Plan Administration functions that the Plan Sponsor performs for the Plan.
 - iii. In the event any of the individuals described in subsection (i) above do not comply with the provisions of the Plan Documents relating to use and disclosure of PHI, the Plan Administrator shall impose reasonable sanctions as necessary, in its discretion, to ensure that no further non-compliance occurs. Such sanctions shall be imposed progressively (for example, an oral warning, a written warning, time off without pay and termination), if appropriate, and shall be imposed so that they are commensurate with the severity of the violation.

“Plan Administration” activities are limited to activities that would meet the definition of payment or health care operations, but do not include functions to modify, amend or terminate the Plan or solicit bids from prospective issuers. “Plan Administration” functions include quality assurance, claims processing, auditing, monitoring and management of carve-out plans, such as vision and dental. It does not include any employment-related functions or functions in connection with any other benefit or benefit plans.

The Plan shall disclose PHI to the Plan Sponsor only upon receipt of a certification by the Plan Sponsor that (a) the Plan Documents have been amended to incorporate the above provisions and (b) the Plan Sponsor agrees to comply with such provisions.

- 3. Disclosure of Certain Enrollment Information to the Plan Sponsor

Pursuant to Section 164.504(f)(1)(iii) of the Privacy Standards (45 CFR 164.504(f)(1)(iii)), the Plan may disclose to the Plan Sponsor information on whether an individual is participating in the Plan or is enrolled in or has disenrolled from a health insurance issuer or health maintenance organization offered by the Plan to the Plan Sponsor.

- 4. Disclosure of PHI to Obtain Stop-loss or Excess Loss Coverage

The Plan Sponsor hereby authorizes and directs the Plan, through the Plan Administrator or Coastal TPA, to disclose PHI to stop-loss carriers, excess loss carriers or managing general underwriters (MGUs) for underwriting and other

purposes in order to obtain and maintain stop-loss or excess loss coverage related to benefit claims under the Plan. Such disclosures shall be made in accordance with the Privacy Standards.

5. Other Disclosures and Uses of PHI

With respect to all other uses and disclosures of PHI, the Plan shall comply with the Privacy Standards.