BANK OF THE WEST

January 1, 2017

PPO Plan

Routine Care Plan

HSA Plan

Summary Plan Description

INTRODUCTION

This Summary Plan Description (referred to herein as the *booklet*) contains detailed information regarding the medical benefits provided under the Bank of the West PPO Plan, the Bank of the West Routine Care Plan, and the Bank of the West HSA Plan (collectively referred to in this *booklet* as the *plan)* to *employees, retirees,* and their *family members.* This *booklet* explains the *plan* as in effect on January 1, 2017.

All italicized words have specific definitions. These definitions can be found either in the specific section to which they relate or in the DEFINITIONS section of this *booklet*. The terms "you" and "your" are italicized in certain sections and, where italicized, mean any *covered person*. Where such terms are used, but not italicized, they mean the *covered employee* or *retiree*, as applicable.

Please read this *booklet* carefully so that you and your *family members* understand all the benefits the *plan* offers. Keep this *booklet* handy in case you have any questions about your coverage.

All claims for *plan* benefits are administered by Anthem Blue Cross Life and Health Insurance Company of California (referred to in this *booklet* as the *claims administrator*). You can contact the *claims administrator* as follows:

Anthem Blue Cross Life and Health Insurance Company of California
P.O. Box 60007
Los Angeles, CA 90060
(877) 216-3990

The *claims administrator* is the named fiduciary for purposes of all claims for benefits made under the *plan.*

GRANDFATHERED PLAN NOTICE

Bank of the West believes the PPO Plan and the Routine Care Plan are "grandfathered health plans" under the Patient Protection and Affordable Care Act (PPACA). As permitted by PPACA, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. A grandfathered health plan means that the plan may not include certain consumer protections of PPACA that apply to other plans – for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in PPACA – for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered status can be directed to the *plan administrator* or HR Connections at (877) 977-6947. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at (866) 444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

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24/7 Nurseline

Your plan includes 24/7 Nurseline, a 24-hour nurse assessment service to help *you* make decisions about *your* medical care. When *you* call 24/7 Nurseline toll free at **(800) 700-0197**, be prepared to provide *your* name, the patient's name (if you're not calling for yourself), the *employee's* or *retiree's* Social Security number, and the patient's phone number. The nurse will ask *you* some questions to help determine *your* health care needs. Based on the information *you* provide, the advice may be:

- Home self-care. A follow-up phone call may be made to determine how well home self-care is working.
- Schedule a routine appointment within the next two weeks, or an appointment at the earliest time available (within 64 hours), with *your physician*. If *you* do not have a *physician,* the nurse will help *you* select one by providing a list of *physicians* who are *participating providers* in *your* geographical area.
- Call *your physician* for further discussion and assessment.
- Go to an emergency room in a *participating provider hospital*.
- Instructions to immediately call 911.

In addition to providing a nurse to help *you* make decisions about *your* health care, 24/7 Nurseline gives *you* free unlimited access to its Audio Health Library featuring recorded information on more than 100 health care topics. To access the Audio Health Library, call toll free **(800) 700-0197** and follow the instructions given.

The *claims administrator* has made arrangements with an independent company to make 24/7 Nurseline available to *you* as a special service. It may be discontinued without notice.

Note: 24/7 Nurseline is an optional service. Remember, the best place to go for medical care is *your physician.*

TYPES OF PROVIDERS

PLEASE READ THE FOLLOWING INFORMATION SO *YOU* WILL KNOW FROM WHOM OR WHAT GROUP OF PROVIDERS HEALTH CARE MAY BE OBTAINED. THE MEANINGS OF WORDS AND PHRASES IN ITALICS ARE DESCRIBED IN THE SECTION OF THIS BOOKLET TITLED "DEFINITIONS".

Participating Providers. The *claims administrator* has established a network of various types of "Participating Providers." These providers are called "participating" because they have agreed to participate in the *claims administrator* preferred provider organization program (PPO). They have agreed to provide *covered persons* with health care at a special low cost. The amount of benefits payable under this *plan* will be different for *non-participating providers* than for *participating providers*. See the definition of "Participating Providers" in the DEFINITIONS section for a complete list of the types of providers, which may be *participating providers*.

The *claims administrator* publishes a directory of Participating Providers. You can get a directory from the *claims administrator*. Please call the *claims administrator* at the *claims administrator's* customer service number listed on your ID card, or you may write to the *claims administrator* and ask to have a directory sent to you. You may also search for a *participating provider* as follows:

Go to the Anthem Blue Cross Life and Health Insurance Company website at www.anthem.com/ca. Click the Menu link at the top of the home page. Click on Find a Doctor, login or search as a guest, and choose the details of your search. If searching as a guest, choose your network. If logged in as a member, your research will be populated.

For California Employees:
Choose Medical, then California. Select a Plan Network, choose Blue Cross PPO (Prudent Buyer) - Large Group. Answer a few questions about your location and service. Choose the PPO provider that you want.

For Non-California Employees:
Select your state. Select a Plan/Network. The name of the network will vary by state, but will be an employer-sponsored plan with "National PPO", "Blue-Card PPO", and/or "Anthem PPO" in the name. Answer a few questions about your location and service. Choose the PPO provider that you want.

Non-Participating Providers. "*Non-Participating Providers"* are providers who have not agreed to participate in the *claims administrator* network. They have not agreed to the *negotiated rates* and other provisions of a contract.

Contracting and Non-Contracting Hospitals. Another type of provider is the "Contracting Hospital." This is different from a *hospital,* which is a *participating provider*. The *claims administrator* has traditionally contracted with most hospitals to obtain certain advantages for patients covered by the plans it administers. While only some *hospitals* are *participating providers*, all eligible hospitals are invited to be *contracting hospitals* and most – over **90%** – accept. **For those that do not (called *non-contracting hospitals*), there is a significant benefit penalty in your *plan*.**

Physicians. "Physician" means more than an M.D. Certain other practitioners are included in this term as it is used throughout the *plan*. This doesn't mean they can provide every service that a medical doctor could; it just means that the *plan* will cover expenses you incur from them when they're practicing within their specialty the same as if a medical doctor provided the care. As with the other terms, be sure to read the definition of "Physician" to determine which providers' services are covered. Only providers listed in the definition are covered as *physicians*. Please note

also that certain providers' services are covered only upon referral of an M.D. (medical doctor) or D.O. (doctor of osteopathy). Providers for whom referral is required are indicated in the definition of "physician" by an asterisk (*).

Other Health Care Providers. "Other Health Care Providers" are neither *physicians* nor *hospitals*. They are mostly freestanding facilities or service organizations, such as ambulance companies. See the definition of "Other Health Care Providers" in the DEFINITIONS section for a complete list of those providers. *Other health care providers* are not part of the *plan's* provider network.

Reproductive Health Care Services. Some *hospitals* and other providers do not provide one or more of the following services that may be covered under your *plan* contract and that you or your *family member* might need: family planning; contraceptive services, including emergency contraception; sterilization, including tubal ligation at the time of labor and delivery; infertility treatments; or abortion. You should obtain more information before you enroll. Call your prospective *physician* or clinic, or call the *claims administrator* at the customer service telephone number listed on your ID card to ensure that you can obtain the health care services that you need.

Participating and Non-Participating Pharmacies. "Participating Pharmacies" agree to charge only the *prescription drug negotiated rate* to fill the *prescription*. You pay only your co-payment amount. "Non-Participating Pharmacies" have not agreed to the *prescription drug negotiated rate*. The amount that will be covered as *prescription drug covered expense* is significantly lower than what these providers customarily charge.

Centers of Expertise Transplant Facilities. The *claims administrator* has established a Centers of Expertise (CME) network of transplant facilities to provide services for specified organ transplants (heart, liver, lung, heart-lung, kidney-pancreas, or bone marrow, including autologous bone marrow transplant, peripheral stem cell replacement and similar procedures). **These procedures are covered only at a CME.** These "CME" agree to accept the *CME negotiated rate* as payment in full for covered services. A *participating provider* in the network is not necessarily a *Centers of Expertise* transplant facility.

SUMMARY OF BENEFITS

THE BENEFITS OF THIS *PLAN* ARE PROVIDED ONLY FOR THOSE SERVICES THAT THE *CLAIMS ADMINISTRATOR* DETERMINES TO BE *MEDICALLY NECESSARY*. THE FACT THAT A *PHYSICIAN* PRESCRIBES OR ORDERS A SERVICE DOES NOT, IN ITSELF, MEAN THAT THE SERVICE IS *MEDICALLY NECESSARY* OR THAT THE SERVICE IS A *COVERED EXPENSE*. CONSULT THIS *BOOKLET* OR TELEPHONE THE *CLAIMS ADMINISTRATOR* AT THE NUMBER SHOWN ON YOUR IDENTIFICATION CARD IF *YOU* HAVE ANY QUESTIONS REGARDING WHETHER SERVICES ARE COVERED.

THIS PLAN CONTAINS MANY IMPORTANT TERMS (SUCH AS "MEDICALLY NECESSARY" AND "COVERED EXPENSE") THAT ARE DEFINED IN THE DEFINITIONS SECTION. WHEN READING THROUGH THIS *BOOKLET*, CONSULT THE "DEFINITIONS" SECTION TO BE SURE THAT YOU UNDERSTAND THE MEANINGS OF THESE ITALICIZED WORDS.

This *booklet* contains detailed information regarding the medical benefits provided under the Bank of the West PPO Plan, the Bank of the West Routine Care Plan, and the Bank of the West HSA Plan, which are component plans under the Bank of the West Flexible Benefits Plan. You need to refer to both documents for a complete description of the Bank of the West PPO Plan, the Bank of the West Routine Care Plan, and the Bank of the West HSA Plan.

Second Opinions. If you have a question about your condition or about a plan of treatment that your *physician* has recommended, you may receive a second medical opinion from another *physician*. This second opinion visit will be provided according to the benefits, limitations, and exclusions of this *plan*. If you wish to receive a second medical opinion, remember that greater benefits are provided when you choose a *participating provider*. You may also ask your *physician* to refer you to a *participating provider* to receive a second opinion.

All benefits are subject to coordination with benefits under certain other plans.

The benefits of this *plan* are subject to the SUBROGATION AND REIMBURSEMENT FOR ACTS OF THIRD PARTIES section.

MEDICAL BENEFITS

DEDUCTIBLES

Calendar Year Deductibles

	PPO Plan*	Routine Care Plan*	HSA Plan**
In Network			
– Covered Person Deductible	**$ 500**	**$1,000**	**$1,500**
– Family Deductible	**$1,500**	**$2,000**	**$3,000**
Non-Network			
– Covered Person Deductible	**$1,500**	**$2,000**	**3,000**
– Family Deductible	**$4,500**	**$4,000**	**$6,000**
	Separate in- and out-of-network deductibles	Separate in- and out-of-network deductibles	Combined in- and out-of-network deductibles. Satisfying one helps satisfy the other.

* Each *covered person* has his or her own deductible. The family deductible applies as a maximum for all *covered family members* when their individual deductibles are combined.

** In the HSA Plan, all *covered family members* share the same family deductible.

Exceptions: In certain circumstances, one or more of these deductibles may not apply, as described below:

– Preventive Care Services provided by a *non-participating provider* are not covered.

– The Calendar Year Deductible will not apply to transplant travel expenses authorized by the *claims administrator*. See MEDICAL MANAGEMENT PROGRAMS: AUTHORIZATION PROGRAM for information on how to obtain prior authorization.

	PPO Plan	Routine Care Plan	HSA Plan
Additional Deductibles			
– Emergency Room Deductible	**$100**	**$75**	**None**
– Inpatient Deductible (with preauthorization) (*non-participating providers* only)	**$500**	**$500**	**None**
– Inpatient Deductible (without preauthorization) (*non-participating providers* only)	**$500***	**$500***	**$500***
– Ambulatory Surgical Center Deductible (with preauthorization) (*non-participating providers* only)	**$500**	**$500**	**$500**

– Ambulatory Surgical Center Deductible (without preauthorization) (*non-participating providers* only**)**	**$500***	**$500***	**$500**

***** An additional $500 non-participating provider fee will be added to the applicable deductible.

Exceptions: In certain circumstances, one or more of these deductibles may not apply, as described below:

– The Emergency Room Deductible will not apply if you are admitted as a *hospital* inpatient immediately following emergency room treatment.

– The Inpatient Deductible will not apply to *emergency* admissions, or to the services provided by a *participating provider*.

– The Ambulatory Surgical Center Deductible will not apply to *emergency services,* or to the services of a *participating provider*.

– The Non-Certification Deductible will not apply to *emergency* admissions or services, or to the services provided by a *participating provider*. See MEDICAL MANAGEMENT PROGRAMS.

CO-PAYMENTS/CO-INSURANCE

Co-Insurance.* After you have met your Calendar Year Deductible, and any other applicable deductible, you will be responsible for the following percentages of *covered expense* you incur:

	PPO Plan	**Routine Care Plan**	**HSA Plan**
– *Participating Providers*	**20%**	**30%**	**20%**
– *Other Health Care Providers*	**20%**	**30%**	**20%**
– *Non-Participating Providers*	**40%**	**50%**	**40%**

Note: In addition to the Co-Insurance shown above, you will be required to pay any amount in excess of *covered expense* for the services of any *other health care provider* or a *non-participating provider*.

***Co-Payments (PPO Plan and Routine Care Plan):**

– Your Co-Payment for *non-participating providers* will be the same as for *participating providers* for the following services. You may be responsible for charges that exceed *covered expense*.

  a. *Emergency services* provided by other than a *hospital;*

  b. The first 48 hours of *emergency services* provided by a *hospital* (the *participating provider* Co-Payment will continue to apply to a *non-participating provider* beyond the first 48 hours if you, in the *claims administrator's* judgment, cannot be safely moved);

  c. An *authorized referral* from a *physician* who is a *participating provider* to a *non-participating provider* (see MEDICAL MANAGEMENT PROGRAMS: AUTHORIZATION PROGRAM);

  d. Charges by a type of *physician* not represented in the network (for example, an audiologist); or

  e. Cancer Clinical Trials.

– Your Co-Payment for office visits to a *physician* who is a *participating provide*r will be **$25** under the **PPO Plan** and **$20** under the **Routine Care Plan**. This Co-Payment will not apply toward the satisfaction of any deductible, nor will it apply toward satisfaction of the Out-of-Pocket Amount.

  Note: This exception applies only to the charge for the visit itself. It does not apply to any other charges made during that visit, such as testing procedures, surgery, etc.

– Your Co-Payment for specified organ transplants (heart, liver, lung, heart-lung, kidney-pancreas, or bone marrow, including autologous bone marrow transplant, peripheral stem cell replacement and similar procedures) authorized by the *claims administrator* and performed at a designated *CME* will be the same as for *participating providers*. **Services for specified organ transplants are not covered when performed at other than a designated *CME*.** See MEDICAL MANAGEMENT PROGRAMS: AUTHORIZATION PROGRAM.

– No Co-Payment will be required for the transplant travel expenses authorized by the *claims administrator*. See MEDICAL MANAGEMENT PROGRAMS: AUTHORIZATION PROGRAM.

Out-of-Pocket Amount*. After each *covered person* has made the following total out-of-pocket payments for *covered expense* incurred during a *calendar year,* each *covered person* will no longer be required to pay a Co-Payment or Co-Insurance for the remainder of that *calendar year,* but will remain responsible for costs in excess of *covered expense*. Your Co-Payments, Deductibles, and Co-Insurance payments will count toward the out-of-pocket maximum.

	PPO Plan*	**Routine Care Plan***	**HSA Plan****
– *Participating providers* and *other health care providers*	**$3,200**/*covered person*	**$5,000**/*covered person*	**$4,000**/*covered person*
	$9,600/family	**$10,000**/family	**$9,000**/family
– *Non-participating providers*	**$6,900**/*covered person*	**$10,000**/*covered person*	**$8,000**/*covered person*
	$20,700/family	**$20,000**/family	**$18,000**/family

* Each *covered person* has his or her own out-of-pocket maximum. The family maximum can be satisfied by any combination of *covered family members*.

** In the HSA Plan, all *covered family members* share the same out-of-pocket maximum. The family maximum can be satisfied by any combination of *covered family members*. Additionally, each *covered family member* has an individual maximum out-of-pocket amount of $6,850. For any given *family member*, the out-of-pocket maximum is met either after the *family member* meets his or her individual maximum, or after the entire family out-of-pocket amount is met.

***Exceptions:**

— Expense which is applied toward any deductible, which is incurred for non-covered services or supplies, or which is in excess of the amount of *covered expense* will not be applied toward your Out-of-Pocket Amount, and is always your responsibility.

Non-Contracting Hospital Penalty. *Covered expense* is **reduced by 25%** for services and supplies provided by a *non-contracting hospital*. This penalty will be deducted from *covered expense* prior to calculating your Co-Payment amount, when applicable, and any benefit payment by the *claims administrator* will be based on such reduced *covered expense*. You are responsible for paying this extra expense. This reduction will be waived only for *emergency services*. To avoid this penalty, be sure to choose a *contracting hospital*.

MEDICAL BENEFIT MAXIMUMS

The *plan* will pay, for the following services and supplies, up to the maximum amounts, or for the maximum number of days or visits shown below:

	PPO Plan	Routine Care Plan	HSA Plan
Skilled Nursing Facility			
– For covered *skilled nursing facility* care	**100 days** per *calendar year*	**100 days** per *calendar year*	**100 days** per *calendar year*
Home Health Care			
– For covered home health services	**100 visits** per *calendar year* *4 hours/visit*	**100 visits** per *calendar year* *4 hours/visit*	**100 visits** per *calendar year* *4 hours/visit*
Home Infusion Therapy			
– For all covered services and supplies received during any one day	**$600*** **Non-participating providers* only	**$600*** **Non-participating providers* only	**$600*** **Non-participating providers* only
Hospice Care			
– For family bereavement counseling per visit; up to four visits during the 12 months following your death	**$25**	**$25**	**$25**
– For all covered hospice care (including bereavement counseling)	**No dollar maximum**	**No dollar maximum**	**No dollar maximum**
Well Baby and Well Child Care (Birth through age 6)			
– For routine examinations and immunizations when provided by a *participating provider*	**Covered 100%**	**Covered 100%**	**Covered 100%**
– For routine examinations and immunizations when provided by a *non-participating provider*	Examinations by *non-participating providers* are not covered Immunizations by *non-participating providers* are covered up to **$12 maximum**	*Non-participating providers* are not covered	*Non-participating providers* are not covered

Preventive Care (Age 7 through adult)			
– For routine examinations and immunizations when provided by a *participating provider*	**Covered 100%**	**Covered 100%**	**Covered 100%**
– For routine examinations and immunizations when provided by a *non-participating provider*	*Non-participating providers* are not covered	*Non-participating providers* are not covered	*Non-participating providers* are not covered
Hepatitis Brand Varicella Zoster Immunizations			
– For each immunization (*participating providers* only)	**Covered 100%**	**Covered 100%**	**Covered 100%**
– For each immunization (*non-participating providers* only)	**$12**	*Non-participating providers* are not covered	*Non-participating providers* are not covered
Physical Therapy, Physical Medicine and Occupational Therapy, including Chiropractor			
– For covered outpatient services	**24** visits per *calendar year*	**24** visits per *calendar year*	**24** visits per *calendar year*
– For each covered visit when provided by a *non-participating provider*	**$25 benefit** per visit	**$25 benefit** per visit	**Covered 60%**
Acupuncture			
– For all covered services	**50** visits per *calendar year* **$25** per visit *(participating provider)* **Covered 60%** (*non-participating provider*)	**50** visits per *calendar year* **$25** per visit *(participating provider)* **Covered 50%** (*non-participating provider*)	**50** visits per *calendar year* **Covered 80%** (*participating provider)* **Covered 60%** (*non-participating provider)*
Transplant Travel Expense			
– For the Recipient and One Companion if the Recipient is a minor child, per Transplant Episode *Pre-authorization required*	**$10,000** maximum benefit per transplant	**$10,000** maximum benefit per transplant	**$10,000** maximum benefit per transplant

o Transportation to/from the *CME*	Covered, subject to **$10,000** maximum benefit	Covered, subject to **$10,000** maximum benefit	Covered, subject to $**10,000** maximum benefit
o For lodging accommodations – maximum daily allowance	**$100** per day, limited to one room, double occupancy	**$100** per day, limited to one room, double occupancy	**$100** per day, limited to one room, double occupancy
o For expenses such as meals	**Not covered**	**Not covered**	**Not covered**
– For the Donor per Transplant Episode *Pre-authorization required*	**$10,000** maximum benefit per transplant	**$10,000** maximum benefit per transplant	**$10,000** maximum benefit per transplant
o Transportation to/from the *CME*	Covered, subject to **$10,000** maximum benefit	Covered, subject to **$10,000** maximum benefit	Covered, subject to **$10,000** maximum benefit
o For lodging accommodations – maximum daily allowance	**$100** per day, limited to one room, double occupancy	**$100** per day, limited to one room, double occupancy	**$100** per day, limited to one room, double occupancy
o For expenses such as meals	**Not covered**	**Not covered**	**Not covered**
Bone Marrow Donor Search			
– For all charges for bone marrow donor searches for covered transplants	**$30,000** maximum benefit per transplant	**$30,000** maximum benefit per transplant	**$30,000** maximum benefit per transplant

PRESCRIPTION DRUG BENEFITS

When your prescription is for a *brand name drug*, the pharmacist will substitute it with a *generic drug*. If you or your doctor requests a *brand name drug* when a *generic drug* substitution exists, you will be responsible for the brand name coinsurance plus the difference in cost between the *generic drug* and the cost of the *brand name drug*. This additional cost will apply even if your physician has indicated "DAW" (Dispense as Written) on the prescription.

PRESCRIPTION DRUG CO-PAYMENTS AND CO-INSURANCE. The following Co-Payments/Co-Insurance apply for each *prescription*:

	PPO Plan	**Routine Care Plan**	**HSA Plan** (after annual deductible)
Participating Pharmacies (30-day supply)			
– *Generic Drugs*	**$5**	**$5**	**20%** of prescription drug *covered expense*
– *Brand Name Formulary Drugs**	**30%** of prescription drug *covered expense* up to **$90** maximum ; **$30** minimum	**30%** of prescription drug *covered expense* up to **$90** maximum; **$30** minimum	**20%** of prescription drug *covered expense*
– *Brand Name Non-Formulary Drugs**	**50%** of prescription drug *covered expense* up to **$150** maximum; **$50** minimum	**50%** of prescription drug *covered expense* up to **$150** maximum; **$50** minimum	**20%** of prescription drug *covered expense* **$50** minimum

***** When your prescription is for a *brand name drug*, the pharmacist will substitute it with a *generic drug*. If you or your doctor requests a *brand name drug* when a *generic drug* substitution exists, you will be responsible for the brand name coinsurance plus the difference in cost between the *generic drug* and the cost of the *brand name drug*. This additional cost will apply even if your physician has indicated "DAW" (Dispense as Written) on the prescription.

Please note that presentation of a prescription to a pharmacy or pharmacist does not constitute a claim for benefit coverage. If you present a *prescription* to a *participating pharmacy*, and the *participating pharmacy* indicates your *prescription* cannot be filled, your deductible, if any, needs to be satisfied, or requires an additional Co-Payment, this is not considered an adverse claim decision. If you want the *prescription* filled, you will have to pay either the full cost, or the additional Co-Payment, for the *prescription drug*. If you believe you are entitled to some *plan* benefits in connection with the *prescription drug*, submit a claim for reimbursement to the *claims administrator*.

	PPO Plan	**Routine Care Plan**	**HSA Plan**
Non-Participating Pharmacies (30-day supply)			
– *Generic Drugs*	**$5** plus **50%** of prescription drug *covered expense*	**$5** plus **50%** of prescription drug *covered expense*	**40%** of prescription drug *covered expense* plus costs in

	plus costs in excess of *covered expense*	plus costs in excess of *covered expense*	excess of *covered expense*
– *Brand Name Formulary Drugs**	Up to **$90** maximum copay; **$30** minimum copay plus **50%** of prescription drug *covered expense* plus costs in excess of *covered expense*	Up to **$90** maximum copay; **$30** minimum copay plus **50%** of prescription drug *covered expense* plus costs in excess of *covered expense*	**40%** of prescription drug *covered expense* plus costs in excess of *covered expense*
– *Brand Name Non-Formulary Drugs**	Up to **$90** maximum copay; **$30** minimum copay plus **50%** of prescription drug *covered expense* plus costs in excess of *covered expense*	Up to **$90** maximum copay; **$30** minimum copay plus **50%** of prescription drug *covered expense* plus costs in excess of *covered expense*	**40%** of prescription drug *covered expense* plus costs in excess of *covered expense*

***** When your prescription is for a *brand name drug*, the pharmacist will substitute it with a *generic drug*. If you or your doctor requests a *brand name drug* when a *generic drug* substitution exists, you will be responsible for the brand name coinsurance plus the difference in cost between the *generic drug* and the cost of the *brand name drug*. This additional cost will apply even if your physician has indicated "DAW" (Dispense as Written) on the prescription.

Mail Service Prescriptions (90-day supply)

	PPO Plan	**Routine Care Plan**	**HSA Plan**
– *Generic Drugs*	**$10**	**$10**	**20%** of prescription drug *covered expense*
– *Brand Name Formulary Drugs**	**30%** of prescription drug *covered expense* up to **$225** maximum; **$75** minimum	**30%** of prescription drug *covered expense* up to **$225** maximum; **$75** minimum	**20%** of prescription drug *covered expense*
– *Brand Name Non-Formulary Drugs**	**50%** of prescription drug *covered expense* up to **$375** maximum; **$125** minimum	**50%** of prescription drug *covered expense* up to **$375** maximum; **$125** minimum	**20%** of prescription drug *covered expense* **$125** minimum

* When your prescription is for a *brand name drug*, the pharmacist will substitute it with a *generic drug*. If you or your doctor requests a *brand name drug* when a *generic drug* substitution exists, you will be responsible for the brand name coinsurance plus the difference in cost between the *generic drug* and the cost of the *brand name drug*. This additional cost will apply even if your physician has indicated "DAW" (Dispense as Written) on the prescription.

****Important Note About Prescription Drug Covered Expense and Your Co-Payment:**
At a *nonparticipating pharmacy*, the plan covers significantly less than what the providers may charge for a prescription, so you will almost always have a higher out-of-pocket expense. However, the overall out-of-pocket expense at a *nonparticipating pharmacy* will not exceed the total cost of the drug.

YOU WILL BE REQUIRED TO PAY YOUR CO-PAYMENT OR CO-INSURANCE AMOUNT TO THE PARTICIPATING PHARMACY AT THE TIME YOUR PRESCRIPTION IS FILLED.

YOUR MEDICAL BENEFITS
HOW COVERED EXPENSE IS DETERMINED

The *plan* will pay for *covered expense* you incur under this *plan*. A charge is incurred when the service or supply giving rise to the charge is rendered or received. *Covered expense* for medical benefits is based on a maximum charge for each covered service or supply that will be accepted by the *claims administrator* for each different type of provider. It is not necessarily the amount a provider bills for the service.

Participating Providers and CME. The maximum *covered expense* for services provided by a *participating provider* or *CME* will be the lesser of the billed charge or the *negotiated rate*. *Participating providers* and *CME* have agreed not to charge you more than the *negotiated rate* for covered services. When you choose a *participating provider,* you will not be responsible for any amount in excess of the *negotiated rate*. If you receive an authorized, specified organ transplant at a *CME*, you will not be responsible for any amount in excess of the *CME negotiated rate* for the covered services of a *CME*.

If you go to a *hospital* that is a *participating provider,* you should not assume all providers in that *hospital* are also *participating providers*. To receive the greater benefits afforded when covered services are provided by a *participating provider,* you should request that all your provider services (such as services by an anesthesiologist) be performed by *participating providers* whenever you enter a *hospital*.

If you are planning to have outpatient surgery, you should first find out if the facility where the surgery is to be performed is an *ambulatory surgical center.* An *ambulatory surgical center* is licensed as a separate facility even though it may be located on the same grounds as a *hospital* (although this is not always the case). If the center is licensed separately, you should find out if the facility is a *participating provider* before undergoing the surgery.

Non-Participating Providers and Other Health Care Providers. The maximum *covered expense* for services provided by a *non-participating* or *other health care provider* will always be the lesser of the billed charge or (1) for a *physician,* the *customary and reasonable charge* or (2) for other than a *physician,* the *reasonable charge*. You will be responsible for any billed charge which exceeds the *customary and reasonable charge* or the r*easonable charge*.

The maximum *covered expense* for *non-participating providers* for services and supplies provided in connection with Cancer Clinical Trials will be the lesser of the billed charge or the amount that ordinarily applies when services are provided by a *participating provider*.

Exception: If Medicare is the primary payor, *covered expense* does not include any charge:

1. By a *hospital,* in excess of the approved amount as determined by Medicare; or

2. By a *physician* who is a *participating provider* who accepts Medicare assignment, in excess of the approved amount as determined by Medicare; or

3. By a *physician* who is a *non-participating provider* or *other health care provider* who accepts Medicare assignment, in excess of the lesser of maximum *covered expense* stated above, or the approved amount as determined by Medicare; or

4. By a *physician* or *other health care provider* who does not accept Medicare assignment, in excess of the lesser of the maximum *covered expense* stated above, or the limiting charge as determined by Medicare.

You will always be responsible for expense incurred which is not covered under this *plan*.

WARNING! Reduction of *Covered Expense* for *Non-Contracting Hospitals*. A small percentage of *hospitals* which are *non-participating providers* are also *non-contracting hospitals*. Except for *emergency* care, *covered expense* **is reduced by 25%** for all services and supplies provided by a *non-contracting hospital*. You will be responsible for paying this amount. You are strongly encouraged to avoid this additional expense by seeking care from a *contracting hospital*. **You can call the customer service number on your identification card to locate a *contracting hospital*.**

DEDUCTIBLES, CO-PAYMENTS AND CO-INSURANCE, OUT-OF-POCKET AMOUNTS, AND MEDICAL BENEFIT MAXIMUMS

After *the claims administrator* subtracts any applicable deductible and your Co-Payment, the *claims administrator* will pay benefits up to the amount of *covered expense,* not to exceed the applicable Medical Benefit Maximum. The Deductible amounts, Co-Payments, Co-Insurance percentages, Out-of-Pocket Amounts and Medical Benefit Maximums are set forth in the SUMMARY OF BENEFITS.

DEDUCTIBLES

Each deductible under this *plan* is separate and distinct from the other. Only charges that are considered *covered expense* will apply toward satisfaction of any deductible.

Calendar Year Deductible. Each *year,* you will be responsible for satisfying the *covered person's* Calendar Year Deductible before the *claims administrator* begins to pay benefits for that *covered person* under the PPO and Routine Care Plans. The *covered expenses* of all *covered persons* of an enrolled family apply toward satisfaction of the Calendar Year Deductible under the HSA Plan.

Family Deductible. The first three *covered persons* of an enrolled family in the PPO Plan and the first two *covered persons* of an enrolled family in the Routine Care Plan who satisfy their Calendar Year Deductibles will satisfy the Family Deductible. Once the Family Deductible is satisfied, no further Calendar Year Deductible expense will be required for any enrolled member of that family. However, the *claims administrator* will not credit any expense previously applied to the Calendar Year Deductible of any other member of the family. Under the HSA Plan, the *covered expenses* of all *covered persons* of an enrolled family apply toward satisfaction of the Family Deductible.

Additional Deductibles

1. Each time you visit an emergency room for treatment, you will be responsible for paying the Emergency Room Deductible. But this deductible will not apply if you are admitted as a *hospital* inpatient from the emergency room immediately following emergency room treatment.

2. Each time you are admitted to a *hospital* or *residential treatment center* that is a *non-participating provider,* you are responsible for paying the Inpatient Deductible. This deductible will not apply to an *emergency* admission.

3. Each time you have outpatient surgery at an *ambulatory surgical center* that is a *non-participating provider,* you are responsible for paying the Ambulatory Surgical Center Deductible. This deductible will not apply to *emergency* surgery.

4. Each time you are admitted to a *hospital* or *residential treatment center* or have outpatient surgery at an *ambulatory surgical center* without properly obtaining Preauthorization, you are responsible for paying the Preauthorization Deductible. This deductible will not apply to an *emergency* admission or procedure, or to services provided at a *participating provider*. Preauthorization is explained in MEDICAL MANAGEMENT PROGRAMS: UTILIZATION REVIEW PROGRAM.

CO-PAYMENTS AND CO-INSURANCE

After you have satisfied any applicable deductible, the *claims administrator* will subtract any applicable Co-Payment and Co-Insurance from the amount of *covered expense* remaining. The *claims administrator* will apply the applicable percentage to the amount of *covered expense* remaining after any deductible has been met.

OUT-OF-POCKET AMOUNTS

Satisfaction of the Out-of-Pocket Amount. If, after you have met your Calendar Year Deductible, you pay Co-Payments or Co-Insurance equal to your Out-of-Pocket Amount per *covered person* during a *calendar year*, you will no longer be required to make Co-Payments or Co-Insurance for any *covered expense* you incur during the remainder of that *year*.

Participating Providers, CMEs and Other Health Care Providers. Under the PPO and Routine Care Plans, only *covered expense* for the services of a *participating provider, CME* or *other health care provider* will be applied to the *participating provider* and *other health care provider* Out-of-Pocket Amount. After this Out-of-Pocket Amount per *covered person* has been satisfied during a *calendar year*, you will no longer be required to make any Co-Payment for the covered services provided by a *participating provider, CME* or *other health care provider* for the remainder of that *year*.

Non-Participating Providers. Under the PPO and Routine Care Plans, only *covered expense* for the services of a *non-participating provider* will be applied to the *non-participating provider* Out-of-Pocket Amount. After this Out-of-Pocket Amount per *covered person* has been satisfied during a *calendar year*, you will no longer be required to make any Co-Payment or Co-Insurance for the *covered services* provided by a *non-participating provider* for the remainder of that *year***.**

Under the HSA Plan, *covered expenses* of *participating providers* and *non-participating providers* are combined for purpose of satisfying the Out-of-Pocket Amount. There is also an individual maximum Out-of-Pocket amount for each *covered family member*.

MEDICAL BENEFIT MAXIMUMS

The *plan* does not make benefit payments for any *covered person* in excess of any of the Medical Benefit Maximums.

CONDITIONS OF COVERAGE

The following conditions of coverage must be met for expense incurred for services or supplies to be considered a *covered expense*.

1. *You* must incur this expense while you are covered under this *plan*. Expense is incurred on the date *you* receive the service or supply for which the charge is made.

2. The expense must be for a medical service or supply furnished to *you* as a result of illness or injury or pregnancy, unless a specific exception is made.

3. The expense must be for a medical service or supply included in MEDICAL CARE THAT IS COVERED. Additional limits on *covered expense* are included under specific benefits and in the SUMMARY OF BENEFITS.

4. The expense must not be for a medical service or supply listed in MEDICAL CARE THAT IS NOT COVERED. If the service or supply is partially excluded, then only that portion which is not excluded will be considered *covered expense*.

5. The expense must not exceed any of the maximum benefits or limitations of this *plan*.

6. Any services received must be those which are regularly provided and billed by the provider. In addition, those services must be consistent with the illness, injury, degree of disability and your medical needs. Benefits are provided only for the number of days required to treat your illness or injury.

7. A *physician* must order all services and supplies.

MEDICAL CARE THAT IS COVERED

Subject to the Medical Benefit Maximums in the SUMMARY OF BENEFITS, the requirements set forth under CONDITIONS OF COVERAGE and the exclusions or limitations listed under MEDICAL CARE THAT IS NOT COVERED, the *claims administrator* will provide benefits for the following services and supplies:

Acupuncture. The services of a *physician* for acupuncture treatment to treat a disease, illness or injury, including a patient history visit, physical examination, treatment planning and treatment evaluation, electroacupuncture, cupping and moxibustion. The *plan* will pay for up to 50 visits during a *calendar year*.

Ambulance. The following ambulance services:

1. Base charge, mileage and non-reusable supplies of a licensed ambulance company for ground service to transport you to and from a *hospital*.

2. Emergency services or transportation services that are provided to you by a licensed ambulance company as a result of a "911" emergency response system* request for assistance if you believe you have an *emergency* medical condition requiring such assistance.

3. Base charge, mileage and non-reusable supplies of a licensed air ambulance company to transport you from the area where you are first disabled to the nearest *hospital* where appropriate treatment is provided if, and only if, such services are *medically necessary* and ground ambulance service is inadequate.

4. Monitoring, electrocardiograms (EKGs; ECGs), cardiac defibrillation, cardiopulmonary resuscitation (CPR) and administration of oxygen and intravenous (IV) solutions in connection with ambulance service. An appropriately licensed person must render the services.

* If you have an *emergency* medical condition that requires an emergency response, please call the "911" emergency response system if you are in an area where the system is established and operating.

Ambulatory Surgical Center. Services and supplies provided by an *ambulatory surgical center* in connection with outpatient surgery.

Autism. Applied Behavioral Analysis (ABA) therapy provided by an ABA-certified *physician*.

Bariatric Surgery. Bariatric surgical procedures when determined by the *claims administrator* to be *medically necessary*.

Blood. Blood transfusions, including blood processing and the cost of unreplaced blood and blood products. Charges for the collection, processing and storage of self-donated blood are covered, but only when specifically collected for a planned and covered surgical procedure.

Breast Cancer. Services and supplies provided in connection with the screening for, diagnosis of, and treatment for breast cancer, including:

1. Routine and diagnostic mammogram examinations.

2. Mastectomy and lymph node dissection; complications from a mastectomy including lymphedema.

3. Reconstructive surgery performed to restore and achieve symmetry following a *medically necessary* mastectomy.

4. Breast prostheses following a mastectomy (see "Prosthetic Devices").

Cancer Clinical Trials. Coverage is provided for services and supplies for routine patient care costs, as defined below, in connection with phase I, phase II, phase III and phase IV cancer clinical trials, if all the following conditions are met:

1. The treatment provided in a clinical trial must either:

a. Involve a *drug* that is exempt under federal regulations from a new drug application, or

b. Be approved by (i) one of the National Institutes of Health, (ii) the federal Food and Drug Administration in the form of an investigational new drug application, (iii) the United States Department of Defense, or (iv) the Department of Veterans Affairs.

2. You must be diagnosed with cancer to be eligible for participation in these clinical trials.

3. Participation in such clinical trials must be recommended by your *physician* after determining participation has a meaningful potential to benefit the *covered person*.

4. For the purpose of this provision, a clinical trial must have a therapeutic intent. Clinical trials to just test toxicity are not included in this coverage.

Routine patient care costs means the costs associated with the provision of services, including drugs, items, devices and services which would otherwise be covered under the *plan*, including health care services which are:

1. Typically provided absent a clinical trial.

2. Required solely for the provision of the investigational drug, item, device or service.

3. Clinically appropriate monitoring of the investigational item or service.

4. Prevention of complications arising from the provision of the investigational drug, item, device, or service.

5. Reasonable and necessary care arising from the provision of the investigational drug, item, device, or service, including the diagnosis or treatment of the complications.

Routine patient care costs do not include any of the items listed below. You will be responsible for the costs associated with any of the following, in addition to the costs of non-covered services.

1. *Drugs* or devices not approved by the federal Food and Drug Administration that are associated with the clinical trial.

2. Services other than health care services, such as travel, housing, companion expenses and other nonclinical expenses that you may require as a result of the treatment provided for the purposes of the clinical trial.

3. Any item or service provided solely to satisfy data collection and analysis needs not used in the clinical management of the patient.

4. Health care services that, except for the fact they are provided in a clinical trial, are otherwise specifically excluded from the *plan*.

5. Health care services customarily provided by the research sponsors free of charge to *covered persons* enrolled in the trial.

Cervical Cancer Screening. Services and supplies provided in connection with a routine test to detect cervical cancer, including Pap smears and any cervical cancer screening test approved by the federal Food and Drug Administration upon referral by your *physician*.

Chemotherapy

Dental Care

1. **Admissions for Dental Care.** Listed inpatient *hospital* services for up to three days during a *hospital stay,* when such *stay* is required for dental treatment and has been ordered by a *physician* (M.D.) and a dentist (D.D.S. or D.M.D.). The *claims administrator* will make the final determination as to whether the dental treatment could have been safely rendered in another setting due to the nature of the procedure or your

medical condition. *Hospital stays* for the purpose of administering general anesthesia are not considered necessary and are not covered except as specified in #2, below.

2. **General Anesthesia.** General anesthesia and associated facility charges when your clinical status or underlying medical condition requires that dental procedures be rendered in a *hospital* or a*mbulatory surgical center*. This applies only if (a) the *covered person* is less than seven years old, (b) the *covered person* is developmentally disabled, or (c) the *covered person's* health is compromised and general anesthesia is *medically necessary*. Charges for the dental procedure itself, including professional fees of a dentist, are not covered.

3. **Dental Injury.** Services of a *physician* (M.D.) or dentist (D.D.S. or D.M.D.) solely to treat an *accidental injury* to natural teeth. Coverage shall be limited to only such services that are *medically necessary* to repair the damage done by *accidental injury* and/or restore function lost as a direct result of the *accidental injury*. Damage to natural teeth due to chewing or biting is not *accidental injury*.

Diabetes. Services and supplies provided for the treatment of diabetes, including:

1. The following equipment and supplies:

    a. Blood glucose monitors, including monitors designed to assist the visually impaired, and blood glucose testing strips.

    b. Insulin pumps.

    c. Pen delivery systems for insulin administration (non-disposable).

    d. Podiatric devices, such as therapeutic shoes and shoe inserts, to treat diabetes-related complications.

    e. Visual aids (but not eyeglasses) to help the visually impaired to properly dose insulin.

    These covered equipment and supplies are covered under your *plan's* benefits for durable medical equipment (see "Durable Medical Equipment").

2. Diabetes education program which:

    a. Is designed to teach a *covered person* who is a patient and covered members of the patient's family about the disease process and the daily management of diabetic therapy;

    b. Includes self-management training, education, and medical nutrition therapy to enable the *covered person* to properly use the equipment, supplies, and medications necessary to manage the disease; and

    c. Is supervised by a *physician*.

Diabetes education services are covered under *plan* benefits for office visits to *physicians*.

3. The following items are covered under your *prescription drug* benefits:

    a. Insulin, glucagon, and other *prescription drugs* for the treatment of diabetes.

    b. Insulin syringes, disposable pen delivery systems for insulin administration.

    c. Testing strips, lancets, and alcohol swabs.

These items must be obtained either from a retail *pharmacy* or through the mail service program (see YOUR PRESCRIPTION DRUG BENEFITS).

Diagnostic Services. Outpatient diagnostic imaging and laboratory services.

Durable Medical Equipment. Rental or purchase of dialysis equipment; dialysis supplies. Therapeutic shoes and inserts for the prevention and treatment of diabetes-related foot complications. Rental or purchase of other medical equipment and supplies which are:

1. Of no further use when medical needs end (but not disposable);

2. For the exclusive use of the patient;

3. Not primarily for comfort or hygiene;

4. Not for environmental control or for exercise; and

5. Manufactured specifically for medical use.

The *claims administrator* will determine whether the item satisfies the conditions above.

Gender Reassignment Surgery. Gender reassignment surgery for a *covered person* who is diagnosed with gender dysphoria, if the *claims administrator* determines that the surgery is *medically necessary*.

Hearing Aid Services. The following hearing aid services are covered when provided by or purchased as a result of a written recommendation from an otolaryngologist or a state-certified audiologist.

1. Audiological evaluations to measure the extent of hearing loss and determine the most appropriate make and model of hearing aid. These evaluations will be covered under *plan* benefits for office visits to *physicians*.

2. Hearing aids (monaural or binaural) including ear mold(s), the hearing aid instrument, batteries, cords and other ancillary equipment.

3. Visits for fitting, counseling, adjustments and repairs for a one-year period after receiving the covered hearing aid.

These items and services are covered under your *plan's* benefits for durable medical equipment (see "Durable Medical Equipment").

No benefits will be provided for the following:

1. Charges for a hearing aid which exceeds specifications prescribed for the correction of hearing loss.

2. Surgically implanted hearing devices (i.e., cochlear implants, audient bone conduction devices). *Medically necessary* surgically implanted hearing devices may be covered under your *plan's* benefits for prosthetic devices (see "Prosthetic Devices").

Hepatitis B and Varicella Zoster Immunizations. Hepatitis B and Varicella Zoster (chickenpox) immunizations by *non-participating providers* are not covered.

Home Health Care. The following services provided by a *home health agency:*

1. Services of a registered nurse or licensed vocational nurse under the supervision of a registered nurse or a *physician*.

2. Services of a licensed therapist for physical therapy, occupational therapy, speech therapy, or respiratory therapy.

3. Services of a medical social service worker.

4. Services of a health aide who is employed by (or who contracts with) a *home health agency*. Services must be ordered and supervised by a registered nurse employed by the *home health agency* as professional coordinator. These services are covered only if you are also receiving the services listed in 1 or 2 above.

5. Medically necessary supplies provided by the home health agency.

In no event will benefits exceed 100 visits during a *calendar year*. A visit of four hours or less by a home health aide shall be considered as one home health visit. Home health care services are subject to prior authorization to determine medical necessity. Please refer to MEDICAL MANAGEMENT PROGRAMS: AUTHORIZATION PROGRAM for information on how to obtain the proper reviews. Home health care services are not covered if received while you are receiving benefits under the "Hospice Care" provision of this section.

Home Infusion Therapy. The following services and supplies when provided by a *home infusion therapy provider* in your home for the intravenous administration of your total daily nutritional intake or fluid requirements, medication related to illness or injury, chemotherapy, antibiotic therapy, aerosol therapy, tocolytic therapy, special therapy, intravenous hydration, or pain management:

1. Medication, ancillary medical supplies and supply delivery (not to exceed a 14-day supply); however, medication which is delivered but not administered is not covered;

2. Pharmacy compounding and dispensing services (including pharmacy support) for intravenous solutions and medications;

3. *Hospital* and home clinical visits related to the administration of infusion therapy, including skilled nursing services including those provided for: (a) patient or alternative caregiver training; and (b) visits to monitor the therapy;

4. Rental and purchase charges for durable medical equipment (as shown below); maintenance and repair charges for such equipment;

5. Laboratory services to monitor the patient's response to therapy regimen.

The *plan's* maximum payment will not exceed **$600** for the services or supplies received during any one day when provided by a *home infusion therapy provider* which is not a *participating provider*.

Home infusion therapy provider services are subject to prior authorization to determine medical necessity. See MEDICAL MANAGEMENT PROGRAMS: AUTHORIZATION PROGRAM for details.

Hospice Care. The services and supplies listed below are covered when provided by a *hospice* for the palliative treatment of pain and other symptoms associated with a terminal disease. You must be suffering from a terminal illness for which the prognosis of life expectancy is 6 months or less, as certified by your *physician* and submitted to the *claims administrator*. Covered services are available on a 24-hour basis for the management of your condition.

1. Interdisciplinary team care with the development and maintenance of an appropriate plan of care.

2. Short-term inpatient *hospital* care when required in periods of crisis or as respite care. Coverage of inpatient respite care is provided on an occasional basis and is limited to a maximum of five consecutive days per admission.

3. Skilled nursing services provided by or under the supervision of a registered nurse. Certified home health aide services and homemaker services provided under the supervision of a registered nurse.

4. Social services and counseling services provided by a qualified social worker.

5. Dietary and nutritional guidance. Nutritional support such as intravenous feeding or hyperalimentation.

6. Physical therapy, occupational therapy, speech therapy, and respiratory therapy provided by a licensed therapist.

7. Volunteer services provided by trained *hospice* volunteers under the direction of a *hospice* staff member.

8. Pharmaceuticals, medical equipment, and supplies necessary for the management of your condition. Oxygen and related respiratory therapy supplies.

9. Bereavement services, including assessment of the needs of the bereaved family and development of a care plan to meet those needs, both prior to and following the *employee's* or *retiree's* or the *family member's* death. Bereavement services are available to surviving members of the immediate family for a period of one year after the death. Bereavement services are limited to 4 visits and include a **$25** copay for each visit. Your immediate family means your spouse, children, stepchildren, parents, and siblings.

10. Palliative care (care which controls pain and relieves symptoms, but does not cure) which is appropriate for the illness.

Your *physician* must consent to your care by the *hospice* and must be consulted in the development of your treatment plan. The *hospice* must submit a written treatment plan to the *claims administrator* every 30 days.

Hospital

1. Inpatient services and supplies, provided by a *hospital*. *Covered expense* will not include charges in excess of the *hospital's* prevailing two-bed room rate unless there is a negotiated per diem rate between the *hospital* and *the claims administrator,* or unless your *physician* orders, and the *claims administrator* authorizes, a private room as *medically necessary*.

2. Services in special care units.

3. Outpatient services and supplies provided by a *hospital,* including outpatient surgery.

Jaw Joint Disorders. The *plan* will pay for splint therapy or surgical treatment for disorders or conditions of the joints linking the jawbones and the skull (the temporomandibular joints), including the complex of muscles, nerves and other tissues related to those joints.

Mental or Nervous Disorders. Covered services shown below for the treatment of *mental or nervous disorders*, provided such services offer a reasonable expectation of improvement and are the lowest level of care consistent with safe medical practice.

1. Inpatient *hospital* services as stated in the "Hospital" provision of this section and services from a *residential treatment center*

2. Visits to a *day treatment center*

3. *Physician* visits during a covered inpatient *stay* or for outpatient psychotherapy or psychological testing for the treatment of *mental or nervous disorders*. *Physician* visits for rehabilitative care (such as physical therapy, occupational therapy, or speech therapy) for the treatment of *mental or nervous disorders*.

Covered services for the treatment of *severe mental disorders* will not be subject to any limitations applicable to *mental or nervous disorders* shown in the SUMMARY OF BENEFITS or under these "Mental or Nervous Disorders" provisions. Such services will be subject to all other terms, conditions, limitations and exclusions, including applicable Medical Benefit Maximums. Please refer to the DEFINITIONS section for a description of "severe mental disorders."

Organ and Tissue Transplants. Services provided in connection with a non-investigative organ or tissue transplant, if you are:

1. The organ or tissue recipient; or

2. The organ or tissue donor.

If you are the recipient, an organ or tissue donor who is not a *covered person* is also eligible for services as described. Benefits are reduced by any amounts paid or payable by that donor's own coverage.

Covered expense does not include charges for services received without first obtaining the *claims administrator's* prior authorization, or which are provided at a facility other than a transplant center approved by the *claims administrator*. See MEDICAL MANAGEMENT PROGRAMS: AUTHORIZATION PROGRAM for details.

You must obtain the *claims administrator's* prior authorization for all services related to specified organ transplants (heart, liver, lung, heart-lung, kidney-pancreas, or bone marrow, including autologous bone marrow transplant, peripheral stem cell replacement and similar procedures) including, but not limited to, preoperative tests and postoperative care.

Specified organ transplants must be performed at a *Center of Expertise (CME)*. **Charges for services provided for or in connection with a specified organ transplant performed at a facility other than a *CME* will not be considered *covered expense*.** See MEDICAL MANAGEMENT PROGRAMS: AUTHORIZATION PROGRAM for details.

Other Cancer Screening Tests. Services and supplies provided in connection with all generally medically accepted cancer screening tests. This coverage is provided according to the terms and conditions of this *plan* that apply to all other medical conditions.

Outpatient Speech Therapy. Outpatient speech therapy following injury or organic disease.

Physical Therapy, Physical Medicine and Occupational Therapy.

The following services provided by a *physician* under a treatment plan which offers a reasonable expectation of significant improvement:

1. Physical therapy and physical medicine provided on an outpatient basis for the treatment of illness or injury including the therapeutic use of heat, cold, exercise, electricity, ultraviolet radiation, manipulation of the spine, or massage for the purpose of improving circulation, strengthening muscles, or encouraging the return of motion. (This includes many types of care which are customarily provided by chiropractors, physical therapists and osteopaths.)

2. Occupational therapy provided on an outpatient basis when the ability to perform daily life tasks has been lost or reduced by illness or injury, including programs which are designed to rehabilitate mentally, physically or emotionally handicapped persons. Occupational therapy programs are designed to maximize or improve a patient's upper extremity function, perceptual motor skills and ability to function in daily living activities.

Benefits are not payable for care provided to relieve general soreness or for conditions that may be expected to improve without treatment. For the purposes of this benefit, the term "visit" shall include any visit by a *physician* in that *physician's* office, or in any other outpatient setting, during which one or more of the services covered under this limited benefit are rendered, even if other services are provided during the same visit.

For the services of a *non-participating provider* only, the *claims administrator's* maximum payment under the PPO Plan and the Routine Care Plan is limited to **$25** for each visit.

Up to a combined maximum of 24 visits in a *year* for all covered services are payable. But, if the *claims administrator* determines that an additional period of physical therapy, physical medicine or occupational therapy is both *medically necessary* and likely to result in a significant improvement to your condition by measurably reducing your physical impairment during that period of additional care, the *claims administrator* will authorize a specific number of additional visits.

Such additional visits are not payable if prior authorization is not obtained and remain limited under the PPO Plan and the Routine Care Plan to **$25** for each authorized additional visit to a *non-participating provider*. (See MEDICAL MANAGEMENT PROGRAMS: AUTHORIZATION PROGRAM.)

Pregnancy and Maternity Care

1. All medical benefits when provided for pregnancy or maternity care, including diagnosis of genetic disorders in cases of high-risk pregnancy. Inpatient *hospital* benefits in connection with childbirth will be provided for at least 48 hours following a normal delivery or 96 hours following a cesarean section, unless the mother and her *physician* decide on an earlier discharge.

2. Medical *hospital* benefits for routine nursery care of a newborn *child,* if the *child's* natural mother is an *employee or retiree,* an enrolled *spouse,* or a *domestic partner*.

Prescription Drug for Abortion. Mifepristone is covered when provided under the Food and Drug Administration (FDA) approved treatment regimen.

Preventive Care (Covered Persons Age 7 and Over). The following services are covered when provided for *covered persons* age 7 and over by a *participating provider*:

1. A *physician's* services for routine physical examinations.

2. Immunizations given as standard medical practice.

3. Radiology and laboratory services and tests ordered by the examining *physician* in connection with a routine physical examination.

Preventive Care services are covered only if provided by a *participating provider*. Hepatitis B and Varicella Zoster Immunizations, Prostate Cancer Screenings, Cervical Cancer Screenings and Breast Cancer Screenings are not provided under these preventive care benefits, except as required by law, but are provided under other benefits specifically stated under this section.

Professional Services

1. Services of a *physician*.

2. Services of an anesthetist (M.D. or C.R.N.A.).

Prostate Cancer Screening. Services and supplies provided in connection with routine tests to detect prostate cancer.

Prosthetic Devices

1. Breast prostheses following a mastectomy.

2. *Prosthetic devices* to restore a method of speaking when required as a result of a covered *medically necessary* laryngectomy.

3. The *plan* will pay for other *medically necessary prosthetic devices,* including:

    a. Surgical implants;

    b. Artificial limbs or eyes; and

    c. The first pair of contact lenses or eye glasses when required as a result of a covered *medically necessary* eye surgery.

Radiation Therapy

Reconstructive Surgery. Reconstructive surgery performed to correct deformities caused by congenital or developmental abnormalities, illness, or injury for the purpose of improving bodily function or symptomatology or creating a normal appearance.

Screening for Blood Lead Levels. Services and supplies provided in connection with screening for blood lead levels if your *child* is at risk for lead poisoning, as determined by your *physician,* when the screening is prescribed by your *physician*.

Severe mental disorders include the following psychiatric diagnoses specified: schizophrenia, schizoaffective disorder, bipolar disorder, major depression, panic disorder, obsessive-compulsive disorder, pervasive developmental disorder or autism, anorexia, and bulimia. "Severe mental disorders" also includes serious emotional disturbances of a child as indicated by the presence of one or more mental disorders as identified in the Diagnostic and Statistical Manual (DSM) of Mental Disorders, other than primary substance abuse or developmental disorder, resulting in behavior inappropriate to the *child's* age according to expected developmental norms. The *child* must also meet one or more of the following criteria:

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

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

3. The *child* meets special education eligibility requirements under state law.

Benefits for severe mental disorders will be provided according to the *plan's* benefits for medical conditions, and will not be subject to *plan* provisions for *mental or nervous disorders.*

Skilled Nursing Facility. Inpatient services and supplies provided by a *skilled nursing facility,* for up to 100 days per *calendar year*. The amount by which your room charge exceeds the prevailing two-bed room rate of the *skilled nursing facility* is not considered *covered expense*. For the purpose of care provided for the treatment of *severe mental disorders* or substance abuse, the term "skilled nursing facility" includes *residential treatment center*.

Skilled nursing facility services and supplies are subject to prior authorization to determine medical necessity. Please refer to MEDICAL MANAGEMENT PROGRAMS for information on how to obtain the proper reviews.

Special Food Products. Special food products and formulas that are part of a diet prescribed by a *physician* for the treatment of phenylketonuria (PKU). Most formulas used in the treatment of PKU are obtained from a *pharmacy* and are covered under your *plan's prescription drug* benefits (see YOUR PRESCRIPTION DRUG BENEFITS). Special food products that are not available from a *pharmacy* are covered as medical supplies under your *plan's* medical benefits.

Substance Abuse. Covered services shown below for the treatment of substance abuse, provided such services offer a reasonable expectation of improvement and are the lowest level of care consistent with safe medical practice.

1. Inpatient *hospital* services as stated in the "Hospital" provision of this section and services from a *residential treatment center*.

2. Visits to a *day treatment center*.

3. *Physician* visits during a covered inpatient *stay* or for outpatient treatment of substance abuse. *Physician* visits for rehabilitative care (such as physical therapy, occupational therapy, or speech therapy).

Treatment for substance abuse does not include smoking cessation programs, nor treatment for nicotine dependency or tobacco use.

Transplant Travel Expense. The following travel expenses in connection with an authorized, specified organ transplant (heart, liver, lung, heart-lung, kidney-pancreas, or bone marrow, including autologous bone marrow transplant, peripheral stem cell replacement and similar procedures) performed at a *CME*, provided the expenses are authorized by the *claims administrator* (See MEDICAL MANAGEMENT PROGRAMS: AUTHORIZATION PROGRAM for details.):

1. For the recipient, and a companion if the patient is a minor child, per transplant episode, up to **$10,000** per episode:

a. Round trip travel to the *CME*.

b. Lodging accommodations, not to exceed **$100** per day, limited to one room, double occupancy.

c. Other expenses, such as meals, are not covered.

2. For the donor, up to **$10,000** per transplant episode:

a. Round trip travel to the *CME*.

b. Lodging accommodations, not to exceed **$100** per day, limited to one room, double occupancy.

c. Other expenses, such as meals, are not covered.

Well Baby and Well Child Care. The following services for a *child* from birth through age 6:

1. Immunizations by a *participating provider* given as standard medical practice for children. Under the PPO Plan, the *claims administrator* will pay a maximum of $12 for each immunization by a *non-participating provider*. Under the Routine Care and HSA Plans, immunizations by *non-participating providers* are not covered.

2. Radiology and laboratory services in connection with routine physical examinations.

Women's Preventive Services. The following services are covered:

1. Well Woman visits.

2. Breastfeeding support, supplies, and counseling.

3. Prescription contraceptives (birth control) and counseling for women.

4. Permanent surgical contraception (sterilization) for women.

5. Counseling for sexually transmitted infections.

6. Counseling for screening for HIV.

7. Screening and counseling for interpersonal and domestic violence.

8. Screening for gestational diabetes.

9. HPV testing.

MEDICAL CARE THAT IS NOT COVERED

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

Acupuncture. Acupuncture treatment except as specifically stated in the "Acupuncture" provision of MEDICAL CARE THAT IS COVERED. Acupressure, or massage to control pain, treat illness or promote health by applying pressure to one or more specific areas of the body based on dermatomes or acupuncture points.

Air Conditioners. Air purifiers, air conditioners, or humidifiers.

Chronic Pain. Treatment of chronic pain, except as specifically provided under the "Hospice Care" or "Home Infusion Therapy" provisions of MEDICAL CARE THAT IS COVERED.

Clinical Trials. Services and supplies in connection with clinical trials, except as specifically stated in the "Cancer Clinical Trials" provision under the section MEDICAL CARE THAT IS COVERED.

Cosmetic Surgery. Cosmetic surgery or other services performed solely for beautification or to alter or reshape normal (including aged) structures or tissues of the body to improve appearance. This exclusion does not apply to reconstructive surgery (that is, surgery performed to correct deformities caused by congenital or developmental abnormalities, illness, or injury for the purpose of improving bodily function or symptomatology or to create a normal appearance), including surgery performed to restore symmetry following mastectomy. Cosmetic surgery does not become reconstructive surgery because of psychological or psychiatric reasons.

Crime or Nuclear Energy. Conditions that result from: (1) your commission of or attempt to commit a felony; or (2) any release of nuclear energy, whether or not the result of war, when government funds are available for treatment of illness or injury arising from such release of nuclear energy.

Custodial Care or Rest Cures. Inpatient room and board charges in connection with a *hospital stay* primarily for environmental change or physical therapy. *Custodial care* or rest cures, except as specifically provided under the "Hospice Care" or "Home Infusion Therapy" provisions of MEDICAL CARE THAT IS COVERED. Services provided by a rest home, a home for the aged, a nursing home or any similar facility.

Services provided by a *skilled nursing facility,* except as specifically stated in the "Skilled Nursing Facility" provision of MEDICAL CARE THAT IS COVERED.

Dental Services or Supplies. Dental plates, bridges, crowns, caps or other dental prostheses, dental services, extraction of teeth, or treatment to the teeth or gums, or treatment to or for any disorders for the jaw joint, except as specifically stated in the "Dental Care" or "Jaw Joint Disorders" provisions of MEDICAL CARE THAT IS COVERED. Cosmetic dental surgery or other dental services for beautification.

Diabetic Supplies. Prescription and non-prescription diabetic supplies, except as specifically stated in "YOUR PRESCRIPTION DRUG BENEFITS" section of this booklet.

Education or Counseling. Educational services, or nutritional counseling, except as specifically provided or arranged by the *claims administrator*, or as stated under the "Diabetes" or "Home Infusion Therapy" provisions of MEDICAL CARE THAT IS COVERED. Food or dietary supplements, except as specifically stated under the "Special Food Products" provision of MEDICAL CARE THAT IS COVERED.

Excess Amounts. Any amounts in excess of *covered expense*.

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

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

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

Government Treatment. Any services provided by a local, state or federal government agency, except when payment under this *plan* is expressly required by federal or state law.

Hearing Aids or Tests. Hearing aids, except as specifically stated in the "Hearing Aid Services" provision of MEDICAL CARE THAT IS COVERED. Routine hearing tests, except as specifically provided under "Preventive Care (Members Age 7 and Over)" and "Hearing Aid Services" provisions of MEDICAL CARE THAT IS COVERED.

Infertility Treatment. Any services or supplies furnished in connection with the diagnosis and treatment of *infertility,* including, but not limited to, diagnostic tests, medication, surgery, artificial insemination, in vitro fertilization, sterilization reversal, and gamete intrafallopian transfer.

Inpatient Diagnostic Tests. Inpatient room and board charges in connection with a *hospital stay* primarily for diagnostic tests which could have been performed safely on an outpatient basis.

Lifestyle Programs. Programs to alter one's lifestyle which may include but are not limited to diet, exercise, imagery or nutrition. This exclusion will not apply to cardiac rehabilitation programs approved by the *claims administrator*.

Mental or Nervous Disorders. Academic or educational testing, counseling, and remediation. *Mental or nervous disorders* or substance abuse, including rehabilitative care in relation to these conditions, except as specifically stated in the "Mental or Nervous Disorders" or "Substance Abuse" provisions of MEDICAL CARE THAT IS COVERED.

Nicotine Use. Smoking cessation programs or treatment of nicotine or tobacco use. Smoking cessation *drugs*.

Not Covered. Services received before your *effective date* or after your coverage ends.

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

Not Specifically Listed. Services not specifically listed in this *plan* as covered services.

Obesity. Services primarily for weight reduction or treatment of obesity. This exclusion will not apply to treatment of morbid obesity, as determined by the *claims administrator*, if the *claims administrator* authorizes the treatment in advance as *medically necessary* and appropriate.

Optometric Services or Supplies. Optometric services, eye exercises including orthoptics. Routine eye exams and routine eye refractions, except as specifically provided under "Preventive Care (Members Age 7 and Over)" provision of MEDICAL CARE THAT IS COVERED. Eyeglasses or contact lenses, except as specifically stated in the "Prosthetic Devices" provision of MEDICAL CARE THAT IS COVERED.

Orthodontia. Braces and other orthodontic appliances or services.

Orthopedic Supplies. Orthopedic shoes (other than shoes joined to braces) or non-custom molded and cast shoe inserts, except for therapeutic shoes and inserts for the prevention and treatment of diabetes-related foot complications as specifically stated in the "Durable Medical Equipment" provision of MEDICAL CARE THAT IS COVERED.

Outpatient Occupational Therapy. Outpatient occupational therapy, except by a *home health agency, hospice* or *home infusion therapy provider* as specifically stated in the "Home Health Care," "Hospice Care," "Home Infusion Therapy," or "Physical Therapy, Physical Medicine and Occupational Therapy" provisions of MEDICAL CARE THAT IS COVERED.

Outpatient Prescription Drugs and Medications. Outpatient prescription drugs or medications and insulin, except as specifically stated in the "Home Infusion Therapy" and "Prescription Drug for Abortion" provisions of MEDICAL CARE THAT IS COVERED or under YOUR PRESCRIPTION DRUG BENEFITS section of this booklet. Non-prescription, over-the-counter patent or proprietary drugs or medicines. Cosmetics, health or beauty aids.

Outpatient Speech Therapy. Outpatient speech therapy except as stated in the "Outpatient Speech Therapy" provision of MEDICAL CARE THAT IS COVERED.

Outside the United States. Services or supplies furnished and billed by a provider outside the United States, unless such services or supplies are furnished in connection with *urgent care* or an *emergency*.

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

Physical Therapy or Physical Medicine. Services of a *physician* for physical therapy or physical medicine, except when provided during a covered inpatient confinement, or as specifically stated in the "Home Health Care," "Hospice Care," "Home Infusion Therapy" or "Physical Therapy, Physical Medicine and Occupational Therapy" provisions of MEDICAL CARE THAT IS COVERED.

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

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

Routine Exams or Tests. Routine physical exams or tests which do not directly treat an actual illness, injury or condition, including those required by employment or government authority, except as specifically stated in the "Well Baby and Well Child Care," "Preventive Care (Members Age 7 and Over)," "Cervical Cancer Screening," "Breast Cancer," "Prostate Cancer Screening," "Screening for Blood Lead Levels," or "Hepatitis B and Varicella Zoster Immunizations" provisions of MEDICAL CARE THAT IS COVERED.

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

Services of Relatives. Professional services received from a person who lives in your home or who is related to you by blood or marriage, except as specifically stated in the "Home Infusion Therapy" provision of MEDICAL CARE THAT IS COVERED.

Sterilization Reversal. Reversal of sterilization.

Telephone and Facsimile Machine Consultations. Consultations provided by telephone or facsimile machine.

Voluntary Payment. Services for which you have no legal obligation to pay, or for which no charge would be made in the absence of insurance coverage or other health plan coverage, except services received at a non-governmental charitable research *hospital*. Such a *hospital* must meet the following guidelines:

1. It must be internationally known as being devoted mainly to medical research;

2. At least **10%** of its yearly budget must be spent on research not directly related to patient care;

3. At least one-third of its gross income must come from donations or grants other than gifts or payments for patient care;

4. It must accept patients who are unable to pay; and

5. Two-thirds of its patients must have conditions directly related to the *hospital's* research.

Work-Related. Work-related conditions if benefits are recovered or can be recovered, either by adjudication, settlement or otherwise, under any workers' compensation, employer's liability law or occupational disease law, even if you do not claim those benefits.

SUBROGATION AND REIMBURSEMENT FOR ACTS OF THIRD PARTIES

Under some circumstances, a *covered person* may need services provided under this *plan* for which a third party may be liable or legally responsible (for example, by reason of negligence, an intentional act, or breach of any legal obligation). By electing to participate in the *plan* and/or accepting such benefits, and as a condition of coverage under and participation in the *plan*, *you* agree to the following conditions under which the services will be provided:

1. As used below:

   a. "*responsible person*" means a third-party insurer, guarantor, program, or anyone else who may be legally responsible for an illness, disease, injury, or condition or the costs thereof (whether in tort, contract, by statute, or otherwise).

   b. "*recovery*" means any actual or potential payment on account of any illness, disease, injury, or condition, for which a *responsible person* may be liable to *you*, regardless of whether the payment results from a settlement, judgment, or otherwise, and regardless of how it is characterized (for example, as economic, non-economic or other compensatory damages, punitive or exemplary damages, actual medical expenses, pain and suffering, wrongful death, or loss of consortium).

   c. "*you*" means *you*, the *covered person*, or anyone acting in *your* stead or on *your* behalf, including *your* estate, parent, or legal guardian.

2. The *plan* shall automatically have a first priority lien upon any *recovery* that *you* receive, or may be entitled to receive, directly or indirectly, from a *responsible person*. The lien shall constitute an equitable lien by agreement and shall be in the full amount of the benefits provided through or paid under this *plan* for the treatment of any illness, disease, injury, or condition for which the *responsible person* may be liable to *you*. *You* hereby consent to this lien and agree to cooperate with the *plan* or its agents or assignees to enforce any rights that the *plan* may have with respect to any *recovery*. *Your* failure to acknowledge the *plan's* lien shall be a sufficient ground for termination of *your* future participation in the *plan*, as well as discontinuance of payment of some or all of *your* future benefits under the *plan*.

3. The *plan* shall have an automatic, specific, and first-priority right of reimbursement, up to the amount of the *plan*'s lien, out of the proceeds of any *recovery* that *you* may receive or be entitled to receive. *You* shall reimburse the *plan*, in full and as a first priority, for benefits provided by or through the *plan*, immediately upon collecting any *recovery* from a *responsible person* or receiving the benefit of such *recovery*. The *plan*'s rights under this section are enforceable regardless of the purpose of the payment by the *responsible person* or how it may be characterized in any agreement or judgment between *you* and the *responsible person*. If the *covered person* is a minor, then any amount recovered by the minor or the minor's representative shall also be subject to the subrogation and reimbursement provisions in this section, regardless of state law and regardless of whether the minor or the minor's representative has access to or control over such funds.

4. The *plan's* lien and its rights of subrogation and reimbursement shall not be affected, reduced, or eliminated without the *plan's* prior written consent. Without limiting the generality of the foregoing, the *plan's* lien and its rights of subrogation and reimbursement shall not be reduced or offset on account of the common fund doctrine, the doctrine of unjust enrichment, the make-whole doctrine, the double-recovery rule, principles of comparative or contributory fault, the argument that another party is liable only in part, the argument that the *recovery* is less than the actual loss suffered by the *covered person*, the argument that the *responsible person's* resources or insurance may be limited, the argument that the *covered person* had to pay legal fees, court costs, or other expenses to obtain the *recovery*, the argument that the *plan* should share in a pro rata allocation of a *covered person's* fees and costs (including attorneys' fees) incurred in pursuit of a claim, or any similar theory whether based on federal common law, state law or some other source. To the extent that such a theory would otherwise have provided equitable or other defenses against the *plan's* lien, each *covered person* disclaims all such defenses and recognizes that the *plan* is providing benefits to the *covered person* in reliance upon that disclaimer. The *plan* shall not be responsible for paying any part of a *covered person's* legal fees or costs in connection with obtaining a *recovery* from a *responsible person*. The *plan* shall be entitled to recover from the *covered person* the value of all services

provided and paid for by, through or on behalf of the *plan*, when the *covered person* is reimbursed or paid for the cost of care by a *responsible person*. The *plan* shall not be required to apportion recoveries and shall remain entitled to one hundred percent (100%) reimbursement from any *recovery* for all benefits provided to the *covered person* on account of the illness, disease, injury or condition that is the subject of the *recovery*, regardless of whether the *covered person* obtains a full or partial recovery (i.e., is "made whole"), regardless of whether the *recovery* is a settlement, judgment, or award, and regardless of the attorneys' fees and costs incurred by the *covered person* in seeking the *recovery* from the *responsible person*. Any *recovery* received by or on behalf of a *covered person* shall first be used to reimburse the benefits and expenses paid by the *plan* (including attorneys' fees and court costs if the plan brings suit in the name of the *covered person*).

5. *You* shall serve as a constructive trustee for the *plan* over any *recovery* you receive to which the *plan* may have a claim. *You* shall segregate any *recovery* received by *you* (up to the amount of the *plan*'s lien) in a separate account, and shall preserve such *recovery* so that the *plan* may enforce its lien and any disputes as to entitlement may be resolved. *Your* failure to hold any *recovery* in trust for the *plan* shall be deemed a breach of *your* duties under the *plan*. Any *recovery* or *overpayment* (as defined below) must be segregated as described in this section until the *plan* has confirmed in writing that no dispute exists. If *you* dissipate or transfer the *recovery* or *overpayment* when the *plan* has a lien upon or claim to such funds, that shall constitute inequitable conduct and a breach of the *plan* by *you*. *You* agree that the *plan* may, without limitation, trace the transferred or dissipated *recovery* or *overpayment* and recover the disputed amount from *your* other assets or assets paid over to a third person (including, without limitation, *your* attorney), all of which for this purpose shall be subject to an equitable lien by agreement in the amount of the *plan's* claim.

6. Within 30 days of the date when a *covered person* or the *covered person's* representative initiates any action to assert a claim against a *responsible person* (for example, by sending notice of the claim or by submitting or filing a claim), the *covered person* must advise the *claims administrator* in writing of that fact. The *plan* shall be entitled to intervene and participate in such action, and the *plan's* lien shall apply to any resulting *recovery* regardless of whether the *plan* elects to intervene.

7. *You* must, in a timely manner, furnish such information and assistance, execute and deliver such instruments and papers, and take such other actions as the *plan* or its agents or assignees may reasonably request to secure, protect, or facilitate the exercise or enforcement of the *plan's* rights or interests. The instruments and papers that *you* may be required to execute may include a separate subrogation agreement that does not conflict with the provisions of this section, if the *plan's* fiduciaries or its counsel deem such an agreement to be necessary or appropriate. *You* shall not do anything to hinder the *plan's* assertion of its rights to a *recovery*. Without the prior written consent of the *plan* or its agents or assignees, as may be applicable, *you* must not take any action that may prejudice the *plan's* rights or interests, including without limitation disbursing or dissipating any *recovery*, or releasing or compromising any claim against a *responsible person* as to which the *plan* may have an interest. *You* must cooperate fully with the *plan* and its fiduciaries, agents or assignees and abide by the terms of the *plan*, including the provisions of this section. The *plan* shall have the right to withhold and/or set off payment of claims and/or benefits pending the resolution of disputes relating to subrogation or reimbursement. Failing to advise the *plan* of a claim against a third party, failing to cooperate with the *plan* or its agents or assignees, disbursing, transferring, or dissipating any *recovery* to which the *plan* has a claim or upon which the *plan* has a lien, or taking actions that prejudice the *plan's* rights or interests would be a material breach of this *plan*, shall entitle the *plan* to the imposition of a constructive trust, and may result in *your* being equitably responsible for reimbursing the *plan*.

8. The *plan* shall be entitled to equitable relief, including without limitation restitution, the imposition of a constructive trust, or an injunction, to the extent necessary to enforce the *plan's* lien and/or to obtain (or to preclude or reverse the transfer, dissipation or disbursement of) such portion of any *recovery* in which the *plan* may have a right or interest. The *plan* shall be entitled to enforce its lien even if the *recovery* is less than the actual loss *you* suffered.

9. If *you* fail, refuse, or are unable to institute legal action against a *responsible person*, then the *plan* shall have the right, at its option and in its sole and absolute discretion, at any time to become subrogated to, and

thereby assume and prosecute, *your* claim against any *responsible person* for amounts paid under the *plan* on account of *your* illness, disease, injury, or condition. The *plan* may exercise that option by written notice to *you* or *your* legal representative. Upon such written notice, *you* or *your* legal representative shall transfer to the *plan* any rights that *you* may have to a *recovery* from a *responsible person* of any amounts paid by the *plan* to *you* or on *your* behalf. The *plan* shall be entitled to prosecute such a claim in *your* name, with or without specific consent. If the *plan* chooses to proceed by subrogation, the *plan* shall be entitled to obtain, out of any *recovery*, the amount of benefits paid or to be paid to *you*, together with the *plan's* costs and attorneys' fees. If the *plan* becomes subrogated to *your* claim against a *responsible person*, *you* must cooperate in the *plan*'s efforts to pursue a recovery, including assisting the *plan*'s attorneys in preparing or pursuing the case and attending hearings, depositions and trial of the case. The *plan*'s subrogation rights are independent of, and in addition to, the rights of reimbursement set forth in this section.

10. It is the intent of the *plan* that you or a covered dependent should recover only one payment for any costs that may be covered or reimbursable under the *plan*. *You* acknowledge and agree that the intent of this section of the *plan* (entitled SUBROGATION AND REIMBURSEMENT FOR ACTS OF THIRD PARTIES) is to restore and preserve the *status quo ante* and to avoid duplicative or undeserved *recovery* or payments to *you*.

11. *You* shall not, without the *plan*'s prior written consent, assign any right, claim, or cause of action against a *responsible person* to recover for any illness, disease, injury, or condition on account of which benefits were paid by the *plan.* Each *covered person* assigns to the *plan* any benefits that the *covered person* may have under any automobile policy or other coverage on account of any illness, disease, injury or condition for which the *plan* pays or provides benefits, to the extent of the *plan's* lien.

12. The *plan* is governed by *ERISA* and, to the extent that such law is not preempted by ERISA, is subject to California law. To the extent that any portion of the *plan* is inconsistent with applicable law in whole or in part, the inconsistent provision shall be construed so that it is given effect to the maximum extent permitted by applicable law, and all other provisions of the *plan* shall remain in full force and effect. Thus, for example, if an applicable law were to limit the amount of the lien provided for in paragraph 2 above, then the lien shall be enforceable in the greatest amount allowable consistent with that law.

13. The *plan's* fiduciaries may (but are not required to) determine in a particular instance that any or all of the *plan's* rights under this section should not be exercised, or that the exercise of such rights should be discontinued. In making such a determination, the *plan*'s fiduciaries may (but are not required to) consider factors such as the size of any potential *recovery*, the likelihood of obtaining a *recovery*, and the cost to the *plan* of doing so.

14. A *covered person* might receive payments through this *plan* that exceed the payments to which the *covered person* is legally entitled under the *plan.* Such payments, to the extent that they exceed the amount to which the *covered person* is legally entitled under the *plan*, are hereinafter referred to as "*overpayments.*" In the event that a *covered person* receives an *overpayment*, (i) the *overpayment* shall belong to the *plan*; (ii) the *plan* shall have a right to reimbursement of the full amount of the *overpayment*; (iii) the *plan* shall have a first-priority equitable lien by agreement upon the overpayment; (iv) the *covered person* shall not have any right to use the *overpayment*; (v) the *covered person* shall segregate and not disburse or dissipate the *overpayment* so that the *overpayment* may be returned to the *plan* and any dispute over entitlement to the *overpayment* can be resolved; (vi) the *covered person* shall be required to return the *overpayment* to the *plan*; (vii) the *covered person* shall cooperate with efforts to recover the *overpayment*; (viii) the *plan* shall automatically have a lien, in the amount of the *overpayment,* upon any monies paid to the *covered person* by the *plan*; (ix) the *plan* shall have a right of equitable restitution with respect to the *overpayment*; (x) the *plan* shall have a right to the imposition of a constructive trust on the *overpayment*; (xi) if the *overpayment* is the subject of a declaratory judgment action, no costs or expenses, including attorneys' fees, may be recovered out of the *overpayment*; and (xii) the *plan* shall be entitled, at its option and in its sole discretion, to recoupment by withholding and retaining any monies payable to the *covered person,* up to the amount of the *overpayment*.

15. If the *plan* takes legal action against a *covered person* to enforce its rights under this section, the *plan* shall be entitled to recover its attorneys' fees and expenses from the *covered person*.

16. The *plan's* fiduciaries, in their sole discretion, may waive the *plan's* right of recovery. To be enforceable, such a waiver must be in writing and signed by a duly authorized representative of the *plan*. The *plan's* waiver of its right of recovery with respect to one claim shall not constitute a waiver of its right of recovery with respect to any other claim; and the *plan's* waiver of its right of recovery with respect to one *covered person* shall not constitute a waiver of its right of recovery with respect to any other *covered person*.

17. For purposes of this section, any action, right or entitlement of the *plan* may be taken, asserted or enforced by the *plan's* fiduciary. Any ambiguity in this section, or any dispute arising out of or in connection with this section, shall be resolved by the *plan* fiduciary, and the interpretation and application of this section shall be committed to the *plan* fiduciary's discretion.

YOUR PRESCRIPTION DRUG BENEFITS

PRESCRIPTION DRUG COVERED EXPENSE

Prescription drug covered expense is the maximum charge for each covered service or supply that will be accepted by the *claims administrator* for each different type of *pharmacy*. It is not necessarily the amount a *pharmacy* bills for the service. You may avoid higher out-of-pocket expenses by choosing a *participating pharmacy*, or by utilizing the mail service program whenever possible. In addition, you may also reduce your costs by asking your *physician*, and your pharmacist, for the more cost-effective *generic* form of *prescription drugs*.

When your prescription is for a *brand name drug*, the pharmacist will substitute it with a *generic drug* unless your *doctor* writes "dispense as written" (DAW). If a member requests a brand name drug when a generic drug substitution exists, the member pays the brand name copay, plus the difference between the cost of the generic drug and the cost of the brand name drug.

Prescription drug covered expense will always be the lesser of the billed charge or the amount shown below. Expense is incurred on the date you receive the *drug* for which the charge is made.

Type of Provider	Maximum Prescription Drug Covered Expense is:
Participating Pharmacies and Mail Service Program	**Prescription Drug Negotiated Rate**
Non-Participating Pharmacies	**Drug Limited Fee Schedule Amount**

When you choose a *participating pharmacy*, the *claims administrator* will subtract any expense which is not covered under your *prescription drug* benefits. The remainder is the amount of *prescription drug covered expense* for that claim. You will not be responsible for any amount in excess of the *prescription drug negotiated rate* for the covered services of a *participating pharmacy*.

When the *claims administrator* receives a claim for *drugs* supplied by a *non-participating pharmacy*, the *claims administrator* first subtracts any expense which is not covered under your *prescription drug* benefits, and then any expense exceeding the *drug limited fee schedule*. The remainder is the amount of *prescription drug covered expense* for that claim.

You will always be responsible for expense incurred which is not covered under this *plan*.

PRESCRIPTION DRUG CO-PAYMENTS

After the *claims administrator* determines *prescription drug covered expense,* the *claims administrator* will subtract your Prescription Drug Co-Payment for each *prescription*. If your Prescription Drug Co-Payment includes a percentage of *prescription drug covered expense,* then the *claims administrator* will apply that percentage to such expense. This will determine the dollar amount of your Prescription Drug Co-Payment.

The Prescription Drug Co-Payments are set forth in the SUMMARY OF BENEFITS.

HOW TO USE YOUR PRESCRIPTION DRUG BENEFITS

When You Go to a Participating Pharmacy. To identify you as a *covered person* covered for *prescription drug* benefits, you will be issued an identification card. You must present this card to *participating pharmacies* when you have a *prescription* filled. Provided you have properly identified yourself as a *covered person*, a *participating pharmacy* will charge only your Co-Payment.

Many *participating pharmacies* display an "Rx" decal with the *claims administrator* logo in their window. For information on how to locate a *participating pharmacy* in your area, call (877) 722-6279.

Please note that presentation of a prescription to a pharmacy or pharmacist does not constitute a claim for benefit coverage. If you present a *prescription* to a *participating pharmacy*, and the *participating pharmacy* indicates your *prescription* cannot be filled, or requires an additional Co-Payment, this is not considered an adverse claim decision. If you want the *prescription* filled, you will have to pay either the full cost, or the additional Co-Payment, for the *prescription drug.* If you believe you are entitled to some *plan* benefits in connection with the *prescription drug*, submit a claim for reimbursement to the *claims administrator* at the address shown below:

Express Scripts, Inc.
Attn: Commercial Claims
P.O. Box 2872
Clinton, Iowa 52733-2872

Participating pharmacies usually have claims forms, but, if the *participating pharmacy* does not have claim forms, claim forms and customer service are available by calling (877) 722-6279. Mail your claim, with the appropriate portion completed by the pharmacist, to the *claims administrator* within 90 days of the date of purchase. If it is not reasonably possible to submit the claim within that time frame, an extension of up to 12 months will be allowed.

When You Go to a Non-Participating Pharmacy. If you purchase a *prescription drug* from a *non-participating pharmacy*, you will have to pay the full cost of the *drug* and submit a claim to the *claims administrator*, at the address below:

Express Scripts, Inc.
Attn: Commercial Claims
P.O. Box 2872
Clinton, Iowa 52733-2872

Non-participating pharmacies do not have the *claims administrator's* prescription drug claim forms. You must take a claim form with you to a *non-participating pharmacy*. The pharmacist must complete the *pharmacy's* portion of the form and sign it. Claim forms and customer service are available by calling (877) 722-6279. Mail your claim with the appropriate portion completed by the pharmacist to the *claims administrator* within 90 days of the date of purchase. If it is not reasonably possible to submit the claim within that time frame, an extension of up to 12 months will be allowed.

When You Are Out of State. If you need to purchase a *prescription drug* out of the state of California, you may locate a *participating pharmacy* by calling (877) 722-6279. If you cannot locate a *participating pharmacy*, you must pay for the *drug* and submit a claim to the *claims administrator*. (See "When You Go to a Non-Participating Pharmacy" above.)

When You Order Your Prescription Through the Mail. You can order certain *prescriptions* through the mail service *prescription drug* program. Not all medications are available through the mail service pharmacy.

The *prescription* must state the drug name, dosage, directions for use, quantity, the *physician's* name and phone number, the patient's name and address, and be signed by a *physician*. You must submit it with the appropriate payment for the amount of the purchase, and a properly completed order form. You need pay only the cost of your Co-Payment.

Your first mail service *prescription* must also include a completed Health and Medication questionnaire. The Health and Medication questionnaire can be obtained by calling the toll-free number below. You need only enclose the *prescription* or refill notice, and the appropriate payment for any subsequent mail service prescriptions, or call the toll-free number. Co-Payments can be paid by check, money order or credit card.

Order forms can be obtained by contacting:

Express Scripts, Inc.
(877) 722-6279
www.express-scripts.com

PRESCRIPTION DRUG UTILIZATION REVIEW

Your *prescription drug* benefits include utilization review of *prescription drug* usage for your health and safety. Certain *drugs* may require prior authorization (e.g., Viagra, Enbrel, Celebrex, Growth Hormone and Lotronex). If there are patterns of over-utilization or misuse of *drugs*, the *claims administrator's* medical consultant will notify your personal *physician* and your pharmacist. The *claims administrator* reserves the right to limit benefits to prevent over-utilization of *drugs*.

PREFERRED DRUG PROGRAM

The *claims administrator* uses a list of *preferred drugs*, which is sometimes called a formulary, to help your doctor make prescribing decisions. The presence of a *drug* on the *plan's preferred drug* list does not guarantee that your physician will prescribe you that drug. This list of outpatient *prescription drugs* is developed by the *claims administrator* Pharmacy and Therapeutics Committee, which is composed of independent *physicians* and pharmacists. The committee reviews the current medical literature to ensure that safe, appropriate, and *medically necessary* medications are included in the list of *preferred drugs*. The committee updates this list quarterly to ensure that it includes *drugs* that are cost-effective, therapeutic choices.

Drugs that are not part of the *claims administrator's* list of *preferred drugs* are available from a *pharmacy* when the prescribing doctor writes "do not substitute" or "dispense as written" on the prescription. Some *drugs* may require prior authorization. If you have a question regarding whether a particular *drug* is on the *claims administrator's preferred drug* list or requires prior authorization, please call the *claims administrator* at (877) 216-3990.

If the *claims administrator* denies a request for prior authorization of a *drug* that is not part of the *claims administrator's preferred drug* list, you or your prescribing *physician* may appeal the *claims administrator's* decision by calling the *claims administrator* at (877) 216-3990. If you are not satisfied with the resolution based on your inquiry, you must follow the claims procedures set forth in CLAIMS PROCEDURES section of this *booklet.*

PRESCRIPTION DRUG CONDITIONS OF SERVICE

To be covered, the *drug* or medication must satisfy all of the following requirements:

1. It must be prescribed by a licensed prescriber and be dispensed within one year of being prescribed, subject to federal and state laws.

2. The Food and Drug Administration (FDA) must approve it for general use.

3. It must be for the direct care and treatment of your illness, injury or condition. Dietary supplements, health aids or drugs for cosmetic purposes are not included. However, formulas prescribed by a *physician* for the treatment of phenylketonuria are covered.

4. It must be dispensed from a licensed retail *pharmacy*, or through your mail service program.

5. It must not be used while you are an inpatient in any facility. Also, it must not be dispensed in or administered by an outpatient facility.

6. For a retail *pharmacy*, the *prescription* must not exceed a 30-day supply.

   Prescription drugs federally-classified as Schedule II which are FDA approved for the treatment of attention deficit disorder and that require a triplicate prescription form must not exceed a 60-day supply. If the *physician* prescribes a 60-day supply for *drugs* classified as Schedule II for the treatment of attention

deficit disorders, the *covered person* has to pay double the amount of Co-Payment for retail *pharmacies*. If the *drugs* are obtained through the mail service program, the Co-Payment will remain the same as for any other *prescription drug*.

7. Certain *drugs* have specific quantity supply limits based on *the claims administrator's* analysis of prescription dispensing trends and the Food and Drug Administration dosing recommendations.

8. For the mail service program, the *prescription* must not exceed a 90-day supply.

9. The *drug* will be covered under YOUR PRESCRIPTION DRUG BENEFITS only if it is not covered under another benefit of your *plan*.

10. *Drugs* for the treatment of impotence and/or sexual dysfunction are limited to six tablets/units for a 30-day period at retail or 18 tablets/units for a 90-day period at mail. Documented evidence of contributing medical condition must be submitted to the *claims administrator* for review.

PRESCRIPTION DRUG SERVICES AND SUPPLIES THAT ARE COVERED

1. Outpatient *drugs* and medications which the law restricts to sale by *prescription*. Formulas prescribed by a *physician* for the treatment of phenylketonuria. These formulas are subject to the Co-Payment for *brand name drugs*.

2. Insulin.

3. Syringes when dispensed for use with insulin and other self-injectable *drugs* or medications.

4. *Prescription* oral contraceptives; contraceptive diaphragms.

5. Injectable *drugs* which are self-administered by the subcutaneous route (under the skin) by the patient or *family member*. *Drugs* with Food and Drug Administration (FDA) labeling for self-administration.

6. All compound *prescription drugs* which contain at least one covered *prescription* ingredient.

7. Diabetic supplies (i.e., test strips and lancets).

8. *Prescription drugs* for treatment of impotence and/or sexual dysfunction are limited to organic (non-psychological) causes.

PRESCRIPTION DRUG SERVICES AND SUPPLIES THAT ARE NOT COVERED

In addition to the exclusions and limitations listed under YOUR MEDICAL BENEFITS: MEDICAL CARE THAT IS NOT COVERED, *prescription drug* benefits are not provided for or in connection with the following:

1. Immunizing agents, biological sera, blood, blood products or blood plasma, except specialty drugs.

2. Hypodermic syringes and/or needles except when dispensed for use with insulin and other self-injectable *drugs* or medications.

3. *Drugs* and medications used to induce spontaneous and nonspontaneous abortions.

4. *Drugs* and medications dispensed or administered in an outpatient setting; including, but not limited to, outpatient *hospital* facilities and *physicians'* offices.

5. Professional charges in connection with administering, injecting or dispensing of *drugs*.

6. *Drugs* and medications which may be obtained without a *physician's* written prescription, except insulin or niacin for cholesterol lowering.

7. *Drugs* and medications dispensed by or while you are confined in a *hospital*, *skilled nursing facility,* rest home, sanitorium, convalescent hospital, or similar facility.

8. Durable medical equipment, devices, appliances and supplies, even if prescribed by a *physician*, except *prescription* contraceptive diaphragms as specified under PRESCRIPTION DRUG SERVICES AND SUPPLIES THAT ARE COVERED.

9. Services or supplies for which you are not charged.

10. Oxygen.

11. Cosmetics and health or beauty aids.

12. *Drugs* labeled "Caution, Limited by Federal Law to Investigational Use" or experimental drugs. *Drugs* or medications prescribed for experimental indications.

13. Any expense incurred for a drug or medication in excess of: (a) the drug limited fee schedule for drugs dispensed by non-participating pharmacies; or (b) the prescription drug negotiated rate, for drugs dispensed by participating pharmacies or through the mail service program.

14. *Drugs* which have not been approved for general use by the Food and Drug Administration.

15. Smoking cessation *drugs*.

16. *Drugs* used primarily for cosmetic purposes (e.g., Retin-A for wrinkles).

17. *Drugs* used primarily for the purpose of treating *infertility* (including but not limited to Clomid, Pergonal, and Metrodin).

18. Anorexiants and drugs used for weight loss except when used to treat morbid obesity (e.g., diet pills and appetite suppressants).

19. *Drugs* obtained outside of the United States.

20. Allergy desensitization products or allergy serum.

21. Infusion *drugs*, except *drugs* that are self-administered subcutaneously.

22. Select classes of drugs where non-preferred medications, which have therapeutic alternatives, have shown no benefit regarding efficacy or side effect over *preferred drugs*. However, this will not apply if the prescriber denotes "dispense as written" or "do not substitute."

23. Herbal, nutritional and dietary supplements except formulas prescribed by a *physician* for the treatment of phenylketonuria.

24. *Prescription drugs* with a non-prescription (over-the-counter) chemical and dose equivalent except insulin.

COORDINATION OF BENEFITS

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

DEFINITIONS

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

Allowable Expense is any necessary, reasonable and customary item of expense which is at least partially covered by at least one Other Plan. For the purposes of determining the *claims administrator* payment, the total value of Allowable Expense as provided under This Plan and all Other Plans will not exceed the greater of: (1) the amount which the *claims administrator* would determine to be eligible expense, if you were covered under This Plan only; or (2) the amount any Other Plan would determine to be eligible expenses in the absence of other coverage.

Other Plan is any of the following:

1. Group, blanket or franchise insurance coverage;

2. Group service plan contract, group practice, group individual practice and other group prepayment coverages;

3. Group coverage under labor-management trusteed plans, union benefit organization plans, employer organization plans, employee benefit organization plans or self-insured employee benefit plans.

4. Medicare. This does not include Medicare when, by law, its benefits are secondary to those of any private insurance program or other non-governmental program.

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

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

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

EFFECT ON BENEFITS

1. If This Plan is the Principal Plan, then its benefits will be determined first without taking into account the benefits or services of any Other Plan.

2. If This Plan is not the Principal Plan, then its benefits may be reduced so that the benefits and services of all the plans do not exceed Allowable Expense.

3. The benefits of This Plan will never be greater than the sum of the benefits that would have been paid if you were covered under This Plan only.

ORDER OF BENEFITS DETERMINATION

The following rules determine the order in which benefits are payable:

1. A plan which has no Coordination of Benefits provision pays before a plan which has a Coordination of Benefits provision. This would include Medicare in all cases, except when the law requires that This Plan pays before Medicare.

2. A plan which covers you as an *employee* or *retiree* pays before a plan which covers you as a dependent. But, if you are retired and eligible for Medicare, and you are covered under a group health plan because

your spouse is still working, Medicare pays (a) after the plan which covers you as a dependent of an active employee, but (b) before any other non-Medicare coverage you may have.

3. For a dependent *child* covered under plans of two parents, the plan of the parent whose birthday falls earlier in the *calendar year* pays before the plan of the parent whose birthday falls later in the *calendar year*. But if one plan does not have a birthday rule provision, the provisions of that plan determine the order of benefits.

Exception to rule 3: For a dependent *child* of parents who are divorced or separated, the following rules will be used in place of Rule 3:

a. If the parent with custody of that *child* for whom a claim has been made has not remarried, then the plan of the parent with custody that covers that *child* as a dependent pays first.

b. If the parent with custody of that *child* for whom a claim has been made has remarried, then the order in which benefits are paid will be as follows:

i. The plan which covers that *child* as a dependent of the parent with custody.

ii. The plan which covers that *child* as a dependent of the stepparent (married to the parent with custody).

iii. The plan which covers that *child* as a dependent of the parent without custody.

iv. The plan which covers that *child* as a dependent of the stepparent (married to the parent without custody).

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

4. The plan covering you as a laid-off or retired employee or as a dependent of a laid-off or retired employee pays after a plan covering you as other than a laid-off or retired employee or the dependent of such a person. But, if either plan does not have a provision regarding laid-off or retired employees, provision 6 applies.

5. The plan covering you under a continuation of coverage provision in accordance with state or federal law pays after a plan covering you as an employee, a dependent or otherwise, but not under a continuation of coverage provision in accordance with state or federal law. If the order of benefit determination provisions of the Other Plan do not agree under these circumstances with the order of benefit determination provisions of This Plan, this rule will not apply.

6. When the above rules do not establish the order of payment, the plan on which you have been enrolled the longest pays first unless two of the plans have the same effective date. In this case, Allowable Expense is split equally between the two plans.

RIGHTS OF THE PLAN AND CLAIMS ADMINISTRATOR UNDER THIS PROVISION

Responsibility For Timely Notice. The *claims administrator* and the *plan* are not responsible for coordination of benefits unless timely information has been provided by the requesting party regarding the application of this provision.

Reasonable Cash Value. If any Other Plan provides benefits in the form of services rather than cash payment, the reasonable cash value of services provided will be considered Allowable Expense. The reasonable cash value of such service will be considered a benefit paid, and the *claims administrator* liability reduced accordingly.

Facility of Payment. If payments which should have been made under This Plan have been made under any Other Plan, the *claims administrator* has the right to pay that Other Plan any amount the *claims administrator* determines

to be warranted to satisfy the intent of this provision. Any such amount will be considered a benefit paid under This Plan, and such payment will fully satisfy the *claims administrator* liability under this provision.

Right of Recovery. If payments made under This Plan exceed the maximum payment necessary to satisfy the intent of this provision, the *claims administrator* has the right to recover that excess amount from any persons or organizations to or for whom those payments were made, or from any insurance company or service plan.

BENEFITS FOR MEDICARE-ELIGIBLE MEMBERS

Coordinating Benefits With Medicare. When coverage is available under more than one group health plan, and if one of the plans is a Medicare health plan, federal law dictates when Medicare will pay first and when Medicare will be a secondary payer. These rules are known as the Medicare secondary payer (or MSP) rules.

Under the MSP rules, if *you* are an *employee* or a *family member* of an *employee*, and entitled to Medicare, *you* will receive the full benefits of this *plan* (meaning the *plan* will pay first, and Medicare will pay second), unless one of the exceptions listed below applies:

1. *You* are receiving treatment for end-stage renal disease following the first 30 months *you* are entitled to end-stage renal disease benefits under Medicare; or

2. *You* are entitled to Medicare benefits as a disabled person, unless *you* have a current employment status as determined by Medicare rules through a group of 100 or more employees (according to federal COBRA legislation). (Note: This exception would not apply to *employees* and *family members* of *employees* covered under this *plan* because the *employer* has more than 100 *employees*.)

The *claims administrator* will apply any charges paid by Medicare for services covered under this *plan* toward *your plan* deductible, if any.

The chart below summarizes when this *plan* must pay primary and when it may pay secondary under the MSP rules.

If you	Situation	Pays first	Pays second
Are 65 or older and covered as an active employee or family member of an active employee	Entitled to Medicare	Group health plan	Medicare
Have end-stage renal disease and group health plan coverage	First 30 months of Medicare eligibility or entitlement	Group health plan	Medicare
	After 30 months of Medicare eligibility or entitlement	Medicare	Group health plan
Are disabled and covered as an employee or family member of an employee	Entitled to Medicare disability benefits		
	The employer has 100 or more employees	Large group health plan	Medicare
	The employer has less than 100 employees	Medicare	Group health plan
Are under age 65, disabled, and covered as a retiree or family member of a retiree	Entitled to Medicare disability benefits	Medicare	Group health plan

Please note that the MSP rules are complex, and the chart and summary above cover only the MSP rules applicable to this *plan*. For more information regarding the MSP rules, visit www.Medicare.gov/publications to view the booklet "Medicare & Other Health Benefits: Your Guide to Who Pays First."

GENERAL PROVISIONS

Providing of Care. The *plan* is not responsible for providing any type of *hospital,* medical or similar care, nor is it responsible for the quality of any such care received.

Continuity of Care. If the *claims administrator* terminates its contractual relationship with a *participating provider* and *you* are undergoing a course of treatment from that provider at the time the contract is terminated, *you* may be able to continue to receive services from that provider (but only if such provider agrees to continue to comply with the same contractual requirements that applied prior to termination). To qualify, *you* must have an acute or a serious chronic condition, a high-risk pregnancy, or a pregnancy in the second or third trimester. *You* may request this continuity of care by calling the customer service telephone number listed on *your* ID card. If approved, services may be received for a limited period of time, but no longer than 90 days, unless *you* cannot be safely transferred to a *participating provider*. Coverage is provided according to the terms and conditions of this *plan* applicable to *participating providers*.

Provider Reimbursement. *Physicians* and other professional providers are paid on a fee-for-service basis, according to an agreed schedule. A participating *physician* may, after notice from the *claims administrator*, be subject to a reduced negotiated rate in the event the participating *physician* fails to make routine referrals to *participating providers*, except as otherwise allowed (such as for *emergency services*). *Hospitals* and other health care facilities may be paid either a fixed fee or on a discounted fee-for-service basis.

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

Payment to Providers. As provided in the GENERAL PLAN INFORMATION section at the end of this *booklet*, the benefits under this *plan* may not be assigned. In all cases, unless otherwise required by applicable state or federal law, the *claims administrator* will determine, in its sole discretion, whether benefits under this *plan* will be paid to *you* or to the provider of services. Any benefits paid to a provider will fulfill the *plan's* obligation to *you* for those covered services.

Financial Arrangements with Providers. The *claims administrator* or an affiliate has contracts with *participating providers* and suppliers for the provision of and payment for health care services rendered to *covered employees, covered retirees* and their *covered family members* entitled to health care benefits under contracts to which the *claims administrator* or an affiliate is a party.

Under such contracts, the negotiated rates paid for certain medical services provided to *covered persons* may differ from the rates paid for persons covered by other types of products or programs offered by the *claims administrator* or an affiliate for the same medical services. *Covered employees, covered retirees* and their *covered family members* are entitled to receive the benefits of only those discounts, payments, settlements, incentives, adjustments and/or allowances specifically set forth in the *plan*.

Also, under arrangements with some providers and suppliers, certain discounts, payments, rebates, settlements, incentives, adjustments and/or allowances, including, but not limited to, pharmacy rebates, may be based on aggregate payments made by the *claims administrator* or an affiliate in respect to all health care services rendered to all persons who have coverage through a program provided or administered by the *claims administrator* or an affiliate. They are not attributed to specific claims or plans and do not inure to the benefit of any covered individual or group, but may be considered by the *claims administrator* or an affiliate in determining its fees or subscription charges.

STATEMENT OF RIGHTS UNDER THE NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

Under federal law, the *plan* may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn *child* to less than 48 hours following a vaginal delivery or less than 96 hours following a delivery by cesarean section. However the *plan* may pay for a shorter stay if the attending physician (e.g., *your physician,* nurse midwife or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, the *plan* may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, the *plan* may not, under federal law, require that a *physician* or *other health care provider* obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce *your* out-of-pocket costs, *you* may be required to obtain pre-certification. For information on pre-certification, contact the *claims administrator*.

STATEMENT OF RIGHTS UNDER THE WOMEN'S CANCER RIGHTS ACT OF 1998

The *plan*, as required by the Women's Cancer Rights Act of 1998, and in consultation with *your physician,* provides benefits for mastectomy-related services including: (i) all stages of reconstruction of the breast on which the mastectomy was performed; (ii) surgery and reconstruction of the other breast to produce a symmetrical appearance; and (iii) prostheses and treatment of physical complications of the mastectomy, including lymphedema. For more information on this benefit, contact the *claims administrator*.

STATEMENT OF RIGHTS UNDER THE GENETIC INFORMATION NONDISCRIMINATION ACT OF 2008

The *plan*, as required by the Genetic Information Nondiscrimination Act of 2008 (GINA), will not collect genetic information (including family medical history) prior to or in connection with enrollment. In addition, the *plan* will not collect or use genetic information for "underwriting purposes," which include the determination of eligibility for benefits under the *plan*, the computation of premium or contribution amounts, and the creation, renewal or replacement of a contract of health insurance or health benefits. GINA also generally prohibits group health plans such as the *plan* from requesting or requiring an individual to undergo a genetic test. There is a research exception that permits a plan to request (but not require) that a participant or beneficiary undergo a genetic test.

Additional information about GINA is available at the Department of Labor's website at www.dol/gov/ebsa/compliance_assistance.html.

CONFIDENTIALITY OF MEDICAL INFORMATION (HIPAA)

The Health Insurance Portability and Accountability Act of 1996 (*HIPAA*) requires that health plans protect the confidentiality of *your* private health information. This protection extends to the *plan*.

The *plan* and the *employer* will not use or further disclose *protected health information* except as necessary for treatment, payment, health plan operations and *plan* administration, or as permitted or required by law. By law, all business associates of the *plan* that use, disclose, maintain, or transmit *protected health information* must also observe *HIPAA's* privacy rules governing that information, and the *plan* requires its business associates to comply with these laws. In particular, the *plan* will not, without authorization, use or disclose *protected health information* for employment-related actions and decisions or in connection with any other benefit or employee benefit plan sponsored by the *employer*. The *plan* is part of an "organized health care arrangement" under which the individual health benefits and the applicable service providers and the applicable insurers may share protected health information for treatment, payment and health care operations and may undertake joint activities to manage the organized health care arrangement's operations and improve the quality of health care it provides.

Under *HIPAA*, *you* have certain rights with respect to *your protected health information*, including certain rights to see and copy the information, receive an accounting of certain disclosures of the information and, under certain circumstances, amend the information. *You* have the right to be notified if the *plan's privacy officer* or its designee determines that an impermissible acquisition, access, use or disclosure has compromised the security or privacy of *your protected health information*. *You* also have the right to file a complaint with the *plan's complaint officer* or with the Secretary of the U.S. Department of Health and Human Services if *you* believe *your* privacy rights under *HIPAA* have been violated.

The *plan* maintains a privacy notice, which provides a more detailed summary of *your* rights under *HIPAA's* privacy rules. For a copy of the notice, if *you* have questions about the privacy of *your* health information, or if *you* wish to file a complaint under *HIPAA*, please contact the *plan's privacy officer* or *complaint officer*, as applicable.

MEDICAL MANAGEMENT PROGRAMS

Benefits are provided only for *medically necessary* and appropriate services. Medical management programs including Utilization Review, Authorization and Case Management are designed to work together with *you* and *your* provider to ensure *you* receive appropriate medical care and avoid unexpected out-of-pocket expense. The utilization review program applies to inpatient *hospital* and *residential treatment center* admissions, outpatient surgery at an *ambulatory surgical center*, and *facility-based care* for the treatment of *mental or nervous disorders, severe mental disorders,* and substance abuse. The authorization program applies to certain specialized services or treatments. The personal case management program helps *you* coordinate and manage long-term intensive medical care.

No benefits are payable, however, unless *your* coverage is in force at the time services are rendered, and the payment of benefits is subject to all the terms and requirements of this *plan*.

Important: Medical management requirements described in this section do not apply when coverage under this *plan* is secondary to another plan providing benefits for *you*.

AUTHORIZATION PROGRAM

The authorization program provides prior authorization for medical care or service by a *non-participating provider,* and for certain "special services."

It is *your* responsibility to obtain authorization before *you* receive any service subject to the authorization program. The toll-free number to call for authorization is shown on *your* plan identification card. Y*ou* must follow the procedures in the CLAIMS PROCEDURE section of this *booklet*, in order to request an authorization or appeal a denial of an authorization.

If *you* receive any such service, and do not follow the procedures set forth in this section and in the CLAIMS PROCEDURE section, *your* benefits will be reduced as shown in the "Effect on Benefits" portion of AUTHORIZATION PROGRAM.

SERVICES REQUIRING AUTHORIZATION

Authorized Referrals. 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.

NOTE: *Authorized referrals* are not required for the services of *physicians* of a type not available within the Network. A *physician's* written referral is required, however, in order for the services of some *physicians* to be covered under this *plan*. Refer to the definition of "Physician" in the DEFINITIONS section.

Special Services

The following special services require prior authorization:

1. Organ and tissue transplants.

2. Travel expense benefits.

3. Visits for physical therapy, physical medicine and occupational therapy beyond those described under the "Physical Therapy, Physical Medicine and Occupational Therapy" provision of *YOUR* MEDICAL BENEFITS: MEDICAL CARE THAT IS COVERED.

4. Home infusion therapy.

5. Home health care.

6. Admissions to a skilled nursing facility.

EFFECT ON BENEFITS

For Services Requiring Authorized Referral

1. The Co-Payment or Co-Insurance for *participating providers* will apply for *medically necessary* and appropriate *authorized referral* services received from a *non-participating provider*.

2. The Co-Payment or Co-Insurance for *non-participating providers* will apply for referral services received from *non-participating providers* that have not been authorized in advance.

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.

WHEN AUTHORIZATION WILL BE PROVIDED

Authorized Referrals. Referrals to *non-participating providers* will be authorized when one of the following criteria is met:

1. There is no *participating provider* who practices the appropriate specialty or provides the required services or has the necessary facilities within a 50-mile radius of *your* residence and the services are authorized as *medically necessary* before the services are received; or

2. Y*ou* are referred to the *non-participating provider* by a *physician* who is a *participating provider* and the services are authorized as *medically necessary* before services are received.

Special Services

1. **Organ and Tissue Transplants.** Authorizations 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 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;

        ii. The providers of related preoperative and postoperative services are approved; and

        iii. The transplant will be performed at a *Center of Expertise (CME)*.

2. **Transplant Travel Expense Benefits.** Authorizations for transplant travel expense benefits will be provided for the recipient or donor only if all of the following criteria are met:

    a. It is 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, authorized by the *claims administrator*;

    b. The organ transplant must be performed at a specific *CME;* and

    c. The specific *CME* is 250 miles or more from the recipient or donor's home.

3. **Physical Therapy, Physical Medicine and Occupational Therapy.** The number of visits for physical therapy, physical medicine and occupational therapy which are payable without prior authorization is stated in the "Physical Therapy, Physical Medicine or Occupational Therapy" provision of YOUR MEDICAL BENEFITS: MEDICAL CARE THAT IS COVERED. A specific number of additional visits will be authorized when:

    a. Additional visits are *medically necessary* and appropriate and likely to result in a significant improvement in *your* condition.

    b. Y*ou* or *your physician* requests approval for the additional benefits prior to those services being rendered.

4. **Home Infusion Therapy.** Authorizations for services by a *home infusion therapy provider* will be provided only if the following criteria are met:

    a. The services are *medically necessary* and appropriate*;* and

b. The attending *physician* has submitted both a prescription and a plan of treatment prior to services being rendered.

5. **Home Health Care.** Authorizations for home health care services will be provided only if the following criteria are met:

   a. The services are *medically necessary* and appropriate and can be safely provided in the *member's* home, as certified by the attending *physician*.

   b. The attending *physician* manages and directs the *member's* medical care at home.

   c. The attending *physician* must establish a definitive treatment plan which must be consistent with the *member's* medical needs and must list the services to be provided by the *home health agency*.

6. **Skilled Nursing Facility.** The *claims administrator* will authorize inpatient services provided in a *skilled nursing facility* if:

   a. *You* require daily skilled nursing or rehabilitation, as certified by the attending *physician*;

   b. *You* were an inpatient in a *hospital* for at least three consecutive days, and are to be admitted to the *skilled nursing facility* within 30 days of *your* discharge from the *hospital*; and

   c. *You* will be treated for the same condition for which *you* were treated in the *hospital*.

Note: Admissions to a *residential treatment center* will not be subject to the authorization program. They are instead subject to the utilization review program (see UTILIZATION REVIEW PROGRAM).

HOW TO OBTAIN AN AUTHORIZATION

For Authorized Referrals. *You* or *your physician* must call the toll-free telephone number printed on *your* identification card prior to scheduling an admission to, or receiving the services of, a *non-participating provider*.

For Special Services Authorizations. *You* or *your physician* must call the toll-free telephone number printed on *your* identification card before the services are rendered.

Claims Procedures

You must also follow the CLAIMS PROCEDURES section in this *booklet* in order to obtain an authorization under this Authorization Program.

THE MEDICAL NECESSITY REVIEW PROCESS

The *claims administrator* will work with *you* and *your* health care providers to cover *medically necessary* and appropriate care and services. While the types of services requiring review and the timing of the reviews may vary, the *claims administrator* is committed to ensuring that reviews are performed in a timely and professional manner. The following information explains the *claims administrator's* review process. In addition, the *medical necessity* review process will meet the requirements in the CLAIMS PROCEDURES section of this *booklet*.

1. A decision on the *medical necessity* of a pre-service request will be made no later than two business days from receipt of the information necessary to make the decision.

2. A decision on the *medical necessity* of a concurrent request will be made no later than one business day from receipt of the information necessary to make the decision.

3. A decision on the *medical necessity* of a retrospective review will be made and communicated in writing no later than 30 days from receipt of the information necessary to make the decision.

4. If the *claims administrator* does not have the information it needs, the *claims administrator* will make every attempt to obtain that information from *you* or *your physician*. If the *claims administrator* is unsuccessful, and a delay is anticipated, the *claims administrator* will notify *you* and *your physician* of the delay and what the *claims administrator* will need to make a decision. The *claims administrator* will also inform *you* of when a decision can be expected following receipt of the needed information.

5. All pre-authorization, pre-service, concurrent and retrospective reviews for *medical necessity* are screened by clinically experienced, licensed personnel (called "Review Coordinators") using preestablished criteria and the *claims administrator's* medical policy. These criteria and policies are developed and approved by practicing providers not employed by the *claims administrator*, and are evaluated at least annually and updated as standards of practice or technology change. Requests satisfying these criteria are certified as *medically necessary*. Review Coordinators are able to approve most requests.

6. A written confirmation including the specific service certified as *medically necessary* will be sent to *you* and *your* provider no later than two business days after the decision.

7. If the request fails to satisfy these criteria or medical policy, the request is referred to a Peer Clinical Reviewer. Peer Clinical Reviewers are health professionals clinically competent to evaluate the specific clinical aspects of the request and render an opinion specific to the medical condition, procedure and/or treatment under review. Peer Clinical Reviewers are licensed in California with the same license category as the requesting provider. When the Peer Clinical Reviewer is unable to certify the service, the requesting *physician* is contacted by telephone for a discussion of the case. In many cases, services can be certified after this discussion. If the Peer Clinical Reviewer is still unable to certify the service, *your* provider will be given the option of having the request reviewed by a different Peer Clinical Reviewer.

8. Only the Peer Clinical Reviewer may determine that the proposed services are not *medically necessary* and appropriate. Y*our physician* will be notified by telephone within 24 hours of a decision not to certify and will be informed at that time of how to request reconsideration. Written notice will be sent to *you* and the requesting provider within two business days of the decision. This written notice will include all of the information described in the CLAIMS PROCEDURES section of this *booklet* for notifications of adverse benefit determination, and in addition, the name and phone number of the Peer Clinical Reviewer making the decision to modify or not certify the request.

9. The written notice will explain how *you* may appeal the determination that the services are not *medically necessary*. Please review the CLAIMS PROCEDURE section of this *booklet* for information regarding such appeals.

10. *You* or *your physician* may request copies of specific criteria and/or medical policy by writing to the address shown on *your plan* identification card. The *claims administrator* will disclose its *medical necessity* review procedures to health care providers through provider manuals and newsletters.

A determination of medical necessity does not guarantee payment or coverage. The determination that services are *medically necessary* is based on the clinical information provided. Payment is based on the terms of *your* coverage at the time of service. These terms include certain exclusions, limitations, and other conditions. Payment of benefits could be limited for a number of reasons, including:

- The information submitted with the claim differs from that given by phone;
- The service is excluded from coverage; or
- *You* are not eligible for coverage when the service is actually provided.

PERSONAL CASE MANAGEMENT

The personal case management program enables the *claims administrator* to authorize *you* to obtain medically appropriate care in a more economical, cost-effective and coordinated manner during prolonged periods of intensive medical care. The *claims administrator* has the right, through a case manager, to recommend an alternative plan of treatment which may include services not covered under this *plan*. It is not *your* right to receive personal case management, nor does the *claims administrator* have an obligation to provide it; the *claims administrator* provides these services at the *claims 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 review procedures, by the attending *physician, hospital* staff, or the *claims administrator's* claims reports. *You* or *your* family may also call the *claims administrator*.

Benefits for personal case management will be considered only when all of the following criteria are met:

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. The *claims administrator's* 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* while maintaining the same standards of care; and

4. *You* (or *your* legal guardian) and *your physician* agree, in a letter of agreement, with the *claims administrator's* recommended substitution of benefits and with the specific terms and conditions under which alternative benefits are to be provided.

Alternative Treatment Plan. If the *claims administrator* 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* makes treatment recommendations only; any decision regarding treatment belong to *you* and *your physician*. The *plan* will, in no way, compromise *your* freedom to make such decisions.

EFFECT ON BENEFITS

1. Benefits are provided for an alternative treatment plan on a case-by-case basis only. The *claims administrator* has absolute discretion in deciding whether or not to authorize services in lieu of benefits for any *member,* which alternatives may be offered and the terms of the offer.

2. The *claims administrator's* authorization of services in lieu of benefits in a particular case in no way commits the *claims administrator* to do so in another case or for another *member*.

3. The personal case management program does not prevent the *claims administrator* from strictly applying the expressed benefits, exclusions and limitations of this *plan* at any other time or for any other *member*.

Note: The *claims administrator* reserves 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 by either party is valid without the prior written consent of the other party.

DISAGREEMENTS WITH MEDICAL MANAGEMENT DECISIONS

If *you* or *your physician* disagrees with a decision, or question how it was reached, *you* or *your physician* may request reconsideration. All requests for reconsideration must follow the requirements in the CLAIMS PROCEDURES section of this *booklet*.

UTILIZATION REVIEW PROGRAM

The *plan* utilization review program evaluates the *medical necessity* and appropriateness of care and the setting in which care is provided. Y*ou* and *your physician* are advised if the *claims administrator* has determined that services can be safely provided in an outpatient setting, or if an inpatient *stay* is recommended. Services that are *medically necessary* and appropriate are certified by the *claims administrator* and monitored so that *you* know when it is no longer *medically necessary* and appropriate to continue those services.

It is *your* responsibility to see that *your physician* starts the utilization review process before scheduling *you* for any service subject to the utilization review program. If *you* receive any such service, and do not follow the procedures set forth in this section, *your* benefits will be reduced as shown in the "Effect on Benefits" portion of the UTILIZATION REVIEW PROGRAM, below.

UTILIZATION REVIEW REQUIREMENTS

Utilization reviews are conducted for the following services:

- All inpatient *hospital stays* and *residential treatment center* admissions;
- Outpatient surgery at an *ambulatory surgical center*; and
- *Facility-based care* for the treatment of *mental or nervous disorders, severe mental disorders,* and substance abuse.

Exceptions: Utilization review is not required for inpatient *hospital stays* for the following services:

- Maternity care of 48 hours or less following a normal delivery or 96 hours or less following a cesarean section; and
- Mastectomy and lymph node dissection.

There are three stages of utilization review:

1. **Pre-service review** determines the *medical necessity* and appropriateness of scheduled, non-emergency inpatient *hospital* and *residential treatment center* admissions, *ambulatory surgical center* services, and *facility-based care* for the treatment of *mental or nervous disorders, severe mental disorders,* and substance abuse.

2. **Concurrent review** determines whether services are *medically necessary* and appropriate when pre-service review is not required or the *claims administrator* is notified while service is ongoing, for example, an emergency admission to the hospital.

3. **Retrospective review** is performed to review services that have already been provided. This applies in cases when preauthorization, pre-service or concurrent review was not completed, or in order to evaluate and audit medical documentation subsequent to services being provided. Retrospective review may also be performed for services that continued longer than originally certified.

EFFECT ON BENEFITS

In order for the full benefits of this *plan* to be payable, the following criteria must be met:

1. The appropriate utilization reviews must be performed in accordance with this *plan*. When pre-service review is not performed as required for an inpatient *hospital* or *residential treatment center* admission, an outpatient surgical procedure at an *ambulatory surgical center,* or for *facility-based care* for the treatment of *mental or nervous disorders, severe mental disorders*, and substance abuse, the benefits to which *you* would have been otherwise entitled will be subject to the Non-Certification Deductible shown in the SUMMARY OF BENEFITS.

2. The services must be *medically necessary* and appropriate. Inpatient *hospital* benefits will be provided only when an inpatient *stay* is *medically necessary* and appropriate. *Facility-based care* for the treatment of

mental or nervous disorders, severe mental disorders, and substance abuse will be provided only when *medically necessary* and appropriate for *your* condition. If *you* proceed with any services that have been determined to be not *medically necessary* and appropriate at any stage of the utilization review process, benefits will not be provided for those services.

3. Services that are not reviewed prior to or during service delivery will be reviewed retrospectively when the bill is submitted for benefit payment. If that review results in the determination that part or all of the services were not *medically necessary* and appropriate*,* benefits will not be paid for those services. Remaining benefits will be subject to previously noted reductions that apply when the required reviews are not obtained.

OBTAINING UTILIZATION REVIEWS

Remember, it is always *your* responsibility to confirm that the utilization review has been performed.

Pre-service Reviews. Penalties will result for failure to obtain pre-service review, before receiving scheduled services, as follows:

1. For all scheduled services that are subject to utilization review, *you* or *your physician* must initiate the pre-service review at least three working days prior to when *you* are scheduled to receive services by following the procedures in "Procedures for Obtaining a Utilization Review and Appealing a Denial of a Review," below.

2. Y*ou* must tell *your physician* that this *plan* requires pre-service review. *Physicians* who are *participating providers* will initiate the review on *your* behalf. Another *participating provider* or *non-participating provider* may initiate the review for *you*, or *you* may call the *claims administrator* directly. The toll-free number for pre-authorization and pre-service review is printed on *your* identification card.

3. If *you* do not receive the certified service within 60 days of the certification, or if the nature of the service changes, a new pre-service review must be obtained.

4. The *claims administrator* will certify services that are *medically necessary* and appropriate. For inpatient *hospital* and *residential treatment center* stays, the *claims administrator* will, if appropriate, certify a specific length of *stay* for approved services. For *facility-based care* for the treatment of *mental or nervous disorders, severe mental disorders*, and substance abuse, the *claims administrator* will, if appropriate, certify the type and level of services, as well as their duration. Y*ou*, *your physician* and the provider of the service will receive a written confirmation showing this information.

Concurrent Reviews

1. If pre-service review was not performed, *you*, *your physician* or the provider of the service must contact the *claims administrator* for concurrent review. For an *emergency* admission or procedure, the *claims administrator* must be notified within one working day of the admission or procedure, unless extraordinary circumstances* prevent such notification within that time period.

2. When *participating providers* have been informed of *your* need for utilization review, they will initiate the review on *your* behalf. Y*ou* may ask a *non-participating provider* to call the toll-free number printed on *your* identification card or *you* may call directly.

3. When the *claims administrator* determines that the service is *medically necessary* and appropriate, the *claims administrator* will, depending upon the type of treatment or procedure, certify the service for a period of time that is medically appropriate. The *claims administrator* will also determine the medically appropriate setting.

4. If the *claims administrator* determines that the service is not *medically necessary* and appropriate, *your physician* or other provider will be notified by telephone no later than 24 hours following our decision. The *claims administrator* will send written notice to *you* and *your physician* or other provider within two

business days following our decision. However, care will not be discontinued until *your physician* or other provider has been notified and a plan of care that is appropriate for *your* needs has been agreed upon.

***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*. Y*ou* may have to prove that such "extraordinary circumstances" were present at the time of the *emergency*.

Retrospective Reviews

1. Retrospective review is performed when the *claims administrator* is not notified of the service *you* received, and are therefore unable to perform the appropriate review prior to *your* discharge from the *hospital* or completion of outpatient treatment. It is also performed when pre-service or concurrent review has been done, but services continue longer than originally certified. It may also be performed for the evaluation and audit of medical documentation after services have been provided, whether or not pre-service or concurrent review was performed.

2. Such services which have been retroactively determined to not be *medically necessary* and appropriate will be retrospectively denied certification.

Procedures for Obtaining a Utilization Review and Appealing a Denial of a Review

In order to obtain a utilization review, *you* must meet certain requirements regarding the notification of the *plan*. This obligation is met when the *claims administrator* receives a *notification of utilization review services*. The c*laims administrator* may request additional information or require a signed unaltered authorization to obtain information from the provider. Failure to comply with the *claims administrato*r's request could have the result discussed in "Effect on Benefits," above.

If *you* or *your* designated patient representative fails to follow the *claims administrator's* procedures for filing a claim for a *pre-service review*, the *claims administrator* will notify *you* or *your* designated patient representative of the failure and the proper procedures to be followed as soon as possible, but no later than 5 days following the failure.

Pre-Service Review

For a *pre-service review*, *you* will be notified of a decision within a reasonable period of time appropriate to the medical circumstances, but not later than 15 calendar days of the date the *claims administrator* receives *notification of utilization review services*. This period may be extended one time by the *claims administrator* for up to an additional 15 days, provided that the *claims administrator* determines such an extension is due to reasons beyond their control and notifies *you*, prior to the expiration of the initial 15 day period, of the circumstances requiring the extension of time and the date by which a decision is expected. If the extension is required due to *your* failure to submit the information necessary to decide the claim, the notice of extension will specifically describe the required information. You, the patient, the attending *physician* or other ordering provider or the facility rendering the service is permitted up to 45 calendar days to provide the necessary information. The *claims administrator* will notify *you* of a decision within 15 days of receiving the necessary information. If the additional necessary information is not received, the *claims administrator* will notify *you* of a decision within 15 calendar days after the expiration of the 45-calendar-day period given to *you* to provide the necessary information. Written notification of the *claims administrator's* decision will be provided to the attending *physician* or other ordering provider, the facility rendering service, and *you* or the patient.

Concurrent Review

For a concurrent review, where an ongoing course of treatment has been approved and the *claims administrator* has determined to reduce or terminate those benefits, *you* will be notified of this reduction or termination sufficiently in advance of the *claims administrator's* decision to allow *you* to appeal the decision. If *you* request an extension of the period of treatment or number of treatments, *you* will be notified of the *claims administrator's* decision as soon as possible, but within 24 hours after the *claims administrator* receives the *notice of utilization review* for any request

to extend the course of treatment for an approved number of treatments, if the *notice* is received at least 24 hours prior to the end of the previously approved course of treatment.

If the *claims administrator* certifies a health care service, notification will be provided in writing to the attending *physician* or other ordering provider, the facility rendering service, and *you* or the patient. For *noncertifications*, notification will be made to the attending *physician* or other ordering provider or facility rendering service by written *notification*, with notice also sent to *you* or the patient.

Retrospective Review

For a retrospective review, *you* will be notified of the *claims administrator's* decision within a reasonable period of time, but not later than 30 calendar days after the date the *claims administrator* receives a *notification of utilization review services*. This period may be extended one time by the *claims administrator* for up to an additional 15 days, provided that the *claims administrator* determines such an extension is due to reasons beyond their control and notifies *you*, prior to the expiration of the initial 30 day period, of the circumstances requiring the extension of time and the date by which a decision is expected. If the extension is required because of *your* failure to submit the information necessary to decide the claim, the notice of extension will specifically describe the required information. You, the patient, the attending *physician* or other ordering provider or the facility rendering the service is permitted up to 45 calendar days to provide the necessary information. The *claims administrator* will notify *you* of a decision within 30 calendar days of receiving the necessary information. If the necessary additional information is not received, the *claims administrator* will notify *you* of a decision within 30 days after the expiration of the 45-calendar-day period given to *you* to provide the information. Written notification of the *claims administrator's* decision will be sent to the attending *physician* or other ordering provider, the facility rendering service, and *you* or the patient.

Notification of Noncertification

The *claims administrator* will provide *you* with written or electronic notification of any *noncertification* as described above. If the notice of *noncertification* is provided electronically, such notice will comply with the standards imposed by the Department of Labor Regulations. Any notice of *noncertification* will set forth, in a manner calculated to be understood by *you*:

- The specific reason or reasons for the *noncertification*;
- References to the specific *plan* provisions on which the noncertification is based;
- A description of any additional material or information necessary for *you* to perfect the claim and an explanation of why such material or information is necessary;
- A description of the *plan*'s review procedures and the time limits applicable to such procedures, including a statement of *your* rights to bring a civil action under Section 502(a) of *ERISA* following a determination of noncertification on review;
- If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the determination of *noncertification*, either the specific rule, guideline, protocol, or other similar criterion, or a statement that such a rule, guideline, protocol or other similar criterion was relied upon in making the *noncertification* and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to *you* upon request; and
- If the noncertification is based on a *medical necessity* or *experimental* treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the *plan* to *your* medical circumstances, or a statement that such explanation will be provided free of charge.

Appeal of Noncertifications

You or a designated patient representative, *physician*, or other provider has the right to an appeal review of any utilization review program determination, by telephone, fax, or in writing. The *claims administrator* will make a full and fair review of the *noncertification*. *You* must complete the appeal review process before filing any civil action or pursuing any other legal remedies. *You* will be provided, upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to *your* claim for benefits.

Procedures for appealing *noncertifications* are described in the CLAIMS PROCEDURES section below, under the provision entitled "Appeals of Adverse Benefit Determinations."

ADDITIONAL DEFINITIONS

Noncertification

A determination by the *claims administrator* that a request for service has been reviewed and, based upon the information provided, is denied, reduced or terminated.

Notification of Utilization Review Services

Receipt of necessary information to initiate review of a request for utilization review services that include the patient's name, *your* name (if different from patient's name), attending *physician's* name, treating facility's name, diagnosis, and date of service.

CLAIMS PROCEDURES

Claims Procedures. The *plan* and this *booklet* titled "Summary Plan Description" contain information on reporting claims, including the time limitations on submitting a claim. Claim forms may be obtained from the *claims administrator*. (Note that the *claims administrator* is the named fiduciary for purposes of resolving all claims for benefits made under the *plan*.) In addition to this information, *ERISA* applies some additional claim procedure rules. The additional rules required by *ERISA* are set forth below. This claims procedure applies to all claims under the *plan* including claims arising under the *plan's* medical management program, including the following:

(i) authorization program;

(ii) utilization review program; and

(iii) *medical necessity* review process.

A "claim" under this claims procedure means any request for medical care, benefits or services under the *plan*, including, for example, requests under the *plan's* medical management programs.

Urgent Care. The *claims administrator* must notify *you*, as soon as possible, but no later than 72 hours after they receive *your* request for benefits, what they determine *your* benefits to be. If *your* request for benefits does not contain all the necessary information, they must notify *you* within 24 hours after they receive it and tell *you* what information is missing. Any notice to *you* by them will be orally, by telephone, or in writing by facsimile or other fast means. *You* have at least 48 hours to give them the additional information they need to process *your* request for benefits. *You* may give them the additional information they need orally, by telephone, or in writing by facsimile or other fast means.

If *your* request for benefits is denied in whole or in part, *you* will receive a notice of the denial within 72 hours after the c*laims administrator's* receipt of the request for benefits, 48 hours after receipt of all the information they need to process *your* request for benefits, or 48 hours after the end of the period given to *you* to provide the specified additional information. For information regarding appeals, please review the Section below titled "Appeals of Adverse Benefit Determination."

Non-Urgent Care Pre-Service (when care has not yet been received). The c*laims administrator* must notify *you,* within 15 days after they receive *your* request for benefits, what they have determined *your* benefits to be. If they need more than 15 days to determine *your* benefits, due to reasons beyond their control, they may have one extension, but must notify *you*, within the initial 15-day period, the circumstances requiring the extension of time, and the date by which a decision is expected to be rendered. But, in any case, even with an extension, the c*laims administrator* cannot take more than 30 days to determine *your* benefits. If the extension is due to a failure by *you* to properly follow the *plan's* procedures for filing a pre-service claim, the c*laims administrator* must notify *you*, within 5 days after they receive *your* request and tell *you* what information is missing. *You* have 45 days to provide the c*laims administrator* with the information they need to process *your* request for benefits. The time period during which the c*laims administrator* is waiting for receipt of the necessary information is not counted toward the time frame in which the c*laims administrator* must make the benefit determination.

If *your* request for benefits is denied in whole or in part, *you* will receive a written notice of the denial within the time frame stated above after the c*laims administrator* has all the information they need to process *your* request for benefits. For information regarding appeals, please review the Section below titled "Appeals of Adverse Benefit Determination."

CONCURRENT CARE DECISIONS

Reduction of Benefits. If, after approving a request for benefits in connection with *your* illness or injury, the c*laims administrator* decides to reduce or end the benefits they have approved for *you*, in whole or in part:

- They must notify *you* sufficiently in advance of the reduction in benefits, or the end of benefits, to allow *you* the opportunity to appeal their decision.
- To keep the benefits *you* already have approved, *you* must successfully appeal the c*laims administrator*'*s* decision to reduce or end those benefits. *You* must make *your* appeal to them at least 24 hours prior to the

occurrence of the reduction or ending of benefits. If *you* appeal the decision to reduce or end *your* benefits when there is less than 24 hours to the occurrence of the reduction or ending of benefits, *your* appeal may be treated as if *you* were appealing an *urgent care* denial of benefits (see the section "Urgent Care," above), depending upon the circumstances of *your* condition.

- If the c*laims administrator* receives *your* appeal for benefits at least 24 hours prior to the occurrence of the reduction or ending of benefits, they must notify *you* of their decision regarding *your* appeal within 24 hours of their receipt of it. If the c*laims administrator* denies *your* appeal of their decision to reduce or end *your* benefits, in whole or in part, they must explain the reason for their denial of benefits and the *plan* provisions upon which the decision was made. *You* may further appeal the c*laims administrator's* decision. For information regarding appeals, please review the Section below titled "Appeals of Adverse Benefit Determination."

Extension of Benefits. If, while *you* are undergoing a course of treatment in connection with *your* illness or injury, for which benefits have been approved, *you* would like to request an extension of benefits for additional treatments:

- *You* must make a request to the c*laims administrator* for the additional benefits at least 24 hours prior to the end of the initial course of treatment that had been previously approved for benefits. If *you* request additional benefits when there is less than 24 hours until the end of the initially prescribed course of treatment, *your* request will be handled as if it was a new request for benefits and not an extension and, depending on the circumstances, it may be handled as an *urgent* or non-urgent care pre-service request for benefits.

- If the c*laims administrator* receives *your* request for additional benefits at least 24 hours prior to the end of the initial course of treatment, for previously approved benefits, they must notify *you* of their decision regarding *your* request within 24 hours of their receipt of it. If the c*laims administrator* denies *your* request for additional benefits, in whole or in part, they must explain the reason for their denial of benefits and the *plan* provisions upon which the decision was made. *You* may appeal the adverse benefit determination. For information regarding appeals, please review the Section below titled "Appeals of Adverse Benefit Determination."

Non-Urgent Care Post-Service (reimbursement for cost of medical care). The c*laims administrator* must notify *you*, within 30 days after they receive *your* claim for benefits, what they determine *your* benefits to be. If they need more than 30 days to determine *your* benefits, due to reasons beyond their control, they are afforded one extension, but must notify *you* within the initial 30-day period that they need more time to determine *your* benefits, the circumstances requiring the extension of time, and the date by which a decision is expected to be rendered. But, in any case, even with an extension, the c*laims administrator* cannot take more than 45 days to determine *your* benefits. If the extension is required because of *your* failure to submit the information necessary to decide the claim, the notice of extension will specifically describe the necessary information and will be provided to *you* within 30 days after they receive *your* claim. *You* have 45 days to provide them with the information they need to process *your* claim. The time period during which the c*laims administrator* is waiting for receipt of the necessary information is not counted toward the time frame in which the c*laims administrator* must make the benefit determination.

If *your* claim is denied in whole or in part, *you* will receive a written notice of the adverse benefit determination within the time frame stated above, or after the c*laims administrator* has all the information they need to process *your* claim. The written notice will explain the reason for the adverse benefit determination and the *plan* provisions upon which the denial decision is based. *You* may appeal the adverse benefit determination. For information regarding appeals, please review the Section below titled "Appeals of Adverse Benefit Determination."

Note: *You*, *your* **beneficiary, or a duly authorized representative may appeal any denial of a claim for benefits** with the c*laims administrator* and request a review of the denial. In connection with such a request:

- Documents pertinent to the administration of the *plan* may be reviewed free of charge; and
- Issues outlining the basis of the appeal may be submitted.

You may have representation throughout the appeal and review procedure.

For the purposes of this provision, the meanings of the terms "urgent care," "non-urgent care pre-service," and "non-urgent care post-service," used in this provision, have the meanings set forth by *ERISA* for a "claim involving urgent care," "pre-service claim," and "post-service claim," respectively.

Manner and Content of Notification of Adverse Benefit Determination

If *your* claim is denied, the c*laims administrator* will notify *you* in writing of such denial. The written notice of denial will include the following information:

1. The specific reason or reasons for the adverse benefit determination;

2. Reference to the specific *plan* provisions on which the determination is based;

3. A description of any additional material or information necessary to perfect the claim and an explanation of why such material or information is necessary;

4. A description of the review procedures and the time limits applicable to such procedures, including a statement of *your* right to bring a civil action under §502(a) of *ERISA*;

5. If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse benefit determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse benefit determination and that a copy of such rule, guideline, protocol, or other criterion will be provided to *you* free of charge upon request.

6. If the adverse benefit determination or *noncertification* is based on a *medical necessity* or *experimental treatment* or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the *plan* to the claimant's medical circumstances, or a statement that such explanation will be provided free upon request.

Appeals of Adverse Benefit Determination

The *plan* will provide *you* with a reasonable opportunity for a full and fair review of an adverse benefit determination including a *noncertification*. If *you* disagree with the determination of the review, *you* have the right to bring a civil action under *ERISA* section 502(a). However, *you* must complete the review before *you* can file any litigation with respect to a denied claim. The term "adverse benefit determination" below includes *noncertification*s under the utilization review program and adverse determinations under the *plan* medical management program.

Appeals of adverse benefit determinations will be governed in accordance with the following procedures:

1. *You* must appeal within 180 days following receipt of notification of an adverse benefit determination;

2. *You* will be provided with the opportunity to submit written comments, documents, records, and/or other information relating to the claim for benefits in conjunction with *your* timely appeal;

3. *You* will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to *your* claim for benefits;

4. The review on (timely) appeal will take into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination;

5. No deference to the initial adverse benefit determination will be afforded upon appeal;

6. The appeal will be conducted by an individual who is neither the individual who made the underlying adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual;

7. Any medical expert(s) whose advice was obtained in connection with the adverse benefit determination shall be identified, without regard to whether the advice was relied upon in making the benefit determination;

8. In deciding the appeal of any adverse benefit determination that is based in whole or in part on a medical judgment, the individual conducting the appeal shall consult with a health care professional:

   (a) who has appropriate training and experience in the field of medicine involved in the medical judgment; and

   (b) who is neither an individual who was consulted in connection with the adverse benefit determination that is subject of the appeal, nor the subordinate of any such individual.

Urgent Care Claims

For appeals involving urgent care, along with the above, these additional rules apply:

1. There is an expedited review in which a request for an expedited appeal or an adverse benefit determination (including *noncertification*s) may be submitted orally or in writing; and

2. The transmission of all necessary information, including the *plan's* benefit determination on review, may be made by telephone, facsimile, or other available similarly expeditious method.

Timing of Notification of Benefit Determination on Review

Urgent Care Claims: In the case of an Urgent Care Claim, *you* will be notified of the *plan's* decision on *your* review as soon as possible, but not later than 72 hours after receiving the request for review.

Pre-Service Claims: For each level of review, the *plan* will notify *you* of its decision not later than 15 days after receipt of the request for review.

Post-Service Claims: In the case of a review of a denial of a claim for reimbursement or other Post-Service Claim, *you* will be notified of the *plan's* decision not later than 30 days after the receipt of the request for review.

Manner and Content of Notification of Benefit Determination on Review

You will be provided with written notification of the determination on review of an adverse benefit determination. In the case of an adverse benefit determination on review, the notification will include the following information:

1. The specific reason or reasons for the adverse benefit determination;

2. Reference to the specific *plan*/policy provisions on which the determination is based;

3. A statement that *you* are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to *your* claim for benefits;

4. A statement of *your* right to bring an action under §502(a) of *ERISA* once *you* have completed both levels of review;

5. In an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse benefit determination, either the specific rule, guideline, protocol, or other similar criterion, or a statement that such a rule, guideline, protocol or other similar criterion was relied upon in making the adverse benefit determination and that a copy of such rule, guideline, protocol, or other criterion will be provided to *you* free of charge upon request, and the following statement: "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your U.S. Department of Labor office and your state insurance regulatory agency."

6. If the adverse benefit determination is based on a *medical necessity* or *experimental treatment* or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the *plan* to the claimant's medical circumstances, or a statement that such explanation will be provided free upon request.

Urgent Care Claims

In addition to the above criteria, the notification on review of Urgent Care Claims will include the following:

1. A description of the expedited review process in which a request for an expedited appeal of an adverse benefit determination may be submitted orally or in writing; and

2. The transmission of all necessary information, including the *plan*'s benefit determination on review, by telephone, facsimile, or other available similarly expeditious method.

External Review (HSA Plan)

Standard External Review. For claims involving medical judgment and rescissions of coverage (other than for failure to pay required premiums or contributions) *you* may request an independent external review within four (4) months of having received your adverse benefit determination on appeal. If there is no corresponding date of the calendar month that is four (4) months after receipt of the adverse benefit determination on appeal, the request must be made by the first day of the fifth (5th) month after receipt of the adverse benefit determination on appeal. For example, if you received the adverse benefit determination on appeal on May 31, the deadline for you to submit a request for external review would be October 1, since September 31 does not exist.

The types of claims that may qualify for external review are claims with respect to:

- medical necessity, as determined by an external reviewer, e.g., appropriateness of health care setting or treatment by a specialist, level of care or effectiveness of a covered benefit, determination of emergency care or preexisting condition; or

- rescission of coverage.

If your final internal appeal is denied (i.e., you receive a final internal adverse benefit determination), you will be notified in writing that your claim is eligible for external review and you will be informed of next steps.

> ***Deemed Exhaustion.*** You may also qualify for external review (or, alternatively, judicial review) if the *plan* fails to strictly adhere to all claims determination and appeal requirements under federal law – other than minor violations that do not cause, and are not likely to cause, prejudice or harm, so long as the violations were for good cause or due to matters beyond the *plan's* control, and that occurred in the context of an on-going, good-faith exchange of information, and do not reflect a pattern or practice of non-compliance – based on so-called "deemed exhaustion".
>
> You may request that the *plan* provide a written explanation of the violation, including a specific description of the bases, if any, for asserting that a particular violation should not cause deemed exhaustion of the internal claims and appeals processes. The *plan* must provide such an explanation within 10 days.
>
> If an external reviewer rejects your request for an immediate external review based on deemed exhaustion, the plan will notify you within 10 days of your opportunity to resubmit your appeal in accordance with the internal appeal processes. Time periods for such re-filing of your claim will begin to run from the date of your receipt of such notice.

Expedited External Review. You may immediately request an expedited external review when you receive:

- an initial internal adverse benefit determination involving a medical condition that would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function if you followed the normal claim procedure guidelines;

- a final internal adverse benefit determination involving a medical condition that would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function if you followed the normal claim procedure guidelines; or

- a final internal adverse benefit determination involving admission , availability of care, continued stay, or a health care item or service for which you received emergency services, but have not been discharged from a facility.

To submit a claim for external review, please contact the *claims administrator*.

If your claim for external review is accepted, it will be assigned to an Independent Review Organization ("IRO"), that will review your claim de novo, that is, as if it had not been previously reviewed. The *plan* must comply with the IRO's ultimate decision without delay, regardless of whether the *plan* intends to seek judicial review (i.e., go to court). Please note that the process of an IRO review may require a nominal filing fee of you as the claimant, not to exceed $25, which will be refunded to you if the adverse benefit determination is reversed through the external review.

Exhaustion of Remedies

Notwithstanding anything to the contrary in the *plan,* no legal action for benefits under the *plan* may be brought unless and until a claimant or duly appointed representative has completed the claims and appeal procedures described in this section of the *booklet* and has received written or electronic notification from the *claims administrator* that the appeal has been denied.

No legal action may be brought under section 502(a) of *ERISA* more than one year after the *claims administrator* notifies the claimant that the appeal has been denied or, if earlier, more than four years after the facts or events giving rise to the allegation(s) in the claim or when the claim first occurred.

Any legal action relating to or arising under the *plan* may only be brought in the United States District Court for the Northern District of California, and such court will have personal jurisdiction over the claimant and any other person named in the action.

HOW COVERAGE BEGINS AND ENDS

HOW COVERAGE BEGINS

ELIGIBLE STATUS

1. **Employees.** *You* are eligible to enroll in the *plan* if you are a regular full-time *employee* or part-time *employee* of the *employer* or if *you* are an *employee* of BancWest Corporation. A part-time *employee* is an *employee* who is scheduled to work at least 20 hours a week in the conduct of the business of the *employer*. *You* are not eligible to enroll in the *plan* if *you* are (i) classified by the *employer* as a temporary employee, a flex employee, intern or consultant; (ii) subject to a written agreement that provides that *you* are not eligible to enroll in the *plan*; or (iii) a member of a group, division or other classification that the *employer* has designated as ineligible to enroll in the *plan*. Notwithstanding the foregoing, if the *employer* determines that a flex employee is a full-time *employee* of the *employer* for purposes of Section 4980H of the Code and related regulations and guidance, then the *employer* may offer that *employee* an opportunity to enroll in "minimum essential coverage" (as defined in Section 36B of the Code), which may be coverage under this *plan* or another plan designated by the *employer*.

2. **Retirees.** *You* are eligible to enroll in the *plan* if you are under age 65 and *your* retiree medical plan permits you to elect between this *plan* and other coverage.

3. **Family Members.** The following are eligible to enroll as *family members*: (a) The *employee's spouse* or *domestic partner*; (b) a *retiree's spouse* or *domestic partner* who is under age 65; and (c) a *child*.

4. **Family Members of Retirees Over the Age of 65.** The following are eligible to enroll as *family members* of a *retiree* who is over the age of 65: (a) The *retiree's spouse* or *domestic partner* who is under the age of 65; and (b) a *child* of the *retiree*.

Definition of Family Member

1. **Spouse** is the *employee's* or *retiree's* spouse under a legally valid marriage that is recognized as such for purposes of federal law. Spouse does not include any person who is: (a) covered as an *employee* or *retiree*; or (b) in active service in the armed forces.

2. **Domestic partner** is the *employee's* or *retiree's* domestic partner, subject to the following:

    a. The *employee (*or *retiree*) and domestic partner have not had a different domestic partner in less than six months.

    b. The *employee* or *retiree* and domestic partner are not related to each other, have assumed mutual obligations for the welfare and support of each other, and have been living together as a couple in the same household for at least six months.

    c. Domestic partner does not include any person who is: (i) covered as an *employee, retiree,* or *spouse;* or (ii) in active service in the armed forces.

3. **Child** or **Children** is the *employee's*, *retiree's*, *spouse*'s or *domestic partner's* natural child, stepchild, foster child, legally adopted child, or *child placed for adoption* with such individual subject to the following:

    a. The child is under age 26.

    b. A child who is *placed for adoption* with the *employee, retiree, spouse* or *domestic partner* is considered to be legally adopted, provided the *benefits administration unit* is provided with satisfactory legal evidence of such placement.

    c. The term "child" does not include: (i) any child for whom the *employee, retiree, spouse* or *domestic partner* is the legal guardian, but who is not the *employee's*, *retiree's, spouse*'s or

domestic partner's natural child, stepchild, foster child, legally adopted child or child *placed for adoption* with such individual; or (ii) any person who is eligible to enroll in this *plan* as an *employee* or *retiree*.

d. If both parents are covered as *employees* or *retirees*, their children may be covered as the *family members* of either, but not of both.

e. If a child is over age 26, the child will qualify as a *family member* if he or she is (i) financially dependent on the *employee, retiree, spouse* or *domestic partner,* and (ii) incapable of self-sustaining employment due to a physical handicap or mental retardation. A *physician* must certify this disability in writing. The *claims administrator* must receive the certification within 31 days of the date the child otherwise becomes ineligible. When a period of two years has passed, the *claims administrator* may request proof of continuing dependency and disability, but not more often than once each year.

This *exception* will last until the child is no longer handicapped or dependent on the *employee, retiree*, *spouse* or *domestic partner* for financial support. A child is considered financially dependent if he or she qualifies as a dependent of the *employee, retiree* or *spouse/domestic partner* for federal income tax purposes.

ELIGIBILITY DATE

1. For *employees,* you become eligible for coverage on the first day of the month coinciding with or following one month of continuous active employment. (This is *your* "waiting" period.)

2. For *retirees,* you become eligible for coverage on the first day of the month following the date you retire from the *employer*.

3. For *family members,* you become eligible for coverage on the later of: (a) the date the *employee* or *retiree* becomes eligible for coverage; or, (b) the date you meet the *family member* definition.

   An overage *child* who enters or returns to an eligible status will become eligible for coverage on the first day of the month following the date the *benefits administration unit* receives an enrollment application for the *family member*.

Exception to the Waiting Period

If, after you have completed the waiting period, you cease to be eligible due to termination of employment, and you return to an eligible status as an *employee* within six months after the date your employment terminated, you will become eligible on the first day of the month following the date you return.

ENROLLMENT

To enroll as an *employee* (or to enroll *family members)*, the *employee* must properly file an application. An application is considered properly filed only if it is made on the *employer's* intranet at www.bankofthewest.essbenefits.com or it is personally signed, dated, and given to the *benefits administration unit* within 31 days from your hire date. To enroll as a *retiree*, the *retiree* must complete a paper application and submit it to the *retirement benefits office* within 31 days of your retirement date. Enrollment and coverage is dependent on such proof of eligibility or continuing eligibility as the *plan* and the *claims administrator* may require.

EFFECTIVE DATE FOR ACTIVE EMPLOYEES

The date you become covered is determined as follows:

1. **Timely Enrollment.** On your eligibility date, provided you enroll before, on, or within 31 days after your eligibility date.

2. **Late Enrollment.** If you fail to enroll within 31 days after your eligibility date, you must wait until the *plan's* next *open enrollment period* to enroll unless you are eligible to enroll during a special enrollment period (see the "Special Enrollment Periods" provision below).

3. **Disenrollment.** If you voluntarily choose to disenroll from coverage under this *plan*, you must wait until the *plan's* next *open enrollment period* unless you are eligible to enroll during a special enrollment period (see the "Special Enrollment Periods" provision below).

4. **Special Enrollment.** If you enroll during a special enrollment period (see the "Special Enrollment Periods" provision below), special effective dates apply. Coverage due to a loss of other coverage or marriage/domestic partnership will be effective on the first day of the month following the date the *benefits administration unit* receives your enrollment application, provided your enrollment application is received within 31 days of your loss of other coverage or marriage/domestic partnership. Coverage due to birth, adoption or *placement for adoption* will be effective on the date of the *child's* birth, adoption or *placement for adoption*, provided the *benefits administration unit receives* your *enrollment application* within 31 days of the *child's* birth, adoption or *placement for adoption.* Coverage due to a CHIP special enrollment right will be effective on the first day of the month following the date the *benefits administration unit* receives your enrollment application, provided your enrollment application is received within 60 days of the occurrence of the CHIP special enrollment event. Coverage due to a qualified change in status under the Bank of the West Flexible Benefits Plan will be effective on the first day of the month following the date the *benefits administration unit* receives your enrollment application, provided your enrollment application is received within 31 days of the qualified change in status event.

Important Note for Newborn and Newly-Adopted Children. If the *employee* or *retiree* (or *spouse* or *domestic partner,* if the *spouse* or *domestic partner* is enrolled) is already covered:(1) any *child* born to the *employee, retiree, spouse* or *domestic partner* will be covered from the moment of birth; and (2) any *child* being adopted by the *employee, retiree, spouse* or *domestic partner* will be covered from the date on which either: (a) the adoptive *child's* birth parent, or other appropriate legal authority, signs a written document granting the *employee, retiree, spouse* or *domestic partner* the right to control the health care of the *child* (in the absence of a written document, other evidence of the *employee's, retiree's, spouse's* or *domestic partner's* right to control the health care of the *child* may be used)*;* or (b) the *employee, retiree, spouse* or *domestic partner* assumed a legal obligation for full or partial financial responsibility for the *child* in anticipation of the *child's* adoption. The written document referred to above includes, but is not limited to, a health facility minor release report, a medical authorization form, or relinquishment form.

In both cases, coverage will be in effect for 31 days. For coverage to continue beyond this 31-day period, the *employee* or *retiree* must enroll the *child* within the 31-day period by submitting a membership change form to the *benefits administration unit*.

Special Enrollment Periods for Active Employees

You may enroll without waiting for the *plan's* next *open enrollment period* if you are otherwise eligible during any one of the special enrollment periods described below. To request special enrollment or obtain more information, contact the *benefits administration unit*.

1. **Special Enrollment for Loss of Other Coverage**

If you (or a *family member)* declined to enroll in the *plan* because of other health insurance or group health plan coverage and you (or a *family member*) lose eligibility for that other coverage, a special enrollment for loss of other coverage is available if you meet all of the following requirements:

a. *You* (or a *family member)* are otherwise eligible for coverage under the *plan.*

b. When coverage under the *plan* was previously offered, you (or a *family member)* were covered under another health plan as an individual or dependent, including coverage under a *COBRA* or CalCOBRA continuation coverage.

c. *You* certified in writing at the time you (or a *family member)* became eligible for coverage under the *plan* that you were declining coverage under the *plan* because you (or your *family member)* already had other coverage.

d. *Your* (or your *family member's)* coverage under the other health plan wherein you (or your *family member)* were covered as an individual or dependent ended because you (or your *family member)* lost eligibility under the other plan or employer contributions toward coverage under the other plan terminated, or your (or your *family member's* coverage) under COBRA or CalCOBRA continuation coverage was exhausted.

e. *You* properly file an application with the *benefits administration unit* within 31 days from the date on which you (or your *family member)* lose coverage.

You (or a *family member*) may lose eligibility for that other coverage if, for example, you legally separate, divorce or cease to be a dependent. A loss of eligibility for coverage may also occur if you (or your *family member*) reaches a lifetime limit on all benefits under a plan, if the employer stops contributing toward your (or your *family member's*) other coverage, or if the other plan no longer offers any benefits to a class of similarly situated individuals.

If you enroll yourself during this special enrollment period, you can also enroll any eligible *family members.*

Coverage will be effective on the first day of the month following the date the *benefits administration unit* receives your enrollment application, provided your enrollment application is received within 31 days of the date on which you lost the other coverage.

2. **Special Enrollment Pursuant to the Children's Health Insurance Program Reauthorization Act of 2009**

If *you* are eligible, but not enrolled, for coverage under the *plan*, *you* may also enroll for coverage under the *plan* prior to the next *open enrollment period* if either of the following conditions is met:

a. *You* or *your* dependent is covered under a Medicaid plan or under a Children's Health Insurance Program (CHIP) and *your* coverage, or *your* dependent's coverage, under such a plan terminates as a result of loss of eligibility for such coverage; or

b. *You* or *your* dependent becomes eligible for premium assistance as to coverage under the *plan* under such Medicaid plan or CHIP plan.

You must provide the *benefits administration unit* with a properly completed enrollment application within 60 days of the occurrence of one of these special enrollment events. Coverage under special enrollment due to loss of coverage under a Medicaid or CHIP plan or eligibility for premium assistance under Medicaid or CHIP will be effective on the first day of the month following the date the *benefits administration unit* receives the properly filed enrollment application, provided your enrollment application is received within 60 days of the occurrence of the special enrollment event. If you do not elect coverage during this special enrollment period, you generally will not be able to enroll in the *plan* until the following *open enrollment period*.

3. **Marriage or New Domestic Partnership**

If you marry or enter into a domestic partnership during the *plan year*, you can enroll yourself (if you were not previously enrolled), your *spouse/domestic partner* and any *children* acquired as a result of your marriage/domestic partnership for coverage, provided the *benefits administration unit* receives your enrollment application within 31 days of your marriage/domestic partnership. Coverage will be effective on the first day of the month following the date your enrollment application is received, provided your enrollment application is received within 31 days of your marriage/domestic partnership.

4. **Newborn Child, Newly Adopted Child or Child Placed for Adoption**

If you or your *spouse/domestic partner* acquires a new *child* through birth, adoption or *placement for adoption* during the *plan year*, you can enroll yourself (if you were not previously enrolled), your *spouse/domestic partner* and the new *child* for coverage, provided the *benefits administration unit* receives your enrollment application within 31 days of the birth, adoption or *placement for adoption.* Coverage will be effective retroactive to the date of the birth, adoption or *placement for adoption*, provided your enrollment application is received within 31 days of the birth, adoption or *placement for adoption.*

5. **Qualified Change in Status Events Under the Bank of the West Flexible Benefits Plan**

If you experience a qualified change in status event under the Bank of the West Flexible Benefits Plan during the *plan year*, you can enroll yourself and any eligible *family members* for coverage, provided the *benefits administration unit* receives your enrollment application within 31 days of the qualified change in status event and such enrollment is otherwise consistent with terms of the Bank of the West Flexible Benefits Plan. Coverage will be effective on the first day of the month following the date your enrollment application is received, provided your enrollment application is received within 31 days of the date of the qualified change in status event.

EFFECTIVE DATE FOR FAMILY MEMBERS OF ACTIVE EMPLOYEES

The date your *family members* become covered is determined as follows:

1. **Timely Enrollment.** On your eligibility date, provided you enroll your *family members* before, on, or within 31 days after your eligibility date.

2. **Late Enrollment.** If you fail to enroll your *family members* within 31 days after your eligibility date, you must wait to enroll them until the *plan's* next *open enrollment period* unless you can enroll them during a special enrollment period (see the "Special Enrollment Periods" provision below).

3. **Disenrollment.** If you voluntarily choose to disenroll your *family members* from coverage under this *plan*, you must wait to reenroll them until the next *open enrollment period* unless you are eligible to enroll them during a special enrollment period (see the "Special Enrollment Periods" provision below).

4. **Special Enrollment.** If your *family members* are enrolled during a special enrollment period (see the "Special Enrollment Periods" provision below), special effective dates apply. Coverage due to loss of other coverage or marriage/domestic partnership will be effective on the first day of the month following the date the *benefits administration unit* receives your enrollment application, provided your enrollment application is received within 31 days of the loss of other coverage or marriage/domestic partnership. Coverage due to birth, adoption or *placement for adoption* will be effective on the date of the *child's* birth, adoption or *placement for adoption*, provided the *benefits administration unit* receives your enrollment application within 31 days of the *child's* birth, adoption or *placement for adoption.* Coverage due to a CHIP special enrollment right will be effective on the first day of the month following the date the *benefits administration unit* receives your enrollment application, provided your enrollment application is received within 60 days of the occurrence of the CHIP special enrollment event. Coverage due to a qualified change in status under the Bank of the West Flexible Benefits Plan will be effective on the first day of the month following the date the *benefits administration unit* receives your enrollment application, provided your enrollment application is received within 31 days of the qualified change in status event.

Special Enrollment Periods for Family Members of Active Employees

1. **Special Enrollment for Loss of Other Coverage**

If your *family member* declined to enroll in the *plan* because of other health insurance or group health plan coverage and your family member loses eligibility for that other coverage, a special enrollment for loss of other coverage is available if your *family member* meets all of the following requirements:

a. *Your family member* is otherwise eligible for coverage under the *plan.*

b. When coverage under the *plan* was previously offered, your *family member* was covered under another health plan as an individual or dependent, including coverage under a *COBRA* or CalCOBRA continuation coverage.

c. *You* certified in writing at the time your *family member* became eligible for coverage under the *plan* that you were declining coverage under the *plan* because your *family member* already had other coverage.

d. *Your family member's* coverage under the other health plan wherein such *family member* was covered as an individual or dependent ended because the *family member* lost eligibility under the other plan or employer contributions toward coverage under the other plan terminated, or the *family member's* coverage under a COBRA or CalCOBRA continuation coverage was exhausted.

e. *You* properly file an application with the *benefits administration unit* within 31 days from the date on which your *family member* lost coverage.

Your *family member* may lose eligibility for that other coverage if, for example, you legally separate, divorce or cease to be a dependent. A loss of eligibility for coverage may also occur if your *family member* reaches a lifetime limit on all benefits under the other plan, if the employer stops contributing toward your *family member's* other coverage, or if the other plan no longer offers any benefits to a class of similarly situated individuals.

If you enroll a *family member* during this special enrollment period and you are not already enrolled, you must also enroll.

Coverage will be effective on the first day of the month following the date the *benefits administration unit* receives your enrollment application, provided your application is received within 31 days of the date on which your *family member* lost the other coverage.

2. **Special Enrollment Pursuant to the Children's Health Insurance Program Reauthorization Act of 2009**

If *your family member* is eligible, but not enrolled, for coverage under the *plan*, *you* may enroll *your* eligible *family member* for coverage under the *plan* prior to the next *open enrollment period* under two additional circumstances:

a. *You* or *your family member* is covered under a Medicaid plan or under a Children's Health Insurance Program (CHIP) and *your* coverage, or *your family member's* coverage, under such a plan terminates as a result of loss of eligibility for such coverage; or

b. *You* or *your family member* becomes eligible for premium assistance as to coverage under the *plan* under such Medicaid plan or CHIP plan.

You must provide the *benefits administration unit* with a properly completed enrollment application within 60 days of the occurrence of one of these special enrollment events. Coverage under special enrollment due to loss of coverage under a Medicaid or CHIP plan or eligibility for premium assistance under Medicaid or CHIP will be effective on the first day of the month following the date the *benefits administration unit* receives the properly filed enrollment application, provided your enrollment application is received within 60 days of the occurrence of the special enrollment event. If you do not elect coverage during this special enrollment period, you generally will not be able to enroll your *family member* in the *plan* until the following *open enrollment period*.

3. **Marriage or New Domestic Partnership**

If you marry or enter into a domestic partnership during the *plan year*, you can enroll your *spouse/domestic partner* and any *children* acquired as a result of your marriage/domestic partnership, provided the *benefits administration unit* receives your enrollment application within 31 days of your marriage/domestic partnership. Coverage for your *family members* will be effective on the first day of the month following the date your enrollment application is received, provided your enrollment application is received within 31 days of your marriage/domestic partnership.

4. **Newborn Child, Newly Adopted Child or Child Placed for Adoption**

If you or your *spouse/domestic partner* acquires a new *child* through birth, adoption or *placement for adoption* during the *plan year*, you can enroll your *spouse/domestic partner* and the new *child* for coverage, provided the *benefits administration unit* receives your enrollment application within 31 days of the birth, adoption or *placement for adoption.* Coverage will be effective retroactive to the date of the birth, adoption or *placement for adoption*, provided your enrollment application is received within 31 days of the birth, adoption or *placement for adoption.*

5. **Qualified Change in Status Events Under the Bank of the West Flexible Benefits Plan**

If your *family member* experiences a qualified change in status event under the Bank of the West Flexible Benefits Plan during the *plan year*, you can enroll the eligible *family member* for coverage, provided the *benefits administration unit* receives your enrollment application within 31 days of the qualified change in status event and such enrollment is otherwise consistent with terms of the Bank of the West Flexible Benefits Plan. Coverage will be effective on the first day of the month following the date your enrollment application is received, provided your enrollment application is received within 31 days of the date of the qualified change in status event.

EFFECTIVE DATE FOR RETIREES

The date you become covered is determined as follows:

1. **Timely Enrollment.** On your eligibility date, provided you enroll before, on or within 31 days of your eligibility date.

IMPORTANT: If you voluntarily choose to disenroll from coverage under your *retiree* medical plan, you and your *family members* will never again be eligible for medical coverage through the *employer.*

EFFECTIVE DATE FOR FAMILY MEMBERS OF RETIREES

The date your *family members* become covered is determined as follows:

1. **Timely Enrollment.** On your eligibility date, provided you enroll your eligible *family members* before, on, or within 31 days after your eligibility date. Eligible *family members* mean those *family members* covered under one of the *employer's* medical plans on the date you retire from the *employer.*

IMPORTANT: If you voluntarily drop *retiree* coverage for *family members,* your *covered family members* will never again be eligible for medical coverage through the *employer* except as one of the applicable special enrollment provisions may apply (see the "Special Enrollment Periods" provision below).

1. **Late Enrollment.** If you fail to enroll your *family members* within 31 days after your eligibility date, you may not later enroll any such family members unless you can enroll them during a special enrollment period (see the "Special Enrollment Periods" provision below).

2. **Special Enrollment.** If your *family members* are enrolled during a special enrollment period (see the "Special Enrollment Periods" provision below), special effective dates apply. Coverage due to marriage/domestic partnership will be effective on the first day of the month following the date the *benefits administration unit* receives your enrollment application, provided your enrollment application is received within 31 days of the marriage/domestic partnership. Coverage due to birth, adoption or *placement for adoption* will be effective on the date of the *child's* birth, adoption or *placement for adoption*, provided the *benefits administration unit* receives your enrollment application within 31 days of the *child's* birth, adoption or *placement for adoption.* Coverage due to a CHIP special enrollment right will be effective on the first day of the month following the date the *benefits administration unit* receives your enrollment application, provided your enrollment application is received within 60 days of the occurrence of the CHIP special enrollment event.

Special Enrollment Periods for Family Members of Retirees

You may enroll newly eligible *family members* during any one of the special enrollment periods described below.

1. **Marriage or New Domestic Partnership**

If you marry or enter into a domestic partnership during the *plan year*, you can enroll your *spouse/domestic partner* and any *children* acquired as a result of your marriage/domestic partnership for coverage, provided the *benefits administration unit* receives your enrollment application within 31 days of your marriage/domestic partnership. Coverage will be effective on the first day of the month following the date your enrollment application is received, provided your enrollment application is received within 31 days of your marriage/domestic partnership.

2. **Newborn Child, Newly Adopted Child or Child Placed for Adoption**

If you or your *spouse/domestic partner* acquires a new *child* through birth, adoption or *placement for adoption* during the *plan year*, you can enroll your *spouse/domestic partner* and the new *child* for coverage, provided the *benefits administration unit* receives your enrollment application within 31 days of the birth, adoption or *placement for adoption.* Coverage will be effective retroactive to the date of the birth, adoption or *placement for adoption*, provided your enrollment application is received within 31 days of the birth, adoption or *placement for adoption.*

3. **Special Enrollment Pursuant to the Children's Health Insurance Program Reauthorization Act of 2009**

You may also enroll *your* eligible *family member* for coverage under the *plan* prior to the next *open enrollment period* under two additional circumstances:

a. *You* or *your family member* is covered under a Medicaid plan or under a Children's Health Insurance Program (CHIP) and *your* coverage, or *your family member's* coverage, under such a plan terminates as a result of loss of eligibility for such coverage; or

b. *You* or *your family member* becomes eligible for premium assistance as to coverage under the *plan* under such Medicaid plan or CHIP plan.

You must provide the *benefits administration unit* with a properly completed enrollment application within 60 days of the occurrence of one of these special enrollment events. Coverage under special enrollment due to loss of coverage under a Medicaid or CHIP plan or eligibility for premium assistance under Medicaid or CHIP will be effective on the first day of the month following the date the *benefits administration unit* receives the properly filed enrollment application, provided the enrollment application is received within 60 days of the occurrence of the special enrollment event. If you do not elect coverage during this special enrollment period, you generally will not be able to enroll your *family member* in the *plan* until the following *open enrollment period*.

QUALIFIED MEDICAL CHILD SUPPORT ORDERS (QMCSO)

In accordance with federal law, the *plan* provides medical coverage to certain *children* (called alternate recipients) if the *plan* is directed to do so by a Qualified Medical Child Support Order (QMCSO). This is an order or judgment from a court, or produced as a result of a state-authorized administrative process directing the *plan* to include the *child* in the *employee's* or *retiree's* coverage.

In addition to requiring the *employee* or *retiree* to provide coverage for the *child*, the law authorizes the *employer* to make applicable payroll deductions, if any.

When the *claims administrator* receives a medical child support order, it will promptly notify both you and the alternate recipient that the order has been received and what procedures the *plan* will use to determine if the order is qualified. Then the *claims administrator* will decide, on the basis of the *plan's* written procedures and within a reasonable time, whether the order is qualified. Once the decision is made, the *claims administrator* will notify you and the alternate recipient by mail.

You can obtain more information on QMCSO procedures by contacting the *claims administrator*. A copy of the *plan's* procedures is available without charge from the *claims administrator.*

OPEN ENROLLMENT PERIOD

The *plan* has an *open enrollment period* once each *year*, at the time designated by the *plan administrator*. During that time, an individual who meets the eligibility requirements as an *employee* under the *plan* may enroll. An *employee* may also enroll any eligible *family members* at that time.

Persons eligible to enroll as *family members* may enroll only under the *employee's plan*.

For anyone so enrolling, coverage under the *plan* will begin on the first day of the new *plan year* following the end of the *open enrollment period*.

RESPONSIBILITY FOR DETERMINING ELIGIBLE FAMILY MEMBERS

If you have a *covered child*, it is your responsibility to notify the *benefits administration unit* in writing within 31 days of the date such *child* no longer meets the *plan's* definition of an eligible *family member*.

If you divorce (or legally separate), it is your responsibility to notify the *benefits administration unit* in writing within 31 days of your divorce (or legal separation)

If you terminate your domestic partnership, it is your responsibility to notify the *benefits administration unit* of such termination in writing within 31 days of the termination. A new domestic partner may not be enrolled under the *plan* until at least six months after the termination has been filed.

The effective date of change for an ineligible *family member* will be the first day of the month following the date you notify the *benefits administration unit* in writing of his or her ineligibility.

Notification of a change from eligible to ineligible is considered properly made only if it is made on the *employer's* intranet at www.bankofthewest.essbenefits.com or it is personally signed, dated, and given to the *benefits administration unit* within 31 days of the loss of eligibility.

HOW COVERAGE ENDS

For Employees

Coverage under this *plan* ends without notice from the *claims administrator* as provided below:

1. If the *plan* terminates, your coverage ends at the same time.

2. If the *plan* no longer provides coverage for the class of *employees* to which you belong, your coverage ends on the effective date of that change.

3. Coverage ends at the end of the period for which contributions have been timely paid or when the required contributions for the next period are not timely paid.

4. If you voluntarily cancel coverage at any time, coverage ends on the contribution due date coinciding with or following the date of voluntary cancellation, as provided by written notice to the *benefits administration unit*.

5. If your coverage ends due to a qualified change in status permitted under the Bank of the West Flexible Benefits Plan, the last day of the month following the date you notify the *benefits administration unit* in writing of the occurrence of such event, provided such notice is made within 31 days of the date the qualified status event occurs.

6. If the *claims administrator* gives you notice in writing that your coverage is being terminated for cause, your coverage ends 60 days after the date of such notice. The *claims administrator* will notify you of its finding that (a) you or your *covered family member* made a fraudulent statement or representation, or omitted any material information in any enrollment, claim or other form in order to obtain coverage, services or *plan* benefits; or (b) or you or your *covered family member* allowed anyone else to use the card identifying you or your *covered family member* as enrolled for coverage under the *plan* and thus entitling you or your *covered family member* to coverage, services or *plan* benefits; or (c) you or your *covered family member* altered any prescription or referral furnished by a *provider.*

7. If you no longer meet the requirements set forth in the "Eligible Status" provision of HOW COVERAGE BEGINS, your coverage ends as of the contribution due date coinciding with or following the date you cease to meet such requirements.

8. Notwithstanding the foregoing, if you are a *covered employee,* your coverage (and coverage for your *family members*) may continue during a temporary leave of absence approved by the *employer* and determined in accordance with the *employer's* policies and procedures regarding approved leaves of absence.

For Family Members of Active Employees

1. If the *plan* terminates, your *family members'* coverage ends at the same time.

2. If the *plan* is amended to delete coverage for *family members* (or a class of *family members*), a *family member*'s coverage ends on the effective date of that change.

3. Coverage for *family members* ends when the *employee's* coverage ends.

4. Coverage ends at the end of the period for which contributions have been timely paid or when the required contributions for the next period are not timely paid. However, in the case of a *child* covered due to a *QMCSO*, you must provide proof that the *child* support order is no longer in effect or that the *child* has replacement coverage which will take effect immediately upon termination. The *child* covered by the order may also lose coverage through loss of eligibility for coverage.

5. If you voluntarily cancel coverage for a *family member* at any time, coverage ends on the contribution due date coinciding with or following the date of voluntary cancellation, as provided by written notice to the *benefits administration unit*.

6. If the *family member's* coverage ends due to a qualified change in status permitted under the Bank of the West Flexible Benefits Plan, the last day of the month following the date you notify the *benefits administration unit* in writing of the occurrence of such event, provided such notice is made within 31 days of the date the qualified status event occurs.

7. If the *claims administrator* gives the *employee* notice in writing that coverage is being terminated for cause, coverage ends 60 days after the date of such notice. The *claims administrator* will notify the *employee* of its finding that (a) the *employee* or *family member* made a fraudulent statement or representation, or omitted any material information in any enrollment, claim or other form in order to obtain coverage, services or *plan* benefits; or (b) the *employee* or *family member* allowed anyone else to use the card identifying the *employee* or *family member* as enrolled for coverage under the *plan* and thus entitling the *employee* or *family member* to coverage, services or *plan* benefits; or (c) the *employee* or *covered family member* altered any prescription or referral furnished by a *provider.*

8. If the *family member* no longer meets the requirements set forth in the "Eligible Status" provision of HOW COVERAGE BEGINS, coverage for such *family member* ends as of the contribution due date coinciding with or following the date he or she ceases to meet such requirements.

   Notwithstanding the foregoing, if a *child* reaches age 26, the *child* will continue to qualify as a *family member* if he or she is (i) covered under this *plan,* (ii) still financially dependent on the *employee, spouse* or *domestic partner,* and (iii) incapable of self-sustaining employment due to a physical handicap or mental retardation. A *physician* must certify this disability in writing. The *claims administrator* must receive the certification within 31 days of the date the *child* otherwise becomes ineligible. When a period of two years has passed, the *claims administrator* may request proof of continuing dependency and disability, but not more often than once each year.

   This exception will last until the *child* is no longer handicapped or dependent on the *employee, spouse* or *domestic partner* for financial support. A *child* is considered financially dependent if he or she qualifies as a dependent of the *employee* or *spouse/domestic partner* for federal income tax purposes.

For Retirees

Your coverage under this *plan* ends without notice from the *claims administrator* as provided below:

1. If the *plan* terminates, your coverage ends at the same time.

2. If the *plan* no longer provides coverage for the class of *retirees* to which you belong, your coverage ends on the effective date of that change.

3. Coverage ends at the end of the period for which contributions have been timely paid or when the required contributions for the next period are not timely paid.

4. If you voluntarily cancel coverage at any time, coverage ends on the contribution due date coinciding with or following the date of voluntary cancellation, as provided by written notice to the *benefits administration unit*. If you move out of the service area, you should contact the *benefits administration unit* regarding your coverage options.

   IMPORTANT: If you voluntarily drop *retiree* coverage, you and your *covered family members* will never again be eligible for medical coverage through the *employer.*

5. If the *claims administrator* gives you notice in writing that your coverage is being terminated for cause, your coverage ends 60 days after the date of such notice. The *claims administrator* will notify you of its finding that (a) you or your *covered family member* made a fraudulent statement or representation, or omitted any material information in any enrollment, claim or other form in order to obtain coverage, services or *plan* benefits; or (b) or you or your *covered family member* allowed anyone else to use the card identifying you or your *covered family member* as enrolled for coverage under the *plan* and thus entitling you or your *covered family member* to coverage, services or *plan* benefits; or (c) you or your *covered family member* altered any prescription or referral furnished by a *provider.*

6. If you no longer meet the requirements set forth in the "Eligible Status" provision of HOW COVERAGE BEGINS, your coverage ends as of the contribution due date coinciding with or following the date you cease to meet such requirements.

7. When you become eligible for Medicare, your coverage will be provided through the Medicare Supplemental Plan. The summary plan description for the Medicare Supplemental Plan may be obtained from the *employer's retirement benefits office*.

For Family Members of Retirees

1. If the *plan* terminates, your *family members'* coverage ends at the same time.

2. If the *plan* is amended to delete coverage for *family members* (or a class of *family members*), a *family member*'s coverage ends on the effective date of that change.

3. Coverage for *family members* ends when the *retiree's* coverage ends. Notwithstanding the forgoing, if coverage is lost due to the *retiree's* death, the surviving *covered spouse* and other surviving *covered family members* may be eligible for continued coverage. For more information, surviving *family members* should contact the *employer's retirement benefits office* or the *benefits administration unit.*

4. Coverage ends at the end of the period for which contributions have been timely paid or when the required contributions for the next period are not timely paid. However, in the case of a *child* covered due to a *QMCSO*, you must provide proof that the *child* support order is no longer in effect or that the *child* has replacement coverage which will take effect immediately upon termination. The *child* covered by the order may also lose coverage through loss of eligibility for coverage.

5. If you voluntarily cancel coverage for a *family member* at any time, coverage ends on the contribution due date coinciding with or following the date of voluntary cancellation, as provided by written notice to the *benefits administration unit.*

   IMPORTANT: If you voluntarily drop *retiree* coverage for your *family members*, your *covered family members* will never again be eligible for medical coverage through the *employer* except as one of the applicable special enrollment provisions discussed under HOW COVERAGE BEGINS may apply.

6. If the *claims administrator* gives the *retiree* notice in writing that coverage is being terminated for cause, coverage ends 60 days after the date of such notice. The *claims administrator* will notify the *retiree* of its finding that (a) the *retiree* or a *family member* made a fraudulent statement or representation, or omitted any material information in any enrollment, claim or other form in order to obtain coverage, services or *plan* benefits; or (b) the *retiree* or a *covered family member* allowed anyone else to use the card identifying the retiree or a *family member* as enrolled for coverage under the *plan* and thus entitling the *retiree* or a *family member* to coverage, services or *plan* benefits; or (c) the *retiree* or *covered family member* altered any prescription or referral furnished by a *provider.*

7. When the *family member* becomes eligible for Medicare, the *family member's* coverage will be provided through the Medicare Supplemental Plan. The summary plan description for the Medicare Supplemental Plan may be obtained from the *employer's retirement benefits office*.

8. If the *family member* no longer meets the requirements set forth in the "Eligible Status" provision of HOW COVERAGE BEGINS, coverage for such *family member* ends as of the contribution due date coinciding with or following the date he or she ceases to meet such requirements.

   Notwithstanding the foregoing, if a *child* reaches age 26, the *child* will continue to qualify as a *family member* if he or she is (i) covered under this *plan,* (ii) still financially dependent on the *retiree, spouse* or *domestic partner,* and (iii) incapable of self-sustaining employment due to a physical handicap or mental retardation. A *physician* must certify this disability in writing. The *claims administrator* must receive the certification within 31 days of the date the *child* otherwise becomes ineligible. When a period of two years

has passed, the *claims administrator* may request proof of continuing dependency and disability, but not more often than once each year.

This exception will last until the *child* is no longer handicapped or dependent on the *retiree, spouse* or *domestic partner* for financial support. A *child* is considered financially dependent if he or she qualifies as a dependent of the *retiree* or *spouse/domestic partner* for federal income tax purposes.

RESPONSIBILITY FOR DETERMINING ELIGIBLE FAMILY MEMBERS

If you have a covered *child*, it is your responsibility to notify the *benefits administration unit* in writing within 31 days of the date such *child* no longer meets the *plan's* definition of an eligible *family member*.

If you divorce (or legally separate), it is your responsibility to notify the *benefits administration unit* in writing within 31 days of your divorce (or legal separation).

If you terminate your domestic partnership, it is your responsibility to notify the *benefits administration unit* of such termination in writing within 31 days of the termination. A new domestic partner may not be enrolled under the *plan* until at least six months after the termination has been filed.

The effective date of change for an ineligible *family member* will be the first day of the month following the date you notify the *benefits administration unit* in writing of their ineligibility.

Notification of a change from eligible to ineligible is considered properly made, only if it is made on the *employer's* intranet at www.bankofthewest.essbenefits.com or it is personally signed, dated, and given to the *benefits administration unit* within 31 days of the loss of eligibility.

If you fail to timely make the notifications described above, you will be responsible for the cost of any benefits provided under the *plan* for the ineligible individual determined from the date such notice was due. In the discretion of the *plan administrator*, other sanctions may also apply including, but not limited to, termination from employment.

You or your *family members* may be entitled to continued benefits under terms which are specified elsewhere under CONTINUATION OF COVERAGE RIGHTS UNDER COBRA and CONVERSION.

CONTINUATION COVERAGE RIGHTS UNDER COBRA

Eligibility for COBRA

In compliance with federal law (PL-99-272), the *employer* offers continuation coverage for you and your *family member*s who are covered by the *plan*. This continuation coverage is called *COBRA* (Consolidated Omnibus Budget Reconciliation Act of 1985). *COBRA* offers continuation of *plan* benefits, subject to certain conditions.

NOTE: *Domestic partners* and *children* who do not qualify as the *covered employee's* dependent are not eligible for *COBRA* continuation coverage. However, this *plan* provides such individuals with continuation coverage under the same terms and conditions it is provided under COBRA to a *covered employee's spouse* and dependent *children*. Also, special rules apply to retirees and family members of retirees. For more information, you should check with *COBRA administrator* or the *employer's retirement benefits office.*

This description is intended to comply with *COBRA*, but it is only a summary of the major features of the law. In any individual situation, the law and its clarifications and intent (as determined by the *plan administrator* in its sole discretion) will prevail over this summary.

If a *covered employee's* or a *covered family member's* coverage under the *plan* terminates due to a *qualifying event*, the *covered employee* or *family member* will be eligible for continued coverage under the *plan* pursuant to the provisions of *COBRA*. Provisions for continued coverage for a *covered employee* who is absent from work due to active service in the armed forces of the United States are explained later in this *booklet*.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which are you eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

For more information about the Marketplace, visit www.HealthCare.gov.

Definitions

When italicized in this section, the following items will have the meanings shown below:

COBRA administrator – ADP Benefits Services is the *COBRA administrator*. If *you* have any questions regarding the *plan* and *COBRA* continuation coverage, contact the *COBRA administrator* as follows:

ADP Benefits Services - COBRA
P.O. Box 1853
Phoenix, AZ 85062-8328
(800) 654-6695

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 a *covered family member*.

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 the *covered employee* has at the time of the *child's* birth or *placement for adoption*, the same coverage that an otherwise eligible *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 coverage or was not offered coverage and such denial or failure to offer constitutes a violation of applicable law. The individual will be considered to have had such 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 *child* of the *employee* is not a *qualified beneficiary* by virtue of the relationship to the *employee*.

Qualifying event – Any of the following events, which would result in the loss of coverage under the *plan* in the absence of *COBRA* continuation coverage:

- Voluntary or involuntary termination of the *employee*'s employment for any reason other than *employee*'s gross misconduct;
- Reduction in an *employee*'s hours of employment to non-eligible status;
- For an *employee*'s *spouse/domestic partner* or *child*, the *employee*'s entitlement to Medicare. For *COBRA* purposes, "entitlement" means the effective date of enrollment in Medicare Part A or Part B, whichever occurs earlier;
- For an *employee*'s *spouse*/*domestic partner* or *child*, the divorce or legal separation of the *employee* and *spouse* or the termination of the domestic partnership;
- For an *employee*'s *spouse*/*domestic partner* or *child*, the death of the *covered employee*; and
- For an *employee*'s *child*, the *child*'s loss of dependent status (e.g., a *child* reaching the maximum age limit).

Sometimes, filing a proceeding in bankruptcy under Title 11 of the United States Code can be a *qualifying event*. If a proceeding in bankruptcy is filed with respect to the *employer*, and that bankruptcy results in the loss of coverage for any *retired employee* covered under the *plan*, the *retired employee* will become a *qualified beneficiary* with respect to the bankruptcy. The *retired employee*'s *spouse*/*domestic partner*, surviving *spouse*/surviving *domestic partner* and *children* may also become *qualified beneficiaries* if the bankruptcy results in the loss of their coverage under the *plan*.

Non-COBRA 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 of Qualifying Event(s)

IMPORTANT! YOU MUST GIVE NOTICE OF SOME QUALIFYING *EVENT*S

An *employee* or *qualified beneficiary* is responsible for notifying the *COBRA administrator* by telephone or in writing within 60 days of the later of the (i) date one of the following *qualifying event*s occurs, or (ii) the date coverage would terminate due to one of the following *qualifying event*s:

- A *child*'s ceasing to be eligible under the requirements of the *plan*; or
- A divorce/termination of domestic partnership or legal separation of the *employee* from his/her *spouse*/*domestic partner*.

Once the *COBRA administrator* is timely notified by phone or in writing of the occurrence of one of these *qualifying event*s, the qualified beneficiar(ies) will be mailed information explaining each *qualified beneficiary's* continuation coverage rights as well as an enrollment form.

For all other *qualifying event*s, the *COBRA administrator* will notify the *qualified beneficiary* of the right to elect continuation coverage.

Election and Election Period

To elect *COBRA* continuation, a *qualified beneficiary* must complete the election form and return it to the *COBRA administrator* within 60 days of the **later** of:

- The date the *qualified beneficiary* would otherwise lose coverage under the *plan* due to a *qualifying event*, or
- The date the *COBRA* continuation coverage election materials were mailed to the *qualified beneficiary*.

IMPORTANT!

If you don't elect continuation coverage during the initial enrollment period, you may not elect it at a later date.

Each individual who is a *qualified beneficiary* with respect to a *qualifying event* has an independent right to elect continuation coverage, even if others in the same family have declined coverage. A parent or legal guardian may elect or decline coverage for minor dependent *children*.

An election of an incapacitated or deceased *qualified beneficiary* can be made by the legal representative of the *qualified beneficiary* or the *qualified beneficiary's* estate, as determined under applicable state law, or by the *spouse*/*domestic partner* 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 *COBRA administrator*.

Effective Date of Coverage

COBRA continuation coverage will be effective retroactively to the date coverage would otherwise have terminated due to the *qualifying event*, provided:

- The *qualified beneficiary(ies)* returns the election form to the *COBRA administrator* within the 60-day election period described above; and
- The *qualified beneficiary(ies)* pays the initial *COBRA* continuation coverage premium within 45 days of the date the *qualified beneficiary*(ies) elects continuation coverage.

See "Election and Election Period" above for exceptions to effective date of coverage when a *qualified beneficiary* initially waives *COBRA* continuation coverage and then revokes his/her 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 *non-COBRA beneficiaries*. If coverage is modified for similarly situated *non-COBRA beneficiaries*, the same modification will apply to *qualified beneficiaries*.

Open enrollment rights, which allow non-*COBRA 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/she does not have special enrollment rights, even though active *employees* not participating in the *plan* have such rights under HIPAA.

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/her deductible amount immediately before that date. If the deductible is computed on a family basis, only the expenses of those *family member*s 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 *employer* makes available to active *employee*s and that provides service in the relocation area must be offered to the *qualified beneficiary*.

Cost of Continued Coverage

A *qualified beneficiary* is responsible for paying the full cost of continuation coverage, plus a 2% administrative charge. This cost includes both the *employee* and *employer* portion of the applicable premium amount. In other words, the cost is 102% of the total *plan* cost for similarly situated *non-COBRA beneficiaries*.

If continuation coverage is extended because of disability, the cost to cover the disabled *qualified beneficiary* for months 19 through 29 (or months 19 through 36 of coverage, if a second *qualifying event* occurs after the initial 18 months of continuation coverage) will be 150% of the total *plan* cost. The cost to cover any associated *qualified beneficiaries* whose coverage is also extended may also increase to up to 150% of the total *plan* cost. You should contact the *COBRA administrator* for more information on the cost of continuing coverage in the event of an extension due to a *qualified beneficiary's* disability.

Payment Information

The initial "premium" (cost of coverage) payment must be made within 45 days after the date of the *COBRA* election by the *qualified beneficiary*.

IMPORTANT!

If you do not make your initial premium payment within the 45-day period, your *COBRA* election will be null and void, and you will lose your right to continue coverage under *COBRA*.

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.

IMPORTANT!

Suspension of Coverage. *COBRA* premiums are due on the first day of the month. If your premium is paid late (but within the 30-day grace period), your continuation coverage will be suspended until the payment is received. You will be responsible for health care costs incurred during any such suspension, however, you could apply for reimbursement of these costs after your continuation coverage payment is received.

Termination of Coverage. Your *COBRA* continuation coverage will end if you do not pay all premiums on a timely basis (i.e., within 30 days of their due date) – so make sure you follow the billing instructions carefully.

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 (other than for reasons of gross misconduct) or reduction of hours of employment, the maximum coverage period for the *covered employee* and/or his/her *family member*s who are *qualified beneficiaries* is up to 18 months from the date coverage would end due to the *qualifying event*. With a disability extension (see "**Disability Extension**" information below), the 18 months may be extended to up to 29 months;
- If the *qualifying event* is a divorce/termination of domestic partnership or legal separation, *child*'s loss of dependency status, death of the *covered employee* or the *covered employee*'s entitlement to Medicare, the maximum coverage period for *family member*s who are *qualified beneficiaries* is up to 36 months from the date coverage would end due to the *qualifying event*.

If a *qualifying event* occurs that provides an 18-month or 29-month maximum coverage period is followed by a second *qualifying event* that allows a 36-month maximum coverage period, the original period may be expanded to up to 36 months, but only for individuals other than the *covered employee* who are *qualified beneficiaries* at the time

of both *qualifying event*s. In no circumstance can the *COBRA* maximum coverage period be more than 36 months from the date coverage would end due to the first *qualifying event*. Also, this additional period of coverage is available only if the second *qualifying event* would have, but for the original *qualifying event*, resulted in a loss of coverage.

For example, a *child* who was originally eligible for continuation coverage due to termination of the *covered employee*'s employment (a *qualifying event*) and who was enrolled for continuation coverage as a *qualified beneficiary* would be entitled to up to 18 months of continuation coverage. If, during this 18-month period, the *child* reaches the upper age limit of the *plan* (a second *qualifying event*), the *child* may be eligible to extend coverage for up to 36 months from the date coverage would end due to the **original** *qualifying event* (the termination of the *covered employee*'s employment), provided the *covered employee* or *qualified beneficiary* properly notifies the *COBRA administrator* of the *child*'s loss of dependency status (see "Notification of *qualifying event(s)*" above).

If the *covered employee* becomes entitled to Medicare (even if his/her entitlement to Medicare is not a *qualifying event*) before a termination of employment or reduction in hours (*qualifying event*s), a *qualified beneficiary* other than the *covered employee* may be eligible for continuation coverage for up to the longer of:

- 36 months from the day on which the *covered employee* became entitled to Medicare; or
- 18 months from the date coverage would end due to the *covered employee*'s termination or reduction in hours.

If the *covered employee* becomes entitled to Medicare within the 18-month period following a termination of employment or reduction in hours (*qualifying event*s) and such entitlement results in a loss of coverage under the *plan*, a *qualified beneficiary* other than the *covered employee* may be eligible for continuation coverage for up to 36 months from the date coverage would end due to the *covered employee*'s termination or reduction in hours.

Disability Extension

If, during the first 60 days of continuation coverage due to the *covered employee*'s termination of employment or reduction in hours, the *covered employee* or any other associated *qualified beneficiary* is determined to be disabled for Social Security purposes, the disabled *qualified beneficiary* and all associated *qualified beneficiaries* may be entitled to up to 29 months of continuation coverage, measured from the date coverage would end due to the *covered employee*'s termination or reduction in hours (the initial *qualifying event*). In order to elect this extension of continuation coverage, the disabled *qualified beneficiary* must:

- Satisfy the legal requirements for being totally and permanently disabled under Title II or Title XVI of the Social Security Act; and
- Be determined and certified to be so disabled by the Social Security Administration.

To elect a disability extension, the *covered employee* or *qualified beneficiary* must furnish the *COBRA administrator* with proof of the Social Security Administration determination of disability no later than 60 days after the latest of (i) the date of the Social Security determination; (ii) the date on which the *qualifying event* occurs; or (iii) the date on which the *qualified beneficiary* loses (or would lose) coverage due to the *qualifying event*. The notice **must** also be provided within the first 18 months of continuation coverage.

Unless coverage terminates on an earlier date (see "When *COBRA* Coverage Ends" information below), this period of extended continuation coverage will end on the earlier of:

- 29 months from the date coverage would have otherwise ended due to the original *qualifying event* (i.e., the *covered employee's* earlier termination or reduction in hours); or
- The end of the month following a period of 30 days after the Social Security Administration's final determination that the *qualified beneficiary* is no longer disabled.

The *qualified beneficiary* **must** notify the *COBRA administrator* of a final determination by the Social Security Administration that he or she is no longer disabled under Title II or Title XVI of the Social Security Act within 30 days of such determination.

Termination of COBRA Continuation Coverage

Continuation coverage ends on the earliest of the following events:

- The end of the 18-, 29- or 36-month continuation period, as applicable;
- The last day of the month following a 30-day period after the Social Security Administration's final determination that a *qualified beneficiary* is no longer disabled (You **MUST** inform the *COBRA administrator* within 30 days of that final determination);
- The date, after the date of the initial continuation coverage election, on which the *qualified beneficiary* first becomes entitled to Medicare coverage;
- The date, after the date of the initial continuation coverage election, on which the *qualified beneficiary* first becomes covered under another group health plan (as an *employee* or otherwise) – unless the other group health plan applies limitations and exclusions, and then only so long as the *qualified beneficiary* is affected by the limitation or exclusion, or until eligibility for continuation coverage otherwise ends;
- The end of the premium period if the *qualified beneficiary* fails to make the required premium payments within 30 days of the due date; and
- The date the *employer* stops offering any group health plans to its *employee*s.

Importantly, *COBRA* continuation coverage may end earlier for any of the same reasons applicable to active *employee*s and their *family member*s.

Consequences of Failure to Elect Continuation Coverage

Your decision whether to elect continuation coverage will affect the future rights of *qualified beneficiaries* under *COBRA* to portability of group health coverage, guaranteed access to individual health coverage and special enrollment rights under Part 7 of Title I of *ERISA*. You should contact the *COBRA administrator* for more information on these important rights.

Keep the Plan Informed of Address Changes

In order to protect your family's rights, you should keep the *employer's benefits administration unit* informed of any changes in the addresses of your *family member*s. You should always keep a copy, for your records, of any notices you send to the *benefits administration unit* or the *COBRA administrator*.

If You Have Questions

Questions concerning the *plan* should be addressed to the *claims administrator*. Questions concerning your *COBRA* continuation coverage rights should be addressed to the *COBRA administrator* as described above. For more information about your rights under *ERISA*, including *COBRA*, the Health Insurance Portability and Accountability Act (*HIPAA*) and other laws affecting group health *plan*s, contact the nearest regional or district office of the U.S. Department of Labor's *Employee* Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA offices are available through EBSA's website.)

CONTINUATION OF COVERAGE DURING MILITARY SERVICE (*USERRA*)

Right to Continuation Coverage. In accordance with the Uniformed Services Employment and Reemployment Rights Act (*USERRA*), a *covered employee* who goes on an unpaid military leave of absence may continue to participate in the *plan* during the *USERRA* leave until the earlier to occur of:

- The 24-month period beginning on the date on which the *covered employee's* absence begins; or
- The period ending on the day after the date on which the *covered employee* fails to apply for or return to a position of employment with the *employer*, as determined in accordance with *USERRA*.

If the *USERRA* leave is 31 days or longer, the *covered employee* may be required to pay up to 102% of the required contributions. If the USERRA leave is for less than 31 days, the *covered employee's* required contributions will remain the same as similarly situated active *employees*.

If the *covered employee* elects to continue group health care coverage, the *covered employee* must pay contributions in the same amount (not to exceed 102% of the total cost of coverage under the *plan*), form and manner as provided for those individuals who elect to continue coverage under *COBRA*. Coverage provided under *USERRA* will run concurrently with any right to continue coverage under *COBRA*.

For more information on your rights under *USERRA* and military leaves, a VETS directory and additional information are available at www.dol.gov/vets. You can also contact the *benefits administration unit* for information.

If your claim for coverage is denied, you can ask for an appeal review. The section of this *booklet* titled STATEMENT OF ERISA RIGHTS provides information about your rights under *ERISA* and tells you how to initiate an appeal review.

CONVERSION COVERAGE

To apply for a conversion plan, *you* must submit an application to the *claims administrator* within 31 days of the date *your* coverage under this *plan* ends. Under certain circumstances, *you* are not eligible for a conversion plan. They are:

1. *You* are not eligible if your coverage under this *plan* ends because contributions are not paid when due because *you* (or the *employee* who enrolled *you* as a *family member*) did not pay the contribution for *your* coverage, if any.

2. *You* are not eligible for a conversion plan if *you* are eligible for health coverage under another group plan when *your* coverage under this *plan* ends.

3. *You* are not eligible for a conversion plan if *you* are eligible for Medicare coverage (Part A or Part B) when *your* coverage under this *plan* ends, whether or not *you* have actually enrolled in Medicare.

4. *You* are not eligible for a conversion plan if *you* are covered under an individual health plan when *your* coverage under this *plan* ends.

5. *You* are not eligible for a conversion plan if *you* were not covered for medical benefits under the *plan* for three consecutive months immediately prior to the termination of *your* coverage.

6. If *you* decide to enroll in a conversion plan, *you* will no longer qualify for *HIPAA* coverage.

Important: The intention of conversion coverage is not to replace the coverage *you* have under this *plan*, but to make available to *you* a specified amount of coverage for medical benefits until *you* can find a replacement. As discussed under the section titled GENERAL INFORMATION, this *plan* is self-insured. The conversion plan will be insured through *Anthem Blue Cross Life and Health Insurance Company of California* and will provide lesser benefits than this *plan*, and the provisions and rates differ. When coverage under the *plan* ends, *you* will receive more information about how to apply for *HIPAA* coverage or a conversion plan, including a postcard for requesting an application and a telephone number to call if *you* have any questions.

DEFINITIONS

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

Accidental injury is physical harm or disability which is the result of a specific unexpected incident caused by an outside force. The physical harm or disability must have occurred at an identifiable time and place. Accidental injury does not include illness or infection, except infection of a cut or wound.

Ambulatory surgical center is a freestanding outpatient surgical facility. 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. It must also meet accreditation standards of the Joint Commission on Accreditation of Health Care Organizations or the Accreditation Association of Ambulatory Health Care.

Authorized referral occurs when *you*, because of *your* medical needs, are referred to a *non-participating provider,* but only when:

1. There is no *participating provider* who practices in the appropriate specialty which provides the required services, or which has the necessary facilities within a 50-mile radius of *your* residence;

2. You are referred in writing to the non-participating provider by the physician who is a participating provider; and

3. The *claims administrator* has authorized the referral before services are rendered.

Average wholesale price is a term accepted in the pharmaceutical industry as a benchmark for pricing by pharmaceutical manufacturers.

Benefits administration unit means the department of the *employer* which handles certain *plan* administration functions as described in the *plan*. The benefits administration unit can be contacted as follows:

Benefits Administration Unit
180 Montgomery Street
San Francisco, CA 94104
(415) 432-3598

Employees can enroll on the Internet and through the *employer's* Intranet at www.bankofthewest.essbenefits.com.

Anthem Blue Cross Life and Health Insurance Company of California is the *claims administrator* for the *plan.*

Brand name prescription drug (brand name drug) is a *prescription drug* that has been patented and is produced by only one manufacturer.

Centers of Expertise (CME) are health care providers which have a Centers of Expertise Agreement in effect with *Anthem Blue Cross Life and Health Insurance Company of California* at the time services are rendered. CME agree to accept the *CME negotiated rate* as payment in full for covered services. A *participating provider* in the network is not necessarily a CME. A provider's participation in the network or other agreement with *Anthem Blue Cross Life and Health Insurance Company of California* is not a substitute for a Centers of Expertise Agreement.

Centers of Expertise negotiated rate (CME negotiated rate) is the fee CME agree to accept as payment for covered services. It is usually lower than their normal charge. CME negotiated rates are determined by Centers of Expertise Agreements.

Child or **Children** meets the *plan's* eligibility requirements for children as outlined under HOW COVERAGE BEGINS AND ENDS.

Claims administrator means *Anthem Blue Cross Life and Health Insurance Company of California.*

COBRA means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

Complaint officer is the SVP and Compensation and Benefits Manager for the *employer.* The complaint officer may be contacted as follows: SVP and Compensation and Benefits Manager, Bank of the West, 180 Montgomery Street, San Francisco, California 94104.

Contracting hospital is a *hospital* which has a Standard Hospital Contract in effect with *Anthem Blue Cross Life and Health Insurance Company of California* to provide care to *covered employees, retirees,* and their *family members*. A contracting hospital is not necessarily a *participating provider*. A list of contracting hospitals will be sent on request.

Covered employee (employee) is the primary covered person; that is, the person who is allowed to enroll under this *plan* for himself or herself and his or her eligible *family members*.

Covered expense is the expense *you* incur for a covered service or supply, but not more than the maximum amounts described in *YOUR* MEDICAL BENEFITS: HOW COVERED EXPENSE IS DETERMINED. Expense is incurred on the date *you* receive the service or supply.

Covered family member (family member) meets the *plan's* eligibility requirements for family members as outlined under HOW COVERAGE BEGINS AND ENDS.

Covered person is the *covered employee, retiree* or *covered family member*.

Covered retiree (retiree) is the primary covered person; that is, the person who is allowed to enroll under this *plan* for himself or herself and his or her eligible *family members.*

Creditable coverage is any individual or group plan that provides medical, hospital and surgical coverage, including continuation or conversion coverage, coverage under a publicly sponsored program such as Medicare or Medicaid, Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), the Federal Employees Health Benefits Program, programs of the Indian Health Service or of a tribal organization, a state health benefits risk pool, or coverage through the Peace Corps. Creditable coverage does not include accident only, credit, coverage for on-site medical clinics, disability income, coverage only for a specified disease or condition, hospital indemnity or other fixed indemnity insurance, Medicare supplement, long-term care insurance, dental, vision, workers' compensation insurance, automobile insurance, no-fault insurance, or any medical coverage designed to supplement other private or governmental plans.

You are considered to have been covered under a creditable coverage if *you*: (1) were covered under a creditable coverage on the date that coverage terminated; (2) were in an eligible status under this *plan* within 63 days of termination of the creditable coverage; and (3) properly enrolled for coverage within 31 days of the eligibility date.

You are also considered to have been covered under a creditable coverage if *your* employment ended, the availability of medical coverage offered through employment or sponsored by an employer terminated, or an employer's contribution toward medical coverage terminated, provided that *you*: (1) were covered under a creditable coverage on the date that coverage terminated; (2) were in an eligible status under this *plan* within 180 days of termination of the creditable coverage; and (3) properly enrolled for coverage within 31 days of the eligibility date.

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

Customary and reasonable charge, as determined annually by the *claims administrator*, is a charge which falls within the common range of fees billed by a majority of *physicians* for a procedure in a given geographic region. If it exceeds that range, the expense must be justified based on the complexity or severity of treatment for a specific case.

Day treatment center is an outpatient psychiatric facility which is licensed according to state and local laws to provide outpatient programs and treatment of *mental or nervous disorders, severe mental disorders,* or substance abuse under the supervision of *physicians*.

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

Drug (prescription drug) means a prescribed drug approved by the Food and Drug Administration for general use by the public. For the purposes of this *plan,* insulin will be considered a prescription drug.

Drug limited fee schedule represents the maximum amounts the *claims administrator* will allow as *prescription drug covered expense* for *prescriptions* filled at *non-participating pharmacies*. These amounts are the lesser of billed charges or the *average wholesale price*.

Effective date, as used in this *booklet,* is the date *your* coverage begins under this *plan*.

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

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

Employee meets the *plan's* eligibility requirements for employees as outlined under HOW COVERAGE BEGINS AND ENDS.

Employer means Bank of the West.

ERISA means the Employee Retirement Income Security Act of 1974, as amended.

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

Facility-based care is care provided in a *hospital*, *psychiatric health facility*, *residential treatment center* or *day treatment center* for the treatment of *mental or nervous disorders, severe mental disorders*, or substance abuse.

Family member meets the *plan's* eligibility requirements for family members as outlined under HOW COVERAGE BEGINS AND ENDS.

Generic prescription drug (generic drug) is a pharmaceutical equivalent of one or more *brand name drugs* and must be approved by the Food and Drug Administration as meeting the same standards of safety, purity, strength, and effectiveness as the *brand name drug*.

HIPAA means the Health Insurance Portability and Accountability Act of 1996, as amended.

Home health agencies are home health care providers which are licensed according to state and local laws to provide skilled nursing and other services on a visiting basis in *your* home, and recognized as home health providers under Medicare and/or accredited by a recognized accrediting agency such as the Joint Commission on the Accreditation of Healthcare Organizations.

Home infusion therapy provider is a provider licensed according to state and local laws as a pharmacy, and must be either certified as a home health care provider by Medicare or accredited as a home pharmacy by the Joint Commission on Accreditation of Health Care Organizations.

Hospice is an agency or organization providing a specialized form of interdisciplinary health care that provides palliative care (pain control and symptom relief) and alleviates the physical, emotional, social, and spiritual discomforts of a terminally ill person, as well as providing supportive care to the primary caregiver and the patient's family. A hospice must be: currently licensed as a hospice pursuant to Health and Safety Code section 1747 or a licensed *home health agency* with federal Medicare certification pursuant to Health and Safety Code sections 1726 and 1747.1. A list of hospices meeting these criteria is available upon request.

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

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

Infertility is: (1) the presence of a condition recognized by a *physician* as a cause of infertility; or (2) the inability to conceive a pregnancy or to carry a pregnancy to a live birth after a year or more of regular sexual relations without contraception.

Investigative procedures or medications are those that have progressed to limited use on humans, but which are not widely accepted as proven and effective within the organized medical community.

Medically necessary procedures, supplies, equipment or services (and procedures, supplies, equipment or services that are of a **medical necessity**) are those which the *claims administrator* determine to be:

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

2. Provided for the diagnosis or direct care and treatment of the medical condition;

3. Within standards of good medical practice within the organized medical community;

4. Not primarily for *your* convenience, or for the convenience of *your physician* or another provider;

5. For gender reassignment surgery, the criteria specified in the *claims administrator's* clinical utilization review guidelines addressing gender reassignment surgery must be met; and

6. The most appropriate procedure, supply, equipment or service which can safely be provided. The most appropriate procedure, supply, equipment or service must satisfy the following requirements:

    a. There must be valid scientific evidence demonstrating that the expected health benefits from the procedure, supply, equipment or service are clinically significant and produce a greater likelihood of benefit, without a disproportionately greater risk of harm or complications, for *you* with the particular medical condition being treated than other possible alternatives; and

    b. Generally accepted forms of treatment that are less invasive have been tried and found to be ineffective or are otherwise unsuitable; and

    c. For *hospital stays*, acute care as an inpatient is necessary due to the kind of services *you* are receiving or the severity of *your* condition, and safe and adequate care cannot be received by *you* as an outpatient or in a less intensified medical setting.

Mental or nervous disorders are conditions that affect thinking and the ability to figure things out, perception, mood and behavior. A mental or nervous disorder is recognized primarily by symptoms or signs that appear as distortions of normal thinking, distortions of the way things are perceived (e.g., 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); bipolar affective disorders including mania and depression; obsessive compulsive disorders; hypochondria; personality disorders (including paranoid, schizoid, dependent, anti-social and borderline); dementia and delirious states; post-traumatic stress disorder; adjustment reactions; reactions to stress; hyperkinetic syndromes; attention deficit disorders; learning disabilities; conduct disorder; oppositional disorder; mental retardation; autistic disease of childhood; anorexia nervosa and bulimia.

Any condition meeting this definition is a mental or nervous disorder no matter what the cause of the condition may be; but medical conditions that are caused by *your* behavior that may be associated with these mental conditions (e.g., self-inflicted injuries) are not subject to these limitations. One or more of these conditions may be specifically excluded in this *plan*.

Negotiated rate is the amount *participating providers* agree to accept as payment in full for covered services. It is usually lower than their normal charge. Negotiated rates are determined by Participating Provider Agreements. Note: If Medicare is the primary payor, the negotiated rate may be determined by Medicare's approved amount (see HOW COVERED EXPENSE IS DETERMINED).

Non-contracting hospital is a *hospital* which does not have a Standard Hospital Contract in effect with *Anthem Blue Cross Life and Health Insurance Company of California* at the time services are rendered.

Non-participating pharmacy is a *pharmacy* which does not have a Participating Pharmacy Agreement in effect with Express Scripts at the time services are rendered. In most cases, *you* will be responsible for a larger portion of *your* pharmaceutical bill when *you* go to a non-participating pharmacy.

Non-participating provider is one of the following providers which does NOT have a Participating Provider Agreement in effect with *Anthem Blue Cross Life and Health Insurance Company of California* at the time services are rendered:

1. A hospital;

2. A physician;

3. An ambulatory surgical center;

4. A home health agency;

5. A facility which provides diagnostic imaging services;

6. A durable medical equipment outlet;

7. A skilled nursing facility;

8. A clinical laboratory; or

9. A home infusion therapy provider.

They are not *participating providers*. Remember that only a portion of the amount which a *non-participating provider* charges for services may be treated as *covered expense* under this *plan*. See YOUR MEDICAL BENEFITS: HOW COVERED EXPENSE IS DETERMINED.

Open enrollment period The *plan* has an *open enrollment period* once each *year*, at the time designated by the *plan administrator*. During that time, an individual who meets the eligibility requirements as an *employee* under the *plan* may enroll. An *employee* may also enroll any eligible *family members* at that time.

Persons eligible to enroll as *family members* may enroll only under the *employee's plan*.

For anyone so enrolling, coverage under the *plan* will begin on the first day of the new *plan year* following the end of the *open enrollment period*.

Other health care provider is one of the following providers:

1. A certified registered nurse anesthetist;

2. A blood bank;

3. A licensed ambulance company; or

4. A hospice.

The provider must be licensed according to state and local laws to provide covered medical services.

Participating pharmacy is a *pharmacy* which has a Participating Pharmacy Agreement in effect with Express Scripts at the time services are rendered. Call *your* local *pharmacy* to determine whether it is a participating pharmacy or call the toll-free customer service telephone number. Many participating pharmacies display an "Rx" decal with the Express Scripts logo in their window so that *you* can easily identify them.

Participating provider is one of the following providers which has a Participating Provider Agreement in effect with *Anthem Blue Cross Life and Health Insurance Company of California* at the time services are rendered:

1. A hospital;

2. A physician;

3. An ambulatory surgical center;

4. A home health agency;

5. A facility which provides diagnostic imaging services;

6. A durable medical equipment outlet;

7. A skilled nursing facility;

8. A clinical laboratory; or

9. A home infusion therapy provider.

Participating providers agree to accept the *negotiated rate* as payment for covered services. A directory of *participating providers* is available upon request.

Pharmacy means a licensed retail pharmacy.

Physician means:

1. A doctor of medicine (M.D.) or doctor of osteopathy (D.O.) who is licensed to practice medicine or osteopathy where the care is provided; or

2. One of the following providers, but only when the provider is licensed to practice where the care is provided, is rendering a service within the scope of that license and is providing a service for which benefits are specified in this *booklet*, and when benefits would be payable if the services were provided by a physician as defined above:

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

    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 licensed clinical psychologist

    f. A chiropractor (D.C.)

    g. An acupuncturist (A.C.)

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

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

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

    k. A speech pathologist*

l. An audiologist*

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

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

o. A *psychiatric mental health nurse* (R.N.)*

p. A nurse midwife**

q. A registered dietitian (R.D.)* for the provision of diabetic medical nutrition therapy only

r. A qualified autism service provider certified by the Behavior Analyst Certification Board

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

**If there is no nurse midwife who is a *participating provider* in *your* area, *you* may call the Customer Service telephone number on *your* ID card for a referral to an OB/GYN.

Placed for Adoption means a *child* with respect to whom the *benefits administration unit* receives legal evidence of (a) the *employee's, retiree's,* or *spouse's/domestic partner's* intent to adopt the *child,* (b) placement for adoption of the *child* with the *employee, retiree,* or *spouse/domestic partner*; and (c) that the *employee, retiree,* or *spouse/domestic partner* has assumed a legal obligation for total or partial support of such *child* in anticipation of adoption of the *child.* The *child's* placement for adoption shall terminate upon the termination of such legal obligation.

Plan is the Bank of the West PPO Plan, the Bank of the West Routine Care Plan, and the Bank of the West HSA Plan, which are component plans under the Bank of the West Flexible Benefits Plan.

Plan Administrator means the *employer.*

Plan year means the *calendar year.*

Preferred drug is a *drug* listed on the *preferred drug program*.

Preferred drug program is a list which the *claims administrator* has developed of outpatient *prescription drugs* which may be cost-effective, therapeutic choices. Any *participating pharmacy* can assist *you* in purchasing *drugs* listed on the *preferred drug program*.

Prescription means a written order or refill notice issued by a licensed prescriber.

Prescription drug covered expense is the expense *you* incur for a covered *prescription drug,* but not more than the maximum amounts described in items 1 and 2 below. Expense is incurred on the date *you* receive the service or supply. Prescription drug covered expense does not include any expense in excess of: (1) the *drug limited fee schedule* for *drugs* dispensed by *non-participating pharmacies;* or (2) the *prescription drug negotiated rate,* for *drugs* dispensed by *participating pharmacies* or by the mail service program.

Prescription drug negotiated rate is the rate that Express Scripts has negotiated with *participating pharmacies* under a Participating Pharmacy Agreement for *prescription drug covered expense*. *Participating pharmacies* have agreed to charge *covered persons* no more than the prescription drug negotiated rate. It is also the rate which Express Scripts accepts as payment in full for mail service *prescription drugs*.

Privacy officer is the SVP and Compensation and Benefits Manager for the *employer.* The privacy officer may be contacted as follows: SVP and Compensation and Benefits Manager, Bank of the West, 180 Montgomery Street, San Francisco, California 94014.

Protected health information includes any information that relates to the past, present, or future physical or mental health of an individual or to payment for the provision of health care of an individual that was created or received by the *plan* and which identifies the individual or has not been de-identified as described in 45 C.F.R. section 164.514(a) and (b).

Prosthetic devices are appliances which replace all or part of a function of a permanently inoperative, absent or malfunctioning body part. The term "prosthetic devices" includes orthotic devices, rigid or semisupportive devices which restrict or eliminate motion of a weak or diseased part of the body.

Psychiatric health facility is an acute 24-hour facility operating within the scope of a state license, or in accordance with a license waiver issued by the state. It must be:

1. Qualified to provide short-term inpatient treatment according to state law;

2. Accredited by the Joint Commission on Accreditation of Health Care Organizations; and

3. Staffed by an organized medical or professional staff which includes a *physician* as medical director.

Benefits provided for treatment in a psychiatric health facility which does not have a Standard Hospital Contract in effect with *Anthem Blue Cross Life and Health Insurance Company of California* will be subject to the *non-contracting hospital* penalty in effect at the time of service.

Psychiatric mental health nurse is a registered nurse (R.N.) who has a master's degree in psychiatric mental health nursing, and is registered as a psychiatric mental health nurse with the state board of registered nurses.

QMCSO is a medical child support order determined by the *claims administrator* to be qualified in accordance with section 609 of ERISA and the *plan's* procedures for determining and implementing qualified medical child support orders.

Reasonable charge is a charge the *claims administrator* considers not to be excessive based on the circumstances of the care provided, including: (1) level of skill; experience involved; (2) the prevailing or common cost of similar services or supplies; and (3) any other factors which determine value.

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

Retired employee (retiree) is a former *employee* who meets the eligibility requirements described in the "Eligible Status" provision of HOW COVERAGE BEGINS AND ENDS.

Retirement benefits office means the *employer's* office of benefits administration for *retirees* and their *family members.* The retirement benefits office can be contacted as follows:

Retirement Benefits Office
2527 Camino Ramon, Mail Stop NC-BO7-1A-A
San Ramon, CA 94583
(925) 843-8318

Severe mental disorders include the following psychiatric diagnoses specified: schizophrenia, schizoaffective disorder, bipolar disorder, major depression, panic disorder, obsessive-compulsive disorder, pervasive developmental disorder or autism, anorexia, and bulimia. "Severe mental disorders" also includes serious emotional disturbances of a *child* as indicated by the presence of one or more mental disorders as identified in the Diagnostic and Statistical Manual (DSM) of Mental Disorders, other than primary substance abuse or developmental disorder, resulting in behavior inappropriate to the *child's* age according to expected developmental norms. The *child* must also meet one or more of the following criteria:

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

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

3. The *child* meets special education eligibility requirements under state law.

Benefits for severe mental disorders will be provided according to the *plan's* benefits for medical conditions, and will not be subject to *plan* provisions for *mental or nervous disorders*..

Skilled nursing facility is an institution that provides continuous skilled nursing services. It must be licensed according to state and local laws and be recognized as a skilled nursing facility under Medicare. For the purpose of care provided for the treatment of *mental or nervous disorders, severe mental disorders,* or substance abuse, the term "skilled nursing facility" includes *residential treatment center*.

Special care units are special areas of a *hospital* which have highly skilled personnel and special equipment for acute conditions that require constant treatment and observation.

Spouse meets the *plan's* eligibility requirements for spouses as outlined under HOW COVERAGE BEGINS AND ENDS.

Stay is inpatient confinement which begins when *you* are admitted to a facility and ends when *you* are discharged from that facility.

Urgent care is the services received for a sudden, serious, or unexpected illness, injury or condition, other than one which is life threatening, which requires immediate care for the relief of severe pain or diagnosis and treatment of such condition.

USERRA means the Uniformed Services Employment and Reemployment Rights Act, as amended.

Year or **calendar year** is a 12-month period starting January 1 at 12:01 a.m. Pacific Time.

***You* (*your*)** refers to the *employee, retiree,* and *family members* who are enrolled for benefits under this *plan*. Where such terms are not italicized, they refer to the *employee* or *retiree.*

STATEMENT OF ERISA RIGHTS

As a participant in the *plan*, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (*ERISA*). *ERISA* provides that all *plan* participants shall be entitled to:

Receive Information About Your Plan and Benefits

- Examine, without charge, at the *plan administrator's* office and at other locations, such as worksites and union halls, all documents governing the *plan*, including insurance contracts, collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the *plan* with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the *plan administrator*, copies of documents governing the operation of the *plan*, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The *plan administrator* may make a reasonable charge for the copies.
- Receive a summary of the *plan's* annual financial report; the *plan administrator* is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

- Continue health care coverage for yourself and your *family members* if there is a loss of coverage under the *plan* as a result of a qualifying event. You or your *family members* may have to pay for such coverage. Review this booklet and the documents governing the *plan* on the rules governing your *COBRA* continuation coverage rights.
- Reduction or elimination of exclusionary periods of coverage for pre-existing conditions under the *plan*, if you have *creditable coverage* from another plan. Note that as of January 1, 2014, the *plan* does not include any pre-existing condition exclusions. You should be provided a certificate of *creditable coverage*, free of charge, from the *plan* when you lose coverage under the *plan*, when you become entitled to elect *COBRA* continuation coverage, when your *COBRA* continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of *creditable coverage*, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage under another employer's non-calendar year group health plan. Effective for plan years beginning on or after January 1, 2014, group health plans and insurers can no longer include pre-existing condition exclusions.

PRUDENT ACTIONS BY PLAN FIDUCIARIES

In addition to creating rights for *plan* participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your *plan*, called "fiduciaries" of the *plan*, have a duty to do so prudently and in the interest of you and other *plan* participants and beneficiaries.

No one, including your *employer*, your union, or any other person may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under *ERISA*.

ENFORCE YOUR RIGHTS

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under *ERISA*, there are steps you can take to enforce the above rights. For instance, if you request a copy of *plan* documents or the latest annual report from the *plan* and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the *plan administrator* to provide the materials requested and to pay you up to $110 a day until you receive the materials, unless the materials are not sent because of reasons beyond the control of the *plan administrator*.

If you have completed the *plan's* claim and appeal procedures and your claim for benefits is denied or ignored, in whole or in part, you may file suit in a state or federal court.

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

ASSISTANCE WITH YOUR QUESTIONS

If you have any questions about your *plan*, you should contact the *plan administrator*. If you have any questions about this statement or about your rights under *ERISA*, or if you need assistance in obtaining documents from the *plan administrator*, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W, Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under *ERISA* by calling the publications hotline of the Employee Benefits Security Administration or accessing its website at http://www.dol.gov/ebsa/.

GENERAL PLAN INFORMATION

Amendments and Termination of the Plan

The *employer* reserves the right to amend or to terminate the *plan* at any time and for any reason, by action of its board of directors or by action of a committee of individual(s) acting pursuant to a valid delegation of authority by the board of directors. If the *plan* is amended or terminated, you may not receive benefits as described in this summary. You may be entitled to receive different benefits, or benefits under different conditions. However, it is possible for you to lose all benefit coverage. This may happen at any time, if the *employer* decides to terminate the *plan* or your coverage under the *plan*. In no event will you become entitled to any vested rights under the *plan*. The provisions of the *plan* cannot be modified orally or in any other manner, except by properly adopted amendment.

Any amendment or termination of the *plan* will not affect payment of a covered expense you incur before the amendment or termination. Notwithstanding the foregoing, any amendment that pertains to matters involving the processing of claims for the payment of covered expenses under the *plan* (and not the calculation of the amount of such covered expenses that may be payable under the *plan*) shall be effective as of the date specified by the board of directors of the *employer* or its delegate at the time of adopting the amendment and shall apply with respect to all pending claims and reviews without regard to the date the covered expense was incurred.

The *plan* is a component plan under the Bank of the West Flexible Benefits Plan, both of which are on file with the *employer*. The full terms of the *plan* include this *booklet* and the Bank of the West Flexible Benefits Plan. You may obtain copies of these documents from *benefits administration unit* for a small fee.

Except as otherwise provided under the terms of the Bank of the West Flexible Benefits Plan, in the event of any conflict between the terms of this *plan* and the Bank of the West Flexible Benefits Plan, the text of this *plan* will control.

Payment of Claims to Others

If any payment for covered charges under the *plan* would be payable to the estate of any person, or to any person who is a minor or otherwise not competent to give a valid release, the *claims administrator* (to the extent permitted by law) may distribute this benefit to any relative of the person by blood or marriage (or to any person who can demonstrate that the person paid your or your *family member's* medical expenses and is entitled to reimbursement) whom it deems to be entitled to the benefit. Any payment made by the *claims administrator* in good faith will discharge the *employer* from all liability to such person to the extent of the payment.

If you have a claim for benefits under the *plan*, you must follow the claims procedures set forth in this *booklet*. If you have any questions regarding how to make a claim for benefits under the *plan*, please contact the *claims administrator.*

Funding and Method of Contributions

The *plan* is self-insured by the *employer* and *plan* benefits are paid from the *employer's* general assets, which means that benefits under the *plan* are not guaranteed under a contract of insurance. The total contributions for the *plan* are determined by the *employer*. Your rate of contribution toward the cost of *plan* benefits is set by the *employer* and may be adjusted from time to time. Your contributions will be used in their entirety prior to using *employer* contributions. The balance of the cost of the *plan*, if any, is paid by the *employer*.

No Assignment

No benefit under the *plan* may be voluntarily or involuntarily assigned or alienated. Notwithstanding the foregoing, the *plan* will pay benefits in accordance with the terms of a Qualified Medical Child Support Order (*QMCSO*). See HOW COVERAGE BEGINS AND ENDS for more information regarding *QMCSO*s.

Governing Law and Venue

This *plan* shall be construed and enforced according to *ERISA*, the Internal Revenue Code and, to the extent applicable, according to the laws of the State of California.

Any claim or action by *you* relating to or arising under the *plan* may only be brought in the United States District Court for the Northern District of California, and such court will have personal jurisdiction over *you* and any *family members* or other participants named in the action.

Proof of Age and Marriage/Domestic Partnership

The *claims administrator* may require you or your *family member*s to furnish satisfactory proof of age as a condition of maintaining coverage of such *family member*s. The *claims administrator* may also require proof of marriage/domestic partnership in the case of a status change to add a *spouse*/*domestic partner*.

Workers' Compensation

The *plan* is not in lieu of, and does not affect any requirements for, coverage by Workers' Compensation Insurance.

Employment Rights

Nothing in the *plan*, this *booklet*, or any benefit communication shall be deemed to give any person any right to remain in the employ of the *employer* or to affect the right of the *employer* to terminate the employment of any person at any time with or without cause. The *employer* reserves the right to terminate your employment at any time for any reason.

Plan Administrator's Authority to Interpret Plan

The *plan administrator* has the full and exclusive authority to interpret the terms of the *plan,* to determine eligibility for benefits and to determine the type and extent of benefits, if any, to be provided under the *plan*, including claims for eligibility for coverage under the *plan*. The decisions of the *plan administrator* are final, conclusive and binding on all persons. In any action to review any such decision by the *plan administrator*, the *plan administrator* shall be deemed to have exercised its discretion properly unless it is proved duly that the *plan administrator* has acted arbitrarily and capriciously.

The *plan administrator* has delegated its authority to determine claims for benefits under the *plan* to the *claims administrator* for the *plan*. The *claims administrator* for the *plan* is identified at the end of this section of the booklet, along with the *claims administrator's* contact information. Where such authority has been delegated to a *claims administrator*, the *claims administrator* has the full and exclusive authority to interpret the particular *plan* and determine claims for benefits under such *plan*. The decisions of the *claims administrator* are final, conclusive and binding on all persons.

For medical coverage, the *plan* has been established on a noninsured basis; all liability for payment of benefits is assumed by the *employer*. While *Anthem Blue Cross Life and Health Insurance Company of California* administers payment of claims, *Anthem Blue Cross Life and Health Insurance Company of California* has no liability for the funding of the *plan*.

While one of the functions of *Anthem Blue Cross Life and Health Insurance Company of California* is to process claims according to the *plan* provisions, all claims under the *plan* are paid by the *employer*, and the *employer* owns the claim files. Therefore, the final decision on any disputed claim may involve review of these files by the *employer*.

Plan Administration

Plan Sponsor

Bank of the West (the *employer*)
180 Montgomery Street
San Francisco, CA 94104

Employer Identification Number (EIN)

94-0475440

Plan Number

506

Plan Year

January 1 to December 31

Plan Administrator

The *employer* is the *plan administrator* within the meaning of the Employee Retirement Income Security Act of 1974, as amended (*ERISA*) for the *plan*.

Bank of the West
180 Montgomery Street
San Francisco, CA 94104

Agent for Service of Legal Process

Bank of the West (the *employer*)
ATTN: Benefits Department
180 Montgomery Street
San Francisco, CA 94104

Claims Administrator

The *claims administrator* is the named fiduciary for resolving all claims for benefits made under the *plan*.

Anthem Blue Cross Life and Health Insurance Company of California
P.O. Box 60007
Los Angeles, CA 90060
(877) 216-3990

Important Notice from Bank of the West About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Bank of the West and about your options under Medicare's prescription drug coverage. This information can help you decide whether you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. **Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.**

2. **Bank of the West has determined that the prescription drug coverage offered by Bank of the West is, on average for all plan participants, expected to pay out as much as the standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.**

When Can You Join a Medicare Prescription Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th through December 7th. However, if you lose your current creditable prescription drug coverage through no fault of your own, you will be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens to Your Current Coverage If You Decide to Join a Medicare Drug Plan?

If you decide to join a Medicare drug plan, and you are also enrolled in one of the Bank of the West medical plans, your coverage with Bank of the West will not be affected.

With your current Bank of the West health plans, you have coverage for prescription drugs when authorized by your physician. Your prescription benefit pays a portion of your prescription drugs after you pay a co-payment based on the medical plan you are enrolled in and the type of drug you are purchasing, usually $5 to $150 per prescription. Your benefit does not have a maximum per year dollar limit.

Also, your current coverage pays for other medical and hospitalization expenses, in addition to prescription drugs. Since your Bank of the West medical plan provides comprehensive prescription drug coverage, you may receive a limited benefit by joining a Medicare drug plan.

If you do decide to join a Medicare drug plan and decide to drop your Bank of the West medical and prescription drug coverage, be aware that you and your dependents will not be able to re-enroll in the Bank of the West Medical Program until the next Open Enrollment Period.

When Will You Pay a Higher Premium (Penalty) to Join a Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with Bank of the West and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go 19 months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For more information about this notice or your current prescription drug coverage...

Contact the Bank of the West Retirement Department at (925) 843-8318 for further information. **NOTE:** You will get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Bank of the West changes. You also may request a copy of this notice at any time.

For more information about your options under Medicare prescription drug coverage...

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverages:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of the “Medicare & You” handbook for their telephone number) for personalized help
- Call (800) MEDICARE – (800) 633-4227. TTY users should call (877) 486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at (800) 772-1213 (TTY (800) 325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare prescription drug plans, you may be required to provide a copy of this notice when you join, to show whether you have maintained creditable coverage and, therefore, whether you are required to pay a higher premium (a penalty).

Date:	January 1, 2017
Name of Entity/Sender:	Bank of the West
Contact—-Position/Office:	Bank of the West Retirement Department
Address:	2527 Camino Ramon, San Ramon, CA 94583
Phone Number:	(925) 843-8318