COUNTY OF ORANGE

WELLWISE
MEDICARE RETIREE HEALTH PLAN
PLAN DOCUMENT

Effective January 1, 2023

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WELLWISE MEDICARE RETIREE HEALTH PLAN

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The COUNTY OF ORANGE Wellwise Medicare Retiree HEALTH PLAN (the "PLAN") assures the County of Orange retirees during the period of this PLAN that all benefits hereinafter described shall be paid to them in the event that they and/or their eligible enrolled dependent(s) incur covered medical and prescription drug expenses.

The PLAN is subject to all the terms, provisions and conditions described within this document.

The COUNTY OF ORANGE caused this PLAN and the terms and benefits described herein to take effect as of 12:01 a.m. Pacific Time on January 1, 2023, at Santa Ana, California 92701.

In addition to this Plan Document, Optum, the Pharmacy Benefits Manager for the Medicare Part D EGWP, will provide retirees with the Evidence of Coverage booklet (EOC) that provides Medicare retirees with additional information related to your Medicare Part D prescription drug benefit.

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ELIGIBILITY AND ENROLLMENT

ELIGIBILITY FOR COVERAGE

The Wellwise Medicare Retiree Health Plan eligibility requirements for covered persons are described in the definitions section of this document. Furthermore, in order to be eligible under this Plan, a retiree or dependent must be enrolled in either (1) Parts A & B of Medicare, or (2) if the retiree or dependent is not eligible for Part A of Medicare, enrolled in Part B of Medicare only. Additional eligibility requirements are included in Section 2 of the EOC.

ENROLLING FOR COVERAGE

Procedures and guidelines for enrolling in the Wellwise Medicare Retiree Health Plan are described in the Benefits Enrollment Guide provided to all County retirees during the annual open enrollment period.

INDIVIDUAL PLAN COVERAGE EFFECTIVE DATES

a) All eligible retirees upon initiation of the PLAN will be covered on the date of inception of the PLAN provided they were enrolled in the Premier Wellwise Health Plan effective January 1, 2023.

b) Retirees and their Dependents shall be eligible for coverage immediately upon their loss of eligibility as an employee provided the retiree was eligible and the dependent was eligible and covered under a County of Orange employee health plan at the time of retirement. Dependents shall be covered on the date application is approved for coverage for them as Dependents and any required contributions for coverage are made to the County. If the Retiree or Dependent does not qualify for coverage under Medicare, such individual is not eligible for coverage under this Plan but may be eligible for coverage under the Wellwise Non-Medicare Retiree Plan. Please refer to the Wellwise Non-Medicare Retiree Plan Document for specific information regarding eligibility and benefits.

c) If application for coverage or for reinstatement is made by a person who is in an eligible status, but whose coverage had never become effective or had terminated because of failure to make the required contributions for Individual's Coverage, the coverage for such person shall take effect as determined by the Plan Administrator.

d) If additional Dependents are acquired while the individual is eligible for Dependent Coverage, the coverage for each such Dependent shall become effective on the date the Dependent qualifies in accordance with the Definition of Dependent provision and has been enrolled in the method determined by the Plan Administrator.

e) A new dependent will be deemed to have been enrolled on the date he becomes eligible for coverage providing formal application for coverage is submitted within 30 days of the dependent's eligibility.

f) If application for coverage or for reinstatement is made by a person who is in an eligible status, but whose coverage had never become effective or had terminated because of failure to make the required contributions for Individual's Coverage, the coverage for such person shall take effect as determined by the Plan Administrator.

ELIGIBILITY AND ENROLLMENT (continued)

INDIVIDUAL TERMINATION OF COVERAGE

Coverage under the PLAN shall terminate on the earliest of the following dates:

a) The date of termination of the PLAN; or

b) The last day of the month that membership ceases in an eligible class; or

c) The date all coverage or certain benefits are terminated on the Covered Person's particular class by modification of the PLAN; or

d) The date the Covered Person becomes a full-time member of the Armed Forces of any country; however, any Covered Person who is absent from work due to service in the uniformed services as defined by USERRA may elect to continue coverage, including their covered dependents, under the PLAN for up to 24 months as required under USERRA; or

e) The date the Covered Person fails to make a required contribution.

f) The date the Covered Person enrolls in another Medicare Part D plan unless it meets the CMS waiver requirements.

Additional details regarding termination are detailed in Chapter 8 of the Evidence of Coverage (EOC).

Termination of PLAN eligibility is subject to regulations under the Consolidated Omnibus Budget Reconciliation Act and regulations requiring extension of benefit eligibility if applicable.

SCHEDULE OF BENEFITS

MEDICAL EXPENSE BENEFITS

The following Medical Expense Benefits are provided by this Plan and administered by the Claims Administrator. Unless otherwise noted, all Covered Medical Expenses are subject to the applicable Deductible, coinsurance and other exclusions or limitations expressed herein.

When utilizing non-Network facilities and providers, the Covered Person is responsible for all charges incurred that are above the URC amount. This may include, but is not limited to, preventive care. Covered Persons who receive emergency services at any emergency facility (including hospital emergency departments), air ambulance services or covered services at in-network facilities will only be responsible for applicable in-network benefit cost sharing amounts as reflected in this schedule of benefits and will not be responsible for any out-of-network charges for any such services.

MEDICAL EXPENSE BENEFITS	**Network**	**Non-Network[1]**
LIFETIME MAXIMUM BENEFIT	None	
CALENDAR YEAR DEDUCTIBLE [2] ▪ Individual	$500	$750
	All Covered Medical Expenses accumulate toward both the Network Deductible and the Non-Network Deductible. Once the Non-Network Deductible is met, the Network Deductible will have been considered to be met for that Calendar Year. The total Deductible amount for the Calendar Year will not exceed the Non-Network Deductible amount.	
OUT-OF-POCKET MEDICAL MAXIMUM BENEFIT [2] – After all medical out-of-pocket expenses (including deductibles and coinsurance) incurred by a Covered Person within a Calendar Year have totaled the amount shown, the PLAN will pay 100% of the remaining Covered Medical Expenses incurred by that Covered Person for the remainder of the Calendar Year. If a Covered Person has a combination of Network and Non-Network services, the out-of-pocket expenses under both will be combined to determine whether the Out-of-Pocket Maximum Benefit has been met.	MEDICAL Individual: $2,500	MEDICAL Individual: $5,000 Does not include the cost of services that are not covered by the PLAN, amounts in excess of Usual, Reasonable and Customary, and the 20% coinsurance reduction for failure to obtain Pre-Admission approval, permissible balance billing charges and/or if you chose a brand drug when a generic equivalent is available, the cost differential would be excluded
COINSURANCE	**The PLAN pays the following percentage of Covered Medical Expenses after the Covered Person pays the Deductible (except as noted below)**	
Preventive care services for children (Birth through 18 years of age)	100% (no Deductible)	
Preventive care services for adults (19 years of age or older)	100% (no Deductible)	
Office Visit (includes Telehealth)	90%	70%
Telemedicine Visit 1-800-TELADOC	90%	Not Covered
Urgent Care	90%	70%
Chiropractic and acupuncture services	90%	70%

SCHEDULE OF BENEFITS

MEDICAL EXPENSE BENEFITS (continued)

MEDICAL EXPENSE BENEFITS	Network	Non-Network[1]
	Combined Network and Non-Network maximum benefit of 25 visits per Calendar Year for chiropractic services and 25 visits per Calendar Year for acupuncture services.	
Emergency Services • Non-network – covered person is responsible for all charges above the current UCR amount	90%	90%
Inpatient Hospital services: • With Pre-Admission Review • Without Pre-Admission Review	90% 90%	70% 50%
Outpatient surgery - hospital	90%	70%
Outpatient surgery – Ambulatory Surgery Center (facility charges)	90%	70% up to a maximum of $1,500/day
Radiology – Advance imaging including MRI, ST, PET Scans, X-ray, and Ultrasound (requires Prior Authorization for complex imaging, unless emergency)	90%	70%
Organ transplants [3]	90%	70%
Home health care (requires Prior Authorization)	90%	70%
	When home health care is authorized as an alternative to continued hospitalization in a Network Hospital, the home health care services will be reimbursed at 90%	
Ambulance services Non-network: Covered person is responsible for all charges above the current URC amount for Ground Ambulance but only responsible for in-network charges for air ambulance services	90%	90%
Durable Medical Equipment (DME) (requires Prior Authorization for equipment over $5,000)	90%	70%
Skilled nursing facility (requires Prior Authorization)	90%	70%
	Combined Network and Non-Network maximum benefit of 100 days per Calendar Year	
Hospice (requires Prior Authorization)	90%	70%
	When Hospice residence immediately follows Inpatient services in a Network Hospital, the Hospice services will be reimbursed at 90%	
Dialysis Services (outpatient)	90%	Within California: 70% up to a maximum of $600 per day Outside California: 70%

SCHEDULE OF BENEFITS

MEDICAL EXPENSE BENEFITS (continued)

MEDICAL EXPENSE BENEFITS	Network	Non-Network[1]
Mental health and substance abuse treatment (severe and non-severe):		
▪ Inpatient		
▪ With Pre-Admission Review	90%	70%
▪ Without Pre-Admission Review	90%	50%
▪ Outpatient	90%	70%
	Preauthorization is required for Applied Behavioral Analysis services and other Outpatient services except for office visits. Failure to obtain preauthorization may result in non-payment of benefits	
Covered Drugs prescribed for emergency treatment or for treatment received while traveling outside of the United States, and not purchased through the Prescription Drug Program	80%	
Certain surgical procedures for treatment of morbid obesity (requires Prior Authorization). Must use designated facilities if surgery occurs within California.[3,4]	90%	Within California: Not Covered Outside California: 70%
All other Covered Medical Expenses	90%	70%

Notes:

1 Covered Persons may be responsible for all out-of-network charges billed for certain services not obtained at an in-network facility.

2 Any amounts the Covered Person pays because the Pre-Admission Review requirements were not met do not apply to the Deductible or the Out-of-Pocket Medical Maximum Benefit accumulation. Out-of-Pocket prescription drug expenses do not apply to the Out-of-Pocket Medical Maximum Benefit accumulation.

3 Refer to Covered Medical Expenses for benefit limitations for organ procurement and travel expenses associated with a covered organ transplant.

4 Refer to How the Plan Works – Centers of Distinction for benefit limitations for bariatric surgeries performed at non-Network facilities within California.

SCHEDULE OF BENEFITS

PRESCRIPTION DRUG PROGRAM

The Medicare Part D Prescription Drug Program is administered by the Pharmacy Benefit Manager.

LIFETIME MAXIMUM BENEFIT	Unlimited	
CALENDAR YEAR DEDUCTIBLE	None	
OUT-OF-POCKET PRESCRIPTION DRUG MAXIMUM BENEFIT: The maximum amount of Prescription Drug coinsurance for which a Covered Person is responsible during a Plan Year.	$4,100 individual	
COINSURANCE	**THE PLAN PAYS**	**THE COVERED PERSON PAYS**
Covered drugs purchased through a Network Retail Pharmacy or approved Mail Order Service		
▪ Tier 1 – Lower cost/commonly used Generic drugs.1 May also include some low-cost brand-name drugs.	80%	20%
Tier 2 – Preferred Drugs (many common brand-name drugs)	75%	25%
Tier 3 – Non-Preferred Drugs (mostly higher cost brand-name drugs)	70%	30%
▪ Tier 4 - Specialty Pharmacy and High-Cost Drugs (see page 22 of the Plan Document for reference).	The remaining percentage of the cost of the covered drug	The percentage of the cost required of the covered person for Specialty Drugs as stated directly above for the respective covered Tier 1 - Generic, Tier 2 -Preferred or Tier 3 Non-Preferred, up to a maximum of $150 required of the covered person per 30 days supply[3].
Catastrophic Coverage – reached when OUT-OF-POCKET PRESCRIPTION DRUG spending exceeds $7,400[3]	95%	Greater of 5% or $10.35 for brand drugs and $4.15 for generic drugs

Notes:

[1] Some higher cost Generic Drugs may be placed in the Preferred Drug or Non-Preferred Drug Tiers.

[2] Member may request up to a 90-day supply for specialty products if they are established on therapy. Additional days-supply above 30 would result in a maximum payment of $300 for a 60-day supply or $450 for a 90-day supply.

[3] If you reach the catastrophic coverage stage, when your out-of-pocket spending (including discounts provided by manufacturers) exceeds $7,400, you will only pay 5% (or a minimum copayment of $10.35 brand or $4.15 generic). See the explanation of catastrophic coverage in the EOC provided by the PBM. Refer to Chapter 4 in the EOC for further details regarding Catastrophic Coverage

The Medicare Part D Prescription Drug Program provides benefits for prescription drugs and medications purchased at a Non-Network Retail Pharmacy or unapproved mail order service as detailed in the EOC Section 2.5 of Chapter 3 of the EOC covers Out of Network (OON) situations.

The Covered Person's coinsurance for prescription drugs and medications that qualify as Covered Drugs under the Medicare Part D Prescription Drug Program can be used to satisfy the Out-of-Pocket Prescription Drug Maximum Benefit. Prescription drugs and medications that qualify as Covered Drugs under the Prescription Drug Program cannot be used to satisfy the Medical Expense Benefits Deductible.

MEDICAL EXPENSE BENEFITS

HOW THE PLAN WORKS

CLAIMS ADMINISTRATOR

The Claims Administrator provides claims administration services for the PLAN's Medical Expense Benefits.

UTILIZATION REVIEW REQUIREMENTS

The PLAN requires pre-service review of certain covered services. This process is called Utilization Review and is conducted by the Claims Administrator. The purpose of Utilization Review is to assist the Covered Person in identifying the most appropriate and cost-effective course of treatment for which benefits will be provided under the PLAN, and to determine whether the services are Medically Necessary. The necessity of medical services is evaluated through:

- Inpatient Hospital Pre-Admission Review for elective Hospital confinements (including concurrent review and discharge planning), and
- Prior Authorization of specialty health care services.

All Inpatient hospitalizations for elective services and certain specialty health care services must be authorized and approved by the Claims Administrator. The Covered Person is responsible for ensuring that Pre-Admission review or Prior Authorization has occurred.

Services that are determined to be not Medically Necessary by the Claims Administrator, either through the Pre-Admission Review or Prior Authorization process, will not be covered by the PLAN. However, the Covered Person and his Physician make the final decision concerning treatment.

Pre-Admission Review – Hospital Admissions

If a Covered Person is to be admitted to a Hospital or Skilled Nursing Facility on an Inpatient basis for any reason other than childbirth, the Covered Person, his representative, or his Physician must contact the Claims Administrator prior to the hospital admission (or, in the case of an Emergency Hospital Confinement, within 48 hours of the commencement of such confinement, or within 72 hours of the commencement of such confinement if it commences on a Saturday, Sunday or statutory legal holiday).

After the Claims Administrator reviews the Covered Person's request for Pre-Admission Review and the Covered Person's Physician's suggested treatment program, the Covered Person, the Covered Person's Physician, and the Hospital will be notified of the Claims Administrator's determination.

If the Covered Person's stay is approved, the Claims Administrator will certify the length of stay and the level of care that is Medically Necessary based on professionally recognized quality standards. The Claims Administrator may also review the Covered Person's progress while hospitalized. Then, before the Covered Person is released from the Hospital, the Claims Administrator may make arrangements to authorize benefits for any necessary care after the Covered Person's discharge.

MEDICAL EXPENSE BENEFITS

HOW THE PLAN WORKS (continued)

Effect of Pre-Admission Review on Benefits

1. Covered Medical Expenses shall not include any charges for Hospital Room and Board, or other services and supplies furnished by the Hospital that are incurred on any day of a Covered Person's Inpatient Hospital confinement determined by the Claims administrator not to be Medically Necessary.

2. If a Covered Person does not obtain Pre-Admission Review approval from the Claims Administrator for a Medically Necessary Hospital stay in a Non-Network Hospital or facility, the applicable coinsurance will be reduced from seventy percent (70%) to fifty percent (50%). Once the Out-of-Pocket Medical Maximum Benefit amount is reached, the applicable coinsurance will be eighty percent (80%). The additional twenty percent (20%) for which the Covered Person is responsible due to failure to obtain Pre-Admission Review approval does not apply to the Deductible or Out-of-Pocket Medical Maximum Benefit amount. Emergency inpatient hospitalizations are excluded from the requirements of this paragraph as Pre-Admission Reviews are not required for services that meet the Emergency Service definition; however, the Claims Administrator must still be notified for emergency inpatient hospitalizations within the time frames specified on the prior page under Pre-Admission Review – Hospital Admissions.

Prior Authorization

The following medical services require Prior Authorization by the Claims Administrator, unless it meets the Emergency Services definition:

- Home health care if a non-Network provider;
- Hospice care in a Hospice facility or through a Hospice program;
- Purchase of durable medical equipment that costs more than $5,000;
- Surgical procedures for treatment of morbid obesity;
- Radiological and nuclear imaging procedures within California on an outpatient, non-emergency basis including, but not limited to, CT (computerized tomography) scan, MRI (magnetic resonance imaging), MRA (magnetic resonance angiography), PET (positive emission tomography scan), and diagnostic cardiac procedures utilizing nuclear medicine;
- Spine surgery and pain management procedures within the United States on a non-emergency basis including, but not limited to lumbar spine surgery, cervical spine surgery, injections, epidurals, and joint blocks.

If Prior Authorization is not obtained, and it is later determined by the Claims Administrator that the services are not Medically Necessary, the services will not be covered under this PLAN. However, the Covered Person and his Physician make the final decision concerning treatment.

CENTERS OF DISTINCTION

Bariatric surgery requires utilization of one of the Claims Administrator's Centers of Distinction facilities for Covered Persons receiving such outpatient services within the State of California:

MEDICAL EXPENSE BENEFITS

HOW THE PLAN WORKS (continued)

If a Covered Person as specified above obtains such services within California from a facility that is not a Center of Distinction, the services will not be covered under this PLAN. Services received outside of the State of California are exempt from this requirement.

For a hip or knee replacement, it is strongly recommended that the Covered Person utilize one of the Claim Administrator's Centers of Distinction to ensure high quality, cost-effective services are received.

For an organ transplant, it is strongly recommended that the Covered Person utilize one of the Claim Administrator's Centers of Distinction to ensure high quality, cost-effective services are received.

EMERGENCY SERVICES FACILITY AND PROVIDER

When a Covered Person obtains treatment for a condition that meets the "Emergency Services' definition stated in this Plan, the Plan pays the Network rate of ninety percent (90%) of the Usual, Reasonable and Customary (URC) amount (after Deductible) until the patient is considered to be medically stable. Covered Person may be responsible for all out-of-network charges billed for certain services not obtained in the emergency facility (e.g., ground ambulance) above the URC amount. Covered Persons who receive Emergency Services at any emergency facility (including hospital emergency departments) or air ambulance will only be responsible for applicable in-network benefit cost sharing amounts and will not be responsible for any out-of-network charges for any such services.

OUTPATIENT DIALYSIS

If a Covered Person receives outpatient dialysis services at a non-Network facility within California, the Claims Administrator will pay a maximum of $600 per day to the provider. The Covered Person may be billed for any difference in cost.

OUTPATIENT AMBULATORY SURGERY CENTERS

If a Covered Person receives services at a Non-Network Ambulatory Surgery Center within California, the Claims Administrator will pay a maximum of $1,500 per day for the facility charges. The Covered Person may be billed for any difference in cost.

CASE MANAGEMENT

Upon identification by the Claims Administrator that a Covered Person is incurring services for treatment of an Illness or Accidental Injury that have the potential for substantial claims, the case may be referred for Case Management. With the concurrence of the primary attending Physician and the Covered Person, the case manager may authorize services and expenses not covered by the PLAN. The purpose of Case Management shall be to provide for a treatment plan and services designed to achieve the earliest and most complete recovery of the patient in the most cost-effective manner. Services authorized by the case manager may include supportive expenses of family members and non-medical expenses necessary to execute the treatment plan. Any such payment, although a valid charge against the PLAN, will not be considered to be a precedent in the disposition of other claims.

MEDICAL EXPENSE BENEFITS

HOW THE PLAN WORKS (continued)

THE CALENDAR YEAR DEDUCTIBLE

Annually, each Covered Person must satisfy the Calendar Year Deductible before most Covered Medical Expenses are reimbursed by the PLAN. The Calendar Year Deductible is different for network and non-network expenses — see chart below.

The Calendar Year Deductible		
	Network Providers	**Non-Network Providers**
Individual Deductible	$500	$750

All covered expenses accumulate toward both the Network Deductible and the Non-Network Deductible. Once the Non-Network Deductible is met, the Network Deductible will have been considered to be met for that Calendar Year. The total Deductible amount for the Calendar Year will not exceed the Non-Network Deductible amount.

Expenses That Do Not Apply Toward the Deductible

The following expenses do not apply toward the Deductible:

- Preventive care services specified in Covered Medical Expenses paragraph g) that are reimbursed by the PLAN at one hundred percent (100%);
- Any Covered Drugs that qualify for coverage under the Prescription Drug Program;
- Any amounts over the URC amount;
- Any amounts the Covered Person pays because the Pre-Admission Review requirements of the PLAN were not met; and
- Any services not considered Covered Medical Expenses or otherwise excluded or in excess of PLAN limits.

MID-YEAR PLAN CHANGE

If you are eligible to change plans mid-year and change to Sharewell, you may be entitled to carry over the amounts accumulated towards your deductible and Out-of-Pocket Maximum Benefit limits to the Sharewell Plan. Contact the Claims Administrator or the Plan Administrator for more information.

NETWORK AND NON-NETWORK BENEFITS

The PLAN includes network and non-network benefits. Each time medical care is needed, the Covered Person decides whether to use a Network Provider or Non-Network Provider.

When medical care is received from a Network Provider, the PLAN pays ninety percent (90%) of the Network Contract Rate for most Covered Medical Expenses (after the Network Deductible). Network Providers agree to not bill the Covered Person for any charges in excess of the Network Contract Rate. The Covered Person pays the Network Deductible and ten percent (10%) of the Network Contract Rate, plus any charges that do not qualify as a Covered Medical Expense or are otherwise excluded or limited by the PLAN. Dollar or visits limits may apply for non-Network care as well (e.g., ambulatory surgery, dialysis, chiropractic treatments, and acupuncture).

MEDICAL EXPENSE BENEFITS

HOW THE PLAN WORKS (continued)

Except as otherwise specified in the Centers of Distinction, Emergency Hospital Emergency Room Care, Outpatient Dialysis, and Outpatient Ambulatory Surgery Center sections above, when medical care is received from a Non-Network Provider, the PLAN pays seventy percent (70%) of the Usual, Reasonable and Customary (URC) amount (after the Non-Network Deductible), except Preventive Care which is covered at 100% regardless of network. The Covered Person pays the Non-Network Deductible, thirty percent (30%) of the URC amount, plus any amounts the non-Network provider charges that exceed URC, any charges that do not qualify as a Covered Medical Expenses or are otherwise excluded or limited by the PLAN, and the twenty percent (20%) coinsurance reduction for failure to follow the Pre-Admission Review and Prior Authorization requirements of the PLAN. Notwithstanding the foregoing, covered Persons who receive emergency services at any emergency facility (including hospital emergency departments), air ambulance services or covered services at in-network facilities will only be responsible for applicable in-network benefit cost sharing amounts and will not be responsible for any out-of-network charges for any such services.

OUT-OF-POCKET MEDICAL MAXIMUM BENEFIT

The Out-of-Pocket Medical Maximum Benefit limits the amount a Covered Person pays for Covered Medical Expenses in a Calendar Year. The Out-of-Pocket Medical Maximum Benefit amounts are different for network and non-network expenses. After a Covered Person's medical out-of-pocket costs, including the Deductible, have totaled $2,500 individual for network expenses or $5,000 individual for non-network expenses, the PLAN will pay one hundred percent (100%) of the remaining Covered Medical Expenses incurred by the Covered Person within the Calendar Year.

If the Covered Person has a combination of network and non-network expenses, the Covered Person's out-of-pocket costs under both will be combined to determine whether the Out-of-Pocket Medical Maximum Benefit amount has been met.

Expenses That Do Not Apply Toward the Out-of-Pocket Medical Maximum Benefit

The following expenses do not apply toward the Out-of-Pocket Medical Maximum Benefit amount:

- Preventive care services specified in Covered Medical Expenses paragraph g) that are reimbursed by the PLAN at one hundred percent (100%);
- Any Covered Drugs that qualify for coverage under the Medicare Part D Prescription Drug Program;
- Any amounts over the URC amount;
- Any amounts the Covered Person pays because the Pre-Admission Review requirements of the PLAN were not met; and
- Any services not considered Covered Medical Expenses or otherwise excluded or in excess of PLAN limits.

OUT-OF-POCKET PRESCRIPTION DRUG MAXIMUM BENEFIT

The Out-of-Pocket Prescription Drug Maximum Benefit limits the amount a Covered Person pays for Covered Prescription Drug Expenses in a Calendar Year. After a Covered Person's prescription drug out-of-pocket costs (i.e., coinsurance) have totaled $4,100 individual, the PLAN will cover remaining Covered Prescription Drug Expenses incurred by the Covered Person within the Calendar Year.

COVERED MEDICAL EXPENSES

The PLAN covers preventive services and other Medically Necessary services and supplies described below which are incurred by a Covered Person. Such services must be incurred by a Covered Person while eligible to receive benefits under the PLAN and recommended by a Physician for the treatment of the Covered Person's Illness, Accidental Injury, or pregnancy, subject to the exclusions and limitations listed within this Plan Document. Unless otherwise noted, all Covered Medical Expenses are subject to the applicable Deductibles and coinsurance listed in the Schedule of Medical Expense Benefits. For Non-Network Providers, Covered Medical Expenses shall include only Usual, Reasonable and Customary charges for the services and supplies described below.

Covered Medical Expenses include:

a) Hospital care for room, board and other Hospital services required for purposes of treatment, but not to exceed for Hospital Room and Board the cost of the most common semi-private room or other accommodations deemed Medically Necessary by the attending Physician.

   The PLAN will allow up to the Network Negotiated Rate or URC amounts charged by the Hospital for necessary Hospital Room and Board, services, medicines, blood plasma that is not replaced, and supplies for diagnosis or treatment of the Illness or Accidental Injury, for which the Covered Person is confined (except services of a Physician, dentist, special nursing in any form, or supplies not used in the Hospital) provided the Covered Person is Hospital confined as a registered bed patient; or the Covered Person has surgery performed in the Hospital; or, the Covered Person received necessary emergency treatment for an Illness or as a result and within seventy-two (72) hours of the time of an accident

   Hospital care associated with dental procedures is covered only under the following circumstances:

   1. The Covered Person exhibits physical, intellectual, or medically compromising conditions, is in need of dental treatment that requires administration of general anesthesia, and for whom administration of a general anesthesia can only be safely performed in a hospital setting. Conditions include but are not limited to mental retardation, cerebral palsy, epilepsy, cardiac problems, and hyperactivity (verified by appropriate medical documentation);

   Such coverage is limited to the charges by the hospital and the anesthesiologist. The actual dental procedure performed by a dentist or oral surgeon during the Hospital stay is not covered.

   For services received at a Non-Network Hospital, benefits will be reduced as described in the Schedule of Medical Expense Benefits if a Pre-Admission Review is not obtained.

   Benefits shall not be payable with respect to charges made by any institution or facility for the care of the sick or injured which does not qualify as a Hospital as defined in the section "Definitions."

b) Medical or surgical services by a Physician;

c) Mental health and substance abuse treatment by a Physician (M.D.; Psychiatrist (M.D.); Psychologist (Ph.D.); Licensed Clinical Social Worker (L.C.S.W.); or Marriage, Family and Child Counselor (M.F.C.C.) upon referral by a Physician. Expenses incurred for Severe Mental Illnesses of a person of any age, and of serious emotional disturbances of a child as defined under (AB88) (1999) will be covered on the same basis as any other medical condition;

MEDICAL EXPENSE BENEFITS

COVERED MEDICAL EXPENSES (continued)

d) Professional services, recommended by a Physician, and provided by a graduate Registered Nurse (R.N.), a Licensed Vocational Nurse (L.V.N.) or an audiologist. Such services shall include a California Registered Nurse Midwife acting within the scope of his license;

e) The following medical services or supplies that are recommended by a Physician:

1) Covered Drugs requiring a Physician's prescription that are prescribed by a Physician for emergency treatment or treatment while traveling outside of the United States and are not purchased through the Prescription Drug Program. All other eligible drugs and medicines requiring a Physician's prescription must be obtained through the PLAN's Prescription Drug Program;

2) Anesthesia, including the charge for administration;

3) Diagnostic and laboratory tests, x-ray services, routine pap tests and blood pressure tests;

4) Oxygen and/or rental of equipment required for its administration;

5) X-ray, radium and radioactive isotope therapy;

6) Braces, crutches, casts, splints, blood, and blood plasma (if not replaced) including the cost of blood, blood plasma and blood processing, or other fluids actually injected into the circulatory system;

7) Initial purchase and fitting of artificial limbs or eyes or other prosthetic appliances;

8) Authorized purchase of durable medical equipment prescribed by a Physician; however, only rental will be authorized for temporary therapeutic use in the treatment of an active Illness or Accidental Injury when rental charges do not exceed the purchase price of the equipment. Temporary use is generally defined as use not to exceed a length of time of six (6) months;

9) Necessary emergency transportation of the Covered Person by a professional ambulance, to or returning from the nearest Hospital or other medical institution equipped and staffed to treat the Illness or Accidental Injury, for Medically Necessary medical treatment that qualifies as a Covered Medical Expense under the PLAN;

f) Preventive Care at No Cost:
Preventive Health Services mean those primary preventive medical Covered Services, including related laboratory services, for early detection of disease as specifically listed below:

1) Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force (USPSTF);

2) Immunizations that have in effect a recommendation from either the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, or the most current version of the Recommended Childhood Immunization Schedule/United States, jointly adopted by the American Academy of Pediatrics, the Advisory Committee on Immunization Practices, and the American Academy of Family Physicians;

MEDICAL EXPENSE BENEFITS

COVERED MEDICAL EXPENSES (continued)

3) With respect to women, such additional preventive care and screenings not described in paragraph 1, as provided for in comprehensive guidelines supported by the United States Health Resources and Services Administration.

Preventive Health Services include, but are not limited to, cancer screening (including, but not limited to, colorectal cancer screening, cervical cancer and HPV screening, breast cancer screening and prostate cancer screening), breast cancer susceptibility gene (BRCA 1 and BRCA 2) testing, osteoporosis screening, and health education. When a covered preventative screening or service is limited by frequency, a year is considered to be a twelve (12) month period. More information regarding covered Preventive Health Services is available at the Claim Administrator's web site or by calling the Claim Administrator's Customer Service.

In the event there is a new recommendation or guideline in any of the resources described in paragraphs 1 through 3 above, the new recommendation will be covered as a Preventive Health Service as of the first plan year than begins twelve (12) months following the issuance of the recommendation.

Immunizations, vaccinations, and inoculations required for foreign travel are not a Covered Medical Expense of the PLAN;

4) Expenses incurred for **preventive care services for adults** (19 years of age or older) provided by a network or non-network Physician or the appropriately designated medical professional within that Physician's office. Preventive care services for adults will be reimbursed at one hundred percent (100%) of covered expenses. The Calendar Year Deductible will not apply to these services.

Covered preventive care services for adults will follow the age criteria and service frequency as recommended by the organizations specified in f) paragraphs 1 and 4 above and will include but not be limited to:

- Preventive health education and counseling
- Height and weight evaluation
- Blood pressure check
- Blood cholesterol examination (Total and HDL)
- Clinical breast examination
- Mammogram
- Well-woman exam, including pap smear
- Prostate examination, including PSA
- Hemoccult test
- Flexible sigmoidoscopy or colonoscopy
- Vision screening
- Testicular examination
- Liver tests
- Screening for diabetes; breast cancer; cervical cancer; Chlamydia; syphilis; osteoporosis; HIV; abdominal aortic aneurysm; or rubella susceptibility

Covered immunizations for adults will follow the age criteria and service frequency as recommended by the organizations in f) paragraph 2 above and will include but not be limited to:

- Influenza

MEDICAL EXPENSE BENEFITS

COVERED MEDICAL EXPENSES (continued)

- Hepatitis A
- Hepatitis B
- Meningococcal
- Pneumococcal vaccine
- Measles, Mumps, Rubella (MMR)
- Rubella (German Measles)
- Tetanus, Diphtheria (Td) booster (every 10 years)
- Chicken Pox (Varicella)
- Shingles, age 60 and over (Zostavax)

Immunizations, vaccinations, and inoculations required for foreign travel are not a Covered Medical Expense of the PLAN;

g) Short-term physical or occupational therapy by a licensed Registered Physical Therapist (R.P.T.) or Occupational Therapist (O.T.) pursuant to a written treatment plan and when therapy is expected to result in a near-term significant improvement, based on a review by the Claims Administrator;

h) Skilled nursing facility for room, board, and other services, not to exceed for Room and Board the most common average semi-private room rate. Coverage is limited to a maximum of 100 days in any one Calendar Year;

i) Pregnancy-related services;

j) Elective abortions only when the life of the retiree or an eligible spouse is in danger;

k) Services for voluntary sterilization;

l) Speech therapy by a speech pathologist to restore loss of speech following Illness or Accidental Injury only;

m) Services by a Home Health Care Agency for continued care and treatment of the Covered Person pursuant to a written treatment plan established and approved in writing by the attending Physician;

n) Hospice services for care and treatment of a terminal Illness or Accidental Injury certified by the attending Physician when the life expectancy of the Covered Person does not exceed six (6) months;

o) Chiropractic manipulations performed by a Doctor of Chiropractic (D.C.) or Doctor of Medicine (M.D.), but not to exceed a maximum benefit of twenty-five (25) visits in any one Calendar Year;

p) Charges for the use of a free standing or outpatient surgical facility, Physician's office surgical suite, or a Hospital for outpatient surgery;

q) Charges for a Second Surgical Opinion by a specialist in the field for which the Covered Person is considering surgery;

r) Charges for medical treatment of Temporomandibular Joint (TMJ) Dysfunction. Dental procedures for treatment of TMJ Dysfunction are excluded;

MEDICAL EXPENSE BENEFITS

COVERED MEDICAL EXPENSES (continued)

s) Charges for organ transplants. Covered Medical Expenses include the following:

1) The cost of organ procurement. When the organ is harvested from a living donor, the PLAN will cover the medical expenses incurred by the organ donor for the surgical procedure and associated Hospital stay for harvesting of the donated organ, to the extent such expenses exceed any benefits available through another plan. Such expenses are limited to the donor's Inpatient Hospital stay for the organ harvesting, and related follow-up care for sixty (60) days following the organ harvesting.

   The medical expenses incurred by a Covered Person in connection with the Covered Person's donation of an organ to an individual who is not a Covered Person under this PLAN are not covered.

2) The cost of a donor search, limited to a maximum benefit of $15,000 per organ transplant when the search is conducted by a Special Transplant Facility or $5,000 per organ transplant when the search is conducted by other facilities.

3) Travel expenses, limited to a maximum lifetime benefit of $10,000 for organ transplants performed at a Special Transplant Facility, or $5,000 for organ transplants performed at other facilities. Travel expenses associated with an organ transplant are covered if the facility at which the transplant is performed is more than 100 ground miles from the organ recipient's home address. Benefits will be based on actual incurred costs. Covered travel expenses include:

   a. Coach airfare on a public airline for the organ recipient and one companion (two companions if the organ recipient is a minor child) to travel to and from the site of the transplant. A "companion" includes the organ recipient's legal spouse, legal parent(s) or legal guardian(s).

   b. Reimbursement for mileage at the then federal maximum rate for use of a personal car or rental car used to travel to and from the site of the transplant.

   c. Up to $200 per day for reasonable and necessary lodging and meals for the organ recipient (while not confined) and companion(s). The $200 per day maximum applies to the organ recipient and companion(s) collectively, not individually.

   The following types of living expenses do not qualify as covered travel expenses:
   - Childcare
   - Charges for house sitting
   - Kennel boarding
   - Reimbursement of any lost wages by the companion(s) during the Covered Person's stay at the transplant facility
   - Charges for the purchase or shipping of home furnishing, automobiles, or personal belongings.

t) Acupuncture when performed by a Doctor of Medicine (M.D.) or by a certified acupuncturist, but not to exceed a maximum benefit of twenty-five (25) visits in any one Calendar Year. A certified acupuncturist includes providers with the following licenses: Doctor of Osteopathy (D.O.), Doctor of Oriental Medicine (D.O.M.), and Certified Acupuncturist (C.A.).

MEDICAL EXPENSE BENEFITS

COVERED MEDICAL EXPENSES (continued)

u) Certain surgical procedures for treatment of severe obesity if the Covered Person meets the National Institute of Health's criteria for surgical intervention and the Claims Administrator's internal guidelines for approval of coverage. **Surgical procedures for treatment of morbid obesity are not covered unless Prior Authorization is obtained and the Covered Person obtains such services at one of the Claims Administrator's Centers of Distinction, if within California;** and

v) Dental treatment for an Accidental Injury to natural teeth.

w) Telehealth for covered services that are appropriately provided through telehealth, subject to the terms and conditions of the plan. In-person contact between a health care provider and the patient is not required for these services, and the type of setting where these services are provided is not limited. "Telehealth" is the means of providing health care services using information and communication technologies in the consultation, diagnosis, treatment, education, care management and self-management of a patient's physical and mental health care when the patient is located at a distance from the health care provider. Telehealth does not include consultations between the patient and the health care provider, or between health care providers, by facsimile machine, or electronic mail.

x) Telemedicine consultation for clinical services provided by the Claims Administrator's vendor. Telemedicine consultations for clinical services provide confidential consultation using a network of U.S. board certified Physicians who are available 24 hours a day by telephone and from 7 a.m. to 9 p.m. by secure online video, 7 days a week (subject to change). Telemedicine Physicians can provide diagnosis and treatment for urgent and routine non-emergency medical conditions and can also issue prescriptions for certain medications. Note: If medications are prescribed, the applicable co-insurance and other requirements of the Prescription Drug Program apply. Telemedicine consultation services are optional and are not intended to replace services from a Covered Person's Physician but are a supplemental service to assist Covered Persons when their Physician is not available, and they need quick access to a Physician. Telemedicine consultation services are not available for specialist services or mental health and Substance Use Disorder Services. Before Telemedicine services can be accessed, the Covered Person must complete and submit a Medical History Disclosure form to the Telemedicine service organization. The Telemedicine consultation fee is considered a network benefit subject to network deductibles and coinsurance. The Plan Administrator may modify, add, or delete this service or components of the service based on an analysis of service results, cost effectiveness, and risk as needed.

Charges for all Covered Medical Expenses shall be deemed incurred on the latest of the following:

a) The date a purchase is contracted;

b) The date delivery is made;

c) The actual date a service is rendered.

PRESCRIPTION DRUG PROGRAM

The Wellwise Medicare Retiree Health Plan includes benefits for Covered Drugs. These benefits are administered by the Pharmacy Benefit Manager.

HOW THE PLAN WORKS

Covered Drugs can be purchased from:

- A Network Retail Pharmacy (up to a 90-day supply);
- The Pharmacy Benefit Manager's Mail Order Service (up to a 90-day supply).
- The Pharmacy Benefit Manager's Specialty Pharmacy (up to a 30-day supply). Specialty drugs may be obtained through both the Specialty Pharmacy, as well as network retail pharmacies, subject to availability. A member may request up to 90-day supply if established on therapy.

The Medicare Part D Prescription Drug Program provides benefits for prescription drugs and medications purchased at a Non-Network Retail Pharmacy or unapproved mail order service as detailed in Section 2.5 of Chapter 3 of the EOC.

FORMULARY INCLUDING PREFERRED DRUGS

The Medicare Part D Prescription Drug has a Formulary. The County's Formulary includes Tier 1 – lower cost/commonly used Generic Drugs (may also include some lower cost Brand-Name drugs) and Tier 2 - Preferred Drugs (many common Brand-Name drugs) that can meet a patient's clinical needs, and in those cases where multiple Brand-Name drugs of comparable clinical effectiveness and safety exist, at a lower cost than other similar Tier 3 – Non-Preferred drugs and Tier 4 – Specialty Drugs. The County's Formulary will change from time to time and some high-cost Generic Drugs may be included in Tier 2 and Tier 3.

The PLAN pays a larger portion of the cost of Tier 1 - Generic Drugs and low-cost Brand-Name drugs and Tier 2 - Preferred Drugs included on the Formulary than for Tier 3 - Non-Preferred Drugs.

The most up-to-date Formulary including Preferred and Non-Preferred Drugs is available on the Pharmacy Benefit Manager's Website. The list includes only the most frequently used Generic Drugs.

FORMULARY EXCLUSIONS

The County's Formulary may exclude certain drugs from coverage when the Pharmacy Benefit Manager has determined a lower cost therapeutically equivalent (comparable clinical effectiveness and safety) drug exists. If the Covered Person or their prescriber believe that it is Medically Necessary for the Covered Person to take the excluded drug, a Prior Authorization request can be submitted to the Pharmacy Benefit Manager. Refer to the Prior Authorization Requirements section below for details.

PLAN BENEFITS

The PLAN pays a percentage of the cost of covered Preventive Products, Tier 1 - Generic Drugs, Tier 2 - Preferred Drugs, and Tier 3 Non-Preferred Drugs, as shown in the following chart.

PLAN LIMITATIONS AND EXCLUSIONS (continued)

Drug Type	The Plan Pays	The Covered Person Pays
Tier 1 – Lower cost/commonly used Generic Drugs[1]. May also include some low-cost brand-name drugs.	80%	20%
Tier 2 – Preferred Drugs (many common brand-name drugs)	75%	25%
Tier 3 – Non-Preferred Drugs (mostly higher cost brand-name drugs)	70%	30%
Tier 4 - Specialty Pharmacy and High-Cost Drugs (see Program description below)	The remaining percentage of the cost of the covered drug	The percentage of the cost required of the covered person for Specialty Drugs as stated directly above for the respective covered Tier 1 - Generic, Tier 2 -Preferred or Tier 3 Non-Preferred, up to a maximum of $150 required of the covered person per 30 days supply[2].
Catastrophic Coverage – reached when OUT-OF-POCKET PRESCRIPTION DRUG spending exceeds $7,400[3]	95%	Greater of 5% or $10.35 for brand drugs and $4.15 for generic drugs
OUT-OF-POCKET PRESCRIPTION DRUG MAXIMUM BENEFIT: The maximum amount of Prescription Drug coinsurance for which a Covered Person is responsible during a Plan Year – Part B drugs do not count towards OOP.	$4,100 individual	

Notes:

[1] Some higher cost Generic Drugs may be placed in the Preferred Drug or Non-Preferred Drug Tiers.

[2] Member may request up to a 90-day supply for specialty products if they are established on therapy. Additional days-supply above 30 would result in a maximum payment of $300 for a 60-day supply or $450 for a 90-=day supply.

[3] If you reach the catastrophic coverage stage, when your out-of-pocket spending (including discounts provided by manufacturers) exceeds $7,400, you will only pay 5% (or a minimum copayment of $10.35 brand or $4.15 generic). See the explanation of catastrophic coverage in the EOC provided by the PBM Refer to Chapter 4 in the EOC for further details regarding Catastrophic Coverage.

The Covered Person's coinsurance for prescription drugs and medications that qualify as Covered Drugs under the Medicare Part D Prescription Drug Program can be used to satisfy the Out-of-Pocket Prescription Drug Maximum Benefit. Prescription drugs and medications that qualify as Covered Drugs under the Prescription Drug Program cannot be used to satisfy the Medical Expense Benefits Deductible.

COVERED PRESCRIPTION DRUG EXPENSES

The plan has a *List of Covered Drugs (Formulary)*. We call it the "Drug List" for short. It tells which Part D prescription drugs are covered under the Part D benefit. The drugs on this list are selected by the plan with the help of a team of doctors and pharmacists. The list must meet requirements set by Medicare. Medicare has approved the Drug List.

PLAN LIMITATIONS AND EXCLUSIONS (continued)

The Drug List also tells you if there are any rules that restrict coverage for your drugs. We will provide you a copy of the Drug List. The Drug List we provide you includes information for the covered drugs that are most commonly used by our members. However, we cover additional drugs that are not included in the provided Drug List. If one of your drugs is not listed in the Drug List, you should visit our website or contact Member Services to find out if we cover it. To get the most complete and current information about which drugs are covered, you can visit the plan's website www.optumrx.com or call Member Services.

QUANTITY LIMITS

For certain drugs, we limit how much of a drug you can get each time you fill your prescription. For example, if it is normally considered safe to take only one pill per day for a certain drug, we may limit coverage for your prescription to no more than one pill per day.

AGE LIMITS

Age limits may apply to certain drug categories or medications, as determined by the Pharmacy Benefit Manager, including but not limited to the following:

- Anti-wrinkle medications which may be covered only to treat acne;
- Topical acne medications;
- Flu medications; and
- Central nervous system (for example Attention Deficit Disorder).

PRIOR AUTHORIZATION REQUIREMENTS

You or your physician may need to get prior authorization for certain drugs. This means you will need to get approval from OptumRx before you fill your prescriptions. If you do not get approval, the drug may not be covered.

HOW TO OBTAIN A PRIOR AUTHORIZATION

For information regarding appeals, refer to Chapters 2, 3 and 7 of the EOC.

MEDICATION THERAPY MANAGEMENT PROGRAM

Medication Management Programs can help members with complex health needs. The program is called a Medication Therapy Management (MTM) program. Members are automatically enrolled into the program if they meet the CMS approved criteria for inclusion, however, members do have the right to opt out of the program. A team of pharmacists and doctors developed the program for us to help make sure that members get the most benefit from the drugs they take.

Some members who take medications for different medical conditions and have high drug costs or are in a DMP to help members use their opioids safely, may be able to get services through an MTM program. A pharmacist or other health professional will give you a comprehensive review of all your medications. During the review, you can talk about your medications, your costs, and any problems or questions you have about your prescription and over-the-counter medications. You'll get a written summary which has a recommended to-do list that includes steps you should take to get the best results from your medications. You'll also get a medication list that will include all the medications you're taking, how much you take,

and when and why you take them. In addition, members in the MTM program will receive information on the safe disposal of prescription medications that are controlled substances.

It's a good idea to talk to your doctor about your recommended to-do list and medication list. Bring the summary with you to your visit or anytime you talk with your doctors, pharmacists, and other health care providers. Also, keep your medication list up to date and with you (for example, with your ID) in case you go to the hospital or emergency room. Also, keep your medication list up to date and keep it with you (for example, with your ID) in case you go to the hospital or emergency room.

If we have a program that fits your needs, we will automatically enroll you in the program and send you information. If you decide not to participate, please notify us and we will withdraw you. If you have any questions about this program, please contact Member Services.

STEP THERAPY

In some cases, the plan requires you to first try certain drugs to treat your medical condition before we will cover another drug for that condition. For example, if Drug A and Drug B both treat your medical condition, we may not cover Drug B unless you try Drug A first. If Drug A does not work for you, we will then cover Drug B.

SPECIALTY PHARMACY PROGRAM

In addition to the Prior Authorization requirement, the Prescription Drug Program also includes a Specialty Pharmacy Program administered by the Pharmacy Benefit Manager. This Program provides assistance and patient education to Covered Persons who require certain medications for treating chronic or complex health conditions including but not limited to the following:

- Acromegaly (e.g., Sandostatin)
- Alpha-1 deficiency (e.g., Aralast, Prolastin)
- Anticoagulants (e.g., Enoxaparin)
- Asthma (e.g., Xolair)
- Biologic response modulator (e.g., Proleukine)
- Botulinum toxins (e.g., Botox)
- Cateplexy in patients with narcolepsy (e.g., Xyrem)
- Chronic granulamatous (e.g., Actimmune)
- Condylomata acuminata (e.g., Alferon)
- Cryopyrin associated periodic syndromes (e.g., Ilaris)
- Cystic fibrosis (e.g., Bethkis, Kalydeco, Pulmozyme)
- Enzyme deficiency or Lysosomal storage disease (e.g., Fabrazyme, Cerezyme)
- Growth hormone and related disorders (e.g., Norditropin, Nutropin)
- Hemophilia and related bleeding disorders (e.g., Humate-P)
- Hepatitis B (e.g., Hepsera)
- Hepatitis C (e.g., Harvoni, Epclusa)
- Hereditary angioedema (e.g., Cinryze)
- HIV (e.g., Stavudine, Truvada)
- Hormonal therapies (e.g., Lupron Depot, Trelstar)
- IGF-1 deficiency (e.g., Increlex)
- Immune deficiency & related disorders (e.g., Gammagard, Gamunex)
- Immune thrombocytopenic purpura (e.g., Nplate)

PLAN LIMITATIONS AND EXCLUSIONS (continued)

- Inflammatory Conditions (e.g., Humira, Stelara, Cimzia)
- Iron overload (e.g., Exjade, Ferriprox)
- Macular degeneration (e.g., Lucentis)
- Multiple sclerosis (e.g., Copaxone, Tecfidera)
- Oncology, injectable (e.g., Carboplatin, Gemcitabine)
- Oncology, oral (e.g., Imatinib Mesylate, Afinitor)
- Oncology, supportive care (e.g., Aredia)
- Osteoarthritis (e.g., Euflexxa, Synvisc)
- Osteoporosis (e.g., Prolia)
- Plaque psoriasis (e.g., Stelara, Humira)
- Psoriatic arthritis (e.g., Stelara, Humira)
- Pulmonary arterial hypertension (e.g., Letairis, Tracleer)
- Respiratory syncytial virus (e.g., Synagis)
- Transplant (e.g., Rapamune, Sandimmune)

Medications through the Specialty Pharmacy Program may require Prior Authorization and are limited to supplies of 30 days or less. Member may request up to a 90-day supply for specialty products if they are established on therapy. They can be obtained through a Network Retail Pharmacy or the Pharmacy Benefit Manager's Specialty Pharmacy. The Plan Administrator and Pharmacy Benefit Manager may mutually agree to add or delete medications from this list as clinically appropriate.

PRESCRIPTION DRUGS THAT ARE NOT COVERED

• The plan cannot cover a drug that would be covered under Medicare Part A or Part B.
• The plan cannot cover a drug purchased outside the United States and its territories.
• The plan usually cannot cover "off-label use." This is any use of the drug other than those indicated on a drug's label as approved by the Food and Drug Administration. Sometimes "off-label use" is allowed. Coverage is allowed only when the use is supported by certain reference books. These reference books are the American Hospital Formulary Service Drug Information, and the DRUGDEX Information System. If the use is not supported by any of these reference books, then our plan cannot cover its "off-label use."

Also, these categories of drugs are not covered by Medicare drug plans:
• Non-prescription drugs (also called over-the-counter drugs)
• Drugs when used to promote fertility
• Drugs when used for the relief of cough or cold symptoms
• Drugs when used for cosmetic purposes or to promote hair growth
• Prescription vitamins and mineral products (except prenatal vitamins) and fluoride preparations
• Drugs when used for the treatment of sexual or erectile dysfunction, such as Viagra, Levitra, and Caverject. Cialis is covered subject to prior authorization.
• Drugs when used for treatment of anorexia, weight loss, or weight gain
• Outpatient drugs for which the manufacturer seeks to require that associated tests or monitoring services be purchased exclusively from the manufacturer as a condition of sale

See the PLAN Limitations and Exclusions section for other limitations and exclusions that apply to the Prescription Drug Program.

PLAN LIMITATIONS AND EXCLUSIONS

No benefits shall be payable under this PLAN with respect to:

a) Any services not Medically Necessary for diagnosis or treatment of the Covered Person's active Illness or Accidental Injury except as provided for under preventive care services; or

b) Any treatment or service not prescribed or recommended by a "Physician" as defined in the "Definitions" section; or

c) Any charges for services rendered by a relative by birth, adoption or marriage will not be eligible; or

d) Any charges for hearing aids, glasses, or eye examinations or correction of vision or fitting of glasses and any charges related to orthoptics, vision therapy, or other special vision procedures, except as provided for under preventive care services; or

e) Any charges for dental services or treatment except for treatment of Accidental Injury to natural teeth, and no payment will be made for dentures or other oral appliances; or

f) Any condition, disability or expense resulting from or sustained as a result of being engaged in an illegal occupation, commission of or attempted commission of an assault or a felonious act; or

g) Any condition, disability or expense resulting from or sustained as a result of being engaged in duty as a member of the Armed Forces of any state or country, war or act of war declared or undeclared; or

h) Any services for care or treatment provided or furnished by the United States Government or the government of any country except as furnished by the Veterans Health Administration; or

i) Any services for which a charge would not have been made in the absence of coverage; or

j) Any condition, disability or expense resulting from injury caused by participating in civil insurrection or a riot; or

k) Any benefit under Workers' Compensation Act or similar legislation, which is due to injury arising out of or in the course of any occupation or employment for wage or profit, except as specifically provided in the PLAN; or

l) Vaccinations, inoculations, preventive shots, routine physical examinations, vitamins and nutritional food or mineral supplements, except as provided for under preventive care services or preventive products; or

m) Expense incurred for the treatment of corns, calluses, or toenails, unless the charges are for the removal of nail roots or for the treatment of a metabolic or peripheral-vascular disease; or

n) Expenses incurred for orthopedic shoes and other supportive appliances for the feet including orthotics applied to shoes; or

o) Expenses incurred for the treatment of weak, strained, or flat feet, or any metatarsalgia or bunion; unless the charges are for an open cutting operation; or

p) Any charges for cosmetic surgery except as the charges relate to such surgery to correct a congenital defect in a covered newborn or to repair the effects of an accident which occurred while the individual is covered under this PLAN; or

q) Any charges related to services for reproductive voluntary sterilization reversal, fertility or infertility, and any charges for artificial insemination, embryo and fetal implants, or charges arising from or related to in vitro fertilization (test-tube baby) other than childbirth; and any charges for genetic testing related to these assisted reproductive technologies; or

PLAN LIMITATIONS AND EXCLUSIONS (continued)

r) Any charges for medical or surgical weight control, weight reduction or weight controlling drugs or counseling except as provided for under Covered Medical Expenses; or

s) Charges related to treatment of learning disabilities; or

t) Charges related to bariatric surgery when not performed at one of the Claims Administrator's Centers of Distinction, if surgery occurred within California.

u) Any charges for convenience items for comfort (e.g., telephone, television, guest trays, and personal hygiene items).

v) Any charges related to long-term care

w) Charges related to Private-duty nursing

COORDINATION OF BENEFITS

This provision shall apply to all sections of the PLAN providing benefits for Covered Medical Expenses including coverage for those individuals covered under Medicare.

Section I. Definitions Applicable To This Provision

The term "Plan" as used in this provision means any plan providing benefits or services for or by reason of medical or dental care or treatment, which benefits or services are provided by (a) group, blanket or franchise insurance coverage under a labor/management trustee plan, union welfare plan, employer organization plan, or employee benefit organization plan, including any Federal or State or other governmental plan or law, toward the cost of which any employer shall have made payroll deductions, or (b) coverage under any plan solely or largely tax-supported or otherwise provided for by or through action of any government.

The term "Plan'' shall be construed separately with respect to each policy, contract, or other arrangement for benefits or services separately with respect to that portion of any such policy, contract, or other arrangement, which reserves the right to take the benefits or services of other Plans into consideration in determining its benefits and that portion which does not.

"This PLAN" as used in this provision means that portion of the contract by name referred to in this document which provides the benefits that are subject to this provision.

"Allowable Expense" means any necessary, reasonable, and customary item of expense at least a portion of which is covered under at least one of the Plans covering the person for whom claim is made.

When a Plan provides benefits in the form of services or supplies rather than cash payments, the reasonable cash value of each service rendered, or supply furnished shall be deemed to be both an Allowable Expense and a benefit paid.

The "Order of Benefit Determination" rules are the rules that determine whether this PLAN pays benefits first (the primary plan) or second (the secondary plan) when compared to another Plan covering the Covered Person.

Section II. Effect on Benefits

A. This provision shall apply in determining the benefits as to a person covered under this PLAN for a claim submission, if for the Allowable Expenses incurred as to such person, the sum of:

   1. the benefits that would be payable under this PLAN in the absence of this provision, and

   2. the benefits that would be payable under all other Plans in the absence therein of provisions of similar purpose to this provision, would exceed such Allowable Expenses.

B. As to any claim submission with respect to which this provision is applicable, the benefits that would be payable under this PLAN in the absence of this provision for the Allowable Expenses incurred as to such person shall be reduced to the extent necessary so that the sum of such reduced benefits and all the benefits payable for such Allowable Expenses under all other Plans shall not exceed the total of such Allowable Expenses. Benefits payable under another Plan include the benefits that would have been payable had claim been duly made, therefore.

GENERAL PROVISIONS (continued)

C. For the purposes of item (B), the rules establishing the order of benefit determination are:

1. A Plan that does not contain a coordination of benefits provision shall be considered the primary plan.

2. When benefits are provided under this PLAN and another Plan which also has a coordination provision, the first of the following rules that describes which Plan pays its benefits before another Plan will be used to determine which Plan is primary.

   a) **Non-Dependent or Dependent.** The Plan that covers the person other than as a dependent, for example as an employee, member, subscriber, or retiree, is primary and the Plan that covers the person as a dependent is secondary. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering the person as a dependent; and primary to the Plan covering the person as other than a dependent (e.g., a retired employee); then the order of benefits between the two Plans is reversed so that the Plan covering the person as an employee, member, subscriber, or retiree is secondary and the other Plan is primary.

   b) **Active or inactive employee.** Another Plan that covers a person as an employee who is neither laid off nor retired is primary. The same would hold true if a person is a dependent of a person covered as a retiree and an employee. If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule is ignored. Coverage provided an individual as a retired worker and as a dependent of an actively working spouse will be determined under the rule labeled 2(a).

   c) **Continuation coverage.** If a person whose coverage is provided under a right of continuation provided by federal or state law also is covered under another Plan, the Plan covering the person as an employee, member, subscriber, or retiree (or as that person's dependent) is primary, and the continuation coverage is secondary. If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule is ignored.

   d) **Longer or shorter length of coverage.** The Plan that covered the person as an employee, member, subscriber, or retiree longer is primary.

   e) If a husband or wife is covered under this PLAN both as a retiree and as an enrolled Dependent, the dependent benefits will be coordinated as if they were provided under another Plan. This means the retiree’s benefit will pay first.

   f) If the preceding rules do not determine the primary Plan, the Allowable Expenses shall be shared equally between the Plans meeting the definition of Plan under this provision. In addition, this PLAN will not pay more than it would have paid had it been primary.

Section III. Right to Receive and Release Necessary Information

For the purposes of determining the applicability of and implementing the terms of this provision of this PLAN or any provision of similar purpose of any other Plan, the PLAN may, without the consent of or notice to any person, release to, or obtain from any Insurance Company or other organization or person any information, with respect to any person, which the deems to be necessary for such purposes. Any person claiming benefits under this PLAN shall furnish to the PLAN such information as may be necessary to implement this provision.

GENERAL PROVISIONS (continued)

Section IV. Facility of Payment

Whenever payments which should have been made under this PLAN in accordance with this provision have been made under any other Plan(s), the PLAN shall have the right, exercisable alone and in its sole discretion, to pay over to any organizations making such other payments any amounts it shall determine to be warranted in order to satisfy the intent of this provision and amounts so paid shall be deemed to be benefits paid under this PLAN and, to the extent of such payments, the County or Fund shall be fully discharged from liability under this PLAN.

Section V. Recovery of Excess Payments

Whenever payments have been made by the Fund with respect to Allowable Expense in a total amount, at any time, in excess of the maximum amount of payment necessary at that time to satisfy the intent of this provision, the Fund shall have the right to recover such payments, to the extent of such excess, from among one or more of the following, as the Fund shall determine: any persons to or for or with respect to whom such payments were made, any insurance companies, any other organizations.

Coverage for Prescription Drugs

When you have other insurance (like employer group health coverage), there are rules set by Medicare that decide whether our plan or your other insurance pays first. The insurance that pays first is called the "primary payer" and pays up to the limits of its coverage. The one that pays second, called the "secondary payer," only pays if there are costs left uncovered by the primary payer. The secondary payer may not pay all of the uncovered costs.

These rules apply for employer or union group health plan coverage:

• If you have retiree coverage, Medicare pays first.
• If your group health plan coverage is based on your or a family member's current employment, who pays first depends on your age, the number of people employed by your employer, and whether you have Medicare based on age, disability, or End-Stage Renal Disease (ESRD).

If you are under 65 and disabled, and you or your family member is still working, your group health plan pays first if the employer has 100 or more employees or is part of a multiple-employer plan in which at least one employer has more than 100 employees.

If you are over 65 and you or your spouse is still working, your group health plan pays first if the employer has 20 or more employees or is part of a multiple-employer plan in which at least one employer has more than 20 employees.

• If you have Medicare because of ESRD, your group health plan will pay first for the first 30 months after you become eligible for Medicare.

These types of coverage usually pay first for services related to them:

• No-fault insurance (including automobile insurance)
• Liability (including automobile insurance)
• Black lung benefits
• Workers' compensation

Note: Medicaid and TRICARE never pay first for Medicare-covered services. They only pay after Medicare, employer group health plans, and/or Medigap have paid.

GENERAL PROVISIONS (continued)

If you have other insurance, tell your doctor, hospital, and pharmacy. If you have questions about who pays first, or if you need to update your other insurance information, please call Optum Rx. Our contact information is on the front cover of this booklet. You may need to give your plan member ID number to your other insurers (once you have confirmed their identity) so your bills are paid correctly and on time

NON-SMOKER INCENTIVE

An incentive of $50 may be claimed by retirees who declare by affidavit that they:

- Have not smoked tobacco during the entire calendar year during which they were enrolled regardless of enrollment date in the PLAN; or
- Smoked and sometime during the calendar year also participated in a smoking cessation program at some point in the calendar year.

GENERAL PROVISIONS

CLAIM PAYMENT DETERMINATION

Claims will be processed and paid in the order they are received by the Claims Administrator without regard to sequence of dates incurred. Adjustments will not be made for claims received later but with an earlier incurred date to be applied to Deductibles or maximum payment level.

PLAN EXCEPTIONS

Any service or treatment excluded by the PLAN which is deemed to be Medically Necessary for the health of the Covered Person and cannot be accomplished through a covered benefit may be submitted to the Plan Administrator for exception. The submission and request for review must be accompanied by a detailed description by the attending Physician justifying the medical necessity and a concurrence by a second opinion Physician at the Covered Person's expense. Requests for exception must be filed within fifteen (15) days of claim denial.

DETERMINATION OF PAYMENT

If, in the opinion of the Claims Administrator, a valid release cannot be rendered for the payment of any benefit payable, under this PLAN, the Claims Administrator may, at its option, make such payment to the individual or individuals as have, in the Claims Administrator's opinion, assumed the care and principal support of the Covered Person and are, therefore, equitably entitled thereto. In the event of the death of the Covered Person prior to such time as all benefit payments due him have been made, the Claims Administrator, may at its sole discretion and option, honor benefit assignments, if any, made prior to the death of such Covered Person.

Any payment made by the Claims Administrator in accordance with the above provisions shall fully discharge the Fund to the extent of such payments.

PLAN DOCUMENT

The Plan Administrator will make available to each Covered Person under this PLAN this Wellwise Medicare Retiree Health Plan Document which shall summarize the benefits to which the person is

GENERAL PROVISIONS (continued)

entitled, to whom benefits are payable, and the provisions of the PLAN principally affecting the Covered Person.

ASSIGNMENT

The Covered Person's benefits may not be assigned except by consent of the Plan Administrator.

CONFORMITY WITH STATE AND FEDERAL STATUTES AND REGULATIONS

Any provision of the PLAN, which on its Effective Date, is in conflict with the statutes or regulations of the jurisdiction of California or the Federal government, which relate to Self-Funded Plans of public entities is hereby amended to conform to the minimum requirements of such statutes or regulations.

PLAN AMENDMENT AND TERMINATION

The County reserves the unlimited right to amend, terminate or merge the Plan in any way. Any amendment, termination or merger to the Plan shall be in writing and shall be adopted by the County in accordance with its normal procedures. However, the Plan Administrator shall have the authority to amend the Plan to comply with applicable law or regulation or to reflect the County's intent.

Any amendment or termination of the Plan shall be effective at such date as the County shall determine except that no amendment or termination shall reduce benefits payable for covered expenses incurred prior to the later of the date the amendment or termination is effective or adopted, except as required or permitted by law.

CHANGE IN FUNDING MECHANISM

The County reserves the unlimited right to change, modify, cancel or otherwise terminate the Plan's funding arrangements, including, by way of example and not by way of limitation, the right to change insurance carriers and the right to provide previously self-insured benefits on a partially insured or fully uninsured basis.

NOTICE AND PROOF OF CLAIM

Written notice of claim hereunder must be given to the PLAN at the claims address printed on the health plan identification card provided to the Covered Person following their enrollment in the PLAN, with particulars sufficient to identify the Covered Person, within 365 days following the date such claim was incurred. Note: Communication regarding pharmacy claims should be addressed by contacting the Prescription Benefits Manager, not the medical plan, by calling the phone number on the identification card.

The Claims Administrator upon receipt of notice required by the PLAN will furnish to the Covered Person or to any other person notifying the Fund of claim on such forms as are usually furnished by it for filing proof of loss.

If such forms are not furnished within fifteen (15) days after receipt of such notice, the Covered Person shall be deemed to have complied with the requirements of the PLAN, as to proof of loss, upon submitting written proof fully describing the occurrence for which claim is made.

GENERAL PROVISIONS (continued)

Failure to furnish notice or proof of claim within the time provided in the PLAN shall not invalidate or reduce any claims if it shall be shown not to have been reasonably possible to furnish such notice or proof and that such notice or proof was furnished as soon as possible.

CLAIM-RELATED DEFINITIONS

Claim

Any request for plan benefits made in accordance with the plan's claims-filing procedures, including any request for a service that must be pre-approved.

The Plan recognizes four categories of health benefit claims:

Urgent Care Claims

"Urgent care claims" are claims (other than post-service claims) for which the application of non-urgent care time frames could seriously jeopardize the life or health of the patient or the ability of the patient to regain maximum function or, in the judgment of a physician, would subject the patient to severe pain that could not be adequately managed otherwise. The Plan will defer to the attending Physician to determine if a claim for Medical benefits is urgent.

Pre-service Claims

"Pre-service claims" are claims for approval of a benefit if the approval is required to be obtained before a patient receives health care (for example, claims involving preauthorization or referral requirements).

Post-Service Claims

"Post-service claims" are claims involving the payment or reimbursement of costs for health care that has already been provided.

Concurrent Care Claims

"Concurrent care claims" are claims for which the Plan previously has approved a course of treatment over a period of time or for a specific number of treatments, and the Plan later reduces or terminates coverage for those treatments. A concurrent care claim may be treated as an "urgent care claim," "pre-service claim," or "post-service claim," depending on when during the course of the Covered Person care the Covered Person file the claim. However, the Plan must give the Covered Person sufficient advance notice of the initial claims determination so that the Covered Person may appeal the claim before a concurrent care claims determination takes effect.

Adverse Benefit Determination

If the Plan does not fully agree with the Covered Person's claim, the Covered Person will receive an "adverse benefit determination" — a denial, reduction, or termination of a benefit, or failure to provide or pay for (in whole or in part) a benefit. An adverse benefit determination includes a decision to deny benefits based on:

- An individual being ineligible to participate in the Plan;
- Utilization review;
- A service being characterized as experimental or investigational or not medically necessary or appropriate;
- A concurrent care decision; and
- Certain retroactive terminations of coverage (rescission of coverage), whether or not there is an adverse effect on any particular benefit at that time.
- Failure to provide additional information as requested by the Plan

GENERAL PROVISIONS (continued)

INITIAL CLAIM DETERMINATION – MEDICAL EXPENSES

For each of the Plan options, the Plan has a specific amount of time to evaluate and respond to claims for benefits. The period of time the Plan has to evaluate and respond to a claim begins on the date the Plan receives the claim. If the Covered Person has any questions regarding how to file or appeal a claim, contact the Claims Administrator for the benefit at issue.

The timeframes on the following pages apply to the various types of claims that the Covered Person may make under the Plan, depending on the benefit at issue.

In the event of an adverse benefit determination, the claimant will receive notice of the determination. The notice will include:

- The specific reasons for the adverse determination;
- The specific plan provisions on which the determination is based;
- A request for any additional information needed to reconsider the claim and the reason this information is needed;
- A description of the plan's review procedures and the time limits applicable to such procedures;
- A statement of the Covered Person's right to bring a civil action following an adverse benefit determination on review;
- If any internal rules, guidelines, protocols or similar criteria was used as a basis for the adverse determination, either the specific rule, guideline, protocols or other similar criteria or a statement that a copy of such information will be made available free of charge upon request;
- For adverse determinations based on medical necessity, experimental treatment or other similar exclusions or limits, an explanation of the scientific or clinical judgment used in the decision, or a statement that an explanation will be provided free of charge upon request;
- For adverse determinations involving urgent care, a description of the expedited review process for such claims. This notice can be provided orally within the timeframe for the expedited process, as long as written notice is provided no later than 3 days after the oral notice;
- For medical claims, information sufficient to identify the claim involved including date of service, healthcare provider, claim amount (if applicable), and denial code;
- For medical claims, upon request the applicable diagnosis and treatment codes used and their meanings;
- A description of the Plan's standard used in denying the claim (for example, a description of the "medical necessity" standard may be included);
- If applicable, a statement of the Covered Person's right to obtain the claim denial and appeal in a foreign language.
- As applicable, a description of the Plan's internal appeal procedures and external review processes; and
- Contact information for certain governmental entities that may assist claimants with appeals and external review.

TIME FRAMES FOR INITIAL CLAIM DECISIONS

Time frames generally start when the Plan receives a claim. (See the special rule for "concurrent care" decisions to limit previously approved treatments.) Notices of benefit determinations generally may be provided through in-hand delivery, mail, or electronic delivery, before the period expires, though oral notices may be permitted in limited cases. A reference to "days" means calendar days.

GENERAL PROVISIONS (continued)

	Urgent Care Claims	Non-Urgent "Pre-Service" Claims	Non-Urgent "Post-Service" Claims	"Concurrent Care" Decision to Reduce Benefits
Time frame for Providing Notice	Notice of determination (*whether adverse or not*) must be provided by the Plan as soon as possible considering medical exigencies, but no later than 72 hours. If the Covered Person request in advance to extend concurrent care, the Plan shall provide notice as soon as possible taking into account medical exigencies, but no later than 24 hours of receipt of the claim, provided that any such claim is made to the Plan at least 24 hours prior to the expiration of the prescribed period of time or number of treatments.	Notice of determination (whether adverse or not) must be provided by the Plan within a reasonable period of time appropriate to the medical circumstances, but no later than 15 days.	Notice of adverse determination must be provided within a reasonable period of time, but no later than 30 days.	Notice of adverse determination must be provided by the Plan enough in advance to give the Covered Person an opportunity to appeal and obtain decision before the benefit at issue is reduced or terminated.

GENERAL PROVISIONS (continued)

Extensions	If the Covered Person claim is missing information, the Plan has up to 48 hours (subject to decision being made as soon as possible) from the earlier of the Plan's receipt of the missing information, or the end of the period afforded to the Covered Person to provide the missing information, to provide notice of determination.	The Plan has up to 15 days, if necessary due to matters beyond the Plan's control, and must provide extension notice before initial 15-day period ends.*	The Plan has up to 15 days, if necessary due to matters beyond the Plan's control, and must provide extension notice before the initial 30-day period ends.*	N/A
Period for Claimant to Complete Claim	The Covered Person has a reasonable period of time to provide missing information (no less than 48 hours from when the Covered Person is notified by the Plan that the Covered Person's claim is missing information).	The Covered Person has at least 45 days to provide any missing information.	The Covered Person has at least 45 days to provide any missing information.	N/A
Other Related Notices	Notice that the Covered Person's claim is improperly filed or that information is missing must be provided by the Plan as soon as possible (no later than 24 hours after receipt of the claim by the Plan).	Notice that the Covered Person's claim is improperly filed must be provided by the Plan as soon as possible (no later than 5 days after receipt of the claim by the Plan).	N/A	N/A

**15- or 30-day extension period (whichever is applicable) is measured from the time that the claimant responds to the notice from the Plan that the claim is missing information.*

GENERAL PROVISIONS (continued)

CLAIM APPEAL PROCEDURES – MEDICAL EXPENSES

If the Covered Person receives notice of an adverse benefit determination and disagrees with the decision, the Covered Person is entitled to apply for a full and fair internal review of the claim and the adverse benefit determination. Appeals are not automatic; the Covered Person (or an appointed representative) can appeal by requesting a claim review in accordance with the time frames described in the chart below. The request must be made in writing, except for urgent care claims which the Covered Person may file orally or in writing and should be filed with the appropriate Claims Administrator.

If the Covered Person's internal appeal of a Medical claim involves an urgent care claim, such that the timeframe for completing an appeal would seriously jeopardize the Covered Person's life or health, the Covered Person may initiate an external review at the same time as the Covered Person's internal appeal.

If the Covered Person files an internal appeal for Medical benefits, the Covered Person will continue to be covered, pending the outcome of the internal appeal. This means that the Plan can't terminate or reduce any ongoing course of treatment without providing advance notice and the opportunity for review.

For Medical claims, if the Plan fails to meet the requirements of the internal claims and appeals process for the Covered Person's claim, the Covered Person are deemed to have exhausted the internal process, and the Covered Person may begin an external review request immediately. However, this will not apply if the error was de minimus, if the error does not cause harm to the Covered Person, if the error was due to good cause or to matters beyond the Plan's control, if it occurs in context of good faith exchaneg of information, or if the error des not reflect a pattern or practice of noncompliance. In that case, Covered Person may resubmit the claim for internal review and ask the Plan to explain why the error is minor and why it meets this exception.

The Claims Administrator will forward the appeal request to the appropriate named fiduciary for review. The review will be conducted by the Claims Administrator (if serving as the reviewer for appeals) or other appropriate named fiduciary of the Plan. In either case, the reviewer will not be the same individual who made the initial adverse benefit determination that is the subject of the review, nor the subordinate of such individual (including any physicians involved in making the decision on appeal if medical judgment is involved). Where the adverse determination is based in whole or in part on a medical judgment, the reviewer will consult with an appropriate health care professional. No deference will be afforded to the initial adverse benefit determination.

The Claims Administrator will ensure that all claims and internal appeals for Medical or Prescription Drug benefits are handled impartially. The persons involved in making the decision won't receive compensation, promotion, continued employment or other similar items based upon the likelihood he or she will support a denial of Plan benefits. The Claims Administrator will ensure that health care professionals consulted are not chosen based on the expert's reputation for outcomes in contested cases, rather than based on the professional's qualifications.

The Covered Person will have the opportunity to submit written comments, documents, records, and other information relating to the claim; and the Covered Person will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits. Whether a document, record, or other information is relevant to the claim will be determined in accordance with the applicable regulations. The Covered Person also is entitled to the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the Covered Person's adverse benefit determination. The review 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.

GENERAL PROVISIONS (continued)

In connection with the Covered Person's internal appeal of a Medical claim, the Covered Person will be able to review the Covered Person's file and present information as part of the review. Before making a benefit determination on review, the Claims Administrator will provide the Covered Person with any new or additional evidence considered or generated by the Plan, as well as any new or additional rationale to be used in reaching the decision. The Covered Person will be given this information in advance of the date on which the notice of final appeal decision is made to give the Covered Person a reasonable opportunity to respond.

The time periods for providing notice of the benefit determination on review depends on the type of claim, as provided in the following chart.

If the Plan fails to meet the requirements of the internal claims and appeals process for a claim and the plan's error is not de-minimus, the Covered Person shall be deemed to have exhausted the internal process and may begin an external review immediately.

The Claims Administrator will provide the Covered Person with written notification of the Plan's determination on review, within the applicable time frames. For urgent care, all necessary information, including the benefit determination on review, will be transmitted between the Plan and the claimant by telephone, fax, or other available similarly expeditious method. In the case of an adverse benefit determination, such notice will indicate:

- The specific reason for the adverse determination on review;
- Reference to the specific provisions of the Plan on which the determination is based;
- A statement that the Covered Person are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits;
- A description of the Covered Person's right to bring a civil action following an adverse determination on review;
- If any internal rules, guidelines, protocols or similar criteria were used as a basis for the adverse determination, either the specific rule, guideline, protocols or other similar criteria or a statement that a copy of such information will be made available free of charge upon request;
- For adverse determinations based on medical necessity, experimental treatment or other similar exclusions or limits, an explanation of the scientific or clinical judgment used in the decision, or a statement that an explanation will be provided free of charge upon request;
- For medical claims, information sufficient to identify the claim including date of service, healthcare provider, claim amount (if applicable), and denial code;
- A description of the Plan's standard used in denying the claim (for example, a description of the "medical necessity" standard may be included);
- For medical claims, upon a request the applicable diagnosis codes and treatment codes used and their meanings;
- A description of the Plan's external review process, including how to initiate an appeal;
- Contact information for certain governmental entities that may assist claimants with appeals and external review;
- If applicable, a statement of the Covered Person's right to obtain the claim denial and appeal denial in a foreign language; and
- A description of the voluntary appeals procedure under the Plan, if any, and the Covered Person's right to obtain additional information upon request about such procedures.

All decisions are final and binding unless determined to be arbitrary and capricious by a court of competent jurisdiction.

GENERAL PROVISIONS (continued)

TIME FRAMES FOR INTERNAL APPEALS PROCESS

The time frame for filing an appeal starts when the Covered Person receives written notice of adverse benefit determination. The time frame for providing a notice of the appeal decision (a "notice of benefit determination on review") starts when the appeal is filed in accordance with the Plan's procedures. The notice of appeals decision may be provided through in-hand delivery, mail, or electronic delivery before the period expires. Urgent care decisions may have to be delivered by telephone, facsimile, or other available expeditious method. References to "days" mean calendar days. The Plan can require two levels of mandatory appeal review.

	*Urgent Care Claims**	*Non-Urgent Care Pre-Service Claims**	*Non-Urgent Care Post-Service Claims**
Period for Filing Appeal	The Covered Person must file an appeal within180 days.	The Covered Person must file an appeal within180 days.	The Covered Person must file an appeal within 180 days.
Time frame for Providing Notice of Benefit Determination on Review	As soon as possible taking into account medical exigencies, but not later than 72 hours after receipt of request for review.	Within a reasonable period of time appropriate to medical circumstances, but not later than 30 days after receipt of request for review. If two levels of mandatory appeal review are required, notice must be provided within 15 days of each appeal.	Within a reasonable period of time, but not later than 60 days after receipt of request for review. If two levels of mandatory appeal review are required, notice must be provided within 30 days of each appeal.
Extensions	None.	None.	None.

** An appeal of a concurrent care decision to reduce or terminate previously approved benefits may be an urgent care, pre-service, or post-service claim, depending on the facts.*

LEVEL TWO APPEAL PROCESS (COUNTY)

If the Covered Person is dissatisfied with the Claims Administrator's Internal Appeal decision, he may submit a written request for a level two appeal to the Plan Administrator within **180 calendar days** of receipt of the Claims Administrator's written response to the Internal Appeal decision. The Plan Administrator, or an agent appointed by the Plan Administrator, will review all matters pertaining to the level two appeal. The Covered Person will be notified promptly of the findings, but not later than 15 calendar days for pre-service claims and 30 calendar days for post-service claims after receipt of the Covered Person's appeal and a properly executed HIPAA release form. A second level of appeal is not available for urgent claims. The Plan Administrator may, at its discretion, waive the level two appeal process and submit the Covered Person's request directly to the External Review Process, as described below.

EXTERNAL REVIEW PROCESS

If the Covered Person's appeal is denied or if the County advises the Covered Person to seek an external review during the second level of appeal, the Covered Person may request an external review of the

Covered Person's claim within four months after being notified of a denied claim. External review is not automatic; the Covered Person must request it. The external review is conducted by an independent review organization (IRO) and its decision is binding on the Covered Person and the Plan, except to the extent other remedies are available under federal law. The procedures for filing an appeal under the external review process are outlined below.

The external review process does not apply to an adverse benefit determination or final internal adverse benefit determination that relates to a participant's or beneficiary's failure to meet the requirements for eligibility under the terms of a group health Plan (for example, worker classification and similar issues). The external review process is only available if the adverse benefit determination involves medical judgment (as determined by the external reviewer) or a rescission of coverage or is otherwise required by applicable law.

Within five days of receiving the Covered Person's request, the Plan will conduct a "preliminary review" to ensure the request can be sent for external review (for example, to ensure the denied claim or appeal doesn't relate to Plan eligibility and that the request is complete). The Plan will notify the Covered Person in writing once the preliminary review is complete; the Covered Person will be informed then if the Covered Person needs to submit additional information and the deadline for doing so.

The IRO assigned to conduct the Covered Person's external review will notify the Covered Person of its acceptance of the assignment and the Covered Person will have 10 business days to submit any additional written information for the IRO to consider. (Within one business day of receiving the Covered Person's additional information, the IRO must share the new material with the Plan. After considering the new information, the Plan *may* reconsider and reverse its claim or appeal denial, stopping the external review procedure.)

The IRO must conduct its external review without giving any weight to the Plan's earlier conclusions or decisions. IROs may consider information beyond the denied claim's records, such as the claimant's medical history, appropriate practice guidelines and Plan terms. The IRO must complete its external review and send notice of its decision to the Covered Person and the Plan within 45 days.

If the IRO reverses the Plan's earlier decision to deny a claim or appeal, the Plan will immediately provide coverage or payment for the claim.

APPEALS OF CLAIMS INVOLVING ELIGIBILITY MATTERS

Appeals involving eligibility matters (that is, eligibility to participate or changes in coverage elections such as the addition or deletion of dependents) should be sent in writing to the Plan Administrator for consideration within **60 calendar days** from the claim payment date or the date of the notice of denial of benefits. The Plan Administrator, or an agent appointed by the Plan Administrator, will review all matters pertaining to the appeal. The Covered Person will be notified promptly of the findings, but not later than 120 calendar days after receipt of the Covered Person's appeal.

ACTS OF THIRD PARTIES

If a Covered Person is injured through the act or omission of another person (a "third party"), the PLAN shall, with respect to services required as a result of that injury, provide the benefits of the PLAN and have an equitable right to restitution or other available remedy to recover the reasonable costs of the services provided to the Covered Person that are paid by the PLAN.

GENERAL PROVISIONS (continued)

The Covered Person is required to:

1. Notify the Claims Administrator in writing of any actual or potential claim or legal action which such Covered Person anticipates bringing or has brought against the third party arising from the alleged acts or omissions causing the injury or Illness, not later than 30 days after submitting or filing a claim or legal action against the third party; and
2. Agree to fully cooperate with the PLAN to execute any forms or documents needed to assist the PLAN in exercising its equitable right to restitution or other available remedies; and
3. Provide the PLAN with a lien, in the amount of costs of benefits provided, calculated in accordance with California Civil Code section 3040. The lien may be filed with the third party, the third party's agent or attorney, or the court, unless otherwise prohibited by law.

A Covered Person's failure to comply with 1 through 3, above, shall not in any way act as a waiver, release, or relinquishment of the rights of the PLAN.

CLAIM APPEAL PROCEDURES FOR PRESCRIPTION DRUGS

Refer to Chapter 7 of the EOC.

HIPAA PRIVACY AND HIPAA SECURITY

The Health Insurance Portability and Accountability Act of 1996, ("HIPAA"), and the regulations issued thereunder at 45 CFR Parts 160 and 164 ("the HIPAA regulations"), impose privacy and security obligations on group health plans that restrict the use and disclosure of protected health information ("PHI") and electronic protected health information ("ePHI"). The County of Orange as PLAN Sponsor, and/or its representative agents (collectively the "County"), desires to permit the PLAN (including its Business Associates, health insurance issuers, HMOs, and their agents) to disclose or to provide for or permit the disclosure of protected health information to the County from time to time.

1. **Uses and Disclosures of PHI**. The PLAN may disclose a PLAN Participant's PHI to the County, for the PLAN administration functions under 45 CFR 164.504(a), to the extent not inconsistent with HIPAA regulations. This includes summary health information for the purposes set forth in Section 164.504(f)(1)(ii) and (iii) of the Privacy Rule.

2. **Restriction on PLAN Disclosure to the County of Orange**. Neither the PLAN nor any of its Business Associates will disclose PHI to the County except upon the PLAN's receipt of the County certification that the PLAN incorporates the agreements of the County under paragraph 4, except as otherwise permitted or required by law.

3. **Privacy Agreements of the County of Orange**. As a condition for obtaining PHI from the PLAN and its Business Associates, the County agrees it will:

    a. Not use or further disclose such PHI other than as permitted by paragraph 2 of this provision, as permitted by 45 CFR 164.508, 45 CFR 164.512, and other sections of the HIPAA regulations, or as required by law;

    b. Ensure that any of its agents, including a subcontractor, to whom it provides the PHI agree to the same restrictions and conditions that apply to the County with respect to such information;

GENERAL PROVISIONS (continued)

c. Not use or disclose the PHI for employment-related actions and decisions or in connection with any other benefit or employee/retiree benefit plan of the County;

d. Report to the PLAN any use or disclosure of the PHI that is inconsistent with the uses or disclosures provided for of which the County becomes aware;

e. Make the PHI of a particular Participant available for purposes of the Participant's requests for inspection, copying and amendment, including the incorporation of any amendments to PHI, and to carry out such requests in accordance with HIPAA regulation 45 CFR 164.524 and 164.526;

f. Make the PHI of a particular Participant available for purposes of required accounting of disclosures by the County pursuant to the Participant's request for such an accounting in accordance with HIPAA regulation 45 CFR §164.528;

g. Make the County internal practices, books, and records relating to the use and disclosure of PHI received from the PLAN available to the Secretary of the U.S. Department of Health and Human Services for purposes of determining compliance by the PLAN with HIPAA regulation 45 CFR §164.501(f);

h. If feasible, return or destroy all PHI received from the PLAN that the County maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, the County agrees to limit further uses and disclosures to those purposes that make the return or destruction of the information unfeasible; and

i. Ensure that there is adequate separation between the PLAN and the County by implementing the terms of subparagraphs 3 .i. (1) through (3), below:

(1) *Employees With Access to PHI*: The employees or other individuals under the control of the County that are the individuals that may access PHI received from the PLAN are referenced within section 6.02 (c) in the HIPAA Policies and Procedures Manual, including but not limited to County Benefits staff and select Human Resources staff members.

(2) *Use Limited to Plan Administration*: The access to and use of PHI by the individuals described in (1), above, is limited to Plan Administration functions as defined in HIPAA regulation 45 CFR §164.504(a) that are performed by the County for the PLAN.

(3) *Mechanism for Resolving Noncompliance*: If the County determines that any person described in (1), above, has violated any of the restrictions described in this provision, then such individual shall be subject to discipline or sanctions in accordance with the practices of the County, taking into account the Privacy Rules standards. The County shall document such discipline or sanctions as required under the Privacy Rules, including the requirement that such documentation be retained for six years.

4. **Security Agreements of the County of Orange**. As a condition of obtaining e-PHI from the Plan, its Business Associates, Insurers and HMOs, the County agrees it will:

a. Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the ePHI that the County creates, receives, maintains, or transmits on behalf of the Plan;

GENERAL PROVISIONS (continued)

b. Ensure that the adequate separation between the Plan and County as set forth in 45 CFR 164.504(f)(2)(iii) is supported by reasonable and appropriate security measures.

c. Ensure that any agent, including a subcontractor, to whom it provides this information agrees to implement reasonable and appropriate security measures to protect the information.

d. Report to the Plan any Security Incident of which it becomes aware. "Security Amendment" shall mean unauthorized access to, use, disclosure, modification, or destruction of, or interference with ePHI.

e. Upon request from the Plan, the County agrees to provide information on unsuccessful unauthorized access, use, disclosure, modification, or destruction of ePHI, to the extent such information is available to the County.

5. **Breach Notifications.** Following the discovery of a Breach of unsecured PHI caused by the County or its agents, the County or its agents shall provide a written notification in plain language of the breach to all individuals whose unsecured PHI has been breached in accordance with 45 CFR § 164.404. A breach is the same definition as stated in 45 CFR 164.402. The County or its agent's notification must include the following information, to the extent possible:

a. A brief description of what happened, including the date of the breach and the date of the discovery of the breach, if known;
b. A description of the types of Unsecured PHI that were involved in the breach (such as whether full name, social security number, date of birth, home address, account number, diagnosis, disability code, or other types of information were involved);
c. Any steps individuals should take to protect themselves from potential harm resulting from the breach;
d. A brief description of what the County or its agent is doing to investigate the breach, to mitigate harm to individual, and to protect against any further breaches; and
e. Contact procedures for individual to ask questions or learn additional information, which shall include a toll-free telephone number, an e-mail address, Web site, or postal address.

6. **Definitions.** All capitalized terms within this provision not otherwise defined by the provisions of this provision shall have the meaning given them in the PLAN or, if no other meaning is provided in the PLAN, the term shall have the meaning provided under HIPAA Privacy Rule or the HIPAA Security Rule.

DEFINITIONS

Whenever any of the following terms are capitalized in this Plan Document, they will have the meaning stated below:

ACCIDENTAL INJURY

A bodily injury which results independently of an Illness as a result of external force or impact including, but not limited to, lacerations, breaks, bruises, and strains. Excluded as "accidental injuries" are injuries as a result of, but not limited to, lifting, turning, stretching, reaching, pulling, pushing, exercising, blisters and injuries while chewing.

AMBULATORY SURGERY CENTERS (ASC)

Health care facilities where surgical procedures not requiring an overnight hospital stay are performed. ASC's can be either general surgery centers that perform various outpatient procedures or an ASC can provide only specialized services.

BRAND-NAME DRUG

A brand name drug is a drug marketed under a proprietary, trademark-protected name.

CALENDAR YEAR

A period of one year beginning with January 1.

CASE MANAGEMENT

Services of the Case Management department of the Claims Administrator under contract with the County, to review medical treatment plans for Illness or Accidental Injury where there is probability of substantial medical expenses. With the concurrence of the primary Physician and the Covered Person, Case Management may authorize services and expenses not specifically addressed in the PLAN. Case Management may also be authorized by the Plan Administrator to provide cost effective alternatives to in-patient psychiatric, alcohol and drug abuse services.

CENTER OF DISTINCTION

One of the Claims Administrator's designated facilities for specified surgical procedures within California.

CLAIMS ADMINISTRATOR

A third-party administrator under contract with the County to administer claims for the Medical Expense Benefits of the PLAN.

PART D COVERED DRUGS

The drugs on the Drug List are only those covered under Medicare Part D.

The Plan generally covers a drug on the plan's Drug List as long as you follow the other coverage rules explained in this chapter and the use of the drug is a medically accepted indication. A "medically accepted indication" is a use of the drug that is *either*:

• Approved by the Food and Drug Administration for the diagnosis or condition for which it is being prescribed.)

• -- *or* -- Supported by certain references, such as the American Hospital Formulary Service Drug Information and the DRUGDEX Information System.

DEFINITIONS (continued)

The Drug List includes brand name drugs and generic drugs.

Over-the-Counter Drugs

Our plan also covers certain over-the-counter drugs. Some over-the-counter drugs are less expensive than prescription drugs and work just as well. For more information, call Member Services.

What is *not* on the Drug List?

The plan does not cover all prescription drugs.

• In some cases, the law does not allow any Medicare plan to cover certain types of drugs (for more about this, see Section 7.1 in this chapter).

• In other cases, we have decided not to include a particular drug on the Drug List. In some cases, you may be able to obtain a drug that is not on the drug list. For more information, please see Chapter 3 of the EOC.

COVERED MEDICAL EXPENSES

Those services covered by the PLAN, including preventive services and other Medically Necessary services and supplies described herein which are incurred by a Covered Person. Such services must be incurred by a Covered Person while eligible to receive benefits under the PLAN and recommended by a Physician for the treatment of the Covered Person's Illness, Accidental Injury, or pregnancy, subject to the exclusions and limitations listed within this Plan Document. Unless otherwise noted, all Covered Medical Expenses are subject to the applicable Deductibles and coinsurance listed in the Schedule of Medical Expense Benefits. For Non-Network Providers, Covered Medical Expenses shall include only Usual, Reasonable and Customary charges.

COVERED PERSON

A person, enrolled in this PLAN, who is a retiree of the County and enrolled eligible Dependents, who meet the requirements in the "Individual Plan Coverage Effective Dates" section, and persons enrolled under the provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985 if applicable.

CUSTODIAL CARE

Care that provides a level of routine maintenance for the purpose of meeting personal needs or helping with the functions or activities of daily living. This is care that can be provided by a layperson that does not have professional qualifications, skills, or training.

DEDUCTIBLE

The amount of Covered Medical Expenses that must be paid by the Covered Person before the PLAN will begin reimbursing most Covered Medical Expenses.

DEPENDENTS

a) Shall be the enrolled legally married spouse or Domestic Partner of the Covered Person. Part D eligible retirees and Part D eligible spouses and dependents of those retirees

b) Shall be a dependent child after their 26th birthday provided the child (1) was incapable of self-sustaining employment by reason of mental retardation or physical handicap prior to age 26, and (2) is chiefly dependent upon the Covered Person for support and maintenance. Such dependent must be enrolled in the health plan when an employee retires in order to be covered as the dependent of the retiree. Proof of such incapacity and dependency must be furnished to the Fund by the Covered

DEFINITIONS (continued)

Person within 31 days following the dependent's 26th birthday. Eligibility for handicapped dependent status will be determined by the Claims Administrator. The Claims Administrator may require, at reasonable intervals during the two (2) years following the Dependent's 26th birthday, subsequent proof of the child's disability and dependency. After such two (2) year period, the Fund may require subsequent proof not more than once each year. The Fund reserves the right to have such dependent examined by a doctor of the Fund's choice to determine the existence of such incapacity.

Excluded as Dependents under a) and b) are:

1) A spouse that is legally divorced from the Covered Person; and

2) Any person(s) while on active duty in any military of any country; however, any person meeting the requirements for service in the uniformed services as defined by USERRA may elect to continue coverage under the PLAN for up to 24 months, as required under USERRA; and

3) Any legally married spouse or Domestic Partner or children of the Covered Person's eligible dependent child.

DOMESTIC PARTNER

An opposite or same sex individual who has legally registered as a domestic partner with a County employee.

EMERGENCY HOSPITAL CONFINEMENT

An Inpatient Hospital confinement for a condition which, unless immediately treated on an Inpatient basis, would jeopardize the patient's life or cause serious impairment to the patient's bodily functions.

EMERGENCY SERVICES

Services provided to stabilize the patient from an unexpected medical condition, including a psychiatric emergency medical condition, manifesting itself by acute symptoms of sufficient severity (including severe pain) that the absence of immediate medical attention could reasonably be expected to result in any of the following:

1. Placing the patient's health in serious jeopardy;
2. Serious impairment to bodily functions;
3. Serious dysfunction of any bodily organ or part;
4. Serious jeopardy to the health of an unborn child.

EXPERIMENTAL OR INVESTIGATIONAL PROCEDURES

Services or supplies as determined by the Claims Administrator or Pharmacy Benefit Manager to be experimental or investigational because:

a) There are insufficient outcomes data available from controlled clinical trials published in peer reviewed literature to substantiate its safety and effectiveness in treatment of the disease or injury involved; or

b) If required by the FDA, approval has not been granted for marketing; or

c) A recognized national medical or dental society or regulatory agency has determined, in writing, that it is experimental, investigational, or for research purposes; or

DEFINITIONS (continued)

d) The written protocols or written informed consent used by the treating facility or any other facility studying substantially the same drug, device, procedure or treatment, states that it is experimental, investigational or for research purposes.

However, this exclusion will not apply with respect to routine patient care services (including drugs) associated with a clinical trial if the Claims Administrator determines the clinical trial meets the following criteria:

Phases I, II, III, or IV level clinical trial that is conducted in connection with the prevention, detection, or treatment of cancer or other life-threatening disease or condition and is:

i) federally funded through a variety of entities or departments of the federal government; or

ii) is conducted in connection with an investigational new drug application reviewed by the Food and Drug Administration; or

iii) is exempt from investigational new drug application requirements.

Routine patient services do not include, and the Plan will not cover:

- the investigational service or supply itself;
- services and supplies listed herein as Exclusion;
- services or supplies related to data collection for the clinical trial;
- services or supplies which, in the absence of private health care coverage, are provided by a clinical trial sponsor or other party, e.g., device, drug, item or service supplied by the manufacturer and not yet FDA approved, without charge to the trial participant.

FORMULARY

A list of prescription drugs that includes Generic, Preferred, and Non-Preferred Brand-Name Drugs. The Formulary may exclude certain drugs from coverage when the Pharmacy Benefit Manager has determined a less-expensive therapeutically equivalent (comparable clinical effectiveness and safety) drug exists. The Pharmacy Benefit Manager determines which drugs are included on the Formulary within the Preferred or Non-Preferred tiers and which drugs are excluded.

GENERIC DRUG

A prescription drug that is approved by the Food and Drug Administration (FDA) as having the same active ingredient(s) as the brand name drug. Generally, a "generic" drug works the same as a brand name drug and usually costs less.

HOME HEALTH CARE AGENCY

A public or private agency or organization that specializes in providing medical care and treatment in the home. Such a provider must meet all of the following conditions:

a) It is primarily engaged in and duly licensed, if such licensing is required, by the appropriate licensing authority to provide skilled nursing services and other therapeutic services.

b) It has policies established by a professional group associated with the agency or organization. This professional group must include at least one Physician and at least one registered graduate nurse (R.N.) to govern the services provided, and it must provide for full-time supervision of such services by a Physician or registered graduate nurse.

c) It maintains a complete medical record on each individual.

d) It has a full-time administrator.

DEFINITIONS (continued)

HOSPITAL

An institution constituted, licensed and operated in accordance with the laws pertaining to hospitals, which maintains on its premises all the facilities needed to diagnose and treat injury and Illness. It is an institution that qualifies as a hospital and a provider of services under Medicare and is accredited as a hospital by the Joint Commission on the Accreditation of Hospitals.

A hospital can specialize in the treatment of mental illness, alcoholism, drug addiction, or other related Illness. It can also provide residential treatment programs, but only if it is constituted, licensed and operated in accordance with laws of legally authorized agencies responsible for medical institutions. It provides all treatment for a fee, by or under the supervision of Physicians with continuous 24-hour nursing services by qualified nurses.

The definition of "Hospital" shall also include Christian Science Sanatoriums.

An institution that is, other than incidentally, a place of rest, a place for the aged, or a nursing home will not be considered a hospital.

Hospitals will also include the following:

- Ambulatory surgical facility – a facility approved by the Claims Administrator as meeting established criteria for handling surgical cases on a same-day basis. This may also include a birthing center.
- Skilled nursing facility – an institution that is primarily engaged in providing Inpatient skilled nursing care and related services for patients who require medical or nursing care. A skilled nursing facility may also provide physical rehabilitation services for injured or sick persons. To do so, it must be constituted, licensed and operated in accordance with the laws of legally authorized agencies and must maintain on its premises all the facilities needed to provide medical treatment of injury or Illness. It must not be, other than incidentally, a place for rest or domiciliary care; for the aged, blind, deaf, mentally deficient, or those suffering from tuberculosis; or a hotel or motel. All skilled nursing care must be provided for a fee by or under the supervision of Physicians with skilled nursing services by nurses.

ILLNESS

Bodily sickness or disease, psychiatric disorders, and congenital abnormalities of a newborn child who is covered as an eligible dependent child. Illness must be medically diagnosed.

INPATIENT

Confinement in a Hospital for which Room and Board charges are made by the Hospital or that exceeds 24 consecutive hours.

MEDICAL EXPENSE BENEFITS

Those benefits of the PLAN other than that available through the Prescription Drug Program.

MEDICALLY NECESSARY

Services or supplies to the extent that they are needed for the diagnosis of an Illness or Accidental Injury or for the medical care of a diagnosed Illness or Accidental Injury. To be considered "Medically Necessary" a service or supply must be determined by the Claims Administrator to meet all of these tests:

- It is ordered by a Physician.

DEFINITIONS (continued)

- It is recognized throughout the Physician's profession as safe and effective, is required for the diagnosis or treatment of an Illness or injury and is employed appropriately in a manner and setting consistent with generally accepted United States medical standards.
- It is not educational in nature (that is, the primary purpose of the service or supply must not be to provide the patient with any of the following: training in the activities of daily living, instruction in scholastic skills such as reading and writing, preparation for an occupation, or treatment for learning disabilities).
- It is not Experimental or Investigational.
- It is not Custodial Care.

For purposes of the PLAN, services or supplies that are provided only because an unnecessary service or supply is being provided will also be considered not Medically Necessary.

In the case of an Inpatient Hospital stay, in addition to meeting the above tests, the length of the stay and Hospital services and supplies will be considered Medically Necessary only to the extent that the Claims Administrator determines them to be not allocable to the scholastic education or vocational training of the patient.

MEDICARE

Title XVIII (Health Insurance for the Aged) of the United States Social Security Act as amended by Social Security Amendment of 1965 or as later amended.

NETWORK CONTRACT RATE

The discounted amount a Network Provider agrees to charge a Covered Person, based on the Network Provider's contract with the Claims Administrator or Preferred Provider Organization.

NETWORK HOSPITAL OR PROVIDER

A Hospital, Physician, or other provider of health care services that has entered into a written agreement with the Claims Administrator to provide health care services or supplies to a Covered Person at negotiated or discounted rates. Non-network radiologists, anesthesiologists, and pathologists that are Network Hospital-based will be considered Network Providers if a Covered Person utilizes a Network Hospital. A listing of Network Providers shall be maintained by the Claims Administrator.

NETWORK RETAIL PHARMACY

A retail pharmacy that has entered into a written agreement with the Pharmacy Benefit Manager to provide prescription drugs to a Covered person at discounted rates. A listing of Network Pharmacies shall be maintained by the Pharmacy Benefit Manager as amended from time to time.

NON-NETWORK HOSPITAL OR PROVIDER

A Hospital, Physician, or other provider of health care services that has not entered into a written agreement with the Claims Administrator to provide health care services or supplies to a Covered Person at negotiated or discounted rates.

NON-NETWORK RETAIL PHARMACY

A retail pharmacy that has not entered into a written agreement with the Pharmacy Benefit Manager to provide prescription drugs to a Covered Person at discounted rates.

DEFINITIONS (continued)

NON-PREFERRED DRUGS

These are mostly higher cost Brand-Name drugs that are selected by the Pharmacy Benefit Manager for inclusion in the Formulary as Non-Preferred Drugs (Tier 3). Some higher cost Generic drugs may also be included in the Non-Preferred Drug tier. The PLAN provides a lower benefit for Non-Preferred Drugs than for Preferred Drugs.

OUT-OF-POCKET EXPENSES

The amount a Covered Person pays for Medical Expense Benefits, including the Deductible or Prescription Drug Expenses. Section 1.2 of the EOC details the definition of OOP for Prescription Drugs.

OUTPATIENT

A Covered Person shall be considered to be an "Outpatient" if treated at a Hospital on a basis other than as a registered bed patient. For purposes of this definition, a stay in the Hospital whether as a registered bed patient or not shall not be considered an "Outpatient" stay if the Hospital stay extends beyond 24 consecutive hours.

PHARMACY BENEFIT MANAGER

A third-party administrator under contract with the County to administer the Prescription Drug Program of the PLAN.

PHYSICIAN

A licensed medical practitioner who is practicing within the scope of his/her license and who is licensed to prescribe and administer drugs or to perform surgery.

Licensed medical practitioners include the following:

- Doctor of medicine (M.D.) or doctor of osteopathy (D.O.)
- Certified registered nurse anesthetist (C.R.N.A.)
- Chiropractor (D.C.)
- Dentist (D.D.S. or D.M.D.)
- Certified or licensed midwife
- Optometrist (O.D.)
- Podiatrist or chiropodist (D.P.M., D.S.C., or D.S.P.)
- Christian Science Practitioner who is authorized by the Mother Church, the First Church of Christ Scientist in Boston, Massachusetts, and is listed in the Christian Science Journal at the time a service is rendered
- Psychologist (Ph.D., Ed.D., or Psy.D.)
- Clinical social worker (C.S.W. or L.C.S.W.)

The following are considered covered medical professionals when they are referred by a Physician, licensed to practice where the care is given, rendering a service within the scope of that license, and providing a service for which benefits are specified in the PLAN:

- Nurse – a nurse is a registered graduate nurse, a licensed practical nurse, or a licensed vocational nurse. A nurse is a professional who has the right the use the respective title and the respective abbreviation R.N., L.P.N., or L.V.N.
- Audiologist
- Occupational therapist (O.T.)
- Physical therapist (R.P.T.)
- Speech pathologist or therapist

DEFINITIONS (continued)

- Marriage, family, and child counselor (M.F.C.C. or L.M.F.T.)
- Home health aide – a person who provides medical or therapeutic care and who reports to and is under the direct supervision of a Home Health Care Agency.

PLAN

The benefits and provisions for payment as described herein as the County of Orange Wellwise Medicare Retiree Health Plan.

PLAN ADMINISTRATOR

Chief Human Resources Officer or his/her designee
County of Orange
Human Resource Services/Employee Benefits
400 Civic Center Dr.
Santa Ana, California 92701

PRE-ADMISSION REVIEW

An evaluation made by the Claims Administrator to determine the number of days of Inpatient Hospital confinement and level of care that will be considered Medically Necessary for the care or treatment of a Covered Person's diagnosed Illness or Accidental Injury. **However, the Covered Person and his Physician make the final decision concerning treatment.**

PREFERRED DRUGS

These are mostly common Brand-Name drugs selected by the Pharmacy Benefit Manager for inclusion in the Formulary as Preferred Drugs (Tier 2). Some Generic drugs may also be included in the Preferred Drug tier. The PLAN provides a higher benefit for Preferred Drugs than for Non-Preferred Drugs.

PRESCRIBER

Licensed medical practitioners who may prescribe medications within the scope of their practice include the following:

- Doctor of medicine (M.D.) or doctor of osteopathy (D.O.)
- Certified registered nurse anesthetist (C.R.N.A.)
- Dentist (D.D.S. or D.M.D.)
- Certified or licensed midwife
- Optometrist (O.D.)
- Podiatrist or chiropodist (D.P.M., D.S.C., or D.S.P.)
- Physician's Assistant (P.A.)
- Registered Nurse Practitioner (R.N.P.)

PRIOR AUTHORIZATION FOR MEDICAL EXPENSES

An evaluation made by the Claims Administrator to determine the Medical Necessity of certain health care services, before the services are rendered in order to determine whether and to what extent the services will be covered by the PLAN. Prior Authorization is required for certain services as identified in this Plan Document. **However, the Covered Person and his Physician make the final decision concerning treatment.**

DEFINITIONS (continued)

PRIOR AUTHORIZATION FOR PRESCRIPTION DRUGS

Approval in advance to get certain drugs. Covered drugs that need prior authorization are marked in the formulary.

ROOM AND BOARD

All charges commonly made by a Hospital on its own behalf for room and meals and all general services and activities needed for the care of registered bed patients.

SEMI-PRIVATE CHARGE

The most common charge made by a Hospital for a room containing two beds but does not include the charge made by the Hospital for Intensive Care.

SEVERE MENTAL ILLNESS

Severe Mental Illness as defined under California Assembly Bill 88 (AB88) (1999) includes the following conditions:

a) Schizophrenia
b) Bipolar disorder
c) Panic disorder
d) Pervasive developmental disorder or autism
e) Bulimia nervosa
f) Schizoaffective disorder
g) Major depressive disorders
h) Obsessive-compulsive disorder
i) Anorexia nervosa

Serious emotional disturbance of a child is defined under (AB88) (1999) as a condition that is:

a) identified in the Diagnostic and Statistical Manual of Mental Disorders, other than a primary substance use disorder or developmental disorder, that results in behavior inappropriate to the child's age according to expected developmental norms, and

b) that meets stringent criteria in Section 5600.3(a)(2) of the Welfare and Institutions guide, which includes the child's inability to function in certain environments.

SPECIAL TRANSPLANT FACILITY

A Network Provider that contracts with the Claims Administrator for certain organ transplants.

THE COUNTY is the County of Orange, California.

THE FUND

The County of Orange Indemnity Health Plans Internal Service Fund (292).

USUAL, REASONABLE AND CUSTOMARY (URC)

The maximum charge that the PLAN will reimburse for an eligible medical care expense received from a Non-Network Provider. The URC is determined from a collective data base of actual charges in the geographical area in which the services are delivered. Any amount charged that exceeds URC will be considered ineligible under this PLAN. URC charges are adjusted periodically to reflect the current costs being incurred for medical services. URC is determined by Claim Administrator's methodology.

DEFINITIONS (continued)

UTILIZATION REVIEW

Services provided by the Claims Administrator through contract with the County to review, in coordination with the attending Physician, Hospital admissions for alternatives of outpatient services, medical necessity of the treatment plan, proposed length of Hospital stay and level of care, post Hospital service alternatives and alternate treatment plans. **However, the Covered Person and his Physician make the final decision concerning treatment.**

WAITING PERIOD

Retired employees are eligible upon active retirement. Terminated employees electing deferred retirement are not eligible beyond the last day of the month in which they terminate employment.

SIGNATURE PAGE

The effective date of benefits, as described in this Plan Document is January 1, 2022.

It is agreed by the County of Orange that the provisions contained in this Plan Document are acceptable and will be the basis for the administration of said County Wellwise Medicare Retiree Health Plan described herein.

IN WITNESS WHEREOF, the County of Orange has executed this Plan Document this thirtieth day of September 2021.

COUNTY OF ORANGE

By: _____

Title: Kim Derrick, Director of Human Resource Services