

CUSD PRUDENT BUYER MEDICAL PLAN

FOR ELIGIBILITY REFER TO GENERAL INFORMATION SECTION.

The plan allows the option of obtaining treatment from a Prudent Buyer Network Provider (PPO) or a provider who does not participate in the Prudent Buyer network. All claims, payments, and questions are handled by United Administrative Services (UAS), the claims administrator for the district. This Plan is effective September 1, 2004.

With the CUSD Prudent Buyer Medical Plan, the plan allows you to seek care from any doctor, medical group, or hospital, but the benefits you receive will be considerably lower if you do not use a Prudent Network Buyer Provider, which means that your out-of-pocket expense will be higher.

You may access coverage under any one of two levels of coverage, in-network and out-of-network. The applicable deductibles and out-of-pocket amounts will be applied depending which provider you utilize.

You may obtain treatment from any Prudent Buyer Network Provider participating doctor or hospital anywhere in California. To you, this means that these doctors and hospitals have agreed to accept the Prudent Network Buyer allowances as full payment for covered services. If you are traveling outside of California or a retiree residing outside of California, the level of coverage differs. Refer to the Schedule of Benefits for deductible, co-payments and maximums.

COVERAGE

The CUSD Prudent Buyer Medical Plan includes comprehensive coverage for hospitalization, outpatient treatment, diagnostic laboratory and x-ray services, and prescription medication, as explained in this summary plan description. You have the option of obtaining treatment from a PPO provider or out-of-network provider.

The plan pays an amount equal to Prudent Buyer allowance depending upon which provider is utilized for medical treatment received, subject to the deductible and co-payments. Refer to the Schedule of Benefits for deductible, co-payment and maximums. Expenses applied toward the deductible in the last 3 months (October, November and December) of a calendar year will also be applied toward the deductible for the next calendar year.

The Prudent Buyer allowance is the dollar amount paid for each particular type of medical service set by the Prudent Buyer Network. Prudent Buyer Providers have agreed to accept the PPO allowance as full payment for covered services for Prudent Buyer members, although they will often list a higher fee.

Upon attaining \$2,000,000 in lifetime benefits, the plan will automatically restore an additional \$1,500 on January 1st of each succeeding year. Additionally, members may apply for more coverage by furnishing the administrator with evidence of insurability.

Any additional limits on the number of visits or days covered are stated under the specific benefit.

CHOICE OF PROVIDERS

The plan covers treatment provided by any physician or surgeon, anywhere in the world, licensed to prescribe and administer all drugs and to perform all surgery deemed necessary by a licensed physician or surgeon.

As a CUSD Prudent Buyer member, you will enjoy significant savings by using a Prudent Buyer Network PPO provider. These providers have agreed to accept the Prudent Buyer allowance as payment in full. In utilizing non-Prudent Buyer providers, you will be responsible for any additional charges in excess of the Prudent Buyer allowance.

Before using a network doctor or hospital, you should always inquire Network the provider is a Prudent Buyer member. To verify if your doctor is a Prudent Buyer member, you may contact United Administrative Services at 408-288-4400, or Blue Cross at 1-800-688-3828 or on-line at www.bluecrossca.com.

If your physician refers you to a specialist, you should request referral to a Prudent Buyer member. This is particularly important for anesthesiologists, radiologists, and for any diagnostic testing.

AVOID PHYSICIAN OVER-CHARGES FROM PRUDENT BUYER PROVIDERS

Upon visiting a Prudent Buyer Network Provider, the doctor's office will bill all expenses to United Administrative Services (UAS) who will remit payment directly to the doctor. You will receive an Explanation of Benefits (EOB) form for each claim. This form will show the amount of the claim(s) and how much will be paid to the doctor under the Prudent Buyer Network allowance. The EOB form will tell you how much you pay to the doctor.

Should you receive a bill from a Prudent Buyer Network Provider for more than the Prudent Buyer Network allowance shown on the EOB, you should send the doctor a photocopy of the statement showing the maximum allowance, with a note reminding the doctor he/she is a Prudent Buyer Network member. You are not required to pay any balance exceeding the Prudent Buyer Network allowance when treated by a member PPO doctor.

For questions regarding a claim, call United Administrative Services at (408) 288-4400.

CUPERTINO UNION SCHOOL DISTRICT PRUDENT BUYER MEDICAL PLAN			
	LEVEL ONE PPO PROVIDERS	LEVEL TWO OUT OF NETWORK	OUT OF NETWORK AREA
Deductible: Individual	\$200	\$300	\$200
Deductible: Family	\$600	\$900	\$600
Annual Out-of-Pocket Maximum	The out of pocket maximum is \$1,000 per individual. Office visits copayments do not apply to the out of pocket maximum.	The out of pocket maximum is 40% of UCR bills Unlimited dollar maximum	The out of pocket maximum is \$2,000 per individual. Office visits copayments do not apply to the out of pocket maximum.
Lifetime Maximum	\$2,000,000 per member	\$2,000,000 per member	\$2,000,000 per member
	BENEFITS FOR COVERED SERVICES	BENEFITS FOR COVERED SERVICES	BENEFITS FOR COVERED SERVICES
Physician Services			
Office visits	\$20 COPAYMENT	\$20 COPAYMENT	\$20 COPAYMENT
Hospital/Skilled Nursing visits	90%	60%	80%
Specialists	\$20 COPAYMENT	\$20 COPAYMENT	\$20 COPAYMENT
Surgeon/Asst. Surgeon	90%	60%	80%
Anesthesiologist	90%	60%	80%
Diagnostic X-ray & Labs	90%	60%	80%
Preventative Care			
Routine Physical Exam	Not covered	Not covered	Not covered
Well Baby Care	Covered from birth to age 2	Covered from birth to age 2	Covered from birth to age 2
Immunizations	Covered from birth to age 2	Covered from birth to age 2	Covered from birth to age 2
Hospital/Surgical Services			
Inpatient	90%	60%	80%
Outpatient	90%	60%	80%
Emergency Services			
Ambulance	90%	60%	80%
Emergency Room	90% after \$50 copay, waived if admitted	60% after \$50 copay, waived if admitted	80% after \$50 copay, waived if admitted
Maternity Services			
Hospital Benefits - Delivery	90%	60%	80%
Outpatient Physician Services	90%	60%	80%
Surgical Services	90%	60%	80%
Prescription Drugs (Retail)			
Generic	\$5 copay	\$5 copay	\$5 copay
Brand	\$15 copay	\$15 copay	\$15 copay
	\$25 copay for each 45 days supply exceeding 90 days	\$25 copay for each 45 days supply exceeding 90 days	\$25 copay for each 45 days supply exceeding 90 days
Prescription Drugs (Mail Order)			
Generic	for 90 day supply \$10 copay	for 90 day supply \$10 copay	for 90 day supply \$10 copay
Brand	\$30 copay	\$30 copay	\$30 copay
Chiropractic Services	90%	60%	80%
Continued Care Services			
Home Health Care	90%	60%	80%
Skilled Nursing Facility	Following discharge from an acute care facility, plan pays 90%	Following discharge from an acute care facility, plan pays 60%	Following discharge from an acute care facility, plan pays 80%
Physical Therapy	90%	60%	80%
Speech Therapy	90%	60%	80%

SUMMARY OF BENEFIT LEVELS

Level One - In-network: The deductible and the out-of-pocket maximum is the lowest for this level of coverage. If you choose a Prudent Buyer Network Provider to receive services, you will receive the highest level of benefits. Prudent Buyer Network Providers offer a substantial discount, which provides the greatest benefits. The deductible is \$200 per individual or \$600 per family per calendar year and the plan pays 90% of the first \$10,000 of covered expenses and then 100% thereafter each calendar year. Physician charges for an office visit require a co-pay amount for each office visit. The office visit co pay amount does not apply to the annual deductible or the out of packet maximum.

Level Two - Out-of Network: This level allows you to seek medical coverage from any medical provider outside of the Prudent Buyer Network, but the benefits you will receive are considerably lower. Your out-of-pocket expense is considerably increased if you choose Level Two benefits. The deductible is \$300 per individual or \$900 per family per calendar year and the plan pays 60% of covered expenses for the remainder of the calendar year. Physician charges for an office visit require a co-pay amount for each office visit. The office visit co pay amount does not apply to the annual deductible or the out of packet maximum.

Out of Area: For those members that reside outside of the Prudent Buyer Provider Network or obtain services outside of the Prudent Buyer Provider Network, the plan will pay 80% of the Usual, Customary and Reasonable Rate for the first \$10,000 after the deductible has been satisfied and then 100% for the remainder of the calendar year. The Deductible is \$200 per person or \$600 per family per calendar year.

When you receive care from a Prudent Buyer Network Provider, you assure yourself of the highest possible benefit. You also save the plan money and help keep medical premiums down, thereby enabling the district to maintain a high level of employee health benefit.

HOW TO SUBMIT A CLAIM

To ensure prompt and efficient claims service please follow these steps in filing a claim:

1. Obtain a claim form from you school or Human Resources.
2. Answer every question on your part of the claim form. **BE SURE TO SIGN YOUR NAME.**
3. Have your doctor complete the reverse side of the claim form, or

- A. Submit an itemized statement that shows the name of the patient and physician and indicates a diagnosis, either written or with an International Classification of Disease.
- B. The Physician(s) may want to submit their own form which is perfectly acceptable. Many participating Prudent Buyer doctors will bill United Administrative Services directly. By law, they must bill Medicare for retirees.
4. Attach all other medical bills to the claim form (or a sheet of paper showing you name, social security number and CUSD Prudent Buyer Medical Plan) and mail them separately to United Administrative Services. Usually only one doctor will have to complete a claim for each illness. The anesthesiologist, assistant surgeon and or consulting doctor do not need to complete a claim form; just send their itemized bills.
5. Be sure that your medical bills are itemized for each type of expense and that dates of all doctor visits are shown.
6. If claims are filed for more than one person, the bills must indicate the expenses for each person and separate form must be filed for each person (per calendar year).
7. All participating hospitals will bill United Administrative Services (UAS) directly. For retirees, they also will bill Medicare directly.
8. For retirees with Medicare (over age 65):
 - A. Obtain a copy of your bill from your doctor at the time of your visit. The doctor's office will bill Medicare for you.
 - B. Wait for your copy of the Medicare payment for that doctor's visit
 - C. When you receive the Medicare statement, attach the original copy of doctor's bill and claim form (or a sheet of paper showing your name, social security number and CUSD Prudent Buyer Medical Plan), and mail to United Administrative Services.
 - D. Most Prudent Buyer doctors will bill United Administrative Services for you.
9. The **EOB form** from UAS for each service will tell you how much you should pay (employee responsibility) for that service to your doctor.
10. In order to receive payment for out-of-state or out-of-the-country medical services, just follow the procedure listed under #3 and #4. In case of emergency outpatient hospital services, please submit an itemized billing with a copy of the emergency room report.

11. For verification of coverage always carry your medical card.
12. Written proof of claim satisfactory to the plan must be submitted within 90 days after the date of the event for which the claim is made. If proof of claim is not sent within the time required, the claim will not be reduced or denied if it was not possible to send proof within this time. However, the proof must be sent as soon as reasonably possible. In any case, the proof required must be sent to the plan no later than one year following the 90 day period specified, unless the Insured Person was legally incapacitated.

REMEMBER .. Promptness and accuracy on your part in completing the claim form insures getting your claim paid at the earliest possible date.

CLAIMS PROCEDURES

The CUSD Prudent Buyer Medical Plan provides that treatment or service must be medically necessary and be covered by your program. United Administrative Services has responsibility for determining whether claims are payable. A practicing physician-consultant retained by the claims administrator must agree if the denial is based on lack of medical necessity. To be considered medically necessary the treatment must be one that cannot be avoided without adversely affecting the patient's condition. The mere fact that your doctor orders the treatment does not mean that it is medically necessary.

Medical Necessity also applies to the type of facility in which you receive care. The Plan does not consider hospitalization medically necessary if the care could be adequately provided in a less expensive facility such as skilled nursing facility or outpatient clinic.

No benefits are payable for care, treatment, services and supplies to the extent that they are not reasonably necessary for treatment of an injury or disease or to the extent that the charges for care, treatment, services or supplies are unreasonable.

CLAIMS REVIEW PROCEDURE

Following is a description of how the Plan processes Claims for benefits. A Claim is defined as any request for a Plan benefit made by a Claimant or by an authorized representative of a Claimant, that complies with the Plan's reasonable procedure for making benefit Claims. A communication regarding benefits that is not made in accordance with these procedures will not be treated as a Claim under these Claims Procedures.

Time limits imposed on the Plan are maximum times and begin with the receipt of the Claim without regard to whether the information necessary to make a benefit determination accompanies the filing. In the event that period of time is extended due to a Claimant's failure to submit information necessary to decide a Claim, the period for making the benefit determination shall be suspended from the date on which the notification of the extension is sent to the

Claimant until the date on which the Claimant or his/her authorized representative responds to the request for additional information.

Time limits imposed on the Covered Person are minimum times and may be extended by the Plan. Time limits for furnishing additional information to the Plan begin when the claimant receives the request for additional information.

There are four (4) categories of Claims, each with somewhat different claim and appeal rules based on the type of Claim involved. The primary difference is the timeframe within which Claims and appeals must be determined. It is very important to follow the requirements that apply to your particular type of Claim. If you have any questions regarding what type of Claim and/or what Claims Procedure to follow, contact your Claims Administrator.

The definitions of the types of Claims are:

Pre-Service Claim

A Pre-Service Claim means any Claim for a benefit under this Plan where the Plan specifically conditions receipt of the benefit, in whole or in part, on approval in advance of obtaining medical care, unless the Claim involves Urgent Care as that term is described below. Pre-Service Claims are, for example, Claims subject to pre-certification.

In the case of a Pre-Service Claim, the following timetable applies:

Notification to Claimant of benefit determination	15 days
Extension due to matters beyond the control of the Plan	15 days (Period tolled for incomplete claims)
Insufficient information on the Claim:	
Notification of	15 days
Response by Claimant	45 days
Notification, orally or in writing, of failure to follow the Plan's procedures for filing a claim	5 days, 24 hours if Urgent Care Claim
Review of adverse benefit determination	30 days

Urgent Care Claim

An Urgent Care Claim is a special type of Pre-Service Claim. A Claim involving Urgent Care is any Pre-Service Claim for medical care or treatment where applying the Pre-Service Claim timeframes described above could seriously jeopardize the life or health of the Claimant; or the ability of the Claimant to regain maximum function; or in the opinion of a Physician with knowledge of the Claimant's medical condition, would subject the Claimant to severe pain that could not be adequately managed without the care or treatment that is the subject of the Claim.

A Physician with knowledge of the Claimant's medical condition may determine if a Claim is one involving Urgent Care. If there is no such Physician, an individual acting on behalf of the Plan and applying the judgment of a prudent layperson that possesses an average knowledge of health and medicine may make the determination.

In the case of a Claim involving Urgent Care, the following timetable applies:

Notification to Claimant of benefit determination	72 hours
Insufficient information on the Claim, or failure to follow the Plan's procedure for filing a Claim:	
Notification to Claimant, orally or in writing	24 hours
Response by Claimant, orally or in writing	48 hours
Benefit determination, orally or in writing	48 hours (following response by Claimant)
Review of adverse benefit determination	72 hours

If there is an adverse benefit determination on a Claim involving Urgent Care, a request for an expedited appeal may be submitted orally or in writing by the Claimant, the attending physician or other authorized representative. All necessary information, including the Plan's benefit determination on review, may be transmitted between the Plan and the Claimant by telephone, facsimile, or other similarly expeditious method. The Plan shall not terminate or reduce benefits prior to completion of the expedited review.

Post-Service Claim

A Post-Service Claim means any Claim for a Plan benefit that is not a Claim involving Urgent Care or a Pre-Service Claim; in other words, a Claim that is a request for payment under the Plan for covered medical services already received by the Claimant.

In the case of a Post-Service Claim, the following timetable applies:

Notification to claimant of benefit determination	30 days
Extension due to matters beyond the control of the Plan	15 days (Period tolled for incomplete Claims)
Insufficient information on the Claim:	
Notification of	15 days
Response by claimant	45 days
Review of adverse benefit determination	60 days

Concurrent Care Claim

A Concurrent Care Claim is any Claim, including an Urgent Care Claim, approved by the Plan involving an ongoing course of treatment to be provided over a period of time or for a specified number of treatments. There are two (2) types of Concurrent Care Claims: (a) where reconsideration of the approval results in a reduction or termination of the initially-approved period of time or number of treatments; and (b) where an extension is requested beyond the initially-approved period of time or number of treatments.

In the case of a Concurrent Care Claim, the following timetable applies:

Reduction or termination prior to end of treatment	72 hours (Urgent Care) 15 days (Pre-Service) 30 days (Post-Service)
Request for extension of treatment (prior to end of Approved treatment)	24 hours
Determination as to extending course of treatment	24 hours (Urgent Care) 15 days (Pre-Service) 30 days (Post-Service)
Review of adverse benefit determination	Reasonable period prior to reduction/termination Standard appeals time frames apply for appeals of extension determinations

If there is an adverse determination on a Claim involving Concurrent Care, a request for an expedited appeal may be submitted orally or in writing by the claimant, the attending physician or other authorized representative. All necessary information, including the Plan's benefit determination on review, may be transmitted between the Plan and the claimant by telephone, facsimile, or other similarly expeditious review. The Plan shall not terminate or reduce benefits prior to completion of the expedited review.

Notice to claimant of adverse benefit determinations

Except with Urgent Care Claims, when the notification may be oral, followed by written or electronic notification within three (3) days of the oral notification, the Claims Administrator shall provide written or electronic notification of any adverse benefit determination. A decision on a Claim is "adverse" if it is (a) a denial, reduction, or termination of, or (b) a failure to provide or make payment (in whole or in part) for a Plan benefit. The notice will state the following, in a manner calculated to be understood by the Claimant:

1. The specific reason or reasons for the adverse determination.
2. Reference to the specific Plan provisions on which the determination was based.
3. A description of any additional material or information necessary for the claimant to perfect the Claim and an explanation of why such material or information is necessary.
4. A description of the Plan's review procedures, incorporating any voluntary appeal procedures offered by the Plan, and the time limits applicable to such procedures. This will include a statement of the Claimant's right to sue in federal court.
5. A statement that the Claimant is 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.
6. If the adverse benefit determination was based on an internal rule, guideline, protocol, or other similar criterion, the specific rule, guideline, protocol, or criterion will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol, or criterion was relied upon in making the adverse benefit determination and a copy will be provided free of charge to the Claimant upon request.
7. If the adverse benefit determination is based on the Medical Necessity or Experimental or Investigational treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances, will be provided. If this is not practical, a statement will be included that such explanation will be provided free of charge, upon request.
8. If the adverse benefit determination involves Urgent Care, a description of the expedited review process applicable to such Claims.

Appeals

Except for Urgent Care Claims, discussed below, an appeal of an adverse benefit determination is considered filed when a Claimant, or an authorized representative, submits a written request for review to:

Plan Administrator
United Administrative Services
P.O. Box 5057
San Jose, California 95150-5057

A request for review will be treated as received by the Plan (a) on the date it is deposited in the U.S. Mail for first-class delivery in a properly-stamped envelope containing the above name and address. The postmark on any such envelope will be proof of the date of mailing.

The Claimant must file an appeal of an adverse benefit determination within 180 days following the Claimant's receipt of the notification of adverse benefit determination, except that the appeal of a decision by the Plan to reduce or terminate an initially-approved course of treatment (see the definitions of a Concurrent Care Claim), the Claimant must submit an appeal within thirty (30) days of the Claimant's receipt of the notification of the Plan's decision to reduce or terminate.

If the appeal involves an Urgent Care Claim, the Claimant or an authorized representative may file a request for expedited appeal orally or in writing. All necessary information for appeal of an Urgent Care Claim denial may be transmitted by telephone, facsimile or other available similarly expeditious method.

The period of time within which a benefit determination on review is required to be made shall begin at the time an appeal is filed in accordance with the procedures of the Plan as outlined above. This timing is without regard to whether all the necessary information accompanies the filing.

A Claimant may submit written comments, documents, records, and other information relating to the Claim. A document, record, or other information shall be considered relevant to a Claim if it:

1. was relied upon in making the benefit determination;
2. was submitted, considered, or generated in the course of making the benefit determination, without regard to whether it was relied upon in making the benefit determination;
3. demonstrated compliance with the administrative processes and safeguards designed to ensure and to verify that benefit determinations are made in accordance with Plan documents and Plan provisions have been applied consistently with respect to all claimants; or

4. constituted a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit.

The review shall 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. The review will not afford deference to the initial adverse benefit determination and will be conducted by a fiduciary of the Plan who is neither the individual who made the adverse determination nor a subordinate of that individual.

If the determination was based on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is Experimental, Investigational, or not Medically Necessary or appropriate, the fiduciary shall consult with a health care professional. The health care professional engaged to review an appeal should be an individual who was neither the person consulted in connection with the adverse determination nor the subordinate of any such individual. This health care professional will have appropriate training and experience in the field of medicine involved in the medical judgment. Additionally, medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the initial determination will be identified, without regard to whether the advice was relied upon in making the benefit determination.

The Plan's decision on review is the plan's final decision, subject to a Claimant's option to elect to submit a benefit dispute to the voluntary level of appeal through arbitration described below.

A Claimant has the right to bring a civil action if the Claimant has filed an appeal and the Claimant's request for coverage or benefits is denied following review and/or voluntary arbitration.

Voluntary appeals through arbitration

A Claimant may elect arbitration when an adverse benefit determination is upheld as explained in the section above, entitled "Appeals."

The Plan waives any right to assert that a Claimant has failed to exhaust administrative remedies because he or she did not elect to submit a benefit dispute to the voluntary level of appeal through arbitration provided by the Plan.

During arbitration, any statute of limitations or other defense based on timeliness is suspended during the time the voluntary appeal through arbitration is pending.

The Plan will provide to the Claimant, at no cost and upon request, sufficient information about arbitration to enable the claimant to make an informed judgment about whether to submit a benefit dispute to arbitration. This information will include a statement that the decision will

have no effect on the Claimant's rights to any other benefits under the Plan; will list the rules of the appeal; state the Claimant's right to representation; enumerate the process for selecting the decision maker; and give circumstances, if any, that may affect the impartiality of the decision maker.

No fees or costs will be imposed on the Claimant as part of the voluntary level of appeal, and the claimant will be told this.

Arbitration is not mandatory.

Questions about your prescription drug coverage. If you have outpatient *prescription drug* coverage and you have questions or concerns, you may call Caremark at 1-888-727-5575. If you are dissatisfied with the resolution of your inquiry and want to file a grievance, you may write to us at the address listed above and follow the formal grievance process.

Problems with claims may also be brought to the attention of the CUSD Human Resources Staff or the Health and Welfare Committee.

DEFINITIONS

1. **Prudent Buyer Providers (PPO)** is an organization operates under contract with the Administrator to provide hospital, medical and surgical services at agreed upon allowances. Prudent Buyer providers are located in California.
2. **Prudent Buyer Allowances** is the dollar amount allowed for each particular type of medical service by Prudent Buyer Providers. Prudent Buyer providers have agreed to accept the allowance as full payment for service for CUSD Prudent Buyer Plan members, although they will often list a higher fee.
3. The **Employee** is the person enrolled according to the eligibility stated in this plan.
4. The **Spouse** is the employee's spouse under a legally valid marriage.
5. The **Child** is the employee's child, step-child or legally adopted child from the moment of placement in your home, your step-child, or a child under your legal guardianship, but only if this child depends on You for support and maintenance and if the child lives with You in a parent-child relationship. The term child does not include a foster child who is eligible for benefits provided by any governmental program or law, unless such inclusion is required by the laws of this state.
6. A **Domestic Partner** and the employee:
 - A. Have an intimate, committed relationship of mutual caring;
 - B. Live together*;
 - C. Agree to be responsible for each other's basic living expenses** during their domestic partnership; they also agree that anyone who is owed these expenses can collect from either of them;
 - D. Are both 18 years of age or older;
 - E. Neither of them is married;
 - F. Neither of them is related to the other as a parent, brother or sister, half-brother or half-sister, niece, nephew, aunt, uncle, grandparent or grandchild;
 - G. Neither of them has a different current domestic partner; and
 - H. Neither of them has had a different domestic partner in the last six months (this condition does not apply if either had a partner who died).

- **Live together** means that the employee and domestic partner share a place to live. They don't both have to be on the rental agreement or deed. It is okay if one or both of them have a separate place somewhere else. Even if one of them leaves the place they share, they still live together as long as the one who left intends to return.
 - ** **Basic living expenses** means the cost of basic food and shelter. It also includes any other expense which is paid by a benefit that the employee or domestic partner gets because of the partnership. For example, if the employee or domestic partner gets health insurance from their job and the insurance covers the partner they will be responsible for medical bills which the insurance does not pay. The employee and domestic partner don't have to split basic living expenses to be domestic partners; they just have to agree to provide these things for their partner if he or she can't provide for him or herself.
7. A **Family Member** is the employee's enrolled spouse or domestic partner and each enrolled eligible child.
 8. A **Member** is the employee or family member.
 9. The **Agreement Date** is the date this plan comes into effect.
 10. The **Effective Date** is the date the member's coverage under this plan begins.
 11. An **Open Enrollment Period** is held each school year with an effective date of September 1st for employees who wish to change medical plans, or add a dependent coverage. Employees switching medical plans at Open Enrollment are not subject to a preexisting condition limitation; however, dependents added to the Plan are subject to a preexisting condition limitation. Kaiser members who move out of the service area can only change medical plans during the Open Enrollment period.
 12. **Medically Necessary** services or supplies are those which meet all of the following criteria, as determined by the plan administrator:
 - A. Appropriate and necessary for the symptoms and diagnosis or treatment of a medical condition covered by the plan, and
 - B. Provided for the diagnosis or direct care and treatment of the medical condition, and
 - C. Within standard of good medical practice within the organized medical community, and
 - D. Not primarily for the convenience of the member, the member's physician or another provider, and

- E. The most cost effective, adequate and safe level of service or supplies which can appropriately be provided. For hospital stays, this means that acute care as a bed patient is needed due to the kind of services the member is receiving or the severity of the member's condition, and that safe and adequate care cannot be received as an outpatient or in less intensified medical setting.

- 13. A **Hospital** is a facility, which provides diagnosis, treatment and care of persons who need acute care inpatient hospital care under the supervision of physicians. It must be licensed as a general acute care hospital according to state and local laws. It must also be registered as a general hospital by the American Hospital Association and meet accreditation standards of the Joint Commission on Accreditation of Hospitals.

- 14. An **Outpatient Surgical Center** is a facility other than a medical or dental office, whose main function is performing surgical procedures on an outpatient basis. It must be licensed as a general acute care hospital according to state and local laws. It must also be registered as a general hospital by the American Hospital Association and meet accreditation standards of the Joint Commission on Accreditation of Hospitals.

- 15. A **Skilled Nursing Facility** is an institution that provides continuous skilled nursing services. It must be licensed according to state and local laws and be recognized as a skilled nursing facility under Medicare.

- 16. **Home Health Agencies and Visiting Nurse Associations** are home health care providers which are licensed according to state and local laws to provide skilled nursing and other services on a visiting basis in the member's home. They must be recognized as home care providers under Medicare.

- 17. A **Physician or Surgeon** means
 - A. A doctor of medicine (M.D.) or a doctor of osteopathy (D.O.) who is licensed to practice medicine or osteopathy where the care is provided, or

 - B. One of the following providers, but only when the provider is licensed to practice where the care is provided, is rendering a service within the scope of that license, is providing a service for which benefits are specified in this agreement, and when benefits would be payable if the services were provided by a physician as defined in A. above:
 - (1) A dentist (D.D.S.)

 - (2) A podiatrist or chiropodist (D.P.M., D.S.P. or D.S.C.)

 - (3) A certified acupuncturist (C.A.)

 - (4) A chiropractor (D.C.)

- (5) A physical therapist (P.T. or R.P.T)*
- (6) A speech pathologist*
- (7) An audiologist
- (8) An occupational therapist (O.T.R.)*

Note: The providers indicated by asterisks (*) are covered only by referral of a physician as defined above.

If your physician refers you to a specialist, you should request referral to a Foundation member. This is particularly important for anesthesiologists, radiologists, and for any diagnostic testing.

- 18. A **Year** is a twelve month period starting each January 1 at 12:01 a.m. Pacific Standard Time.
- 19. **Custodial Care** is care provided primarily to meet the personal needs of the member. This includes help in walking, bathing or dressing. It also includes preparing food or special diets, feeding, administration of medicine which is usually self-administered or any other care which does not require continuing services of medical personnel.
- 20. **Special Care Units** are special areas of a hospital which have highly skilled personnel and special equipment for acute conditions that require constant treatment and observation.
- 21. **Experimental Procedures** are all procedures not generally provided as treatment by the organized medical community in California, and those that are mainly limited to laboratory and/or animal research.
- 22. **Investigative Procedures** are experimental procedures that have progressed to limited use on humans, but which are not widely accepted as proven and effective procedures within the organized medical community in California.
- 23. **Mental, Nervous Disorders and Substance Abuse Disorders** are those conditions, which are listed in the International Classification of Diseases as diagnostic codes 290-319. All of these conditions are specifically excluded under this plan. Refer to Mental Health Coverage section.
- 24. **Accidental Injury** is physical harm or disability which is the result of a specific unexpected incident caused by an outside force. The physical harm or disability must have occurred at an identifiable time and place. Accidental injury does not include illness or infection, except infection of a cut or wound.
- 25. A **Totally Disabled Member** is one who, because of illness or injury, is unable to work for income in any job for which he or she is qualified or for which he or she becomes

qualified by training or experience, and who is in fact unemployed. A totally disabled family member is one who is unable to perform all activities usual for a person of that age.

26. **Administrator** is United Administrative Services.
27. **District** is the Cupertino Union School District.
28. **Plan** is the Cupertino Union School District Prudent Buyer Medical Plan.
29. **Retiree** means a person receiving retirement benefits under the State Teachers Retirement System, Public Employees Retirement System or Federal Social Security Law and who has been employed by the District.
30. **Coinsurance Amount** is the percentage amount payable by this plan, constituting benefits for covered expenses.
31. **Hospice** means an agency licensed or certified by the state in which it is located to provide hospice care.
32. **Hospice Care** means medically necessary and/or palliative treatment administered to a terminally ill person. Such treatment may include short-term care as an inpatient in a hospice unit or care in the person's home. All services must be planned, implemented and evaluated by an interdisciplinary team of trained volunteers and professionals, including at least a physician, registered nurse, clergy/counselors and other staff who have expertise in providing hospice care.
33. **Well Baby Care** is routine examinations and immunizations for eligible dependent children from birth to age two.
34. **Medical Emergency** is defined as medical services that are immediately required to treat a sudden, serious or unexpected illness or injury, or to provide medical services to alleviate severe pain associated with a sudden, serious or unexpected illness or injury. Examples of medical emergencies are; uncontrollable bleeding; loss of consciousness or confusion, especially after a head injury; severe shortness of breath or difficulty breathing; apparent heart attack symptoms; and broken bones.

COVERED EXPENSES

1. Charges of a hospital for services and supplies rendered during confinement except that charges for room and board shall not exceed the hospital's semi-private room rate; charges of a hospital for confinement in an intensive care unit, contagion ward, isolation or private accommodation, when such confinement is certified by the attending physician as being medically necessary by reason of the severity of the insured person's condition.

2. Other Inpatient Hospital Care.

Subject to any limitations specified in the Schedule of Benefits, benefits include the use of operating rooms, delivery rooms, nurseries, recovery rooms, equipment therein, and also the following:

- A. Oxygen and carbon dioxide, including equipment and administration thereof.
 - B. Intravenous injection and solutions, such as glucose and serum.
 - C. Prescription drugs and biologicals.
 - D. Whole blood and blood derivatives, and administration and processing of same by the hospital, but not including blood procurement charges or charges for maintenance of a blood bank.
 - E. Dressings, splints, and casts, but not including special braces.
 - F. Diagnostic services; the following procedures to diagnose a condition, in response to specific symptoms, ordered or performed by a physician or other Licensed Health Care Professional licensed to render the services:
 - (1) Radiology, ultrasound and nuclear medicine services.
 - (2) Laboratory and pathology services.
 - (3) Electrocardiogram, electroencephalogram, ultrasound and other diagnostic procedures.
 - G. Anesthesia, including continuous epidural anesthesia when used for control of chronic, intractable pain due to terminal cancer or when used for control of acute post-operative pain following select procedures. Anesthesia services are not available in connection with care which is not a Benefit.
3. Outpatient hospital: surgical procedure, accidental injuries and medical emergencies (shock, acute poisoning, hemorrhaging, etc.) Emergency room treatment that is not considered a medical emergency will require a \$50.00 co-payment that is in addition to the annual plan deductible. The deductible will be waived if the treatment is considered a medical emergency.
4. Ambulatory Surgical Center
5. Radiation therapy, chemotherapy and hemodialysis treatment.

6. Skilled Nursing Facility or Rehabilitation Facility Treatment
 - A. For confinement in skilled nursing or rehabilitation facility which immediately follows at least three days of hospital confinement. Includes ambulance service for transfer from hospital. Charges of a hospital for services and supplies rendered during confinement except that charges for room and board shall not exceed the hospital's semi-private room rate.
 - B. The services must be consistent with the illness, injury, degree of disability and medical needs of the patient. Benefits are only provided for the number of days required to treat the member's illness or injury. Services must be those which are regularly provided and billed by a Skilled Nursing Facility.
 - C. The patient must remain under the active medical supervision of a Physician. The Physician must be treating the illness or injury for which the patient is confined in the Skilled Nursing Facility.
7. Surgeon's Charges by a Physician for the performance of surgical procedures.
8. Anesthesia Charges and its administration when these are not covered as Hospital charges.
9. Physician's Charges for medical care and treatment including;
 - A. Emergency room visits at hospital or clinics.
 - B. Inpatient hospital visits during a covered inpatient stay (except those relating to surgery), limited to one a day unless additional visits are needed due to the member's medical condition.
 - C. Extra time spent when the physician is detained to treat a member in critical condition who requires constant care.
 - D. Services of a physician at his office or in your home for treatment of illness or disease.
10. Nursing, Physiotherapy, and Occupational Therapy Charges for:
 - A. Private duty nursing care by a Nurse;
 - B. Treatment by a licensed physiotherapist; and
 - C. Treatment by a licensed occupational therapist.

The person providing the care must not live with or be related to the Insured Person or to his or her spouse.

11. Radiological and Laboratory Charges for diagnostic purposes and preventive screening tests that the physician determines to be medically necessary based on family medical history:

- A. X-rays
- B. Radiological treatment;
- C. Diagnostic laboratory tests;
- D. Low-dose mammography screening
- E. Annual cervical cancer screening test (pap smear); and
- F. Endoscopy and arthroscopy

12. Cosmetic Surgery and related charges is covered only:

- A. Within 12 months after and as a result of an injury sustained while insured under this plan;
- B. For replacement of diseased tissue surgically removed while insured under this plan;
- C. For the initial reconstruction of a breast after a mastectomy for which the patient was insured under this plan for the mastectomy; and
- D. Repair of bodily damage covered by disease and/or radiation treatment while insured under this plan.

13. Women's Health and Cancer Rights Act of 1998

Your plan covers medical and surgical benefits for mastectomies. This coverage includes:

- A. reconstruction of the breast on which the mastectomy was performed;
- B. surgery and reconstruction of the other breast to produce symmetrical appearance;
- C. prosthesis and physical complications of all stages of mastectomy, including lymphedemas.

The coverage is subject to the Plan's annual deductibles and coinsurance provisions.

14. Ambulance and Air Ambulance are allowed at the prevailing reasonable and customary charges and subject to the following:
 - A. Professional ambulance service when used to transport the insured person directly from the place where he/she is injured or becomes ill to the hospital(s) where treatment is given.
 - B. Professional ambulance service when also used to transport insured member from general hospital or emergency room to hospitals of specialty treatment, or to home hospital area.
 - C. Transportation by air ambulance from one hospital to another will be allowed when certified by the attending physician as being medically necessary by reason of the severity of the insured person's condition. This also includes transportation to the United States from a foreign country.
 - D. Services must be provided by an air ambulance, a licensed ambulance company, by professional non-air ambulance or on a regularly scheduled flight on a commercial airline when:
 - (1) Special and unique Covered Hospital Services are required which are not provided by a local Hospital;
 - (2) Transportation is medically necessary as deemed by the Administrator; and
 - (3) Transportation is to the nearest Hospital equipped to furnish the services.
 - E. Base charge, mileage and non-reusable supplies of a licensed ambulance or ambulance company.
 - F. Monitoring, electrocardiograms (EKG'S or ECG'S), cardiac defibrillation, cardio- pulmonary resuscitation (CPR) and administration of oxygen and intravenous (IV) solutions in connection with ambulance service. An appropriately licensed person must render the services.
15. Home Health Care by approved home health care agency as recommended by physicians does not include custodial care.
16. Physical therapy.
17. Injections and allergy testing and treatments.

18. Dental benefit: inpatient hospital benefits are provided for up to three days during each period of hospital confinement for:
 - A. Dental surgery or extraction when required under general anesthesia;
 - B. Treatment to the teeth, gums or their dependent tissues when certified by the attending physician as being medically necessary, because the conditions under treatment are of such nature as to endanger the life of the insured person; and
 - C. Dental care in accident cases - payment will be made for services incident to the treatment of injuries to the natural teeth, jaws and their dependent tissues customarily performed by dentists and oral surgeons. The services do not include the cost of or services for restoration of function or appearance (dentures, braces, etc.). These are covered by CUSD dental plans.

19. Pregnancy and Maternity Care

Covered expenses for pregnancy and maternity care, including termination of pregnancy for medical reasons.

Covered expense for hospital benefits for routine nursery care of a newborn Child, if the Child's natural mother is enrolled under this Agreement.

20. Organ and Tissue Transplants

Expenses for an organ transplant with such procedures limited to those transplants that are medically necessary and to the extent that they are not deemed experimental or investigative.

Experimental procedures are all procedures not generally provided as treatment by the organized medical community in California, and those that are mainly limited to laboratory and/or animal research.

Investigative procedures are experimental procedures that have progressed to limited use on humans, but which are not widely accepted as proven and effective procedures within the organized medical community in California.

21. Hospice care benefits: provided for a terminally ill person with a six-month or less life expectancy upon certification of a physician. The following services are covered:
 - A. Nursing services by or under supervision of a registered nurse;
 - B. Necessary medical equipment including oxygen;

C. Home health aide; and

D. Counseling.

22. Artificial limbs or eyes. This includes services of an orthotist and prosthetist in connection with evaluation or the fitting of an orthotic or prosthetic device when those services are billed as part of the charge of the artificial limbs or eyes.

Provided that benefits shall cover artificial limbs or eyes, only when such devices are:

A. Affixed to the body externally;

B. Required to replace all or any part of any limb or eye;

C. Required to support or correct a defect or form or function of a permanently inoperative or malfunctioning limb or eye.

And further provided benefits do not extend to the repair or replacement of prosthetic devices occasioned by misuse or loss.

23. Rental or purchase of dialysis equipment, dialysis supplies and rental or purchase of other medical equipment and supplies, including hearing aids which are:

A. Ordered by a physician;

B. Of no further use when medical need ends;

C. Usable only by the patient;

D. Not primarily for the Member's comfort or hygiene;

E. Not for environmental control;

F. Not for exercise;

G. Manufactured specifically for medical use;

H. Approved as effective and usual and customary treatment of a condition as determined by the Plan; and

I. Not for prevention purposes.

Rental charges that exceed the reasonable purchase price of the equipment are not covered, as determined by the Administrator.

24. Prescription Drugs: Please refer to the section in this handbook titled Prescription Coverage.
25. Chiropractic Care except for vitamin supplements, lumbar supports or pillows or massage therapy or maintenance therapy.
26. Routine physical exams are included as a benefit only for eligible dependent children from birth to age two, which includes well baby care.
27. Charges for oxygen and the rental of equipment for the giving of oxygen.
28. Effective March 1, 2005, the plan will reimburse Covered Expenses, for Routine Patient Care Costs in connection with participation in Cancer Clinical Trials as defined below.

Cancer Clinical Trials - Definition

Phase 1, Phase II, Phase III and phase IV cancer clinical trials, if all the following conditions are met:

The treatment provided in a clinical trial must either:

1. Involve a drug that is exempt under federal regulations from a new drug application, or
2. Be approved by:
 - A. One of the National Institutes of Health;
 - B. The federal Food and Drug Administration in the form of an investigational new drug application;
 - C. The United States Department of Defense; or
 - D. The United States Veteran's Administration.

Routine Patient Care Costs – Definition

The costs associated with the provision of services, including drugs, items, devices and services which would otherwise be covered under the Plan, including health care services which are:

1. Typically provided if a clinical trial were not involved.
2. Required solely for the provision of the investigational drug, item, device or service.
3. Clinically appropriate monitoring the investigational item or service.
4. Used to prevent complications arising from the provision of the investigational drug, item, device or service.
5. Are considered to be reasonable and necessary care arising from the provision of the investigational drug, item, device or service, including the diagnosis or treatment of the complications.

Routine Patient Care Costs do not include any of the following:

1. Drugs or devices not approved by the federal Food and Drug Administration that are associated with the Cancer Clinical Trial.
2. Services other than health care services, such as travel, housing, companion expenses and other non-clinical expenses that you may require as a result of the treatment provided for the purposes of the clinical trial.
3. Any item or service provided solely to satisfy data collection and analysis needs not used in the clinical management of the patient.
4. Health care services that, except for the fact they are provided in a clinical trial, are otherwise specifically excluded from the Plan.
5. Health care services customarily provided by the research sponsors free of charge to patients enrolled in the trial.

Additional Provisions

1. The covered Person must be diagnosed with cancer for Routine Patient Care Costs to be eligible under this Endorsement.
2. Participation in Cancer Clinical trials must be recommended by the physician of the Covered Person after determining the Covered Person's participation has a meaningful potential to benefit the Covered Person.

3. For the purpose of this Endorsement, the Cancer Clinical Trial must have a therapeutic intent.
4. Cancer Clinical Trials just to test toxicity are not eligible under this Endorsement.
5. Only Covered Expenses Incurred on or after March 1, 2005 will be eligible under this Endorsement.
6. Excess reimbursement benefits paid under this Endorsement shall not create any legal presumption that either HCC Life Insurance Company or its Underwriting Manager has recommended, directed, endorsed or required any Covered Person's participation in the Cancer Clinical Trial.
7. Excess Reimbursement benefits paid under this Endorsement shall be subject to all terms and conditions of the Policyholder's Plan.

EXCLUSIONS AND LIMITATIONS

Benefits are NOT provided for the following:

1. Services or supplies that are not Medically Necessary as defined in Definitions, and Experimental or Investigative procedures as defined in Definitions.
2. Services received before the Member's Effective Date or during an inpatient stay that began before the Member's Effective Date. Services received after the Member's coverage ends except as specifically stated under Extension of Benefits.
3. Any amounts in excess of the Prudent Buyer Network allowance for professional services of non- Prudent Buyer Network providers except for dual coverage.
4. Services not specifically listed as covered services.
5. Services for which the Member is not legally obligated to pay and Services for which no charge is made to the Member. Services for which no charge is made to the Member in the absence of insurance coverage, except services received at a non-governmental charitable research Hospital. Such a Hospital must meet the following guidelines:
 - A. It must be internationally known as being devoted mainly to medical research;
 - B. At least ten percent of its yearly annual expenditure must be spent on research not directly related to patient care;
 - C. At least one-third of its gross income must come from donations or grants other than gifts or payments for patient care;
 - D. It must accept patients who are unable to pay; and

- E. Two-thirds of its patients must have conditions directly related to the Hospital's research.
- 6. Work-related conditions if benefits are recovered or can be recovered, either by adjudication, settlement or otherwise, under any workers' compensation, employer's liability law or occupational disease law, even if the Member does not claim those benefits.
- 7. Conditions caused by an act of war.
- 8. Any service provided by a local, state or federal government agency.
- 9. Any services to the extent that the Member is entitled to receive Medicare benefits for those services, whether or not Medicare benefits are actually paid. Any services for which payment may be obtained from any other local, state or federal government agency (except Medi-Cal).
- 10. Professional services received from a person who lives in the Member's home or who is related to the Member by blood or marriage.
- 11. Inpatient room and board charges in connection with a hospital stay primarily for environmental change, physical therapy or treatment of chronic pain. Custodial care or rest cures. Services provided by a rest home, a home for the aged, a nursing home or any similar facility. Services provided by a Skilled Nursing Facility, except as specifically stated in Skilled Nursing Facility under Covered Expenses.
- 12. Inpatient room and board charges in connection with a hospital stay primarily for diagnostic tests which could have been performed safely on an outpatient basis.
- 13. Treatment for hyperkinetic syndromes, learning disabilities, behavioral problems, mental retardation or autistic disease of childhood.
- 14. Braces, other orthodontic appliances or orthodontic services.
- 15. Dental plates, bridges, crowns, caps or other dental prostheses, dental services, extraction of teeth, or treatment to the teeth or gums, except as specifically stated under Covered Expenses. Cosmetic dental surgery or other services for beautification.
- 16. Routine hearing tests.
- 17. Optometric services, eye exercises including orthoptics, routine eye exams and routine eye refractions. Eyeglasses or contact lenses, except as specifically stated under Covered Expenses.

18. Outpatient occupational therapy, except following surgery, injury, or non-congenital organic disease.
19. Outpatient speech therapy, except following surgery, injury or non-congenital organic disease.
20. Charges in connection with Cosmetic Surgery are covered only if
 - A. Within 12 months after and as the result of an injury sustained while insured under this plan;
 - B. For replacement of diseased tissue surgically removed while insured under the plan;
 - C. For the initial reconstruction of a breast after a mastectomy for which benefits are paid under this plan; and
 - D. Repair of bodily damage covered by disease and/or radiation treatment while insured under this plan.
21. Services primarily for weight reduction or treatment of obesity. This exclusion will not apply to surgical treatment of obesity if:
 - A. Surgical treatment of obesity is necessary to treat another life-threatening condition involving obesity; and
 - B. It has been documented that non-surgical treatments of obesity have failed.
22. Procedures or treatments to change characteristics of the body to those of the opposite sex.
23. Sterilization reversal, treatment of infertility, artificial insemination and in vitro fertilization, including implantation of fertilized egg embryo or gamete transfer procedures and related care.
24. Orthopedic shoes* (except when joined to braces) or shoe inserts*, air purifiers, air conditioners, humidifiers, exercise equipment and supplies for comfort, hygiene or beautification. Educational services, nutritional counseling or food supplements. Telephone consultations.

*Orthopedic shoes and shoe inserts are payable only for injuries incurred while covered under this plan.

25. Routine physical exams or tests which do not directly treat an actual illness, injury or condition, including those required by employment or governmental authority, except well baby as defined under definitions.
26. Any eye surgery solely for the purpose of correcting refractive defects of the eye such as near sightedness (myopia) and astigmatism.
27. Mental, nervous and substance abuse disorders as defined in Definitions.

Note: There is no exclusion for pre-existing conditions under this plan.

COORDINATION OF BENEFITS

The CUSD Prudent Buyer Medical Plan contains a Coordination of Benefits ("COB") provision which applies when an individual has medical or dental care coverage under more than one plan so that the total benefits available will not exceed, but can approach or equal, 100% of the allowable expenses.

Coordination of Benefits applies when a member, or a member's children are also covered under a spouse's medical plan.

An allowable expense is any necessary, usual and customary expense covered at least in part, by one of the plans.

"Plan" means benefits or services provided by:

1. Group insurance or group-type coverage, whether insured or uninsured;
2. Employee-sponsored Blue Cross, Blue Shield or other pre-payment coverage;
3. Group-type contracts;
4. Coverage under a governmental plan;
5. Coverage required or provided by law; and
6. Medical benefits coverage in group or group-type and individual automobile "no fault" type contracts.

"Plan" does not include:

1. A state plan under Medicaid;
2. Benefits under a law or plan when, by law, its benefits are in excess to those of any private insurance plan;
3. Individual or family coverage, except as provided above; and
4. School accident type coverage. These cover grammar, high school, and college student for accidents only, including athletic injuries, either on a 24-hour basis or on a "to and from school" basis.

All benefits described in this booklet for medical and prescription drug coverage are subject to this provision.

When a claim is made, the primary plan pays its benefits without regard to any other plans. The secondary plan adjusts its benefits so that the total benefits available will not exceed the allowable expenses. No plan pays more than it would without the coordination provision.

A plan without a coordination provision is always the primary plan. If all plans have such a provision the following rules apply:

1. The plan covering **the patient directly, rather than as employee's dependent**, is primary and **others are secondary**.
2. When this Plan and another plan cover the same child as a dependent of different persons, called "parents":
 - A. The benefits of the plan of the parent whose birthday falls earlier in the year are determined before those of a plan of the parent whose birthday falls later in that year; but
 - B. If both parents have the same birthday, the benefits of the plan which covered the other parent longer are determined before those of the plan which covered the other parent for a shorter period of time.
3. In the case of a child of separated or divorced parents, the benefits of the plan covering the child as a dependent will be determined as follows:
 - A. The plan of the natural parent having legal custody of the child;
 - B. The plan of the current spouse, if any, of the natural parent, having legal custody of the child; and

- C. The plan of the natural parent not having legal custody of the child.
- 4. The plan covering a person as an active employee is primary to the plan covering the person as a retired or laid-off employee or any dependent thereof.
- 5. If 1, 2, 3 or 4 do not apply, the plan covering the patient longest is primary.

Coordination with Prepaid Plans

Regardless of whether this Plan may be considered primary or secondary under its coordination of benefits provisions, in the event an Eligible Individual (i) has coverage under the indemnity program of this Plan, and (ii) has coverage under a prepaid program under another Group Plan (regardless of whether the Eligible Individual must pay a portion of the premium for such plan), and (iii) incurs expenses normally covered under the prepaid program, then this Plan will only reimburse the co-payments required of the Eligible Individual under the prepaid plan, and only if such co-payments are required of every person covered by that program. Except for the co-payments specified above, the Plan will not pay expenses of eligible employees or dependents covered by prepaid programs of other plans.

For purposes of this Plan, the term “prepaid program” shall include health maintenance organizations, individual practice associations, and other programs that the District in its sole discretion deems to be essentially similar to such prepaid arrangements.

Medicare Coordination Of Benefits

This plan is the primary payer for active duty employees covered by Medicare, and for retired employees under the age of 65. Since Medicare Benefits will, in large measure, duplicate the benefits provided under the plan described in this booklet, medical coverage under this plan for any insured individual, whether employee or dependent, will be modified to take Medicare benefits into account on the earliest date that any coverage under Medicare would become effective for that individual (generally, coverage under Medicare can become effective on the first day of the month in which the individual attains age 65). The Medical expenses benefits of this plan will be coordinated to maintain the existing level of benefits as described herein and will pay for covered expenses not payable by Medicare. This includes the deduction for hospital Medicare.

**HOSPITAL PREADMISSION
CERTIFICATION AND CONCURRENT REVIEW**

Your CUSD Prudent Buyer Medical Plan includes a Preadmission Certification and Concurrent Review Program. This program is intended to reduce cost and personal problems arising from unneeded hospitalization. Additionally, it helps avoid claim denials and review for medical necessity after you have already incurred the expenses.

The Preadmission, Certification and Concurrent Review is a program designed to:

1. Determine if services are medically necessary;
2. Determine if the care can be obtained on an outpatient basis;
3. Review length of hospital stay prior to and just after admission; and
4. Periodically review the hospital stay after admission to determine if hospitalization continues to be appropriate.

Preadmission, Certification and Concurrent Review does not apply to Medicare recipients.

Preadmission review requires you to instruct your physician to notify Health Care Evaluation (HCE) at least **THREE WORKING DAYS BEFORE ANY SCHEDULED NON-EMERGENCY ADMISSION** to the hospital. The telephone number is 1-800-333-3018 and is also printed on your ID card. The doctor does all the rest.

HOSPITAL AND PHYSICIAN PREFERRED PROVIDER PLAN

As mentioned, your CUSD Prudent Buyer Medical Plan includes a Hospital and Physician Preferred Provider feature (PPO). A list of participating hospitals and doctors will be provided to you upon request. You may call United Administrative Services if you have any questions regarding status of specific hospitals and doctors at (408) 288-4400, or you may check the provider web site at www.bluecrossca.com

THIRD PARTY LIABILITY AND ACCIDENTS

If any other person, firm or corporation shall be responsible for the sickness or injury of a covered employee or covered dependent:

1. The plan shall be entitled to full extent of its payment for benefits for such sickness or injury, to the proceeds of any settlement of judgment that may result from the exercise of any rights or recovery of the covered employee or dependent against such person, firm or corporation.
2. The covered employee or dependent shall hold such rights of recovery in trust for the Plan, but only to the extent of its payment for such benefits.
3. The covered employee or dependent shall execute and deliver to the Plan such instruments and papers submitted by the Plan as may be appropriate to secure the rights

and obligations of the Plan and the employee or dependent established by this provision. The execution of an agreement to hold recovery proceeds in trust for the Plan shall be a condition precedent to the furnishing of benefits for such sickness or injury by the Plan.

4. The Plan shall pay out of such proceeds actually recovered a proportional share (based on the amount of recovery) of the fee incurred by the covered employee or covered dependent for attorney services in collecting from such person, firm or corporation, or its insurer.

Covered charges hereunder resulting from accidental injury involving a private passenger vehicle shall be reduced to the extent such charges are payable without regard to liability under any automobile insurance company.

RIGHT OF RECOVERY

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

EXTENSION OF BENEFITS

1. If a member is Totally Disabled when coverage ends and is under the treatment of a Physician, benefits may continue to be provided for services treating the totally disabling illness or injury. No benefits are provided for services treating any other illness, injury or condition.
2. A member confined as an inpatient in a hospital or skilled nursing facility is considered Totally Disabled as long as the inpatient stay is medically necessary and no written certification of the total disability is required.
3. A member not confined as an inpatient who wishes to apply for total disability benefits must submit written certification by the physician of the total disability. The administrator must receive this certification within 90 days of the date coverage ends under this agreement. At least once every 90 days while benefits are extended, the administrator must receive proof that the member's total disability is continuing.
4. Benefits are provided until one of the following occurs
 - A. The member is no longer Totally Disabled; or
 - B. The maximum lifetime benefits are paid; or

- C. The member becomes covered under another group health plan that provides coverage without limitation for the disabling illness or injury; or
- D. The date 12 months following the date in which the disabled member's coverage ended.