MASTER PLAN DOCUMENT AND PLAN DESCRIPTION OF

THE COUNTY OF KERN

POINT OF SERVICE

EMPLOYEE MEDICAL BENEFIT PLAN

Effective January 1, 2017

NOTE: THIS DOCUMENT IS CURRENTLY UNDER REVIEW FOR COMPLIANCE WITH THE AFFORDABLE CARE ACT AND IS SUBJECT TO REVISION TO ENSURE ADHERENCE TO APPLICABLE STATE OR FEDERAL STATUE

Revised January 2017

I. ELIGIBILITY AND COVERAGE ***1***

II. SUMMARY OF MEDICAL BENEFITS ***2***

A. SUMMARY OF LIMITING FACTORS 2
B. SCHEDULE OF BENEFITS 3
C. PROCEDURES REQUIRING PRIOR AUTHORIZATION 7
D. POS PLAN PROVIDER COVERAGE 8
1. Network Provider 8
2 Non-Network Provider 8
E. MAXIMUM BENEFITS 9
F. COSTS 9
1. Benefit Percentages 9
2. Copayments and Deductibles 9
3. Out-of-Pocket Maximums 9
G. DESCRIPTION OF BENEFITS AND SERVICES 10
1. Abortion 10
2. Allergy Injections and Surveys 10
3. Ambulance Service 10
4. Ambulatory Surgical Center 10
5. Bariatric Procedures 10
6. Birthing Centers 10
7. Chemical Dependency (Substance Abuse) / Mental Health 10
8. Chemotherapy 10
9. Chiropractic Treatment 11
10. Contraceptives 11
11. Dental Care for Accidental Injury 11
12. Diabetic Supplies and Education 11
13. Diagnostic Services 11
14. Dialysis 12
15. Disposable Medical Supplies 12
16. Durable Medical Equipment (DME) 12
17. Emergency Room Treatment 13
18. Home Health Care Services 13
19. Hospice Care Expenses 13
20. Hospital Inpatient Services 14
21. Hospital Outpatient Services 14
22. Newborn Care Expenses 14
23. Oral Surgery – For diagnosed Condition(s) or Covered Injury 14
24. Organ Transplants 15
25. Physical/Occupational Therapy 17
26. Physician Services 17
27. Pregnancy 18
28. Prescription Drugs 18
29. Preventive Care 18
30. Prosthetics 19
31. Radiation Therapy 20
32. Rehabilitation Facility 20
33. Rehabilitation Services 20
34. Skilled Nursing Facility 20
35. Speech Therapy 20
36. Sterilization 20
37. Surgery 21
a) Surgeon *21*

38. *TEMPOROMANDIBULAR JOINT (TMJ) DYSFUNCTION* ... *22*
39. *URGENT CARE* ... *22*
40. *VISION CARE* ... *22*
H. EXCLUSIONS FROM COVERAGE ... 22

III. CARE MANAGEMENT ... 27

A. PRIOR AUTHORIZATION REQUIREMENTS ... 27
B. PRIOR AUTHORIZATION FOR HOSPITAL CONFINEMENT ... 27
C. HOSPITALIST PROGRAM ... 28

IV. CLAIMS ... 28

1. *Filing a Claim* ... *29*
2. *Post-Service Claims* ... *29*
3. *Pre-Service Claims* ... *29*
4. *Concurrent Care Claims* ... *30*
5. *Appealing a Denied Claim* ... *31*
1. *Level One Review* ... *32*
2. *Response to Your Appeal* ... *32*
3. *Level Two Review* ... *32*
4. *Plan Administrator Review* ... *33*
5. *Independent Review* ... *33*
6. *Obtaining Medical Records* ... *35*
7. *Designated Decision Maker* ... *35*
8. *Confidentiality* ... *35*
9. *Receipt of Documents* ... *35*

V. COORDINATION OF BENEFITS / THIRD PARTY LIABILITY ... 36

A. *Application of Coordination of Benefits* ... *36*
B. *The Plan Administrator's Right to Pay Others* ... *38*
C. *Recovery of Excessive Payments by the Plan Administrator* ... *38*
D. *Facility of Payment* ... *38*
E. *Important Information for Medicare-Eligible Individuals* ... *38*
F. *Right of Reimbursement / Subrogation* ... *39*
G. *Right of Recovery* ... *39*
H. *Protected Health Information* ... *40*
1. *Participant's Health Information Rights* ... *40*
2. *Third Parties; Business Associates* ... *41*
3. *Filing a Complaint* ... *41*

VI. PLAN ADMINISTRATION ... 42

A. PLAN ADMINISTRATOR ... 42
B. CLAIMS ADMINISTRATOR ... 43
C. PARTICIPANT ... 43

VII. GENERAL PROVISIONS ... 45

A. LEGAL COMPLIANCE/CONFORMITY ... 45
B. EFFECT OF PRIOR COVERAGE ... 45
C. SEVERABILITY ... 45
D. STATUS OF EMPLOYMENT RELATIONS ... 45
E. HEADINGS ... 45
F. WORD USAGE ... 45
G. TITLES FOR REFERENCE ... 46
H. CLERICAL ERROR ... 46
I. MISSTATEMENTS ... 46

VIII. DEFINITIONS 46

IX. IDENTIFICATION OF PLAN 53

I. ELIGIBILITY AND COVERAGE

An Employee should refer to the eligibility information contained in the County of Kern Health Benefits Eligibility Policy for Active Employees booklet to determine health plan eligibility for employees or dependents. Eligible Employees must complete an application form to enroll and pay the required contributions, if applicable.

The County of Kern Health Benefits Eligibility Policy for Active Employees booklet includes information regarding the following:

- Eligibility
- Termination of Coverage
- Reinstatement of Coverage
- Continuation of Coverage (COBRA)
- Leaves of Absence
- Continuation of Coverage during a Family and Medical Leave (FMLA)

For information regarding the Health Insurance Portability Act (HIPAA), please refer to the County of Kern HIPAA Policy. These policies may be found at www.KernCountyHealthBenefits.com.

II. SUMMARY OF MEDICAL BENEFITS

A. Summary of Limiting Factors

This document serves as the Master Plan Document and as the Summary Plan Description for this Plan. This document describes the conditions under which this Plan will pay for medical care. There may be circumstances when a Participant and his medical provider determine that medical care which is not covered by this Plan is appropriate. All decisions regarding medical care are up to a Participant and his medical provider. Determination of benefits is solely at the discretion of the Plan Sponsor and its administrator.

Several factors affect the Participant's receipt of the benefits described in the Schedule of Benefits which follows. The Participant must be properly enrolled and have coverage that is effective and which is not limited by any exclusions. The Participant's benefits are subject to coverage limits, claims limitations, satisfaction of Participant costs, and coordination of benefits provisions. Benefits are listed and described first, subject to the limitations described in detail in subsequent sections. Services are as specified; exclusions are examples only.

B. *Schedule of Benefits*

	Point of Service Plan <u>In-Network</u>	Point of Service Plan <u>Out-of-Network</u>
WHO DIRECTS YOUR CARE	Member (some services require prior authorization)	Member (some services require prior authorization)
WHO PROVIDES YOUR CARE	Anthem Blue Cross and Blue Cross/Blue Shield provider or any licensed provider rendering covered services if directed by the Plan Administrator.	Any licensed provider rendering covered services when referral/authorization was not obtained for In-Network benefits. When Anthem Blue Cross and Blue Cross/Blue Shield providers are used as out-of-network providers, their fee discount reduces your out-of-pocket expenses.
Calendar Year Deductible	$0	$200 per individual / $400 per family (2 family members must meet $200)
Calendar Year Out-of-Pocket	Medical: $1,000 per individual / $3,000 per family Pharmacy: $5,600 per individual / $10,200 per family	Medical: $2,000 per individual / $4,000 per family (2 family members must meet $2,000) (no pharmacy benefit)
Lifetime Maximum	$0	$0
	You Pay	**Plan Pays**
Specialist Physician Visits**	$25 copay	70% coverage R&C (after deductible)
Primary Care Physician Visit	$15 copay	70% coverage R&C (after deductible)
Allergy Injections and Testing (including serum)*	$0 copay	70% coverage R&C (after deductible)
Ambulance*	$0 copay	$0 copay (deductible waived)
Cardiac Rehabilitation*	$0 copay	70% coverage R&C (after deductible)
Chemotherapy	$0 copay	70% coverage R&C (after deductible)
Chiropractic Care (maximum 30 visits / year)	$20 maximum benefit / visit	$20 maximum benefit / visit

IMPORTANT NOTICE:

*These services may require prior authorization by the Plan. (*See section C. Procedures Requiring Prior Authorization. Page 7.*)

**Specialist Physician visits require referral authorization except for the Out-of-Area plan. Failure to obtain a referral when required can result in a reduction of benefits requiring a deductible to be met and plan payment limited to 70% of the remaining Reasonable and Customary (R&C) charges. Contact Point of Service Plan Customer Service at 1-855-KERNPOS or 1-855-537-6767 with questions.

Benefits for inpatient or outpatient hospital services performed at Kern Medical will be payable at 100% ($0 copay, no deductible), subject to any limitations noted (emergency room copayments apply).

	Point of Service Plan <u>In-Network</u>	Point of Service Plan <u>Out-of-Network</u>
	You Pay	**Plan Pays**
Diabetic Patient Education	$25 copay	70% coverage R&C (after deductible)
Diagnostic, X-ray and Laboratory Services*	$0 copay	70% coverage R&C (after deductible)
Dialysis (Renal Dialysis)*	$0 copay	70% coverage R&C (after deductible)
Disposable Medical Supplies*	$0 copay	70% coverage R&C (after deductible)
Durable Medical Equipment*	$0 copay	70% coverage R&C (after deductible)
Emergency Room/Facility – Medical Emergency (facility fee)	$75 copay (waived if admitted)	$75 copay (waived if admitted)
Emergency Room/Facility – Medical Emergency (Physician fee)	$0 copay	$0 copay (deductible waived)
Emergency Room/Facility – Non-Medical Emergency (facility fee)	$75 copay (waived if admitted)	70% coverage R&C (after deductible)
Emergency Room/Facility – Non-Medical Emergency (physician Fee)	$0 copay	70% coverage R&C (after deductible)
Home Health Care* (maximum 40 visits / year)	$0 copay	70% coverage R&C (after deductible)
Hospice Care* – Inpatient Room & Board	$0 copay	70% coverage R&C (after deductible) – maximum $7,500 / Lifetime
Hospice Care* – Inpatient Ancillary	$0 copay	70% coverage R&C (after deductible) – maximum $3,000 / Lifetime
Hospice Care* – Outpatient	$0 copay	70% coverage R&C (after deductible) – maximum $3,000 / Lifetime
Hospital Services* – Inpatient	$150 copay per day up to a $750 Calendar Year maximum	70% coverage R&C (after deductible)
Hospital Services* – Outpatient	$0 copay	70% coverage R&C (after deductible)
Maternity Care*	$100 copay	70% coverage R&C (after deductible)
Outpatient Surgery* (Facility fee)	$100 copay	70% coverage R&C (after deductible)
Outpatient Surgery* (Physician fee)	$0 copay	70% coverage R&C (after deductible)

IMPORTANT NOTICE:

*These services may require prior authorization by the Plan. (*See section C. Procedures Requiring Prior Authorization. Page 7.*)

**Specialist Physician visits require referral authorization except for the Out-of-Area plan. Failure to obtain a referral when required can result in a reduction of benefits requiring a deductible to be met and plan payment limited to 70% of the remaining Reasonable and Customary (R&C) charges. Contact Point of Service Plan Customer Service at 1-855-KERNPOS or 1-855-537-6767 with questions.

Benefits for inpatient or outpatient hospital services performed at Kern Medical will be payable at 100% ($0 copay, no deductible), subject to any limitations noted (emergency room copayments apply).

	Point of Service Plan <u>In-Network</u>	Point of Service Plan <u>Out-of-Network</u>
	You Pay	**Plan Pays**
Physical, Speech and Occupational Therapy* (maximum 60 visits combined / year)	$0 copay	70% coverage R&C (after deductible)
Preventive Health Evaluation (18 yrs. of age & over) - (maximum 1 visit / year)	$0 copay	Not Covered
Preventive Gynecologic Evaluation (maximum 1 visit / year)	$0 copay	Not Covered
Preventive Prostate Evaluation	$0 copay	Not Covered
Preventive Mammograms	$0 copay	Not Covered
Preventive Diagnostic Services and Immunizations	$0 copay	Not Covered
Preventive Well Baby Care (Up to 2 years of age)	$0 copay	70% coverage R&C (after deductible) – maximum $200 / year for all well child care
Preventive Well Child Care (2 to 17 years of age)	$0 copay	Not Covered
Radiation Therapy	$0 copay	70% coverage R&C (after deductible)
Second Surgical Opinions	$25 copay	70% coverage R&C (after deductible)
Skilled Nursing Facility (maximum 120 days / year)	$0 copay	70% coverage R&C (after deductible)
Urgent Care Facility	$15 copay	70% coverage R&C (after deductible)
Urgent Care Physician	$0 copay	70% coverage R&C (after deductible)
Wigs due to hair loss following chemotherapy (maximum $150 / year)	$0 copay	70% coverage R&C (after deductible)
All Other Covered Expenses	$0 copay	70% coverage R&C (after deductible)

IMPORTANT NOTICE:

*These services may require prior authorization by the Plan. (*See section C. Procedures Requiring Prior Authorization. Page 7.*)

**Specialist Physician visits require referral authorization except for the Out-of-Area plan. Failure to obtain a referral when required can result in a reduction of benefits requiring a deductible to be met and plan payment limited to 70% of the remaining Reasonable and Customary (R&C) charges. Contact Point of Service Plan Customer Service at 1-855-KERNPOS or 1-855-537-6767 with questions.

Benefits for inpatient or outpatient hospital services performed at Kern Medical will be payable at 100% ($0 copay, no deductible), subject to any limitations noted (emergency room copayments apply).

	Point of Service Plan In-Network	Point of Service Plan Out-of-Network
	You Pay	**Plan Pays**
Chemical Dependency	**Inpatient:** $150/day up to $750/calendar year maximum; $0 copay at Kern Medical **Outpatient:** $25 copay – For medically necessary services and/or medical diagnosis	**Inpatient:** 70% coverage (after deductible) **Outpatient:** 70% coverage (after deductible) – For medically necessary services and/or medical diagnosis
Mental Health	**Inpatient:** $150/day up to $750/calendar year maximum; $0 copay at Kern Medical **Outpatient:** $25 copay – For medically necessary services and/or medical diagnosis	**Inpatient:** 70% coverage (after deductible) **Outpatient:** 70% coverage (after deductible) – For medically necessary services and/or medical diagnosis

IMPORTANT NOTICE:

*These services may require prior authorization by the Plan. (*See section C. Procedures Requiring Prior Authorization. Page 7.)*
**Specialist Physician visits require referral authorization except for the Out-of-Area plan. Failure to obtain a referral when required can result in a reduction of benefits requiring a deductible to be met and plan payment limited to 70% of the remaining Reasonable and Customary (R&C) charges. Contact Point of Service Plan Customer Service at 1-855-KERNPOS or 1-855-537-6767 with questions.

Benefits for inpatient or outpatient hospital services performed at Kern Medical will be payable at 100% ($0 copay, no deductible), subject to any limitations noted (emergency room copayments apply).

C. Procedures Requiring Prior Authorization

Prior authorization helps Participants receive Medically Necessary, cost-effective health care. Ultimately, the Participant is responsible for making sure prior authorization is obtained but in most cases network providers will contact the Claims Administrator on the Participant's behalf. The Plan may cover some of the services listed below without prior authorization if the services are used to treat an Emergency. See Section G for a description of coverage for Emergency Medical Services.

The following services and procedures *require* prior authorization to be covered by the Plan:

Allergy injections (Immunotherapy)
Ambulance – non-emergency transportation
Bariatric surgery – consultation and treatment
Cardiac catheterization, angioplasty, stents
Cosmetic, plastic and reconstructive surgery
Dental trauma
Diabetic equipment billed over $250 per item
Dialysis
Durable medical equipment (DME) and medical supplies billed over $250 per item
Genetic services
Home health care, including infusion services
Hospice
Hospital inpatient admissions
Hyperbaric medicine
Injectable drugs
Inpatient mental health and chemical dependency
Intensive Outpatient Program (mental health)
Psychological and neurological testing
Maternity/obstetrical care after first prenatal visit
Neurosurgery – consultation and treatment
Oral surgery performed at a medical facility or freestanding surgery center
Organ and tissue transplants
Orthodontic treatment subject to specific guidelines
Out-of-area specialists (not in Kern County)
Procedures in an outpatient facility or ambulatory surgery center (colonoscopy, EGD and sigmoidoscopy do not require prior authorization).
Pain management
Podiatry -- consultation and treatment
Prosthetics and orthotics billed over $250 per item
Radiology services • Angiogram • Angioplasty • CT angiography • CT scans • Discogram/myelogram • Embolization • MRI / MRA • PET scan • Thallium

RAST testing	
Rehabilitative services • Cardiac • Neurocognitive • Occupational	 • Physical • Pulmonary • Speech
Skilled nursing facility admissions	
Sleep studies	
Stereotactic Radiosurgery (Cyber knife and Gamma knife) procedures	
TMJ surgery	
Varicose vein procedures	

Please note: This prior authorization list is subject to change at any time.

D. POS Plan Provider Coverage

1. NETWORK PROVIDER

Network providers are Hospitals, Physicians or other providers who have agreed to provide health care services to plan Participants at negotiated rates. Participants can contact the County of Kern Point of Service Plan Member Service Center at 1-855-KERNPOS or 1-855-537-6767 or visit www.kernpos.com and follow the link for "Provider Search".

To receive Network benefits, a Participant must choose a provider within the Network. To receive Network benefits, a Participant must use providers within the Network only. The provider may treat the patient or refer the patient to a Specialist, Hospital or other health care provider. The member is ultimately responsible to ensure services received are from Providers within the Network.

For any treatment other than preventive care, OB/GYN providers will be considered Specialists and will be subject to the Specialist copay.

2 NON-NETWORK PROVIDER

A Participant may seek treatment from any licensed provider. Treatment does not need to be coordinated with a Primary Care Physician (PCP). However, choosing a provider who is not affiliated with the Network will reduce the benefits provided by the Plan.

Reasonable and Customary limits will be waived and Network provider benefits will be payable to non-Network providers under these circumstances, which include, but are not limited to:

- Professional services of an emergency room Physician, radiologist, pathologist or anesthesiologist when services are rendered in a Network facility.
- Treatment of a Medical Emergency.
- Approved authorized services not available by a Network provider as determined by the Plan administrator.

E. Maximum Benefits

Subject to the exclusions, conditions, and limitations stated in this document, the Plan will pay benefits to or on behalf of a Participant for covered medical expenses described in this article up to the maximum amounts specified in the Schedule of Benefits.

The Plan will pay benefits for the Reasonable and Customary charges for services and supplies which are ordered by a Physician. However, Reasonable and Customary limitations will not apply to In-Network claims or those exceptions for non-Network providers as indicated in Sections D and E listed above. Services must be furnished by an eligible provider and must be Medically Necessary.

The obligation of this Plan shall be fully satisfied by the payment of allowable expenses in accordance with the Schedule of Benefits. Benefits will be paid for the reimbursement of medical expenses incurred by the Participant if all provisions mentioned in this document are satisfied. All payments made under this Plan for allowable charges will be limited to the lesser of Reasonable and Customary or the applicable Network amount unless otherwise specified.

F. Costs

1. BENEFIT PERCENTAGES

After satisfaction of any applicable deductible, the Plan will provide the level of payment indicated in the Schedule of Benefits. The Participant is responsible for the remaining percentage.

2. COPAYMENTS AND DEDUCTIBLES

A Participant may be assessed a copay for Physician office visits, Hospital services, emergency room visits, urgent care facility services, preventive care and other services according to the Schedule of Benefits.

3. OUT-OF-POCKET MAXIMUMS

The maximum amount a Participant must pay (including deductibles) toward eligible expenses. The following Participant expenses do not accumulate to the annual out of pocket maximum;

- Co-payments,
- Expenses not covered by the plan,
- Costs in excess of “reasonable and customary”.

G. Description of Benefits and Services

Benefits for all services are limited to the maximum amounts stated in the Schedule of Benefits.

1. ABORTION

Induced termination of a pregnancy by any acceptable means medically indicated by a diagnosis affecting the mental or physical health of the mother.

2. ALLERGY INJECTIONS AND SURVEYS

Therapeutic treatment or diagnosis of allergies.

3. AMBULANCE SERVICE

Medically Necessary ground or air ambulance services by licensed ground or air ambulance to a Hospital when medical supervision or life support is necessary in transporting the Participant.

Non-Emergency facility-to-facility transport when ordered by the attending Physician.

4. AMBULATORY SURGICAL CENTER

Facility charges for procedures performed in an accredited Ambulatory Surgical Center and associated services and supplies.

5. BARIATRIC PROCEDURES

Medically necessary bariatric procedures are covered and require prior authorization.

6. BIRTHING CENTERS

Facility charges for procedures performed in a Birthing Center and associated services and supplies.

7. CHEMICAL DEPENDENCY (SUBSTANCE ABUSE) / MENTAL HEALTH

The Plan covers outpatient treatment for crisis intervention, short-term evaluation, and substance abuse rehabilitation. Visits may include mental health consultations, medication management, and psychological testing. The Plan also provides benefits for inpatient treatment in a hospital setting or a partial inpatient program in a mental health or substance abuse facility.

8. CHEMOTHERAPY

A regimen comprised of a single agent or a combination of anti-cancer agents clinically recognized for treatment of a specific type of cancer, including modifications and combinations appropriate to the history of the cancer or according to protocol specifying the combination of drugs, doses, and schedules for administration of the drugs.

Drug Requirements

- Use that is included as an indication on the drug's label as approved by the FDA or

- Use of an FDA-approved drug for an off-label purpose that is medically accepted for an anti-cancer therapeutic regimen as evidenced by major drug compendia, medical literature, and/or accepted standards of medical practice.
- Use of drugs to treat toxicities or side effects of the cancer treatment regimen when the drug is administered in relation to chemotherapy, including off-label uses supported by medical literature.

9. Chiropractic Treatment

Diagnostic evaluations and treatments by manipulation and other modalities. Benefits are limited to the maximums stated in the Schedule of Benefits.

10. Contraceptives

Contraceptives, including vaginal diaphragms, implantable devices, injectable contraceptives, intra-uterine devices (IUDs), and cervical caps, are covered only when a network physician prescribes the device. Removal of contraceptives are not covered unless medically necessary.

11. Dental Care for Accidental Injury

Dental services performed in conjunction with treatment to teeth, gums or a fractured jaw, but only when:

- The services are necessitated as a direct result of an Accidental Injury; and
- The Injury is not caused by biting or chewing.

In reference to injury to a tooth, benefit coverage is limited to the repair of sound and natural teeth to their pre-Injury level. Coverage will be limited to 72 hours from the date of injury. Exceptions to the time limitation will be allowed when a delay in treatment is medically indicated.

12. Diabetic Supplies and Education

Covered services and supplies include, but are not limited to:

- Blood glucose monitors;
- Podiatric (foot) appliances for prevention of complications associated with diabetes (in accordance with Medicare guidelines);
- Insulin pumps and insulin pump supplies;
- Diabetes education services (up to 4 visits with a licensed dietician per Lifetime).

Please refer to the prescription drug benefit summary for information regarding disposable supplies such as test strips and solutions for blood glucose monitors, visual reading and urine testing strips, injection aids, syringes, lancets, automatic lancing devices, drawing up devices and monitors for the visually impaired.

13. Diagnostic Services

Services performed for the express purpose of determining the cause of definite symptoms experienced by the patient, not in connection with routine physical

examinations except as specified in this Plan Document. Covered expenses include, but are not limited to:

- Pathology
- Radiology
- Physician's Interpretation.

14. DIALYSIS

Hospital-based, outpatient dialysis centers or home dialysis. Coverage includes dialysis treatment at a dialysis center, hemodialysis and training in the operating of dialysis equipment, including supplies for and maintenance of dialysis equipment used in a Participant's home.

15. DISPOSABLE MEDICAL SUPPLIES

The following covered services and supplies include, but are not limited to:

- Sterile surgical supplies required immediately after surgery which are provided by the hospital or healthcare agency.
- Ostomy supplies.
- Supplies needed to operate or use covered Durable Medical Equipment, prosthetics or orthotics.
- Supplies needed for use by skilled home health or home infusion personnel, but only during the course of their required services.

Diabetic supplies (e.g., insulin syringes, test strips, lancets, alcohol swabs) are covered by the Prescription Drug Program.

16. DURABLE MEDICAL EQUIPMENT (DME)

The following covered services and supplies include, but are not limited to:

- DME, such as crutches, walkers, oxygen and equipment for the administration of oxygen, standard manual Hospital beds. For mastectomy-related supplies, see the *Surgery – Cosmetic, Plastic and Reconstructive Surgery* benefit.
- Rental DME items may not become the property of the Participant and must be returned to the DME provider when no longer needed or upon termination of the Participant's coverage, whichever occurs first. If the equipment is not returned by the Participant or returned in poor condition, the Participant may be responsible for the replacement or repair cost unless the purchase price has been paid by the Plan. Rental benefits are provided up to the purchase price.
- Medically Necessary supplies to operate DME are covered.
- Non-Medically Necessary DME, such as exercise equipment, sports equipment, equipment intended to enhance athletic ability and hygienic equipment, is not covered.
- More than one DME device designed to provide essentially the same functional assistance is not covered.

17. EMERGENCY ROOM TREATMENT

a) Life-Threatening/Sudden & Serious Illness

Immediate care required for a life-threatening Medical Emergency or Accidental bodily injury which, if untreated, or if treatment is delayed, could result in death or serious bodily impairment.

b) Non-Emergency Use

Care received for Sickness or Injury which does not qualify as life-threatening.

18. HOME HEALTH CARE SERVICES

a) Services

Part-time or intermittent nursing care provided or supervised by a Registered Nurse (R.N.) to the limit provided for Nursing Care; part-time or intermittent home health aide services, primarily for the patient's medical care; physical, occupational, speech, or respiratory therapy by a licensed qualified therapist; diabetic nutrition counseling provided by or under the supervision of a registered dietician; or medical supplies, laboratory services, drugs, and medications prescribed by a Physician which must be administered by a medical professional. Benefits are limited to the maximums stated in the Schedule of Benefits.

b) Requirements

Services must be provided in the patient's home under a written plan of the patient's attending Physician's stating the diagnosis, certifying that the Home Health Care is in lieu of Hospital Confinement, and further specifying the type and extent of treatment.

19. HOSPICE CARE EXPENSES

a) Services

- Hospice room and board while the terminally ill person (diagnosed by the attending Physician as having six months or less to live) is an inpatient in a Hospice;
- Outpatient and other customary Hospice services provided by a Hospice or Hospice team; and
- Counseling services provided by a member of the Hospice team.

b) Requirements

These services and supplies are eligible only if the Hospice operates as an integral part of a Hospice Care Agency and the Hospice team includes at least a doctor and a registered graduate nurse. Each service or supply must be:

- Provided under a Hospice Care Agency program that meets standards set by the Plan. If such a program is required by federal or state law to be licensed, certified, or registered, it must meet that requirement;
- Provided while the terminally ill person is in a Hospice Care Program; and
- Ordered by the doctor directing the Hospice Care Program.

- Benefits for non-Network providers are limited to the maximums stated in the Schedule of Benefits

20. HOSPITAL INPATIENT SERVICES

Included, but are not limited to:

- Medically Necessary Hospital Confinement for acute conditions or care
- Semi-private room and board (unless only private rooms are available)
- Private rooms if determined to be Medically Necessary
- Hospital services for dental treatment are not covered unless Medically Necessary due to a serious medical condition

21. HOSPITAL OUTPATIENT SERVICES

Services rendered in an Outpatient department of a Hospital, including, but not limited to, the following:

- Allergy testing
- Chemotherapy
- Dialysis
- Emergency Room Services
- Laboratory Tests and X-rays
- Pre-Admission Testing
- Radiation Therapy
- Respiratory Therapy
- Surgical Services

22. NEWBORN CARE EXPENSES

Medically Necessary expenses incurred by an eligible, enrolled newborn infant during his initial confinement, including services and supplies furnished by a Hospital and by a Physician to care for the newborn infant during initial Hospital Confinement. Inpatient Physician care includes, but is not limited to, examinations and the circumcision of male infants. If the newborn's delivery is uncomplicated and the infant is not required to stay in the Hospital longer than the mother, the inpatient Hospital deductible stated in the Schedule of Benefits will be waived for the infant only.

23. ORAL SURGERY – FOR DIAGNOSED CONDITION(S) OR COVERED INJURY

Benefits are limited to the following procedures:

- Excision of tumors or cysts from the mouth
- Apicoectomy (excision of tooth root without excision of the tooth), in lieu of a successful root canal procedure
- Osseous surgery
- Excision of exostoses of the jaws and hard palate (provided that this procedure is not done in preparation for dentures)
- Treatment of fractures of facial bones
- External incision and drainage of cellulitis
- Incision of accessory sinuses, salivary glands or ducts

Dental services or supplies such as dental plates, bridges, crowns, caps or other dental prostheses, dental care, extraction of teeth or treatment to the gums are not covered except as stated in the Dental Care for Accidental Injury or the TMJ benefits.

24. ORGAN TRANSPLANTS

Transplant-related services must be provided at or arranged by a Transplant Facility designated and approved by the Plan Administrator. Participants should contact the County of Kern Point of Service Plan Member Service Center for information on designated Transplant Facilities.

Hospital, surgical and medical services rendered by a participating provider for human transplants are covered, provided they meet requirements for the specific transplant surgery. These include, but are not limited to:

- Cornea
- Heart
- Heart/Lung
- Kidney
- Pancreas/Kidney
- Simultaneous Pancreas/Kidney
- Liver
- Lung (single or double)
- Allogeneic (donor) bone marrow transplants (see donor provision below)
- Autologous bone marrow transplants (autologous stem cell and peripheral stem cell support) for the following conditions:
    - acute lymphocytic or non-lymphocytic leukemia
    - advanced Hodgkin's lymphoma
    - advanced non-Hodgkin's lymphoma
    - advanced neuroblastoma
    - breast cancer
    - multiple myeloma
    - epithelial ovarian cancer
    - testicular, mediastinal, retroperitoneal and ovarian germ cell tumors

Transplant services and supplies include the recipient's medical and surgical services in connection with the transplant including, but not limited to:

- immunosuppressive medications
- organ and tissue search and procurement
- harvesting and storage of bone marrow
- pre-transplant evaluation

In order to be considered as covered services, the transplant and the transplant-related services and supplies must meet all of the following requirements:

- All organ and tissue transplant services require prior authorization.

- All transplant-related services must be provided at or arranged by a Transplant Facility designated and approved by the Plan Administrator. Participants should contact the County of Kern Point of Service Plan Member Service Center for information on designated Transplant Facilities.
- The transplant must be Medically Necessary and appropriate for the Participant's medical condition.
- The transplant must not be experimental, unproven, or investigational for the Participant's condition.
- When both the recipient and the donor are Participants, each is entitled to the benefits of this Plan.

When only the recipient is a Participant, both the donor and the recipient are entitled to the benefits of this Plan, but the donor benefits are limited to only those not available from any other source to which the donor may have access. Benefits for the donor will be charged against the recipient's coverage under this Plan.

- No expenses are payable for a Participant who donates an organ or tissue, unless the person who receives the transplant is a Participant under this Plan.
- No benefits will be provided for a pancreas transplant that is not performed in conjunction with a kidney transplant, or which is performed after the Participant has received a kidney transplant.

If a human organ or tissue transplant is provided from a living donor to a human transplant recipient:

- When both the recipient and the donor are Participants, each is entitled to the Benefits of this Plan.
- When only the recipient is a Participant, both the donor and the recipient are entitled to the benefits of this Plan, but the donor benefits are limited to only those not available from any other source. Benefits for the donor will be charged against the recipient's coverage under this Plan.
- No expenses are payable for a Participant who donates an organ or tissue, unless the Participant who receives the transplant is a covered Participant under this Plan.
- If any organ or tissue is sold rather than donated to a recipient covered under this Plan, no expenses will be payable.

The transplant (or transplant-related service or supply) must not be excluded, as described under Exclusions and Limitations. Failure to meet all of the foregoing requirements may result in non-payment for the transplant and all transplant-related services and supplies.

Transplant Travel and Lodging

The following transplant travel and lodging benefits will be payable, subject to pre-arrangement by the designated transplant coordinator and any maximums stated:

- The Plan pays reasonable and necessary expenses for lodging and meals for the patient (while not confined) and one companion. Benefits are paid at a per diem rate of up to $50 for one person or up to $100 per day for all Family members.

- Travel and lodging expenses are available only if the transplant recipient resides more than 50 miles from the approved Center of Excellence.
- If the patient is a covered Dependent minor child, the transportation expenses of two companions will be covered and lodging and meal expenses will be reimbursed up to the $100 per diem rate for all Family members.
- There is a combined overall lifetime maximum of $10,000 per Participant for all transportation; lodging and meal expenses incurred by the transplant recipient and companion(s) and reimbursed under this Plan in connection with all transplant procedures.

25. PHYSICAL/OCCUPATIONAL THERAPY

Medically Necessary services, as certified by a Physician, rendered by a certified or licensed physical therapist or registered occupational therapist. Therapy rendered by a licensed therapist to restore the loss or impairment of motor functions resulting from illness, disease or Injury. Coverage ends once maximum medical recovery has been achieved and further treatment is primarily for maintenance purposes. Only therapy designed to restore motor functions needed for activities of daily living (such as walking, eating, dressing, etc.) is covered. Benefits are limited to the maximums stated in the Schedule of Benefits.

26. PHYSICIAN SERVICES

- Primary Care Physician (PCP) and Specialist office visits other than Health Maintenance and Preventive Services (see the Preventive Care section of this Schedule of Benefits for further details).
- A PCP can be any of the following types of Physician: Family Practice, General Practice, Internal Medicine, and/or Pediatrics.
- Professional fees associated with diagnostic laboratory and X-ray, chemotherapy, radiation therapy.
- Inpatient Hospital Physician services (subject to the provisions of the hospitalist program).
- Emergency room or Urgent Care Facility Physician services.
- Professional fees for the surgeon and necessary assistant surgeon associated with Medically Necessary surgical procedures.

Reasonable and necessary services of a Physician are covered services. Services include, but are not limited to, the following:

- Allergy Injections
- Allergy Testing
- Cardiac Rehabilitation
- Chemotherapy
- Dermatology Testing
- Dialysis
- Emergency Room Services
- Infusion Therapy
- Injections
- Interpretation of Diagnostic Tests
- Radiation Therapy
- Respiratory Therapy

27. PREGNANCY

Pregnancy care is covered as any other medical condition. Coverage includes, but is not limited to:

- Normal pregnancy
- Complications of pregnancy
- Refer to the County of Kern Health Benefit Eligibility Policy Booklet for information on enrolling a newborn infant.

This Plan shall not restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section. This Plan shall not require that a provider obtain authorization from the Plan or the Plan Administrator for prescribing a length of stay not in excess of the above periods, and nothing is to prevent the mother's or newborn's attending health care provider and the mother from agreeing to an earlier discharge; notwithstanding the above, compliance with this Plan's policy of prior authorization for maternity care management shall be required.

Regular Plan benefits (as specified in the applicable sections of this document) are payable for expenses incurred by the Employee, spouse or Dependent child.

Services required for the normal management of pregnancy, including any condition usually associated with the management of a difficult pregnancy but not considered a complication of pregnancy. Antepartum and postpartum care of the mother is included.

Services required for the treatment of complication of pregnancy, including any physical effect directly caused by pregnancy but considered to be an effect of a normal pregnancy, conditions related to ectopic pregnancy or conditions requiring cesarean section.

Care for Miscarriage.

28. PRESCRIPTION DRUGS

Please refer to the Prescription Drug Benefit Summary for details regarding your prescription drug coverage.

29. PREVENTIVE CARE

Coverage for preventive care will be provided in accordance with the Affordable Care Act and other applicable federal law. Services covered are likely to include all preventive services that have been rated A or B by the U.S. Preventive Services Task Force but may be limited to minimum requirements of applicable recommended guidelines.

a) Adult

Benefits are payable as stated in the Schedule of Benefits for the following cancer screening tests, which include, but are not limited to:

- Pap Test

- Prostate Testing for individuals age 40 and over
- Mammograms for individuals age 40 and over (unless the patient is high-risk)
- Fecal Occult Testing
- Colonoscopy, subject to the guidelines established by the American Cancer Society

b) Adult

Benefits are payable as stated in the Schedule of Benefits for routine medical examinations.

c) Child

Benefits are payable as stated in the Schedule of Benefits for routine periodic office visits, diagnostic tests, pediatric immunizations and flu shots.

30. PROSTHETICS

A Participant should remind his health care provider that prior authorization is required.

The following internal prosthetics, when Medically Necessary and surgically implanted, are covered, including but not limited to:

- Electronic heart pacemakers, intraocular lenses, and joints
- For post-operative breast prostheses following a mastectomy, see the Cosmetic, Plastic and Related Reconstructive Surgery Benefit.

The following external prosthetics, when Medically Necessary, are covered:

- Artificial limbs or eyes including the initial purchase and replacements due to physical growth for a continuously covered Member. Artificial limbs are limited to standard items and must be adequate to provide a reasonable level of functionality for normal daily activities.
- Breast prostheses following a mastectomy
- Wigs following chemotherapy or radiation treatment covered up to $150

Replacements of Prosthetics are covered when needed due to normal wear for which the prosthetic device was designed or physical growth.

Women's Health and Cancer Rights Act

This notice is required by the Women's Health and Cancer Rights Act of 1998 (WHCRA) to inform Participants of their rights relating to coverage provided through the Plan in connection with a mastectomy. Plan Participants have rights to coverage provided in a manner determined in consultation with the attending Physician for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prosthesis and treatment of physical complications from all stages of mastectomy, including lymphedema.

31. RADIATION THERAPY

Radiation therapy by X-ray, radon, radium, and radioactive isotopes.

32. REHABILITATION FACILITY

Facility charges for rehabilitation treatment performed in a Rehabilitation Facility and associated services and supplies.

33. REHABILITATION SERVICES

Rehabilitation Services include, but are not limited to:

- Physical, occupational, speech and neurocognitive therapy.
- Cardiac/pulmonary rehabilitation Services
- Short-term physical, speech, or occupational therapy to treat acute conditions when significant improvement can be expected in a predictable time, beginning from the date of the initial evaluation for any separate and distinct illness or condition.
- Speech therapy is limited to restoration of speech that is lost due to an illness or injury, or correction of speech deficits related to an Accident or surgical procedure.

34. SKILLED NURSING FACILITY

a) Services

Services and supplies (other than personal items and professional services) provided while the patient is under continuous medical care and requires 24-hour nursing care, and room and board. Benefits are limited to the maximums stated in the Schedule of Benefits.

b) Requirements

Confinement must be ordered by the Physician as Medically Necessary for convalescence from the illness or Injury that caused the Hospital Confinement.

The attending Physician completes a treatment plan which includes a diagnosis, the proposed course of treatment and the projected date of discharge from the facility.

35. SPEECH THERAPY

Therapy rendered by a certified speech therapist/pathologist on the recommendation and evaluation of a Physician to restore already established speech loss due to an illness or injury or to correct an impairment due to congenital defect for which corrective surgery has been performed. Benefits are limited to the maximums stated in the Schedule of Benefits.

36. STERILIZATION

Sterilization is covered, regardless of Medical Necessity. Reversal of sterilization is excluded from the plan and not covered.

37. SURGERY

a) Surgeon

Charges for multiple surgical procedures will be a covered expense subject to certain provisions, which include, but are not limited to:

- If bilateral or multiple surgical procedures are performed by one surgeon, benefits will be determined based on the Reasonable and Customary Charge that is allowed for the primary procedures. Then a portion of the Reasonable and Customary Charge will be allowed for each additional procedure performed through the same incision; as well as for each additional procedure performed through a separate incision. Any procedure that would be an integral part of the primary procedure or is unrelated to the diagnosis will be considered "incidental" and no benefits will be provided for such procedures.
- If multiple unrelated surgical procedures are performed by two or more surgeons on separate operative fields, benefits will be based on the Reasonable and Customary Charge for each surgeon's primary procedure. If two or more surgeons perform a procedure that is normally performed by one surgeon, benefits for all surgeons will not exceed the Reasonable and Customary percentage allowed for that procedure; and
- If an assistant surgeon is required, the assistant surgeon's covered charge will not exceed 25% of the surgeon's Reasonable and Customary allowance.

b) Anesthesiologist

Services of a qualified anesthesiologist (not the services of an operating surgeon or a surgical assistant) to administer regional or general anesthesia in connection with a covered surgical service is covered under the plan. Usual related care rendered in connection with the administration of anesthesia is covered.

c) Cosmetic, Plastic and Reconstructive Surgery

Cosmetic, plastic and reconstructive surgery is covered under certain circumstances which include, but are not limited to:

- Cosmetic, plastic and related reconstructive surgery is limited to the correction of congenital birth defects and effects of Sickness or Injury, which cause significant anatomical functional impairment, but only if such surgery is reasonably expected to correct the condition or Sickness.
- Surgical services are covered for a Medically Necessary mastectomy; reconstruction of the breast on which the mastectomy has been performed; and surgery and reconstruction of the other breast to produce a symmetrical effect.
- Prostheses and services related to physical complication from all stages of mastectomy, including lymphedema area covered.
- Any other cosmetic, plastic or related reconstructive surgeries are not covered.

d) Dental Surgery

Dental services for the treatment of a fractured jaw or an injury to sound natural teeth. Benefits are payable for the services of a Physician, Dentist or dental surgeon, provided the services are rendered for treatment of an Accidental Injury.

38. TEMPOROMANDIBULAR JOINT (TMJ) DYSFUNCTION

Covered services and supplies recognized as effective and appropriate by the medical or dental profession as necessary to treat TMJ, myofacial pain dysfunction syndromes and other associated disorders. Orthodontic services and/or appliances are not covered.

Surgery for the treatment of TMJ requires prior authorization.

39. URGENT CARE

Covered Urgent Care Services are payable for treatment which requires prompt medical attention after normal business hours that are not severe enough to require treatment at a hospital Emergency Room. Please refer to the schedule of benefits for plan benefits.

40. VISION CARE

Medically necessary treatment of vision-related illness or injury is covered under the plan. All routine vision services, including the prescribing, fitting and dispensing of corrective vision lenses and appliances are covered by the plan's Vision coverage, except eyeglasses or contact lenses after cataract surgery which are covered under the plan. Please refer to the Vision benefit summary for details.

H. Exclusions from Coverage

The following exclusions apply to this Plan except that if any exclusion is contrary to any law to which this Plan is subject, the provision is hereby automatically changed to meet the law's minimum requirement.

Abortion. Abortion of an elective nature, except as specified.

Acupuncture.
Acupuncture treatment, acupressure or massage to control pain, treat illness or promote health by applying pressure to one or more specific areas of the body based on dermatoses or acupuncture points.

Biofeedback.
The technique of using monitoring devices to furnish information regarding an autonomic bodily function, such as heart rate or blood pressure, in an attempt to gain some voluntary control over that function.

Charges for services which are not Medically Necessary.

Contraceptives. Contraceptives, including vaginal diaphragms, implantable devices, injectable contraceptives, intra-uterine devices (IUDs), and cervical caps, are covered

only when a network physician prescribes the device. Removal of contraceptives are not covered unless medically necessary.

Cosmetic or Reconstructive Surgery. Cosmetic or reconstructive surgery unless the surgery is necessary for:

(a) repair or alleviation of damage resulting from an Accident;
(b) because of infection or Sickness; or
(c) because of congenital disease, developmental condition or anomaly of a covered Dependent child which has resulted in a functional defect.

A treatment will be considered cosmetic for either of the following reasons:

(a) its primary purpose is to beautify or
(b) there is no documentation of a clinically significant impairment, meaning decrease in function or change in physiology due to illness, Injury, or congenital abnormality.

The term "cosmetic services" includes those services which are described in IRS Code Section 213(d)(9).

Custodial Care. Charges for custodial care, domiciliary care, rest cures, services that are primarily educational in nature (except as specified), or any maintenance-type care which is not reasonably expected to improve the patient's condition (except Hospice Care as specified).

Dental Treatment. Any dental treatment or services, except specified services and Medically Necessary Hospital expenses.

Educational or Vocational Testing. Services for educational or vocational testing or training, except diabetes training or as pre-authorized by the plan.

Excess Charges. The part of an expense for care and treatment of an Injury or Sickness that is in excess of the Reasonable and Customary Charge, except as specified under *Emergency Treatment* of if pre-authorized by the plan.

Exercise Programs. Exercise programs for treatment of any condition, except for Physician-supervised cardiac rehabilitation, occupational or physical therapy covered by this Plan.

Experimental or Investigative. For the purposes of determining eligible expenses under the Plan, a treatment (other than off label drug use) will be considered to be experimental or investigational if:

- The treatment is governed by the US Food and Drug Administration (FDA) and the FDA has not approved the treatment for the particular condition at the time the treatment is provided; or
- The treatment is subject to ongoing phase I, II, or III clinical trials as defined by the National Institute of Health, National Cancer Institute, or FDA; or

- There is documentation in published US peer-reviewed medical literature that states that further research, studies, or clinical trials are necessary to determine safety, toxicity or efficacy of the treatment.

Any expenses for experimental or investigational treatment, or any Hospital confinement or treatment that results from the experimental or investigational treatment will be excluded from coverage by the Plan.

Eye Care. Glasses, contact lenses, or eye examinations and/or treatment of refractive error for the correction of vision or fitting of glasses, except as specified. Surgical procedures for the improvement of vision when vision can be corrected through the use of glasses or contact lenses.

Felony Participation/Illegal Occupation. The insurer (the Plan) shall not be liable for any loss to which a contributing cause was the insured's commission of or attempt to commit a felony or to which a contributing cause was the insured's being engaged in an illegal occupation.

Foot Care. Non-surgical treatment of deformities of the toes and feet, including routine foot care for treatment of corns and calluses. This exclusion does not apply when related to the treatment of diabetes.

Functional Therapy. Charges made for functional therapy for learning or vocational disabilities or for speech, hearing and/or occupational therapy, unless specifically covered under another provision of this Plan.

Government Coverage. Charges for services or supplies provided by the Veterans Administration or in any Hospital or institution owned, operated, or maintained by the United States Government for a military service-related Sickness or Injury.

Hair Loss. Care and treatment for hair loss including wigs, hair transplants or any drug that promises hair growth, whether or not prescribed by a Physician, except for wigs after chemotherapy or radiation therapy up to the limit shown in the Schedule of Benefits.

Hearing Aids and Exams for Fittings. Charges for services or supplies in connection with hearing aids or exams for their fitting.

Holistic Care. Except as specified under benefits for Chiropractic treatment.

Hospital Employees. Professional services billed by a Physician or nurse who is an employee of a Hospital or Skilled Nursing Facility and paid by the Hospital or facility for the service.

Incarceration. Charges for medical services rendered while incarcerated in a federal, state or any other governmental detention facility in conjunction with committing or attempting to commit a crime.

Infertility Treatment. Any infertility treatment, testing, or any procedure for which the purpose is to enhance the possibility of reproduction.

Massage Therapy. Charges are not covered, even when recommended or prescribed by a Physician.

No Charge. Care or treatment for which there would not have been a charge if no coverage had been in force.

No Obligation to Pay. Charges incurred for which the Plan has no legal obligation to pay.

No Physician Recommendation. Care, treatment, services or supplies not recommended and approved by a Physician; or treatment, services or supplies when the Participant is not under the regular care of a Physician. Regular care means ongoing medical supervision or treatment which is appropriate care for the Injury or Sickness.

Obesity. Non-surgical treatment of obesity, including obesity drugs, food replacement programs, health clubs, nutrition education for weight loss, and weight reduction programs (including related supplies and laboratory tests included in such programs).

Occupational. Care and treatment of an Injury or Sickness that is occupational (arises from work for wage or profit including self-employment), which is covered by Workers' Compensation.

Orthoptics and/or Visual Therapy.

Personal Comfort Items. Personal comfort items or other equipment, such as, but not limited to, air conditioners, air-purification units, humidifiers, electric heating units, orthopedic mattresses, blood pressure instruments, scales, elastic bandages or stockings, nonprescription drugs and medicines, and first-aid supplies and non-hospital adjustable beds.

Physician Visits. Charges made by a doctor for phone calls or interviews when the Physician does not see the patient for treatment. This also includes charges for failure to keep a scheduled visit or charges for completion of forms.

Prescription Drugs (except as specified or those taken or administered in whole or in part during confinement in a licensed facility) are not covered by this Plan. Benefits for prescription drugs are administered separately. Please refer to your Prescription Drug Benefit Summary for details.

Private Duty Nursing.

Relationships. Professional services performed by a person who ordinarily resides in the Participant's home <u>or</u> is related to the Participant as a spouse, parent, child, brother or sister, whether the relationship is by blood or exists in law.

Replacement Braces. Replacement of braces of the leg, arm, back, neck or artificial arms or legs, unless there is sufficient change in the Participant's physical condition to

make the original device no longer functional or the age of the brace makes it no longer functional.

Services Before or After Coverage. Care, treatment or supplies for which a charge was incurred before a person was covered under this Plan or after coverage ceased under this Plan.

Sex Changes. Care, services or treatment for non-congenital transsexualism, gender dysphoria or sexual reassignment or change. This exclusion includes medications, implants, hormone therapy, surgery, medical or psychiatric treatment.

Smoking Cessation. Care and treatment for smoking cessation programs, including smoking deterrent patches, unless Medically Necessary, and authorized due to a severe active lung Illness such as emphysema or asthma.

Speech Therapy for remedial or educational purposes or for initial development of natural speech. This applies to children who have not established a natural speech pattern for reasons that do not relate to a congenital defect. In these cases, speech therapy would be considered educational in nature and not eligible for coverage. Speech therapy would **not** meet coverage criteria for these conditions, including, but not limited to: chronic voice strain, congenital deafness, delayed speech, developmental or learning disorders, environmental or cultural speech habits, hoarseness, infantile articulation, lisping, mental retardation, resonance, stuttering, and voice defects of pitch, loudness, and quality.

Sterilization Reversal.

Travel or Accommodations. Charges for travel expense, whether or not recommended by a Physician, except for ambulance charges as defined as a covered expense or as noted under the transplant transportation benefits on page 16.

Vitamins. Charges for vitamins, minerals, non-prescription food and/or food supplements and non-prescription dietary drugs.

War. Any loss that is due to a declared or undeclared act of war.

III. CARE MANAGEMENT

A. Prior Authorization Requirements

Certain services are only covered if prior authorization is obtained from the Plan Administrator's Prior Authorization Unit. Prior authorization is a review process that determines if the proposed service is a covered benefit and if it meets Medical Necessity requirements in advance. The Plan makes prior authorization decisions based on the Physician's recommendations and nationally recognized medical guidelines that apply to certain procedures and services. Typically a Network Physician will contact the Plan Administrator's Prior Authorization Unit to obtain prior authorization; however, the Participant is ultimately responsible for ensuring that the prior authorization process is followed. Failure to obtain prior authorization will result in a denial of benefits. This penalty applies to all services related to the procedure requiring prior authorization. However, if this Plan is secondary due to Coordination of Benefits with another plan, prior authorization will not be required. You can contact the Plan Administrator for additional information regarding the prior authorization process

Please refer to schedule of procedures requiring Prior Authorization on page 7.

The prior authorization requirement may be waived if any of the above services or procedures are necessary due to a Medical Emergency.

B. Prior Authorization for Hospital Confinement

If a Participant's confinement is not managed by the Hospitalist Program, and he requires Hospital confinement for an Injury or Sickness, Hospital admission authorization and length of stay approval must be obtained from the Plan Administrator's Prior Authorization Unit prior to a non-emergency admission. In the event of an emergency admission, authorization must be obtained within 48 hours or as soon as reasonably possible given the facts and circumstances of the emergency admission.

Full benefits for covered Hospital charges will be paid only for approved admissions and confinement days. Failure to obtain prior authorization will result in a denial of benefits. However, if this Plan is secondary due to Coordination of Benefits with another plan, prior authorization will not be required.

If confinement extends beyond the approved length of stay, additional days must be authorized by the Plan Administrator's Prior Authorization Unit. The same requirements and reduction penalties will apply to the additional days.

Charges for any part of a Hospital confinement not deemed to be Medically Necessary by the Plan Administrator's Prior Authorization Unit will be excluded.

The Plan Administrator's Prior Authorization Unit does not verify, authorize or guarantee payment of benefits. The Plan Administrator's Prior Authorization Unit authorization means only necessity of treatment. It is not a certification of benefits.

C. Hospitalist Program

A "hospitalist" is a Physician who specializes in the care of patients who have been admitted to a Hospital. The County of Kern Employee Medical Plan has arranged for the inpatient care to be provided by one of these specialists while the patient is confined in a participating Hospital for acute care.

Care provided by hospitalists is beneficial to the patient because:

- Hospitalists are Hospital-based Physicians. They are readily available to patients for urgent matters and will monitor the patient's condition throughout the Hospital stay.

- Hospitalists specialize in treating patients confined in a Hospital. As specialists, their focus is on the rapidly improving technology used in Hospitals.

- Hospitalists work with special nurse care managers to monitor the patient's needs and progress during the Hospital stay and help plan for any covered services a patient may need after discharge from the Hospital.

Hospitalists are responsible for coordinating care for all network hospital confinements, excluding admissions for pediatric care, neonatal ICU and maternity. Charges for physicians' services for hospital-confined patients not authorized by the plan or by the hospitalist are not covered.

IV. CLAIMS

This section provides you with important information about the County of Kern POS Plan. In this section, you will find information regarding the claims review process, the rights guaranteed to you under Federal law and additional administrative information. If you need more information or assistance on benefits matters, contact Point of Service Plan Customer Service at 1-855-KERNPOS or 1-855-537-6767.

A. Plan Document Governs

This document serves as the Master Plan Document and as the Summary Plan Description for this Plan. In all cases, this Summary Plan Description document controls the administration and operation of the Plan. If a conflict exists between this Summary Plan Description and any other documents, this Plan document will govern.

B. Discretionary Authority of Plan Administrator and Plan Fiduciaries

In carrying out their responsibilities, the County, the Plan Administrator, and the Plan fiduciaries have the discretionary authority to interpret the terms of the Plan and to determine the eligibility for benefit payment. Any interpretation or determination made by such discretionary authority shall be given full force and effect, unless it can be shown that the interpretation was arbitrary and capricious.

C. Claims and Appeals Procedures for the Plan

1. FILING A CLAIM

When you receive care from a network PCP or specialist, they will file a claim on your behalf; you need not contact anyone. Claims are reviewed and paid by the Claims Administrator in accordance with the rules and provisions contained in the Plan document. If the claim submitted by your PCP or specialist is denied for any reason, you and your health care provider will be notified of the denial as described below in more detail.

If you are required to request prior authorization for health care federal law considers your request for preauthorization technically as a claim, and thus you are entitled to appeal if authorization is denied. Different types of claims include: Post-Service (the most common), Pre-Service, and Concurrent Care.

2. POST-SERVICE CLAIMS

When your network PCP or specialist files a claim on your behalf, such a claim is considered a ***Post-Service Claim***. If your Post-Service Claim is denied, you will receive a written notice from the Claims Administrator within 30 days of the Claims Administrator receiving the claim. The letter or notice will explain the reason for denial and refer to the provision(s) of the Plan on which the denial is based. In addition, the Claims Administrator will tell you whether the denial was based on an internal rule, guideline, protocol or similar criterion and offer to provide you with a copy of such guidelines, free of charge.

If the denial was based on account of questionable medical necessity or the experimental nature of the requested service, the Claims Administrator will offer to send you a written explanation of the scientific or clinical basis for the denial, also free of charge. You will receive a Claim Appeals form and a copy of the appeals procedures. As in all other appeals under this Plan, you have 180 days after receiving notice of denial in which to file an appeal.

3. PRE-SERVICE CLAIMS

If you are required to notify the Claims Administrator or receive approval prior to obtaining a benefit under the Plan, such a request is considered a ***Pre-Service Claim***. If your Pre-Service Claim was submitted properly with all the necessary information, you will receive a written notice of the Claims Administrator's decision within fifteen (15) days after it receives the submission. If the Claims Administrator needs more time to respond, it will notify you before the 15 days have passed and tell you when it expects to

respond, but this will never be more than 30 days from the time you made your first request.

If your request is filed improperly (for example, it is missing required information), the Claims Administrator will notify you within fifteen (15) days on how to correct it. Once you are notified of this request for additional information, you have forty-five (45) days to provide the information. If you fail to respond and the 45 days lapse, your Pre-Service Claim will be denied. If all the information is received within the 45-day timeframe, the Claims Administrator will notify you in writing of its determination within fifteen (15) days after it receives the needed information. If the Claims Administrator determines that your Pre-Service Claim is denied; the notice will explain the reason for the denial and refer to the Provision(s) of the Plan on which the denial is based. In addition, the Claims Administrator will tell you whether the denial was based on an internal rule, guideline, protocol or similar criterion and offer to provide you with a copy of such guidelines, free of charge. If the denial was based on account of questionable medical necessity or the experimental nature of the requested service, the Claims Administrator will offer to send you a written explanation of the scientific or clinical basis for the denial, also free of charge. You will receive a Claim Appeals form and a copy of the appeals procedures.

As in all other appeals under this Plan, you have 180 days after receiving notice of denial in which to file an appeal.

4. CONCURRENT CARE CLAIMS

Generally there are two instances in which this type of claim is made:

- The Claims Administrator approves an ongoing course of treatment to be provided over a certain period of time or for a specific number of treatments and the Claims Administrator reduces or ends treatment before the end of the time period or number of treatments. Under this situation, the discontinuance or reduction is considered a denial of services and if you wish to appeal the denial, you must follow the procedures noted on page **Error! Bookmark not defined.**.

- The Claims Administrator approves an ongoing course of treatment to be provided over a certain period of time or for a specific number of treatments, and you request the Claims Administrator to extend the treatment. Under this situation, your request will be decided within 24 hours by the Claims Administrator, provided that your request is made at least 24 hours prior to the end of the approved treatment. **Note that if your request for extended treatment is not made at least 24 hours prior to the end of the approved treatment, your request will be answered within 72 hours.**

If the Claims Administrator denies your request for ongoing treatment, such notice will be given to you as soon as possible but no later than 24 hours (72 hours if your request is made after the 24-hour period as described above) following your request so that you have sufficient time to appeal (see page **Error! Bookmark not defined.**) and obtain a determination before the health benefit is reduced or terminated.

You will receive a written confirmation of the determination, which will explain the reason for denial and will refer to the provision(s) of the Plan on which the denial is

based. In addition, the Claims Administrator will tell you whether the denial was based on an internal rule, guideline, protocol or similar criterion and offer to provide you with a copy of such guidelines, free of charge. If the denial was based on account of questionable medical necessity or the experimental nature of the requested service, the Claims Administrator will offer to send you a written explanation of the scientific or clinical basis for the denial, also free of charge.

You will receive a Claim Appeals form and a copy of the appeals procedures. As with all other appeals under this Plan, you have 180 days after receiving notice of denial in which to file an appeal.

Note that if an ongoing course of treatment was previously approved for a specific period of time or number of treatments, and you request to extend treatment in a non-urgent circumstance, your request will be considered a new claim and decided according to post-service or pre-service timeframes, whichever applies.

5. Appealing a Denied Claim

Federal law considers the phrase *Denied Claim* to include a denial, reduction, termination of or a failure to provide or make payment for a benefit requested. It also includes a denial, reduction, termination or failure to provide for a benefit determined to be experimental or investigational.

The first step to resolving a dispute is to contact the Claims Administrator by telephone at 1-855-KERNPOS or 1-855-537-6767. Ask to speak to a customer service representative. Under federal law and regulations, your telephone inquiry is NOT considered a formal appeal. Rather, it is considered an informal way of attempting to resolve a dispute prior to filing a written appeal. After receiving the initial denial, you have 180 days to appeal the decision. **Contacting the Claims Administrator by phone does not begin the formal appeals process.** The formal process is described below.

D. *The Appeals Process*

1. Level One Review

If you disagree with a claim determination and you wish to appeal, you must contact the Claims Administrator in writing within 180 days of receiving the denial in order to formally request an appeal, using the appeal form provided to you. Be sure that your request includes the following:

- The patient's name and the identification number from the ID card,
- The date(s) of health care service(s),
- The provider's name,
- The reason(s) you believe the claim should be paid,
- Any documentation or other written information to support your request for claim payment.

A qualified individual who was not involved in the original decision being appealed will be appointed to decide your appeal. The Claims Administrator may consult with, or seek the participation of, medical experts as part of the appeal resolution process. By filing an appeal, you consent to this referral and the sharing of pertinent health claim information. Upon request and free of charge you have the right to reasonable access to and copies of, all documents, records, and other information relevant to your claim for benefits.

2. Response to Your Appeal

You will be provided with written or electronic notification of the decision on your appeal as follows:

- For appeals of ***Pre-Service Claims***, the first level appeal will be conducted and you will be notified by the Claims Administrator of its decision within **15** days from receipt of a request for appeal of a denied claim.
- For appeals of ***Post-Service Claims***, the first level appeal will be conducted and you will be notified by the Claims Administrator of its decision within **30** days from receipt of a request for appeal of a denied claim.
- For appeals of ***Concurrent Care Claims,*** you or your doctor can appeal at anytime as long as it is before 180 days from the date of the denial. The time frames for the Claims Administrator to respond to your appeal depend on the situation. For example, if the claim is for continuing urgent care, the Claims Administrator will respond to your appeal as soon as possible, not later than 72 hours.

3. Level Two Review

If a Participant's Level One Appeal is denied, he has the right to obtain Level Two Review. Level Two Review is voluntary.

A Participant's decision whether or not to appeal a Level One Review decision will have no effect on his rights to benefits under the Plan. In addition, the Plan waives any right to argue that you have not exhausted the appeals process by not requesting Level Two Review.

A Participant may, however, only request Level Two Review after timely filing an appeal for Level One Review and receiving a decision as outlined in the previous section. There are two types of Level Two Review depending on the type of Health Benefit Action a Participant is appealing: Plan Administrator Review for a Health Benefit Action that is based solely on administrative reasons for not covering a benefit or paying a Claim (such as benefit not covered by the Plan or available benefits exhausted) and Independent Review for a Health Benefit Action based on a determination that a service or item is not Medically Necessary or the service or item is experimental, unproven, or investigational.

4. Plan Administrator Review

Level Two Review of a denied appeal of a Health Benefit Action that is based solely on administrative reasons for not covering a benefit or paying a Claim (such as benefit not covered by the Plan or available benefits exhausted) is conducted by the Plan Administrator. A Participant can request such review by submitting within 30 days of receipt of the Level One decision a written request for Level Two Review to:

County of Kern Point of Service Plan
PO Box 11268
Bakersfield, CA 93389-1268

In the request for Plan Administrator Review, a Participant should state the reason the Claim should be reconsidered and copies of any relevant documentation, including background information. A Participant will be notified if more information is necessary. Relevant information from the Level One Review and the information a Participant provide will be forwarded to the Plan Administrator.

The Plan Administrator will decide the Level Two Review request within 30 days. The Plan Administrator may affirm, modify, or reverse the appeal decision from the Level One Review. To the extent the Level Two Review overturns denial of claim payment; the Plan Administrator will authorize payment of your Claim.

5. Independent Review

Level Two Review of a Health Benefit Action based on a determination that a service or item is not Medically Necessary or the service or item is experimental, unproven or investigational is conducted by an Independent Review Organization ("IRO"). A Participant can request such review by submitting a written request for Level Two Review to Claims Administrator at the address above stating the reason the Level One decision should be reconsidered and copies of any relevant documentation, including background information.

A Participant must submit his request for Second Level Review within the following timelines after receipt of the Level One appeal decision: 72 hours for an Expedited Appeal and thirty days for a standard appeal.

The County of Kern Point of Service Employee Medical Plan Member Service Center will provide a Participant, at no cost and upon request, information about the Independent Review process to enable him to make an informed decision about whether

to submit a dispute to this voluntary level of appeal. The information will include the information described in this document, plus, the rules governing Independent Review.

The Independent Review will be conducted by an organization that is external to the Plan and specializes in performing external independent reviews for plans like the County of Kern Point of Service Employee Medical Plan. If a Participant desires an Independent Review, he needs to submit his request for Independent Review within the applicable timeframe - 72 hours for an Expedited Appeal and 30 days for a standard appeal - to the Claims AdministratorClaims Administrator with any comments, additional information, and relevant documents that you want considered by the IRO.

The Claims AdministratorClaims Administrator will submit the request and information supplied by the Participant, along with all other documentation that has been used in previous determinations, to the IRO.

The IRO will evaluate the relevant information provided by the Participant and the Claims AdministratorClaims Administrator for the Level Two Review and recommend a final decision. The Reviewer will forward a copy of its recommended decision to the Participant, the Plan Administrator, and the Claims AdministratorClaims Administrator within the following timeframes after receipt of the appeal:

- 72 hours for an Expedited Appeal
- 30 days for a Standard Appeal

The Plan Administrator may, in its sole discretion and upon notice to the Participant, decide to review the recommended decision to determine if it is consistent with eligibility requirements and eligible benefits under the Plan and, based on that determination, accept, modify or reverse the recommended decision. The Plan will notify a Participant of the results of its review within the following timeframes after the receipt of the recommended decision:

- 48 hours for an Expedited Appeal
- 10 days for a Standard Appeal

The following applies to all Level One and Level Two Appeals: Under the agreements creating the terms of the Plan, the Plan Administrator has sole authority to make final determinations regarding any application for benefits, the interpretation of the Plan, and any administrative rules adopted by the Plan Administrator. Benefits under this Plan will be paid only if and when the Plan Administrator or persons to whom it has delegated such decision-making authority, in their sole discretion, decide the Member or beneficiary is entitled to benefits under the terms of the Plan.

The Plan Administrator’s decisions in such matters are final and binding on all persons dealing with the Plan or claiming a benefit from the Plan. If challenged in court, it is the intention of the Plan Administrator, and the Plan provides, that the decision is to be upheld unless it is determined to be arbitrary or capricious by the court or an arbitrator having jurisdiction over such matters.

6. OBTAINING MEDICAL RECORDS

State law permits Participant to ask for a copy of his medical records from the health care providers that treats him. A Participant's request must be in writing and must specify who he wants to receive the records. The health care provider who has your records will provide the Participant or the person he specifies with a copy of your records.

7. DESIGNATED DECISION MAKER

If a Participant has a designated health care decision-maker, that person must send a written request for access to, or for copies of, your medical records. The medical records must be provided to the health care decision-maker or a person designated in writing to be a Participant's health care decision-maker.

8. CONFIDENTIALITY

If a Participant participates in the review or appeal process, the relevant portions of his medical records may be disclosed only to individuals authorized to participate in the review process for the medical condition under review. These individuals may not disclose a Participant's medical information to anyone else.

9. RECEIPT OF DOCUMENTS

Any written notice, acknowledgement, request, decision, or other written document required to be mailed is deemed received by the person to whom the document is properly addressed on the fifth business day after being mailed. "Properly addressed", means the person's last known address.

V. COORDINATION OF BENEFITS / THIRD PARTY LIABILITY

A. Application of Coordination of Benefits

Coordination of benefits (COB) is a process regulated by law that determines financial responsibility for payment of covered expenses when an individual is covered by two or more group health plans. The objective of COB is to ensure that the group health plans – combined - will not pay more than 100% of covered expenses. Some self-funded medical plans may not apply the same Coordination of Benefits provisions as the County POS Plan. In those cases, the rules stated herein may not apply resulting in an exception to normal claim-handling processes.

The County's COB activities will not interfere with your medical care.

Coordination of benefits is a bookkeeping activity that occurs between two medical plans or HMOs. However, you may occasionally be asked to provide information about your other coverage.

The primary plan pays benefits first without regard to other coverage that may exist. A secondary plan pays after the primary plan. It typically takes into account what the primary plan paid so that payment from all applicable plans do not exceed 100% of the total covered expense.

The following rules describe which plan is primary and which plan is secondary:

1. Subscriber vs. Dependent - The plan covering the person as a subscriber (for example an employee or retiree) is primary, and the plan that covers the person as a dependent is secondary.
2. Plan without COB Provision - A plan that does not contain a coordination of benefits provision is always primary.
3. Child Covered By More Than One Plan - The order of payment when a child is covered by more than one plan is:
   a. Birthday Rule - The primary plan is the plan of the parent whose birthday is earlier in the year if:
      - The parents are married;
      - The parents are not separated (whether or not they have ever been married); or
      - A court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage.

   If both parents have the same birthday, the plan that covered either of the parents longer is primary.

b. Court-Ordered Responsible Parent - If a court decree states that one of the parents is responsible for the child's health care expenses or health care coverage and the Plan Administrator of that parent has actual knowledge of those terms, that plan is primary. This rule applies to claim determination periods or plan years starting after the Plan Administrator is given notice of the court decree.

c. Parents Not Married, Divorced, or Separated - If there is no court order specifying responsibility for the child's health care coverage and the parents are not married, separated (whether or not they ever have been married), or divorced, the order of benefits is:

- The plan of the custodial parent,
- The plan of the spouse of the custodial parent,
- The plan of the noncustodial parent,
- The plan of the spouse of the noncustodial parent.

4. Active vs. Inactive Employee - The plan that covers a person as an active employee is primary in relation to a plan that covers the person as a laid-off or retired employee. When the person has the same status under both plans, the plan provided by active employment is first to pay.

5. Length of Coverage - If the preceding rules do not determine the order or payment, the plan that covers the individual longer is primary.

6. Equal Sharing - If none of the preceding rules determines the primary plan, covered expenses will be shared equally between the plans.

EFFECT ON THE BENEFITS OF THIS PLAN

When this Plan is secondary, it may reduce its benefits so that the total benefits paid are not more than 100% of total covered expenses. If you are an individual eligible for Medicare, please see the special note below concerning the coordination of your benefits.

DEPENDENT COVERAGE UNDER THIS PLAN AND AN HMO

If a dependent is covered under this Plan and a Health Maintenance Organization (HMO), the HMO is the primary plan.

If the dependent is in a "staff-model HMO" (e.g., Kaiser), he or she may obtain medical care from a qualified provider under this Plan (see page 8) who is not on the staff of the HMO. In that case, coordination of benefits will not apply and this Plan will pay benefits according to Plan provisions. (This Plan does reserve the right to collect reimbursement from the staff model HMO for any expenses that are covered by the staff model HMO.)

RIGHT TO RECEIVE AND RELEASE INFORMATION

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under this Plan and other plans. The Plan

Administrator may obtain the facts it needs from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under this Plan and other plans covering the person claiming benefits. The Plan Administrator need not tell or obtain the consent of any person to do this. Each person claiming benefits under this Plan must give the County any facts it needs to apply those rules and determine benefits payable.

B. The Plan Administrator's Right to Pay Others

A *payment made* under another plan may include an amount that should have been paid under this Plan. If this happens, the County may pay that amount to the organization that made the payment. That amount will then be treated as though it were a benefit paid under this Plan. The County will not have to pay that amount again.

C. Recovery of Excessive Payments by the Plan Administrator

If the payment amount made by the County is more than it should have paid under this COB provision, the County may recover the excess from one or more of the persons it has paid, or for whom it has paid, or for any other person or organization that may be responsible for the benefits or services provided for the covered person.

D. Facility of Payment

A payment made under another plan may include an amount that should have been paid under this Plan. If it does, the Claims Administrator may pay that amount to the organization that made the payment. That amount will then be treated as a benefit payable under this Plan, and the Claims Administrator will not have to pay that amount again. The term *payment made* can mean the reasonable cash value of the health care service provided.

E. Important Information for Medicare-Eligible Individuals

If you (or your spouse) are eligible for coverage under Medicare while you are a Participant in this Plan, your benefits payable under the Plan might be affected. An individual is considered eligible for Medicare if he or she is:

- Covered under Medicare, or
- Not covered under Medicare because he or she refused, dropped or failed to make proper request for Medicare coverage.

If you are an active employee covered under a County health care program and are eligible for Medicare, Medicare will generally be considered the secondary payer of benefits while this Plan will be primary. (See the section *Coordination of Benefits* on page for 36 details on primary and secondary plans.)

Medicare is also the secondary payer for an:

- Active employee's dependent,
- Active employee's covered dependent who is eligible for Medicare due to a disability (regardless of age), or
- Individual receiving treatment for end-stage renal disease (during the first 30 months of such treatment).

F. Right of Reimbursement / Subrogation

This provision applies when you or your covered dependents receive or are eligible to receive reimbursement from a third party as the result of an illness or injury. This provision will apply whether or not the third party admits liability for payment. The purpose of this provision is to ensure that no benefit payments are duplicated under this Plan.

The term *third party reimbursement* includes any source of health care reimbursement. Examples: settlement, judgment, or uninsured/underinsured/no-fault motorist insurance coverage.

If third party reimbursement is or may be due to you or your covered dependents, but is not yet paid, the Claims Administrator may advance benefit payment to the individual. The individual must agree to:

- Promptly notify the Claims Administrator of any payment received from the third party, and
- Reimburse the Claims Administrator the benefits advanced under the POS Plan, up to the amount of any reimbursement received from the third party.

Any benefit paid will be subject to all provisions that apply under this Plan.

In the event a covered individual refuses to reimburse the Claims Administrator in accordance with the terms of this provision, the Claim Administrator has the right to deduct the amount of benefits paid from any future benefits payable to the covered individual or to any other covered family member. The Claims Administrator has the right to bring legal action against the covered individual to recover any balance owed under the terms of this provision.

G. Right of Recovery

Whenever an overpayment is made, the Plan has the right to recover the excess payment from the recipient (including you, an insurance company or any other organization receiving excess payments). Recovery will be from any source making payment to the full extent of payments made by the Plan, regardless of whether or not the Participant has been made whole or fully compensated for his/her illness/injury. If necessary, the Plan Administrator may withhold payment on future benefits until the overpayment is recovered.

Further, whenever payments have been made based on fraudulent information provided by you, the Plan will exercise the right to withhold payment on future benefits until the overpayment is recovered.

H. Protected Health Information

Introduction

This Plan and its business associates (see below) are required to protect the confidentiality of Protected Health Information (PHI) pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA) as amended in 2009 by the Health Information Technology for Economic and Clinical Health Act (HITECH). There are also regulations issued by the U.S. Department of Health and Human Services and the Office of Civil Rights that provide guidance on what constitutes adequate privacy protocols and mandate breach notifications in certain circumstances. The regulations also explain Participant rights and responsibilities with respect to PHI.

The laws and regulations are complex, but the core principle is that the Plan must use PHI only in accordance with the uses and disclosures permitted by HIPAA. That means the Plan must use and disclose PHI for purposes only related to health care treatment, payment for health care and health care operations.

"Payment" includes activities undertaken by the Plan to obtain contributions or premiums, or determine or fulfill its responsibility for coverage and provision of Plan benefits that relate to an individual to whom health care is provided. Note that in disclosing PHI in such circumstances, the Plan does *not* need to obtain Participant consent. These activities include, but are not limited to, the following:

- To pay claims for treatment, coordinate with another health care plan, and pay for health care operations;
- To disclose PHI to the Plan Sponsor in order to administer the Plan properly and discharge its responsibilities as a fiduciary. The Plan Sponsor has signed a certification agreeing not to disclose or use PHI other than as permitted by Plan or as required by law;
- To respond to public health oversight data requirements as required by law; and
- To comply with workers' compensation and similar programs that provides benefits for work-related injuries and illnesses, regardless of fault.

1. PARTICIPANT'S HEALTH INFORMATION RIGHTS

Participant rights with respect to health information encompass both the covered entity and their business associates. Although Participants have the right under HIPAA to make certain requests of the covered entities and business associates, there is no mandate that the covered entity or business associate *grant* the request, except under very limited circumstances.

Under HIPAA, Participants have the right to:

- Receive a written copy of the Plan Sponsor's Notice of Privacy Practices regarding PHI;
- Receive confidential communications of his or her health information, including disclosures for treatment, payment and health care operations relating to the Participant;
- Inspect and copy health information (at cost) used to make decisions about his or her medical care, including information used for denying or granting a claim and/or appeal;
- Receive an accounting of certain disclosures of his or her health information;
- Change his or her health information under certain circumstances;
- Request restriction or limitation on the PHI used or disclosed about the Participant for treatment, payment or health care operations. This is automatically granted if the Participant has paid for the health care service or item in full, out-of-pocket.
- Request that the Plan Administrator communicate with the Participant about PHI in a certain way or at a certain location. For example, the Participant can request the administrator contact him or her at work instead of at home.
- File a complaint with the Plan or with the Secretary of Health and Human Services if the Participant believes that his or her rights under HIPAA have been violated.

2. THIRD PARTIES; BUSINESS ASSOCIATES

HIPAA now requires that any third party service provider to the Plan that uses PHI in the service that it renders (known as "Business Associates") strictly comply with HIPAA security standards by implementing administrative safeguards that are consistent with the regulations. Business associates typically include third party Plan Administrators and health actuaries. Safeguards include mandated policies and procedures to protect the confidentiality, integrity and availability of electronic PHI; technical safeguards such as passwords and encryption; and security-related policies and procedures. The Plan Sponsor has taken steps to ensure that its contracts with Business Associates include language that obligates them to comply with HIPAA and implement privacy safeguards and notification procedures that meet the requirements of the regulations.

3. FILING A COMPLAINT

Any Participant or beneficiary may file a Privacy Complaint whenever he or she believes that the Plan or Plan Administrator is not complying with HIPAA or PHI-related regulations. Complaints may be filed with the Plan's Privacy Contact Officer or the Secretary of the Department of Health and Human Services, Hubert Humphrey Building, 200 Independence Avenue S.W., Washington D.C. 20201. Complaints must be filed in writing and describe the acts or omissions that is the subject of the complaint. A complaint to the Secretary must name the entity that is the subject of the complaint and be filed within 180 days of when the Participant or beneficiary learned or should have learned about the act or omission complained of, unless the Secretary waives this time limit.

All complaints must be submitted in writing. You will not be penalized for filing a complaint.

Important Note

The foregoing is intended to be only a short summary of the Plan's Privacy Practices and how it uses Protected Health Information ("PHI"). For more complete information, Participants should contact Susan Wells who is the Privacy Contact Officer and request this Plan's "Notice of Privacy Practices with Respect to Protected Health Information".

VI. PLAN ADMINISTRATION

A. Plan Administrator

Any duly authorized representative of the Plan Sponsor may exercise any authority or responsibility allocated or reserved to the Plan Administrator under this Plan, identified in Section IX.

The Plan Administrator shall have the right to hire all persons providing services to the Plan and to appoint a Claims Administrator, identified in Section IX, to receive, initially review, and process claims for benefits.

The Plan Administrator shall have the exclusive authority and responsibility to call and attend the meetings at which this Plan's claim funding policy and method are reestablished and reviewed.

The Plan Administrator shall have the discretionary authority and responsibility to construe and interpret terms of this Plan; to make factual determinations, including all questions of claim eligibility; to establish the policies, interpretations, practices, and procedures of this Plan; to adopt and implement procedures, including Care Management, in its sole discretion; to decide whether care or treatment is Medically Necessary and whether a charge meets Reasonable and Customary criteria; and to render final decisions on review of claims as described in this Plan Document. All interpretations under the Plan, and all determinations of fact made in good faith by the Plan Administrator will be final and binding on the Participants and beneficiaries and all other interested parties.

Furthermore, the Plan Administrator shall have the right to determine the amount, manner, and time of payment of any benefits under this Plan.

The Plan Administrator has a duty to maintain records and to file reports required by law. This duty shall include complying with applicable reporting or disclosure requirements.

The Plan Administrator shall forward documents pertaining to the administration of claims to the Claims Administrator and notify the Claims Administrator in writing of

changes with respect to Participants and other facts necessary for determining Plan coverages and for processing claims for Plan benefits.

For purposes of determining the applicability of the coordination of benefits and subrogation provisions of this Plan or any provision with a similar purpose that is in another plan and for purposes of implementing those provisions, the Plan Administrator or Claims Administrator may release necessary information to, or obtain necessary information from, any other organization or individual.

An amendment to the Plan may be retroactively effective but shall not adversely affect the rights of a Participant under this Plan for covered medical expenses provided after the effective date of the amendment but before the amendment is adopted.

The Plan shall furnish a summary of a material reduction in covered services or benefits to Participants within 60 days after the change has been adopted by the Plan.

Notwithstanding that the Plan Sponsor is established with the intention that it be maintained indefinitely, the Plan Administrator reserves the unlimited right to terminate or merge the Plan at any time without prior written notice to any Participant. Such termination shall be evidenced by action of the majority of the Board of Supervisors. The date of the merger or termination will be the date specified in the enabling action. Termination of the Plan shall apply to all Participants (including those on continuation coverage). Additionally, the Plan Sponsor reserves the right to determine from time to time the level of contribution required from Participants for Plan coverage.

B. Claims Administrator

The Claims Administrator, identified in Section IX, shall have the authority and responsibility to administer the Plan’s claims procedures, to process claims for benefits in accordance with Plan provisions, and to file claims with the insurance companies, if any, who issue stop loss insurance policies to the Plan.

C. Participant

As a Participant in this Plan, the Employee is entitled to certain rights. All employees participating in this Plan shall be entitled to:

1. Examine, without charge, at the Plan Administrator’s office, all Plan documents, including insurance contracts, collective bargaining agreements, and copies of documents, such as detailed annual reports and Plan descriptions.

2. Obtain copies of all Plan documents and other Plan information upon written request to the Plan Administrator. (The Plan Administrator may make a reasonable charge for the copies.)

If you have any questions about this statement or about your rights under HIPAA, you should contact the nearest office of the Employee Benefits Security Administration, U.S.

Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under HIPAA by calling the publications hotline of the Employee Benefits Security Administration.

The Participants in this Plan have the sole right to select their own providers of health care. The Plan will not choose a provider for any Participant, or have any liability for any acts, omissions, or conduct of any provider. The Plan's only obligation is to make payments according to the terms of this Plan Document. The payments that the Plan makes are not an attempt to fix the value of any services or supplies provided to a Participant.

A Participant will have the right to assign the payment of any benefits for which he is eligible under this Plan to any eligible provider of services. If a provider makes a representation to the Claims Administrator that a person covered under this Plan has made an assignment of benefit payments to the provider, the Claims Administrator will make payment to the provider based on that representation.

VII. GENERAL PROVISIONS

A. Legal Compliance/Conformity

This Plan shall be interpreted, construed, and administered in accordance with applicable state or local laws of the Employer's principal place of business to the extent such laws are not preempted by federal law. If any provision of the Plan Document or Employer's Plan is contrary to any law to which it is subject, the provision is hereby automatically changed to meet the law's minimum requirement.

B. Effect of Prior Coverage

Coverage for any Participant under this Plan Document replaces any prior coverage in effect for that Participant provided by the Employer under any immediately prior plan document or policy.

C. Severability

In the event that any provision of this Plan shall be held to be illegal or invalid for any reason by a court of competent jurisdiction, such illegality or invalidity shall not affect the remaining provisions of the Plan and the Plan shall be construed and enforced as if such illegal or invalid provision had never been contained in the Plan.

D. Status of Employment Relations

The adoption and maintenance of this Plan shall not be deemed to constitute a contract between the Employer and the Employees or to be consideration for, or an inducement or condition of, the employment of an Employee. Nothing in this Plan shall be deemed to affect the right of the Employer to discipline or discharge any Employee at any time or the right of the Employee to terminate his employment at any time. Nor shall anything in this Plan be deemed to give the Employer the right to require any Employee to remain in its employ or give the right to any Employee to be retained in the employ of the Employer.

E. Headings

Headings are for reference and not for interpretation or construction.

F. Word Usage

Whenever words are used in this document in the singular or masculine form, they shall where appropriate be construed so as to include the plural, feminine, or neuter form.

G. Titles for Reference

The titles used within this document are for reference purposes only. In the event of a discrepancy between a title and the content of a section, the content of a section shall control.

H. Clerical Error

No clerical errors made by the Employer, Plan Administrator, or the Claims Administrator in keeping records pertaining to this coverage or delays in making entries in such records will invalidate coverage otherwise validly in force or continue coverage otherwise validly terminated. Upon discovery of any error, an equitable adjustment of any benefits paid will be made.

I. Misstatements

If any relevant fact as to an individual to whom the coverage relates is found to have been misstated, an equitable adjustment of contributions will be made. If the misstatement affects the existence or amount of coverage, the true facts will be used in determining whether coverage is in force under this Plan and its amount.

VIII. DEFINITIONS

Accident and Accidental means an unforeseen or unexplained sudden occurrence by chance, without intent or volition.

Affordable Care Act refers to legal changes impacting health care plans instituted by the United States government, also called "Health Care Reform," and should be considered inclusive of the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act and other associated changes in federal law and regulation that will take precedence over any conflicting provisions contained herein.

Allowable Expense means any Medically Necessary, Reasonable and Customary item of expense which is covered at least in part under one or more of the plans covering the person for whom a claim is made. If a plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered will be considered an Allowable Expense and a benefit paid.

Ambulatory Surgical Center is a licensed facility that is used mainly for performing outpatient surgery, has a staff of Physicians, has continuous Physician and nursing care by Registered Nurses (R.N.s) and does not provide for overnight stays.

Birthing Center means any freestanding or Hospital-based facility which provides an "at home" atmosphere for the delivery of babies. This facility must be licensed and operated in accordance with the laws pertaining to Birthing Centers in the jurisdiction where the facility is located.

The Birthing Center must provide facilities for obstetrical delivery and short-term recovery after delivery; provide care under the full-time supervision of a Physician and either a Registered Nurse (R.N.) or a Licensed Nurse-midwife; and have a written agreement with a Hospital in the same locality for immediate acceptance of patients who develop complications or require pre- or post-delivery confinement.

Calendar Year means a twelve-month period beginning on the first day of January and ending on the last day of the following December.

Chemical Dependency is the condition caused by regular excessive compulsive drinking of alcohol and/or physical habitual dependence on drugs that result in a chronic disorder affecting physical health and/or personal or social functioning. This does not include dependence on tobacco and ordinary caffeine-containing drinks.

Claims Administrator means the current third-party vendor the Plan Administrator has contracted for claims administration services.

COBRA means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

Covered Charge means any expense that is eligible for benefits and not otherwise excluded under this Plan.

Custodial Care is care (including room and board needed to provide that care) that is given principally for personal hygiene or for assistance in daily activities and can, according to generally accepted medical standards, be performed by persons who have no medical training. Examples of Custodial Care are help in walking and getting out of bed; assistance in bathing, dressing, feeding; or supervision over medication which could normally be self-administered.

Dentist is a person who is properly trained and licensed to practice dentistry and who is practicing within the scope of such license.

Durable Medical Equipment means equipment that (a) can withstand repeated use, (b) is primarily and customarily used to serve a medical purpose, (c) generally is not useful to a person in the absence of an illness or Injury and (d) is appropriate for use in the home.

Eligible Dependent means an individual who meets the requirements for such status as stated in the County of Kern Employee Medical Benefits Eligibility Policy booklet.

Eligible Employee means a person who is an active, regular Employee of the Employer, regularly scheduled to work sufficient hours for the Employer in an Employer/Employee relationship, as specified in the County of Kern Health Benefits Eligibility Policy for Active Employees booklet.

Employer is County of Kern or qualified *Special Districts*.

Enrollment Date is the first day of coverage.

Family means a Participant and his Dependents. Under any benefit section, a "covered Family member," as of any given time, is a Family member for whom coverage is then in force under the section.

Home Health Care Agency is an organization the main function of which is to provide Home Health Care services and supplies and which is federally certified as a Home Health Care Agency and licensed by the state in which it is located, if licensing is required.

Hospice Care Agency is an organization the main function of which is to provide Hospice Care services and supplies and which is licensed by the state in which it is located, if licensing is required.

Hospital is an institution which is engaged primarily in providing medical care and treatment of sick and injured persons on an inpatient basis at the patient's expense and which fully meets these tests: it is accredited as a Hospital by the Joint Commission on Accreditation of Healthcare Organizations; it is approved by Medicare as a Hospital; it maintains diagnostic and therapeutic facilities on the premises for surgical and medical diagnosis and treatment of sick and injured persons by or under the supervision of Registered Nurses (R.N.s); and it is operated continuously with organized facilities for operative surgery on the premises.

The definition of "Hospital" shall be expanded to include the following:

A facility operating legally as a Rehabilitation Facility for rehabilitative care.

Hospital Confinement. Any confinement in a Hospital for which a charge is made for room and board.

Injury means an Accidental physical Injury to the body caused by unexpected external means.

Intensive Care Unit is defined as a separate, clearly designated service area that is maintained within a Hospital solely for the care and treatment of patients who are critically ill. This also includes what is referred to as a "coronary care unit" or an "acute care unit." It has facilities for special nursing care not available in regular rooms and wards of the Hospital; special life saving equipment which is immediately available at all times; at least two beds for the accommodation of the critically ill; and at least one Registered Nurse (R.N.) in continuous and constant attendance 24 hours per day.

Legal Guardian means a person recognized by a court of law as having the duty of taking care of the person and managing the property and rights of a minor child.

Licensed Practical Nurse or Licensed Vocational Nurse means an individual who is licensed to perform nursing service by the state in which the person performs such service and who is performing within the scope of that license.

Lifetime, used in this Plan in the context of benefit maximums and limitations, refers to the "lifetime" of coverage under this Plan, not to the term of an individual's life.

Medical Emergency means a sudden onset of a condition with acute symptoms requiring immediate medical care and includes such conditions as heart attacks, cardiovascular accidents, poisonings, loss of consciousness or respiration, convulsions or other such acute medical conditions.

Medically Necessary care and treatment is recommended or approved by a Physician or Dentist; is consistent with the patient's condition or accepted standards of good medical and dental practice; is medically proven to be effective treatment of the condition; is not performed mainly for the convenience of the patient or provider of medical and dental services; is not conducted for research purposes; and is the most appropriate level of services which can be safely provided to the patient.

Medicare is the Health Insurance for the Aged and Disabled program under Title XVIII of the Social Security Act as amended.

Mental Disorder means any disease or condition, regardless of whether the cause is organic, that is classified as a Mental Disorder in the current edition of International Classification of Diseases, published by the U.S. Department of Health and Human Services.

Network means the Hospitals, Physicians and other health care providers who are members of or affiliated with the provider Network contracted by the Plan.

Obesity is defined as having a BMI (Body Mass Index) of 30 or greater.

Outpatient Care is treatment including services, supplies and medicines provided and used at a Hospital under the direction of a Physician to a person not admitted as a registered bed patient; or services rendered in a Physician's office, laboratory or X-ray facility, an Ambulatory Surgical Center or the patient's home.

Participant is a person covered under this Plan or the legal representative or guardian of a minor or incompetent person covered under this Plan.

Physician means a Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Doctor of Dental Surgery (D.D.S.), Doctor of Medical Dentistry (D.M.D.), Doctor of Podiatry (D.P.M.), Doctor of Chiropractic (D.C.), Audiologist, Certified Nurse Anesthetist, Licensed Family and Marriage Counselor, Nurse Practitioner (N.P.), Occupational Therapist, Optometrist (O.D.), Physician Assistant (P.A.), Physiotherapist, Psychiatrist, Psychologist (Ph.D.), Registered Physical Therapist, Social Workers working under the direct supervision of a physician (including, but not limited to; S.W., M.S.W., L.C.S.W., A.C.S.W.), Speech Language Pathologist. In addition, the above providers must be licensed and regulated by a state or federal agency and must be acting within the scope of his or her license.

Plan means County of Kern Point of Service Plan, which is a medical benefit plan for eligible Employees of County of Kern and qualified *Special Districts* and is described in this document.

Plan Administrator is the County of Kern. The County, as the Administrator of the Plan, has and will contract with various third-party vendors to perform its administrative duties and to act as its agent for claims administration, utilization management services, and network administration.

Plan Sponsor is the County of Kern.

Plan Year is the twelve-month period beginning on either the effective date of the Plan or on the day following the end of the first Plan Year, which is a short Plan Year.

Pregnancy is childbirth and conditions associated with Pregnancy, including complications.

Primary Care Physician means a Family Practitioner, General Practitioner, Internist or Pediatrician.

Reasonable and Customary Charge is a charge which is not higher than the usual charge made by the provider of the care or supply and does not exceed the usual charge made by most providers of like service in the same area. This test will consider the nature and severity of the condition being treated. It will also consider medical complications or unusual circumstances that require more time, skill or experience.

The Plan will base Plan benefits on the actual charge billed if it is less than the Reasonable and Customary Charge.

Reasonable and Customary limitations will not apply to Network re-priced claims or those exceptions for non-Network providers indicated in Sections II, D and II, E.

Registered Nurse means a professional person who is licensed to perform nursing service by the state in which the person performs such service and who is performing within the scope of that license.

Rehabilitation Facility means an inpatient medical facility that is licensed as a Hospital or freestanding Rehabilitation Facility, where licensure is required, or it may be CARF accredited. Physicians and Registered Nurses are on staff and available. This type of facility provides physical, occupational and speech therapy by licensed therapists and also have available a program of structured cognitive therapy. Social work and discharge planning are provided, to include planning for care and equipment needs after discharge.

Sickness is a person's illness, disease or pregnancy (including complications).

Skilled Nursing Facility is a facility that fully meets all of these tests:

- It is licensed to provide professional nursing services on an inpatient basis to persons convalescing from Injury or Sickness. The service must be rendered by

a Registered Nurse (R.N.) or by a Licensed Practical Nurse (L.P.N.) under the direction of a Registered Nurse. Services to help restore patients to self-care in essential daily living activities must be provided.

- Its services are provided for compensation and under the full-time supervision of a Physician or with Physician services available at all times under an established agreement.

- It provides twenty-four hour per day nursing services by licensed nurses, under the direction of a full-time Registered Nurse (R.N.).

- It has established methods and written procedures for the dispensing and administration of drugs.

- It maintains a complete medical record on each patient.

- It has an effective utilization review plan.

- It is not, other than incidentally, a place for the provision of rest, custodial care, or education or for care required by reason of age, drug addiction, alcoholism, mental retardation, or mental disorders.

- It is approved and licensed by Medicare.

This term also applies to charges incurred in a facility referring to itself as an extended care facility, convalescent nursing home or any other similar nomenclature.

Specialists mean those practitioners other than a Family Practitioner, General Practitioner, Internist or Pediatrician.

Spinal Manipulation/Chiropractic Care means skeletal adjustments, manipulation or other treatment in connection with the detection and correction by manual or mechanical means of structural imbalance or subluxation in the human body. Such treatment is done by a Physician to remove nerve interference resulting from, or related to, distortion, misalignment, or subluxation of, or in, the vertebral column.

Subrogation is the legal process by which the Plan, after paying a loss, seeks to recover the amount of the loss from another party who is legally liable for it.

Surgical Procedure shall include but not be limited to one or more of the following types of medical procedures performed by a Physician:

- Incision, excision or electrocauterization and shave biopsy of any part of the body.
- Manipulative reduction or treatment of a fracture or dislocation, including application of a cast or traction.
- Laser beam photocoagulation.
- Suturing of a wound, surgical debridement and dressing of burns; acne surgery.
- Diagnostic and therapeutic endoscopic procedures.

- Surgical injection treatments of aspirations.
- Cardiac catheterizations and other arterial or venous catheterizations.
- Maternity procedures.
- Transplantation of organ(s).

Third Party Liability allows the Plan to recover the benefits it provided for the health care services furnished due to an accident, from a plan member who recovers a settlement or judgment from a third party liable for their injuries.

Total Disability as it applies to an Employee means the Employee is unable, as a result of Sickness or Injury, to perform the normal duties of his occupation and is not performing work of any kind for wage or profit. As it applies to a Dependent, it means that the Dependent, as a result of Sickness or Injury, is unable to perform the normal duties appropriate to a person in good health of the same sex and age.

Urgent Care Facility shall mean a facility other than a free clinic providing medical care and treatment of Sick or Injured persons on an Outpatient basis. In addition, it must meet all of the following tests:

- It is accredited by the Joint Commission on Accreditation of Hospitals or is approved by the federal government to participate in federal and state programs.

- It maintains on-premise diagnostic and therapeutic facilities for surgical and medical diagnosis and treatment by or under the supervision of duly qualified Physicians.

- It is operated continuously with organized facilities for operative surgery on the premises.

- It is staffed with continuous Physician services and registered professional nursing services whenever a patient attends the facility.

- It does not provide services or other accommodations for patients to stay overnight.

Waiting Period shall mean any period of time imposed by the Plan between the first day of employment and the first day of eligibility for coverage under the Plan.

IX. IDENTIFICATION OF PLAN

PLAN**:** County of Kern Point of Service Employee Medical Plan

PLAN SPONSOR:

County of Kern
1115 Truxtun Avenue, Fifth Floor
Bakersfield, CA 93301

PLAN SPONSOR TAX ID NO.: 95-6000925

PLAN NO.: 501

CLAIMS ADMINISTRATOR:

HealthEdge Administrators
5701 Truxtun Avenue, Suite 100
Bakersfield, CA 93309

TYPE OF BENEFITS PROVIDED: See Schedule of Benefits

TYPE OF PLAN ADMINISTRATION: Self-Funded Third Party

PLAN ADMINISTRATOR/AGENT FOR LEGAL PROCESS/NAMED FIDUCIARY:

County of Kern
1115 Truxtun Avenue, Fifth Floor
Bakersfield, CA 93301

CONTRIBUTIONS TO PLAN:

Contributions for the Plan are provided partially by contributions of the Plan Sponsor and partially by contributions of Covered Employees

PLAN YEAR: Ends December 31st