GOLD COAST JOINT BENEFITS TRUST

SUMMARY PLAN DESCRIPTION

Effective February 1, 2007

As Revised
July 1, 2009
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I. FOREWORD

The Board of Directors of the GOLD COAST JOINT BENEFITS TRUST is pleased to present you with this booklet describing the Trust’s Indemnity Medical Plan (the “Plan”) as of September 1, 2006. It replaces all previous benefit booklets and inserts.

This booklet explains the Trust’s Indemnity Medical Plan, which includes medical, Prescription Drug, Mental Illness, Substance Abuse, and chiropractic benefits. The Trust also provides indemnity dental and vision benefits, which are described in separate booklets available from the Trust Administrator and your school district employer.

The Trust also offers medical coverage through health maintenance organizations (“HMO”). The HMO medical plans are described in separate booklets available to all Trust Participants from the Trust Administrator and your school district employer.

Please take the time to read this booklet and become familiar with the Plan’s benefits, its rules of eligibility, and the use of its programs. We encourage you to share this booklet with your family since they, too, have an interest in the benefits available under the Trust. You will periodically receive updates to this booklet advising you of changes in benefit and eligibility rules. Please keep the updates with this booklet.

In order to receive the full benefits provided by the Plan, you must comply with all Plan provisions. If you do not, you may become responsible for some of the Doctor or Hospital charges incurred.

If you have any questions concerning your benefits, we encourage you to contact the Trust Administrator at:

Delta Health Systems (DHS)
P.O. Box 80
Stockton, California 95201
Telephone: 1-800-556-5918

The office of the Trust Administrator is open from 7:30 a.m. to 5:00 p.m., Monday through Friday.

BOARD OF DIRECTORS
AUTHORIZED SOURCES OF INFORMATION

If you have any questions about your benefits, you may only rely upon this booklet, any supplements or amendments, if any, the Trust Agreement, and the written statements of the Trust Administrator and his or her authorized agents. Oral statements or written representations made by individuals other than authorized personnel are not authoritative sources of information. No school district or employee organization, or any representative of any school district or employee organization, is authorized to interpret the Plan on behalf of the Board of Directors, nor can such person act as an agent of the Board of Directors. Questions as to eligibility, benefits and other matters should be submitted in writing to the Trust Administrator.

PLAN AMENDMENTS AND INTERPRETATION

The Board of Directors may amend the Plan described in this booklet in writing. Only the Board of Directors is authorized to interpret the Plan described in this booklet. The Board has broad discretion to interpret the Plan, and its interpretation of the Plan described in this booklet is final and binding on all parties. All rights to benefits shall be determined in accordance with this Plan as interpreted by the Board of Directors.

The Board of Directors has the right, upon sixty days advance written notice to the districts and the unions, to modify the benefits described herein if the contributions to the Trust and the reserves of the Trust are insufficient to maintain the Plan as described herein.
II. DEFINITIONS OF TERMS

Words and phrases that have their initial letters capitalized have the meanings defined below. It is important for you to become familiar with these terms to understand the descriptions of your benefits.

“Benefit Percentage Payable” means the percentage that the Plan will pay of any Covered Expense. The percentage that the Plan pays depends on which of the Plans you are enrolled in, whether you are using a Contract Provider, and, if your Covered Expense is for a Hospital admission, whether your Hospital admission has been pre-certified in accordance with Section VII.H. See Section VII.B, and the Schedule of Benefits for more information on the Benefit Percentage Payable.

“Calendar Year Deductible” or “Deductible” means the dollar amount of Covered Expenses that the Participant must pay per calendar year before the Participant is entitled to Major Medical Benefits. The Deductible for each of the Plans is listed in the Schedule of Benefits (see Section IV.).

“Contract Hospital” means a Hospital that participates in a network or Preferred Provider Organization which the Trust uses to provide care and treatment to Participants at a specified rate.

“Non-Contract Hospital” means a Hospital that does not participate in a network or Preferred Provider Organization to provide care and treatment to Participants.

“Contract Physician” means a Physician who participates in a network or Preferred Provider Organization which the Trust uses to provide care and treatment to Participants at a specified rate.

“Non-Contract Physician” means a Physician who does not participate in a network or Preferred Provider Organization to provide care and treatment to Participants.

“Contract Provider” means any provider of healthcare services, including Physicians, labs and Hospitals, that participates in a network or Preferred Provider Organization which the Trust uses to provide care and treatment to Participants at a specified rate.

“Non-Contract Provider” means any provider of healthcare services, including Physicians, labs and Hospitals, that does not participate in a network or Preferred Provider Organization to provide care and treatment to Participants.

“Covered Expenses” or “Covered Charges” means the charges or expenses incurred by a Participant while eligible under the Plan, which are:
1. Medically Necessary, and
2. not excluded under the terms of the Plan, and
3. The lesser of the following:
   a. the negotiated contract rate of a Contract Provider or, if you use a non-
      Contract Provider, the UCR allowance for the service rendered by the
      health care provider;
   b. the charge billed by the Physician or other provider;
   c. The plan specified limit or allowance for the particular service, procedure,
      treatment or supply; or
   d. if the charges are also covered under a different plan, the Preferred
      Provider Organization rate charged under a plan with which this Plan is
      coordinating.

In addition, Covered Expenses shall not include out-of-pocket expenses incurred by a Participant
as the result of non-compliance with the Hospital Contracting or Hospital Utilization Review
provisions of this Plan (see Section VII.H.).

“Doctor” or “Physician” or “Surgeon” means a licensed Doctor of Medicine (M.D.) or Doctor
of Osteopathy. “Doctor” also includes a dentist, licensed podiatrist, chiropodist, acupuncturist or
chiropractor, within the scope of limits of their practice, with one exception: a dentist is not
covered as a Physician, Surgeon, or Doctor under this Plan except as specifically stated.
Christian Science practitioners are included if listed in the current Christian Science Journal.
Where a Physician is specifically defined in a benefit provision, that definition shall prevail over
this general definition.

“Domestic Partner” means a person who has legally established a Domestic Partnership with an
Employee in accordance with California Family Code Sections 297 by registering the Domestic
Partnership with the Secretary of the State of California. A Domestic Partnership may be formed
between same-sex partners or opposite-sex partners where at least one partner is age 62 or older
and meets certain eligibility criteria under the Social Security Act.

“Emergency” means a medical condition which, if not immediately treated, is likely to result in
death, permanent disability, prolonged temporary disability or unwarranted prolongation of
treatment, increased risk of more complex or hazardous treatment, development of chronic
illness, or inordinate physical or psychological suffering.

“Employee” means all persons covered by a collective bargaining agreement between a district
and a union, employees of a district covered by a participation agreement, persons retired from
employment with a district, and persons serving on the governing board of a district.

“Experimental” or “Experimental Treatment” means any procedure, device, Drug, treatment,
or medicine, or the use thereof, which falls within any of the following categories:
1. Which is considered by any governmental agency or subdivision, including but not limited to the Food and Drug Administration, the Office of Health Technology Assessment, or the Centers for Medicare and Medicaid Services (CMS) in its Medicare Coverage Issues Manual to be experimental or investigational; or

2. Which is not covered under Medicare reimbursement laws, regulations or interpretations; or

3. Which is not commonly and customarily recognized by the medical profession in the state where treatment is rendered as appropriate for the condition being treated in that:
   a. The medical procedure, equipment, treatment or course of treatment, or Drug or medicine is under investigation or is limited to research;
   b. The techniques are restricted to use at centers which are capable of carrying out disciplined clinical efforts and scientific studies;
   c. The procedures are not proven in an objective way to have therapeutic value or benefit; and
   d. The procedure’s or treatment’s effectiveness is medically questionable.

“Home Health Care Agency” means an organization or agency which meets the requirements for participation as a “Home Health Care Agency” under Medicare.

“Hospital” means an institution operated pursuant to law which meets the following requirements:

1. It is equipped with permanent facilities for diagnosis, major surgery, and 24-hour continuous nursing service by Registered Nurses (R.N.) and 24-hour continuous supervision by a staff of Physicians licensed to practice medicine (other than Physicians whose license limits their practice to one or more specified fields). It also includes a Psychiatric Health Facility as defined in Section 1250.2 of the California Health and Safety Code, when service is rendered there for psychiatric or mental conditions.

2. It is primarily engaged in providing diagnostic and therapeutic facilities for medical and surgical care of injured and sick persons on a basis other than as a rest home, nursing home, a place for the aged, a place for alcoholics or a place for substance abusers. If a unit or area of a Hospital is operated for the care of convalescent patients or for rehabilitation purposes, charges incurred for confinement in such a unit or area shall not be considered charges made by a Hospital nor shall such a unit or area be considered a part of the Hospital.

“Intensive Care Unit” means a section within a Hospital which is operated exclusively for critically ill patients and provides special supplies, equipment and constant observation and care by Registered Nurses (R.N.) or other highly trained Hospital personnel. It does not include any
Hospital facility maintained for the purpose of providing normal post-operative recovery treatment or service.

“Medicare” means the insurance program established by Title XVIII of the Federal Social Security Act of 1965, as amended.

“Medically Necessary” services or supplies are those determined under the Plan to be:

1. Appropriate and necessary for the symptoms, diagnosis or treatment of the injury or illness;

2. Not Experimental, educational, or investigational;

3. Within the standards of good medical practice within the organized medical community;

4. Not primarily for the convenience of the Participant, the Participant’s Physician or another provider; and

5. The most appropriate supply or level of service which can be safely provided. For Hospital stays, this means that acute care as an inpatient is necessary due to the kind of services the Participant is receiving or the severity of the Participant’s condition, and that safe and adequate care cannot be received as an outpatient or in a less intensified medical setting.

The Trust Administrator may use Professional Review Organizations or other professional medical opinion to determine if health care services are Medically Necessary.

“Mental Illness” means a pathological state of mind, regardless of whether such state is the result of physical causes, psychological causes, or a combination of both, producing clinically significant psychological (including but not limited to, affective, cognitive, and behavioral) or physiological symptoms (illness) together with impairment in one or more major areas of functioning (disability).

Some examples of Mental Illnesses are: major depressive disorder, bipolar disorder, generalized anxiety disorder, panic disorder, post-traumatic stress disorder, schizophrenia, adjustment disorders, borderline personality disorder, dementia, delirium, attention-deficit/hyperactivity disorder, eating disorders, and substance-related disorders (e.g., alcohol abuse).

“Nurse” or “Registered Nurse” (R.N.) means a registered graduate nurse licensed under the appropriate laws to provide nursing care or services. The term shall not include the Participant’s spouse, child, brother, sister or parent, or any other person who ordinarily resides in the Participant’s home.

“Outpatient Facility” or “Facility” means a health care facility that provides outpatient services including, but not limited to, x-ray, laboratory, diagnostic services, and emergency care, and which may be operated by or in connection with a hospital. Hospitals, Hospital emergency rooms, and Outpatient Surgery Centers are not Outpatient Facilities.
“Outpatient Surgery Center” means a state licensed freestanding outpatient surgical facility that is primarily engaged in providing surgical services for ambulatory patients on an outpatient basis, where the patient is admitted to and discharged from the facility within 24 hours. Outpatient Surgery Centers are also referred to as ambulatory surgical centers or outpatient surgicenters. Hospitals are not Outpatient Surgery Centers.

“Participant” means any Employee or dependent eligible and enrolled to receive benefits under this Plan.

“Pharmacist” and “Licensed Pharmacist” means a person who is licensed to practice pharmacy by the governmental authority having jurisdiction over the licensing and practice of pharmacy.

“Plan” means the Indemnity Medical Plan provided by the Trust as described in this booklet and as amended by the Board of Directors. The term Plan also refers to any one or more of the Plans offered under the Indemnity Medical Plan. When not capitalized, the term plan refers to a plan of benefits not offered under the Indemnity Medical Plan (for instance plan may refer to one of the HMO plans offered by Gold Coast Joint Benefits Trust.)

“Preferred Provider Organization” or "PPO" means an organization under contract with the Trust through which Hospitals, laboratory and radiology facilities, Physicians and other providers of healthcare services contract to provide hospitalization and medical services to Participants payable on the basis of negotiated rates.

“Prescription Drug” or “Drug” means any medication or article which may be lawfully dispensed, as provided under the Federal Food, Drug and Cosmetic Act, including any amendment thereto, only upon a written or oral prescription of a Physician or dentist licensed by law to administer it. The term “Drug” also includes insulin and diabetic supplies, including syringes, needles and test material.

“Professional Review Organization” means a third party under contract with the Trust which is responsible for determining whether the confinement of a Participant to a Hospital is Medically Necessary, and if Medically Necessary, to determine the number of Medically Necessary days for such confinement.

“Sickness” means a sickness or disease which does not arise out of or in the course of employment or any occupation for wage or profit and includes pregnancy, childbirth, or related medical conditions.

“Skilled Nursing Facility” means a facility which:

1. Holds a license as a skilled nursing home (if required by the state);

2. Operates primarily for the skilled nursing care and rehabilitation of sick or injured persons as inpatients;
3. Has a written agreement with a Hospital to accept patients who no longer require Hospital treatment but require continued skilled nursing care;

4. Gives 24-hour nursing service under the direction of a full-time Registered Nurse;

5. Has a Physician, who is a staff member of a general Hospital, on call at all times; and

6. Is not, other than incidentally, a place for alcoholics, substance abusers or the mentally ill; a place for rest, custodial care or the aged; a hotel or any similar institution.

“Substance Abuse” means a condition of psychological and/or physiological dependence or addiction to alcohol or psychoactive drugs or medications, which results in functional (physical, cognitive, mental, affective, social or behavioral) impairment.

“Total Disability” means an Employee who is wholly and continuously prevented by injury or Sickness from engaging for wages or profit in the occupation for which he/she is qualified based on education and training. For a retiree or dependent spouse, “Total Disability” means the inability, due to Sickness or injury, to engage in the substantial and material activities engaged in prior to the start of disability. For a dependent child, “Total Disability” means confinement to the house or a Hospital due to Sickness or injury.

“Trust” means the Gold Coast Joint Benefits Trust as established by the Trust Agreement.

“Trust Administrator” means Delta Health Systems ("DHS"), P.O. Box 80, Stockton, CA 95201, (800) 556-5918.

“Urgent Care Center” means a medical facility other than a hospital emergency department where ambulatory patients can be treated on a walk-in basis, without an appointment, and receive immediate care. Urgent Care Centers and Walk-in Centers are typically open after-hours, and provide the same services as a family or primary medical care physician. Outpatient Surgery Centers and Hospital emergency departments are not Urgent Care Centers.

“UCR” means an allowance that the Trust has determined is an appropriate payment for the service(s) rendered in the provider's geographic area, based on such factors as the Trust's evaluation of the value of the service(s) relative to the value of other services, market considerations, and provider charge patterns. For more information about how the Plan determines UCR, see Section VII.B.

Any agreement as to fees or charges made between the Participant and the health care provider does not bind the Trust in determining its liability with respect to expenses incurred.
Once you become eligible, you may choose to be covered under either: (1) the Indemnity Medical Plan described in this booklet; or (2) one of the prepaid medical plans that are offered by Health Maintenance Organizations ("HMO"), and are also provided through the Gold Coast Joint Benefits Trust. Your eligible dependents must be covered under the same medical plan that you choose for yourself.

The HMO plans currently provided under the Gold Coast Joint Benefits Trust are Health Net, PacifiCare, and Kaiser. The Trust Administrator and your school district employer will provide you with separate booklets that describe the HMO plans. Your eligible dependents must be covered by the same HMO plan you choose for yourself.

The Trust’s Indemnity Medical Plan consists of two separate Plans described in the Schedule of Benefits (see Section IV.). If you choose to be covered under the Indemnity Medical Plan, your district will automatically assign you to the appropriate Plan based on the district’s policies. Contact the Trust Administrator or your district if you are unsure about which of the two Plans covers you. Your eligible dependents must be covered by the same indemnity plan in which you are enrolled.

If you and your spouse are both Employees, both of you may choose to be covered by the same medical plan, or you may each choose between one of the Trust’s prepaid plans or the indemnity Plan available through your district. You, your spouse and your dependent children will be covered in accordance with the Trust’s Coordination of Benefits rules (see Section IX.). If you and your spouse choose separate plans, each of you must use the respective plan in which you have enrolled and may not use the other plan as a dependent, unless you each have first exhausted your benefits under your primary plan (see Exclusion 30, Section VII. F.).

When you enroll, you will select your medical plan. You will be notified of your eligibility date by your school district. You will also be furnished with enrollment forms and asked to complete the enrollment forms for the plan which you have chosen. It is very important that you complete and return the forms as soon as possible. If you do not return the forms, your claims will be denied. If you do not complete the forms on time, or if you do not correctly fill in all of the required information, it may cause services and reimbursements to be delayed or denied. If you need help in completing the forms, the Trust Administrator will be pleased to help you. You can reach the Trust Administrator Monday through Friday, 7:30 a.m. to 5:00 p.m., at 1 (800) 556-5918.

By participating in this Plan, you are agreeing to have any dispute with the GOLD COAST JOINT BENEFITS TRUST and its agents and their employees regarding any claims for benefits decided by neutral arbitration, giving up your right to a jury or court trial, and agreeing to a reduced period of limitations in which to initiate your claim. See Section X. for a description of the Plan’s Appeal and Arbitration Procedures.
If you are eligible for benefits under the self-pay provisions of this Plan, and you elect not to continue coverage, or you cease to make the required payments to the Plan, you cannot re-elect to participate in any medical, dental or vision plan unless a change in your employment status occurs which re-qualifies you as an eligible Employee. (See Sections VIII.D., VIII.G.2., VIII.G.3., and VIII.G.4. for more information on self-pay provisions and see Section VIII.A. for the Waiver of Coverage rules.)

**Transfers**

Once you have enrolled in the plan of your choice, transfers from one plan to another are permitted only during the Trust’s open enrollment period. Open enrollment is normally held once each year with coverage changes becoming effective the first day of the month following the month during which open enrollment takes place.

If you were formerly covered by the Trust’s Indemnity Medical Plan and wish to be covered again after an intervening period of coverage under an HMO plan, any amounts of coverage previously applied toward the Indemnity Medical Plan Lifetime Maximum and Mental Illness benefit maximum will still apply.
IV. SCHEDULE OF BENEFITS
FOR THE INDEMNITY MEDICAL PLAN

The Indemnity Medical Plan consists of two plans, each of which provide different benefits. Please check with the Trust Administrator or your school district to determine which of the two Plans covers you and your dependents. Voluntary Self-Pay Retirees are covered by Plan 4. The following chart summarizes what portion of Covered Expenses will be paid under each of the two Plans. It also highlights several rules which, if not followed, may result in higher costs to you.

**Calendar Year Deductible**

<table>
<thead>
<tr>
<th>Plan</th>
<th>Deductible</th>
</tr>
</thead>
<tbody>
<tr>
<td>Plan 2</td>
<td>$100 per person; $300 per family</td>
</tr>
<tr>
<td>Plan 4</td>
<td>$400 per person; $1200 per family</td>
</tr>
</tbody>
</table>

The Calendar Year Deductible is waived for Covered Expenses incurred under the Mental Illness, Substance Abuse, Chiropractic and Prescription Drug Programs.

**Coinsurance Limit (Participant’s Out-of-Pocket Limit)**

<table>
<thead>
<tr>
<th></th>
<th>Contract Provider</th>
<th>Non-Contract Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>Plan 2</td>
<td>$1,000</td>
<td>$1,000</td>
</tr>
<tr>
<td>Plan 4</td>
<td>$2,000</td>
<td>No Limit</td>
</tr>
</tbody>
</table>

**Plan Lifetime Maximum:** $2,000,000

**Benefit Percentage Payable (Amount Paid by the Plan)**

After the Calendar Year Deductible has been met, the Benefit Percentage Payable for Covered Charges are as follows:

**Hospital Expenses**

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<thead>
<tr>
<th></th>
<th>Contract Provider</th>
<th>Non-Contract Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>Plan 2</td>
<td>100% of Covered Charges</td>
<td>80% of Covered Charges up to the Coinsurance Limit; 100% thereafter</td>
</tr>
<tr>
<td>Plan 4</td>
<td>90% of Covered Charges up to the Coinsurance Limit; 100% thereafter</td>
<td>70% of Covered Charges</td>
</tr>
</tbody>
</table>

*Important Note:* If you or your covered dependent do not obtain Pre-Certification (see Section VII.H.) prior to a scheduled Hospital stay or within the time period indicated for an Emergency admission, the Plan will only pay only 80% of the applicable Benefit Percentage Payable shown above.
### Outpatient Surgery Centers (also known as ambulatory surgical centers)

<table>
<thead>
<tr>
<th>Plan 2</th>
<th>Plan 4</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Contract Provider</strong></td>
<td><strong>Non-Contract Provider</strong></td>
</tr>
<tr>
<td>100% of Covered Charges</td>
<td>80% of Covered Charges up to a maximum of $2,000</td>
</tr>
<tr>
<td>90% of Covered Charges up to the Coinsurance Limit; 100% thereafter</td>
<td>70% of Covered Charges up to a maximum of $2,000</td>
</tr>
</tbody>
</table>

**Important Note:** If you use a Non-Contract Outpatient Surgery Center, the Fund will pay a maximum benefit of $2,000. Physician and surgeon fees are not included in this $2,000 maximum. You will be responsible for your share of UCR, any charges in excess of UCR, and all charges incurred after the Fund has exceeded its $2,000 maximum benefit. Additionally, any expense you incur at a Non-Contract Outpatient Surgery Center will not count towards your Coinsurance Limit.

### Physician (including maternity, well-woman visits and immunizations), Outpatient Facility (Lab & X-Ray), Urgent Care Center, and Podiatry Expenses

<table>
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<th>Plan 2</th>
<th>Plan 4</th>
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<tbody>
<tr>
<td><strong>Contract Provider</strong></td>
<td><strong>Non-Contract Provider</strong></td>
</tr>
<tr>
<td>80% of Covered Charges up to the Coinsurance Limit; 100% thereafter</td>
<td>80% of UCR up to the Coinsurance Limit; 100% thereafter</td>
</tr>
<tr>
<td>80% of Covered Charges up to the Coinsurance Limit; 100% thereafter</td>
<td>60% of UCR</td>
</tr>
</tbody>
</table>

**Important Note:** If you or your covered dependent do not obtain Pre-Certification (see Section VII.H.) prior to a scheduled Hospital stay, the Plan will only pay only 80% of the applicable Benefit Percentage Payable shown above.

### Skilled Nursing Facility*

<table>
<thead>
<tr>
<th>Plan 2</th>
<th>Plan 4</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Contract Provider</strong></td>
<td><strong>Non-Contract Provider</strong></td>
</tr>
<tr>
<td>80% of Covered Charges up to the Coinsurance Limit; 100% thereafter</td>
<td>80% of UCR up to the Coinsurance Limit; 100% thereafter</td>
</tr>
<tr>
<td>80% of Covered Charges up to the Coinsurance Limit; 100% thereafter</td>
<td>80% of UCR</td>
</tr>
</tbody>
</table>

*Only payable if confinement begins within 14 days of a Hospital stay of 3 or more days; no more than 90 days per year whether paid at 80% or 100%.
## Hospital Emergency Room

<table>
<thead>
<tr>
<th>Plan</th>
<th>Contract Provider</th>
<th>Non-Contract Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>100% of Covered Charges, if Medically Necessary</td>
<td>100% of Covered Charges, if Medically Necessary</td>
</tr>
<tr>
<td>4</td>
<td>90% of Covered Charges, if Medically Necessary</td>
<td>90% of Covered Charges, if Medically Necessary</td>
</tr>
</tbody>
</table>

**Important Note:** If you or your covered dependent do not obtain Pre-Certification (see Section VII.H.) within the time period indicated for an Emergency admission, the Plan will only pay only 80% of the applicable Benefit Percentage Payable shown above.

## Prostate Antigen Testing

All plans: 100% of Covered Charges up to $28 per test for members age 40 and over, up to one test per calendar year.

## Allergy Testing and Allergy Serum

<table>
<thead>
<tr>
<th>Plan</th>
<th>Contract Provider</th>
<th>Non-Contract Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>80% of Covered Charges up to the Coinsurance Limit; 100% thereafter</td>
<td>80% of UCR up to the Coinsurance Limit; 100% thereafter</td>
</tr>
<tr>
<td>4</td>
<td>80% of Covered Charges up to the Coinsurance Limit; 100% thereafter</td>
<td>60% of UCR</td>
</tr>
</tbody>
</table>

## Home Health Services*

<table>
<thead>
<tr>
<th>Plan</th>
<th>Contract Provider</th>
<th>Non-Contract Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>80% of Covered Charges up to the Coinsurance Limit; 100% thereafter</td>
<td>80% of UCR up to the Coinsurance Limit; 100% thereafter</td>
</tr>
<tr>
<td>4</td>
<td>80% of Covered Charges up to the Coinsurance Limit; 100% thereafter</td>
<td>80% of UCR</td>
</tr>
</tbody>
</table>

*No more than 60 visits per calendar year whether paid at 80% or 100%.
Hospice Care*

<table>
<thead>
<tr>
<th></th>
<th>Contract Provider</th>
<th>Non-Contract Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>Plan 2</td>
<td>100% of Covered Charges for home or inpatient care</td>
<td>100% of Covered Charges for home or inpatient care</td>
</tr>
<tr>
<td>Plan 4</td>
<td>90% of Covered Charges for home or inpatient care</td>
<td>90% of Covered Charges for home or inpatient care</td>
</tr>
</tbody>
</table>

* No more than 60 days of home care. Inpatient care limited to maximum benefit of $150 per day, for maximum of 30 days.

Durable Medical Equipment

<table>
<thead>
<tr>
<th></th>
<th>Contract Provider</th>
<th>Non-Contract Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>Plan 2</td>
<td>80% of Covered Charges up to the Coinsurance Limit; 100% thereafter</td>
<td>80% of UCR up to the Coinsurance Limit; 100% thereafter</td>
</tr>
<tr>
<td>Plan 4</td>
<td>80% of Covered Charges up to the Coinsurance Limit; 100% thereafter</td>
<td>80% of UCR</td>
</tr>
</tbody>
</table>

All Other Covered Expenses

<table>
<thead>
<tr>
<th></th>
<th>Contract Provider</th>
<th>Non-Contract Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>Plan 2</td>
<td>80% of Covered Charges up to the Coinsurance Limit; 100% thereafter</td>
<td>80% of UCR up to the Coinsurance Limit; 100% thereafter</td>
</tr>
<tr>
<td>Plan 4</td>
<td>80% of Covered Charges up to the Coinsurance Limit; 100% thereafter</td>
<td>80% of UCR</td>
</tr>
</tbody>
</table>

For non-Hospital Covered Expenses under Plan 2, the Plan pays the applicable Benefit Percentage Payable shown in the tables above up until the Participant reaches his or her Coinsurance Limit, then the Plan pays 100% of Covered Expenses thereafter for the remainder of the calendar year. The same rule applies if Contract Providers are used under Plan 4. If Non-Contract Providers are used under Plan 4 any amounts that the participant is required to pay will not count towards his or her Coinsurance Limit (the Coinsurance Limit is essentially unlimited).

Certain Covered Expenses do not apply to the Coinsurance Limit for any of these two Plans. See Section VII.C. for a list of these Covered Expenses.
Mental Illness and Substance Abuse Program – Indemnity Only
Plan 2 retirees and Voluntary Self-Pay Retirees in Plan 4 are not eligible for this benefit.

Plan 4 Indemnity Medical Plan Participants, not including Voluntary Self-Pay Retirees, are eligible for benefits under this program.

Benefits are provided through US Behavioral Health Plan California (USBHPC) only. No benefits will be paid unless the treatment plan has been pre-certified and approved by USBHPC.

Outpatient Mental Illness
The Plan pays 100% of Covered Charges after the required copay per visit:
Visits 1 through 5: no copay
Visits 6 through 20: $10 copay per visit
Visits 21 through 52: $25 copay per visit
Maximum of up to 52 visits per year. All visits must be approved by USBHPC.

Inpatient Mental Illness and Substance Abuse Treatment
The Plan pays 90% of Covered Charges up to 30 days per calendar year, with a lifetime maximum of 90 days. (Maximum number of days is a combined benefit for all inpatient Mental Illness and Substance Abuse Treatment per Participant.)

Outpatient Substance Abuse Treatment
The Plan pays 80% of Covered Charges up to 30 days per calendar year, with a lifetime maximum of 90 days.

Employee Assistance Program (EAP) – Indemnity & HMO

Plan 2 Retirees and Voluntary Self Pay Retirees in Plan 4 are not eligible for the Employee Assistance Program (EAP).

Benefits under the EAP are available to active employees and District Paid Retirees in Plan 4, whether they are enrolled in the Indemnity Medical Plan or in a Trust-sponsored HMO.

The Plan pays 100% of Covered Charges for up to 5 visits per calendar year. For Indemnity Medical Plan Participants, all EAP visits will be counted towards the annual maximum of 52 visits offered under the Outpatient Mental Illness benefit. The EAP is not available to retirees.

Chiropractic Care
Benefits are provided through Chiropractic Health Plan of California (CHPC) only. No benefits will be paid unless CHPC pre-certifies and approves the treatment plan. The Plan pays 100% of Covered Charges after the required copay per visit, as shown below:
<table>
<thead>
<tr>
<th>Plan 2</th>
<th>$10 copay per visit; maximum of 45 visits per calendar year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Plan 4</td>
<td>$20 copay per visit; maximum of 30 visits per calendar year</td>
</tr>
</tbody>
</table>
Prescription Drug

**Walk-in Retail Pharmacy**
After the required copay as shown below, the Plan pays 100% of Covered Charges per prescription or refill when purchased at a Medco-affiliated pharmacy. Prescriptions purchased at a walk-in pharmacy are obtainable for up to a 30-day supply.

<table>
<thead>
<tr>
<th>Plan</th>
<th>Generic</th>
<th>Preferred Brand</th>
<th>Non-Preferred Brand</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>The greater of $8 or 20%</td>
<td>The greater of $15 or 20%</td>
<td>The greater of $25 or 25%</td>
</tr>
<tr>
<td>4</td>
<td>$10</td>
<td>The greater of $25 or 15%</td>
<td>The greater of $40 or 25%</td>
</tr>
</tbody>
</table>

**Mail Order Plan**
After the required copay as shown below, the Plan pays 100% of Covered Charges per 90-day prescription or refill when purchased through the Medco Health Home Delivery Service.

<table>
<thead>
<tr>
<th>Plan</th>
<th>Generic</th>
<th>Preferred Brand</th>
<th>Non-Preferred Brand</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>$10</td>
<td>$20</td>
<td>$35</td>
</tr>
<tr>
<td>4</td>
<td>$20</td>
<td>$50</td>
<td>$75</td>
</tr>
</tbody>
</table>
V. HOW TO FILE A CLAIM

If you use a Contract Provider, the Contract Provider will file your claim for you, and you will not need to submit bills to the Trust Administrator.

If, however, you do not use a Contract Provider, you should:

1. Obtain a medical claim form from the Trust Administrator or your district office.

2. Complete and sign the form and give it to your Doctor for completion. Return the completed claim form, with the itemized bills attached, to the claims department at the address indicated on the claim form. Claim forms must be used; cancelled checks or receipts are not acceptable.

3. For charges to be covered under the Plan, claim forms must be received by the Trust Administrator, or any other location designated on the form, no later than one year from the date expenses were incurred.

If you have any questions about your benefits or need any assistance completing the claim form, the staff of the Trust Administrator will be pleased to help. They can be reached Monday through Friday, 7:30 a.m. to 5:00 p.m., at 1 (800) 556-5918.

THE TRUST WILL NOT PAY AND IS NOT RESPONSIBLE FOR PAYING A CLAIM IF THE TRUST ADMINISTRATOR RECEIVES THE CLAIM FORM MORE THAN ONE YEAR AFTER THE DATE SERVICES OR SUPPLIES WERE PROVIDED.
VI. ELIGIBILITY PROVISIONS

If you are an Employee of a school district or other public agency participating in the GOLD COAST JOINT BENEFITS TRUST, you and your eligible dependents are eligible for health and welfare benefits pursuant to the terms of the collective bargaining agreements between the union(s) and the participating public agency or the terms of the participation agreement between the Trust, the participating public agency, and the union.

Retirees are eligible for benefits under this Plan only if they are eligible under the rules of the participating district from which they retired.

A. Dependents

Dependents are defined as your lawful spouse or Domestic Partner, as well as your unmarried children and your Domestic Partner’s children who are less than 19 years of age. Dependent children shall also include unmarried children who are less than age 25 and attend an accredited school full-time or who are less than age 25 and qualify as dependents for federal income tax purposes.

Children include:

1. Your natural children and those of your spouse or Domestic Partner;

2. Your adopted children (beginning on the date of placement for the purpose of adoption) and those of your spouse or Domestic Partner; and

3. Any other children provided:
   a. They are dependent upon you for support, and
   b. You or your spouse or Domestic Partner has been lawfully appointed the child’s guardian or conservator.

The Plan also covers your disabled dependent child regardless of age if your child, while covered, becomes incapable of self-support due to a mental or physical disability which occurs before the child’s 19th birthday. Coverage continues until: (1) such dependent is capable of self-support; or (2) your coverage terminates. The dependent must be claimed by you or your spouse or Domestic Partner for federal income tax purposes, and the Trust may require periodic re-certification of the dependent child’s disability.

The term “dependent” shall not include any person who is in full-time military service.

If both you and your spouse or Domestic Partner are eligible as an Employee, each shall be eligible both as an Employee and as a dependent. If a person has such dual coverage, the total amount of benefits payable under this Plan shall in no event exceed the amount
of expense actually incurred for which benefits are provided, less any applicable deductions for noncompliance with the Plan rules.

If both parents of an eligible dependent child are Employees, such child shall be eligible as a dependent of each. If a child has such dual coverage, the total amount of benefits payable under this Plan shall in no event exceed the amount of expense actually incurred for which benefits are provided, less any applicable deductions for noncompliance with Plan rules.

B. Effective Date of Coverage

The effective date of coverage for eligible Employees and their eligible dependents is pursuant to the collective bargaining agreement or memorandum of understanding.

Coverage for a newborn child begins at birth, provided the Trust Administrator receives an application to enroll the child(ren) within 30 days of the date of birth. Coverage for other newly acquired eligible dependents will begin on the date the dependent becomes an eligible dependent, provided the Trust Administrator receives an application to enroll the dependent(s) within 30 days of the date acquired. If the forms are not submitted to the Trust Administrator on time, or if all of the required information is not correctly filled in, services and reimbursements may be delayed.

C. Termination of Coverage

1. Employee

Your benefit coverage will cease on the last day of the calendar month in which any of the following events occur:

a. You enter full-time military service (e.g., Army, Navy, or Air Force);

b. You are no longer eligible;

c. The required contributions are not made to the Trust;

d. The participating school district ceases to participate in the Trust under a contribution agreement; or

e. The Plan is terminated.

2. Dependents

Eligibility for your dependents will cease on the last day of the calendar month in which any of the following events occur:

a. The dependent enters full-time military service (e.g., Army, Navy, or Air Force);
b. Th’e eligibility for the Employee ceases;

c. The dependent ceases to be eligible as a dependent as set forth in the eligibility provisions for dependents;

d. With respect to a dependent spouse, the Employee and spouse become legally divorced; or

e. With respect to a Domestic Partner, the Employee and Domestic Partner terminate, dissolve, or nullify their Domestic Partnership in accordance with California law.
VII. MAJOR MEDICAL BENEFITS

The benefits described in this booklet are for Employees and dependents who are enrolled in the Indemnity Medical Plan (the “Plan”) offered by the Gold Coast Joint Benefits Trust, which actually consists of two separate Plans: Plan 2 and Plan 4. Unless otherwise indicated, all benefits under these two Plans are the same. No Mental Health or Substance Abuse benefits are provided for members enrolled in Plan 2 or for Voluntary Self-Pay Retirees enrolled in Plan 4. If you are unsure of which of the two Plans you are enrolled in, please contact the Trust Administrator at 1 (800) 556-5918.

How much of any of your medical expenses the Plan will cover depends upon many factors. Initial charges, with some exceptions, will be subject to a Calendar Year Deductible, which is your responsibility to pay (see Section VII.A.). Once the Deductible is satisfied, the Plan pays its share of Covered Charges, and you must pay your share of Covered Charges, known as coinsurance. If you use a Contract Provider, Covered Charges are based on a special, negotiated rate. If you use a non-Contract Provider, the Provider can charge whatever he or she wants, but the Plan will only pay based on the UCR allowance for the service rendered. Charges in excess of the UCR allowance are always your responsibility. The Plan’s payment of Hospital charges varies depending upon whether or not you choose to use the Plan’s Hospital Contracting Program (see Section VII.G.) and whether the admission has been pre-certified (see Section VII.H.). The Plan’s payment of Physician, testing and laboratory charges also varies depending on your use of the Plan’s Contract Physician and Outpatient Facility Program (see Section VII.K.). You are free to choose whichever provider you want. However, if you choose a provider outside of the Anthem Blue Cross Network, your out-of-pocket costs will be higher than if you stayed within the Network. This Section VII explains in more detail how benefits are paid.

A. Calendar Year Deductible

The Calendar Year Deductible (the “Deductible”) is the dollar amount of Covered Expenses that you must pay per calendar year before you are entitled to Major Medical Benefits. The Deductible for the two Plans are listed in the Schedule of Benefits (see Section IV.).

Once the Deductible has been satisfied, it does not apply to subsequent services or treatments received within the calendar year. So that you will not have to satisfy the Deductible late in one calendar year and early in the following calendar year, any expenses incurred and applied against the Deductible paid in the last three months of a calendar year will be applied towards the Deductible for the next calendar year.

Normally, the Deductible is applied separately to each member of the family. However, if two or more eligible members of your family are injured in the same accident, the Covered Expenses which result from the accident will be combined and only one Deductible will be charged, regardless of the number of family members injured.
The Deductible will be waived for Covered Expenses incurred for Pre-Admission tests, chiropractic care, Mental Illness, and Substance Abuse treatment, and Prescription Drugs.

B. Benefit Percentage Payable, Coinsurance Percentage, and UCR

The Plan pays a different percentage of a Covered Expense, called the Benefit Percentage Payable, depending upon: (1) which of the two Plans you are enrolled in; (2) whether you have used an Anthem Blue Cross network provider, also called a Contract Provider; and (3) whether your Hospital admission has been certified in advance. The remainder, called the “Coinsurance Percentage,” (or your out-of-pocket expense) is your responsibility. The Benefit Percentages Payable are shown in the Schedule of Benefits (see Section IV.), and are explained on the following pages.

The Plan will cover your medical expenses up to the applicable Benefit Percentage Payable, but only after you have satisfied any required Deductible or copayment. A copayment is the amount that a Participant must pay to the Contract Provider at the time the service or supply is rendered. Some Anthem Blue Cross Contract Providers charge an upfront fee based upon the provider’s estimate of the Deductible and Coinsurance Percentage that you owe. Because the Plan does not corroborate this estimate, it is up to you to discuss in advance your provider’s billing practices.

The amount the Plan will pay for charges by Non-Contract Providers is based on the UCR allowance. If you use a Non-Contract Provider, any copayments or charges above UCR are your responsibility and are excluded from the calculation of the Deductible and the Coinsurance Limit. Contract Providers charges, on the other hand, are negotiated and paid at a specified contract rate, which is usually lower than the UCR allowance.

The Plan’s UCR allowances are amounts that the Trust has determined are appropriate charges for the service(s) rendered in the provider's geographic area, based on such factors as the Trust's evaluation of the value of the service(s) relative to the value of other services, market considerations, and provider charge patterns. Non-Contract Providers often charge more than UCR. If that happens, you are responsible for any charges above UCR. The Trust Administrator will send you an “Explanation of Benefit Statement” (EOB) that shows the UCR allowance, if applicable.

For Example: Suppose you are enrolled in Plan 4 and are treated for a broken nose. Assume that you have already satisfied the Deductible under Plan 4 for the calendar year, but not the applicable Coinsurance Limit. If you use a Contract Physician, the Plan will pay 80% of the Covered Expense, which is a specified contract rate. If, on the other hand, you use a Non-Contract Physician, the Plan will only pay 60% of the UCR allowance (which is the Covered Expense). The UCR allowance is generally higher than the contract rate. If the Non-Contract Physician charges you $100 more than the UCR allowance, then you will be responsible for the $100, as well as 40% of the UCR rate.
C. Coinsurance Limit

After your Deductible has been met, the Plan pays Covered Expenses at the Benefit Percentages Payable specified in the Schedule of Benefits (see Section IV.) until you have paid your annual Coinsurance Limit. Once you have reached the annual Coinsurance Limit of:

**Plan 2** - $1,000 annually per Participant  
**Plan 4** - $2,000 annually per Participant (for Contract Provider expenses only)

the Plan will pay 100% of Covered Expenses for the rest of the calendar year. The amount counted towards your Coinsurance Limit is generally a percentage of the contract rate charged by a Contract Provider or if you are covered by Plan 2, a percentage of the UCR Covered Expense charged by a Non-Contract Provider. Unlike Plan 2, however, if you use a Non-Contract Provider and you are in Plan 4 there is no Coinsurance Limit and the Plan will never pay 100% of your Covered Charges. Amounts paid by the Plan never count towards your Coinsurance Limit.

Expenses that are not applied to the Coinsurance Limit are as follows:

1. The Calendar Year Deductible;
2. Any charges paid by the Plan;
3. Hospital charges incurred at a Non-Contract Hospital, unless you are in Plan 2;
4. Charges incurred at a Non-Contract Outpatient Surgery Center
5. Any charges incurred as a result of using Non-Contract Providers under Plan 4;
6. Expenses incurred as a result of non-compliance with the provisions of the Hospital Utilization Review and Pre-Certification Programs;
7. Copayments made by a Participant for Mental Illness and Substance Abuse, chiropractic, and Prescription Drug benefits; and
8. Any copayments or charges above UCR.

*For Example:* Suppose you incur Hospital expenses in the amount of $15,000 and Physician expenses in the amount of $8,000. If you used Contract Providers, the Covered Charges, which is based on a special negotiated rate, for the Hospital services is $10,000 and the contract rate for your Physician expenses is $6,000. If you used Non-Contract Providers, the Covered Charges for your Hospital services is the full $15,000 and for your Physician services is $8,000. The Non-Contract Physician charges of $8,000 are within UCR. (If the Non-Contract Physician charges were more than UCR, you would be responsible for 100% of any amounts above UCR). This example assumes that you have complied with the Plan’s Hospital Utilization and Pre-Certification Programs. Example A
shows how the claim would be paid under Plan 2 using Contract Providers and then using Non-Contract Providers. Example B shows the same scenario if the claim were paid under Plan 4. Under Plan 4 any Non-Contract Provider expenses that you are required to pay are not applied to your Coinsurance Limit.

**Example A – Plan 2**

$15,000 Allowable Hospital Charge, reduced to $10,000 while in Contract Hospital.  
$8,000 Non-Hospital Charges (Physician and Other Non-Hospital Providers), reduced to $6,000 when using Contract Providers

<table>
<thead>
<tr>
<th>Charge</th>
<th>Plan Pays</th>
<th>You Pay</th>
<th>Contract Provider Expenses</th>
</tr>
</thead>
<tbody>
<tr>
<td>$10,000</td>
<td>$10</td>
<td>$100</td>
<td><em>Contract Hospital Expense</em></td>
</tr>
<tr>
<td></td>
<td>$9,900</td>
<td></td>
<td><em>Calendar Year Deductible: 100% Paid by You</em></td>
</tr>
<tr>
<td>$6,000</td>
<td>$5,000</td>
<td>$1,000</td>
<td><em>Hospital Charges (after Deductible): 100% Paid by Plan; 0% Paid by You</em></td>
</tr>
<tr>
<td>$16,000</td>
<td>$14,900</td>
<td>$1,100</td>
<td><em>Non-Hospital Charges: Plan pays 80% until you reach your Coinsurance Limit; then 100% paid by Plan</em></td>
</tr>
</tbody>
</table>

**Responsibility for Total Charges Payable**

<table>
<thead>
<tr>
<th>Charge</th>
<th>Plan Pays</th>
<th>You Pay</th>
<th>Non-Contract Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>$15,000</td>
<td>100</td>
<td>$100</td>
<td><strong>Non-Contract Hospital Expense</strong></td>
</tr>
<tr>
<td>$8,000</td>
<td>13,900</td>
<td>1,000</td>
<td><strong>Calendar Year Deductible: 100% Paid by You</strong></td>
</tr>
<tr>
<td>$23,000</td>
<td>$21,900</td>
<td>$1,100</td>
<td><strong>Non-Hospital Charges: Deductible and Coinsurance Limit have already been met, therefore Plan pays 100% (normally Plan pays 80% until you reach the Coinsurance Limit)</strong></td>
</tr>
</tbody>
</table>

**Total Charges Payable**

25
Example B – Plan 4

$15,000 Allowable Hospital Charge, reduced to $10,000 while in Contract Hospital.
$8,000 Non-Hospital Charges (Physician and Other Non-Hospital Providers), reduced to $6,000 when using Contract Providers

<table>
<thead>
<tr>
<th>Charge</th>
<th>Plan Pays</th>
<th>You Pay</th>
<th>Contract Provider Expenses</th>
</tr>
</thead>
<tbody>
<tr>
<td>$10,000</td>
<td>$8,640</td>
<td>$400</td>
<td>Contract Hospital Expense</td>
</tr>
<tr>
<td></td>
<td></td>
<td>960</td>
<td>Calendar Year Deductible: 100% Paid by You</td>
</tr>
<tr>
<td>6,000</td>
<td>4,960</td>
<td>1,040</td>
<td>Hospital Charges (after Deductible): 90% Paid by Plan; 10% Paid by You as Coinsurance*</td>
</tr>
<tr>
<td>$16,000</td>
<td>$13,600</td>
<td>$2,400</td>
<td>Non-Hospital Charges: 80% Paid by Plan; 20% Paid by You*, until you reach your Coinsurance Limit;</td>
</tr>
</tbody>
</table>

**Responsibility for Total Charges Payable**

<table>
<thead>
<tr>
<th>Non-Contract Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>$15,000</td>
</tr>
<tr>
<td>10,220</td>
</tr>
<tr>
<td>8,000</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>$23,000</td>
</tr>
</tbody>
</table>

* When Covered Charges paid by you, not including the Deductible, reach $2,000 in a calendar year, you have reached your annual Coinsurance Limit, and any further Covered Charges you incur from Contract Providers are paid by the Plan for the rest of the calendar year. See Section VII.C.

** Non-Contract Provider Covered Expenses do not count toward your Coinsurance Limit or towards your annual Deductible. See Section VII.C.

D. **Lifetime Maximum**

The Lifetime Maximum for Major Medical Benefits is $2,000,000 per Participant. All prescription drugs and medical expenses paid by the Plan accrue to the Lifetime Maximum, including charges under Major Medical Benefits, the Mental Illness and Substance Abuse Program, and the Chiropractic Program.
E. **Covered Major Medical Expenses**

The Plan pays benefits for Medically Necessary services and supplies that are authorized by a Physician for the treatment of an injury or Sickness of a Participant, provided that the service or supply is not excluded under the terms of the Plan (see Part VII.F). Below is a list of services and supplies that are covered as Major Medical Benefits under the Indemnity Medical Plan.

1. Hospital room, board and general nursing services, up to the Hospital’s daily ward and semi-private rate. Covered Expenses for a private room will be the Hospital’s average two-bed room rate for each day of confinement.

2. Care in the Hospital’s Intensive Care Unit, up to the full cost-per day.

3. Charges made by a Hospital for medical services and supplies.

4. Operating and recovery room charges.

5. Charges made by a Physician for medical care and treatment and for performing a surgical procedure, including surgical implants.

6. Charges made for diagnostic tests.


8. Charges made for the cost and giving of an anesthetic.

9. Charges for private duty nursing by an R.N. or L.P.N.

10. Home health services by a Home Health Care Agency under a home health care plan. Such plan must have been established in lieu of Hospital or Skilled Nursing Facility confinement.

   Up to 60 visits during any calendar year will be considered a Covered Expense. Each visit by a member of a home health care team is considered as one home health care visit. Four hours of home health aide services is considered as one home health care visit.

11. Charges for the rental or purchase, whichever costs less, of durable medical equipment, including dialysis equipment, used in the patient’s home. To be covered, Anthem Blue Cross must authorize all durable medical equipment with a cost of $2,000 and above.

12. Charges for artificial limbs, eyes and other prosthetic devices and replacements.

13. Charges for casts, splints, trusses, crutches and braces (except dental braces).
14. Charges for oxygen and rental of equipment for the giving of oxygen.

15. Charges for physical therapy prescribed by your Physician. A treatment plan must be certified by your Physician and treatment must be given by a licensed therapist.

16. Charges for acupuncture limited to 18 visits per calendar year. Treatment must be given by a licensed acupuncturist.

17. Charges for ambulance service to and from a local Hospital. The ambulance must be licensed under state laws regulating the operation of ambulatory services.

Other charges will be considered if specialized treatment is needed at a Hospital specially equipped to furnish the treatment. If the specially equipped Hospital is not a local facility, the Plan will allow the use of a bus, train, or regularly scheduled airline.

18. Charges for routine annual pap smears, including office visit and evaluation of lab tests.

19. Charges for services in connection with a non-Experimental organ or tissue transplant for:
   a. A Participant who receives the organ or tissue;
   b. A Participant who donates the organ or tissue; and
   c. An organ or tissue donor who is not a Participant if the organ or tissue recipient is a Participant. Benefits are reduced by any amounts paid or payable by that donor’s own health coverage.

20. Charges for blood and blood plasma, except when replaced.

21. Skilled Nursing Facility charges. Confinement therein must start within 14 days of a Hospital stay of 3 or more days. It must also be for continued treatment of the condition causing the Hospital stay. Up to 90 days of confinement per calendar year will be considered a Covered Expense.

22. Secondary coverage (for covered dependents who have primary coverage under another group health plan) for FDA approved Drugs and medicine requiring the written prescription of a Physician and dispensed by a Physician or Licensed Pharmacist.

23. Charges for routine mammographic examinations as diagnostic screening procedures, as follows:
   a. A baseline mammogram for female Participants age 35 to 39;
b. One mammogram every 2 years (unless recommended more frequently by the attending Physician) for female Participants age 40 to 49; and

c. An annual mammogram for female Participants age 50 and over.

24. Charges for diagnostic x-ray and laboratory tests and for the non-surgical treatment of morbid obesity by a Physician, provided the Participant receiving the treatment has a Body Mass Index (BMI) of 40+ when treatment is started. Plan benefits will be paid for gastrointestinal bypass surgery for morbid obesity only after pre-certification.

25. Charges for well-baby care for dependent children from birth to age 17, including routine nursery care and circumcision. Charges also include preventive care consisting of:

a. Physician services for routine physical examinations;

b. Immunizations; and

c. Laboratory services in connection with routine Physician examinations.

26. Immunization charges for Participants other than as described in item 25 above.

27. 100% of Covered Charges for Prostate Specific Antigen Test for Participants age 40 and over, up to a maximum benefit of $28 per test, one test per calendar year.

28. For Plan 4 Participants older than 39 years old only — up to $150 towards the cost of a physical examination, subject to the following: a. One exam per year for Participants age 50 and older; and b. One exam every two years for Participants age 40 through 49.

29. Inpatient detoxification only.

30. Hospice Care —

a. Home hospice: Maximum of 60 days; payable at 100% of network allowance or 100% of UCR.

b. Inpatient hospice: Maximum of 30 days, limited to a per diem of $150 per day.

31. Temporomandibular Jaw Disorder (TMJ): $1500 lifetime maximum for non-surgical treatment; payable at 80% until you reach your Coinsurance Limit.

32. As required by the Women’s Health and Cancer Rights Act of 1998, reconstructive surgery of the breast on which a mastectomy is performed, surgery on the other breast to provide a symmetrical appearance, and prosthesis and
services in connection with physical complications of all stages of mastectomy, including lymphedemas.

33. Routine testing to detect abdominal aortic aneurysm is covered up to a maximum of $250 per calendar year.

34. 50% of expenses incurred for the treatment of infertility. The lifetime maximum benefit for expenses incurred in the treatment of infertility is $20,000. Please Note: charges for artificial insemination and in vitro fertilization are not covered.

F. Exclusions and Limitations

There are some services, supplies or equipment for which, or circumstances when, this Plan will not pay benefits. In addition to any other limitations or exclusions described in this Plan, the Plan will not pay for any Expenses incurred in connection with any of the following:

1. Services and supplies that are not Medically Necessary.

2. Services, supplies or equipment for which a charge is not customarily made in the absence of insurance. This does not apply to charges incurred at a charitable research Hospital or covered by Medi-Cal.

3. Injury or Sickness arising out of or in the course of employment or self-employment.

4. Declared or undeclared war, or act of war. Conditions caused by release of nuclear energy, whether or not the result of war.

5. Expenses which are not approved by a licensed health care provider.

6. Any amounts by a Non-Contract Provider in excess of the UCR allowance.

7. Cosmetic surgery, except for repair of damage caused by accidental bodily injury while eligible under this Plan. The term “cosmetic surgery” means surgery to change the shape or structure of, or otherwise alter a portion of the body, performed solely or primarily for the purpose of improving appearance and not as a result of a disease or condition which, in accordance with accepted medical practice, requires surgical intervention to cure, alleviate pain, or restore function. Restorative surgery performed during or following surgery which was required as a result of illness or injury shall not be considered cosmetic. Reconstructive surgery performed to correct a congenital disease or defect shall not be considered cosmetic.

8. Eye examination for the purpose of prescribing corrective lenses, fitting glasses or correcting visual acuity via surgical procedures.
9. Glasses, hearing aids, or contact lenses, except the first pair of glasses or contact lenses when required because of surgery.

10. Radial keratotomy, lasik or any other surgical procedure performed to correct visual acuity.

11. Charges made by a health care provider who is related to or living with the Participant requiring treatment.

12. Any period of custodial care confinement in a Hospital or Skilled Nursing Facility, except as specifically stated in the Skilled Nursing Facility definition.

13. Dental plates, bridges, crowns, caps or other dental prostheses, dental services, extraction of teeth or treatment to the teeth or gums, except for dental treatment required by injury to natural teeth as a direct result of injury while insured. Benefits for hospitalization will be paid if hospitalization is demonstrated to be Medically Necessary to the performance of dental services. These benefits will be paid on an 80% reimbursement rate.

14. Procedures or treatments to change characteristics of the body to those of the opposite sex.

15. Sterilization reversal, artificial insemination and in vitro fertilization.

16. Expenses incurred for Hospital, surgical and in-Hospital Physician services or supplies in excess of reduced Plan benefits resulting from noncompliance with the provisions of the Hospital Utilization Review and Pre-Certification Programs.

17. Charges that are used to satisfy the Calendar Year Deductible.

18. Chiropractic services obtained from Non-Contract Providers or Contract Providers that have not been pre-authorized by Chiropractic Health Plan of California.

19. Prescription Drug benefits except as described in Section VII.N. or under the Coordination of Benefits provisions under Section IX.

20. Outpatient speech therapy, except following surgery, injury or noncongenital Sickness.

21. For Plan 2 and Voluntary Self-Pay Retirees in Plan 4—any expenses incurred for Mental Illness and Substance Abuse treatment, whether inpatient or outpatient.


23. See Section VII.G. for exclusions and limitations under the Hospital Contracting Program.
24. See Section VII.K. for exclusions and limitations under the Contract Physician and Outpatient Facility Program.

25. See Section VII.H. for exclusions and limitations under the Hospital Utilization Review and Pre-Certification Program.

26. See Section VII.L. for exclusions and limitations under the Mental Illness, Alcohol and Substance Abuse Program.

27. See Section VII.M. for exclusions and limitations under the Chiropractic Program.

28. See Section VII.N. for exclusions and limitations under the Prescription Drug Program.

29. Services, supplies or equipment covered under any plan, other than the Indemnity Medical Plan, offered by Gold Coast Joint Benefits Trust, if the plan is a primary plan for coordination of benefits purposes. If such services, supplies or equipment are not available as a covered item under the dependent’s primary plan, and this Plan is the dependent’s secondary Plan for Coordination of benefits purposes, then this plan will pay according to its rules upon receipt of a letter of declination of benefits payable from the primary plan.

30. The Employee Assistance Program does not provide benefits to retirees or their dependents.

31. Any illness or injury incurred in, or aggravated during, performances of services in uniformed services. In determining whether an illness or injury was incurred in or aggravated during military service, the Board will give deference to any determination by the Department of Veterans Affairs.

G. Hospital Contracting Program

The Trust has entered into a contract with Anthem Blue Cross to provide medical care and treatment in Contract Hospitals at special, reduced rates. Anthem Blue Cross has a policy against discrimination in admission, service and quality of care for its Hospitals.

YOU ARE FREE TO USE ANY HOSPITAL OF YOUR CHOICE. YOUR OUT-OF-POCKET COSTS WILL INCREASE SIGNIFICANTLY, HOWEVER, IF YOUR NON-EMERGENCY ADMISSION IS NOT PRECERTIFIED AND YOU USE A NON-CONTRACT HOSPITAL.

This Section G describes the benefits and consequences of using or not using the Plan’s Hospital Contracting and Pre-Certification program. For a detailed description of how to obtain Pre-Certification see Section VII.H.
1. **Contract Hospital – Admission Pre-Certified:**
   a. If you are admitted to a Contract Hospital; and
   b. Your admission is pre-certified in accordance with Section VII.H.

   The Plan pays the applicable Contract Provider Benefit Percentage Payable for non-Emergency Hospital services after payment of the applicable Deductible.

2. **Contract Hospital – Admission Not Pre-Certified:**
   a. If you are admitted to a Contract Hospital; but
   b. Your admission is not pre-certified.

   The Plan pays 80% of the applicable Contract Provider Benefit Percentage Payable, after the applicable Deductible has been met.

3. **Non-Contract Hospital – Admission Pre-Certified:**
   a. If you are admitted to a Non-Contract Hospital; and
   b. Your admission is pre-certified in accordance with Section VII.H.

   The Plan pays the applicable Non-Contract Provider Benefit Percentage Payable after payment of the applicable Deductible.

4. **Non-Contract Hospital – Admission Not Pre-Certified:**
   a. If you are admitted to a Non-Contract Hospital; but
   b. Your admission is not pre-certified.

   The Plan pays 80% of the applicable Non-Contract Provider Benefit Percentage Payable, and you owe the remainder after payment of the applicable Deductible.
Physician Charges Incurred During an Admission

5. Contract Hospital – Admission Not Pre-Certified:
   a. If you are admitted to a Contract Hospital; but
   b. Your admission is not pre-certified.

The Plan pays 80% of the applicable Contract Provider Benefit Percentage Payable for services provided by a Contract Physician during a Hospital admission, and you owe the remainder after payment of the applicable Deductible.

6. Non-Contract Hospital – Admission Not Pre-Certified:
   a. If you are admitted to a Non-Contract Hospital; but
   b. Your admission is not pre-certified.

Assuming the Deductible has been met, the Plan pays 80% of the applicable Non-Contract Provider Benefit Percentage Payable at the UCR rate for services provided by a Contract Physician during a Hospital admission, and you owe the remainder, plus any amounts in excess of the UCR rate.

Certification is also required for the duration of each Hospital admission.

The Plan pays 80% of the applicable Contract Provider Benefit Percentage Payable for each day in excess of the number of days certified as Medically Necessary in a Contract Hospital. The Plan pays 80% of the applicable Non-Contract Provider Benefit Percentage Payable, and you owe the remainder, for each day in excess of the number of days certified as Medically Necessary in a Non-Contract Hospital.

Certification is also required for Emergency Hospital admissions.

1. Emergency Hospital Admission – Certification Obtained
   a. If you are admitted to either a Non-Contract or Contract Hospital; and
   b. You obtain certification within two business days of your admission in accordance with Section VII.H.

The Plan pays the applicable Contract Benefit Percentage Payable shown in the Schedule of Benefits for Covered Expenses incurred in an Emergency, after payment of the applicable Deductible.
2. **Emergency Hospital Admission – Certification Not Obtained**
   
a. If you are admitted to either a Contract Hospital or a Non-Contract Hospital for an Emergency; and

b. You fail to obtain certification within two business days.

The Plan pays 80% of the applicable Provider Benefit Percentage Payable for the Covered Expense, and you owe the balance, after payment of the applicable Deductible.

There are three situations where you may use a Non-Contract Hospital and still be reimbursed at the full Contract Hospital Benefit Percentages Payable listed in the Schedule of Benefits. Those situations are:

1. **Emergencies:** The Non-Contract Provider Benefit Percentage Payable will not be imposed for using a Non-Contract Hospital in an Emergency, provided you obtain certification within two business days of your admission in accordance with Section VII.H. However, if continued hospitalization is needed, you may be required to transfer to a Contract Hospital as soon as it is medically safe to be transported. If you decide to remain in the Non-Contract Hospital after the acute Emergency period, the applicable Non-Contract Benefit Percentage Payable will be imposed.

2. **No Contract Hospital in Area:** If you or your dependent receive inpatient Hospital care within a 30-mile radius of your work or home where no Contract Hospital exists, or you are out of the network area, benefits will be payable as if you had used a Contract Hospital.

3. **Specialized Services are Needed that are not Available at a Contract Hospital:** In rare cases, there may be certain procedures requiring special facilities that are not available in the Anthem Blue Cross Hospital network. In the event you need such a procedure, PRE-CERTIFICATION MUST BE OBTAINED so that you may be admitted to a Non-Contract Hospital and still be reimbursed at the full Contract Hospital Benefit Percentage Payable.

You can access the Anthem Blue Cross website at www.anthem.com/ca/ to find a Contract Hospital. The listing is updated periodically; therefore, it is important you verify that the Hospital selected is a Contract Hospital.

**Please be sure to advise your Physician about our Hospital contracting program as soon as it becomes apparent that you may need hospitalization.**
H. Hospital Utilization Review and Pre-Certification Program

In an effort to avoid unnecessary hospitalizations, the Plan has a Hospital Utilization Review Program. The Hospital Utilization Review Program is also administered by Anthem Blue Cross. All non-Emergency Hospital admissions must be certified in advance.

All Emergency Hospital admissions must be certified within two business days of the admission. This applies to both Contract and Non-Contract Hospital admissions.

The utilization review performed by Blue Cross is limited to determining:

1. Whether the medical procedures and services authorized by your Physician are Medically Necessary;

2. Whether the Hospital confinements for care could have been given on an outpatient basis; and

3. Whether the proposed confinements are for a period that is longer than necessary.

*Anthem Blue Cross does not determine whether the procedures and services under review are otherwise covered by this Plan. Please contact the Trust Administrator to determine such coverage questions.*

Many Hospital admissions are scheduled. They can be planned in advance if the condition is not immediately life threatening or an Emergency. Therefore, when your Doctor recommends that you or a covered dependent needs to be hospitalized, Anthem Blue Cross should be notified 10 days BEFORE your appointment or admission. Specifically you must:

1. Explain to the Physician that your medical Plan requires pre-admission certification.

2. Ask the Physician to call the toll-free number 1 (800) 274-7767 to review the proposed treatment with an Anthem Blue Cross medical professional. If your Physician does not want to call, **YOU MUST CALL.**

3. You or your Physician should have the following information ready before contacting Anthem Blue Cross:
   - Name, address, date of birth and telephone number of patient.
   - Name and social security number of the Employee.
   - Date of admission.
• Admitting diagnosis and requested length of stay.
• Name, address and telephone number of Hospital and attending Physician.
• Name of the Trust: Gold Coast Joint Benefits Trust.

In an Emergency, the patient, family or Physician MUST call the Anthem Blue Cross number listed above within 2 business days after the patient is admitted in order to qualify for full benefits.

For Maternity, Anthem Blue Cross should be notified within 30 days prior to the expected delivery date.

**Continued Stay Review** — Once you have entered the Hospital following preadmission certification or following an Emergency admission, Anthem Blue Cross will continue to monitor your stay to determine the appropriate length of confinement and the necessity of medical services. If Anthem Blue Cross concludes your continued hospitalization is unnecessary, you and your Doctor will be notified.

**YOU ARE RESPONSIBLE FOR CONTACTING ANTHEM BLUE CROSS IF THE HOSPITAL OR PHYSICIAN DOES NOT CONTACT ANTHEM BLUE CROSS.**

If you or your dependents do not receive pre-admission certification prior to a scheduled Hospital stay or within two days of an Emergency admission, the following payment penalties will apply:

The Plan will pay only 80% of the applicable Benefit Percentage Payable for Hospital and medical expenses, including Physician charges related to the Hospital confinement.

If Anthem Blue Cross determines that continued hospitalization is unnecessary, the above payment penalty will apply to that portion of the hospitalization that exceeds the approval of the Continued Stay Review.

**SPECIAL INFORMATION FOR THOSE RETIREES RESIDING OUTSIDE OF CALIFORNIA**

Contact the Trust Administrator to obtain a “First Health” version of the Plan’s ID card. You will need that ID card in addition to your Anthem Blue Cross ID card.

**Hospital Admission Authorization** — All Hospital admissions must be authorized by Anthem Blue Cross. Anthem Blue Cross’ phone number is (800) 274-7767.

**Network** — The network that is used by the Trust outside of California is provided by First Health. You can locate a list of First Health Hospitals, Physicians and Outpatient
Facilities by accessing First Health’s website at www.firsthealth.com. The password you will need is “GCJ”.

**Hospital Claims** – must be sent to First Health for pre-pricing. Their address is shown on the First Health ID card.

**Chiropractic** – For states other than California, the network of chiropractors that is utilized by the Trust is Chirosource. To locate a network chiropractor, please call Chirosource at (800) 680-9997.

**PRE-CERTIFICATION RIGHT OF APPEAL**

If Anthem Blue Cross determines that a Hospital admission is not Medically Necessary, or has determined that a proposed length of stay may be too lengthy, Blue Cross will notify you in writing of its refusal to certify the admission or length of stay. Prior to being admitted, or receiving the treatment in question, you and/or your Doctor have the right to appeal the certification denial to Anthem Blue Cross, but you do not have the right to appeal the pre-certification denial to the Board of Directors of the Trust. This pre-service appeal is conducted by telephone. Please dial 1 (800) 274-7767 to start the appeal, which is heard by an Anthem Blue Cross Physician reviewer who did not participate in the initial decision.

You also have the right to appeal a certification denial to Anthem Blue Cross after you have been admitted or received the treatment in question. This appeal is conducted in writing. A complete copy of your medical records must be submitted to Anthem Blue Cross. An Anthem Blue Cross Physician reviewer, who did not participate in the initial decision, rules on the appeal.

The choice to receive Hospital services is yours. However, if your Hospital confinement has not been authorized, or if you remain in the Hospital beyond the number of days that have been approved, reimbursement by the Plan will be subject to the reductions indicated above.

**ALTERNATE MEDICAL CARE**

If there is a covered condition that, in the review organization’s opinion, is likely to be of substantial duration and/or susceptible to adequate treatment in a less expensive setting, the Plan will notify the attending Physician and you about an alternate medically acceptable plan of treatment.

The alternate plan will be developed by health care professionals and be consistent with generally accepted medical practice. You and the attending Physician are encouraged to review the alternate plan and adopt those portions of the plan that are mutually agreeable to Anthem Blue Cross, the attending Physician and you.

The alternate plan may detail specific treatments, different site of care, or different levels of care. To the extent that the suggested services under the treatment plan are not usually
covered by the Plan, they will be reimbursed at the levels specified in the alternate plan of treatment.

I. Pre-Admission Tests

If a Hospital admission becomes necessary, the Hospital may require routine tests and/or x-rays as part of the admission policy. The charges for such tests and/or x-rays will be paid at 100% of Covered Charges if the tests:

1. Are performed on an outpatient basis;
2. Are performed within 10 days before a covered Hospital admission;
3. Are performed in connection with a covered Hospital admission;
4. The Hospital admission is deemed required by your Physician prior to the tests being performed;
5. Would have been covered if performed as an inpatient; and
6. The tests are not repeated after Hospital admission unless medical records document both:
   a. The results of the original tests; and
   b. That repeat tests are Medically Necessary.

Pre-admission test expenses are not subject to the Calendar Year Deductible.

REMEMBER: You must contact Anthem Blue Cross prior to any Hospital admission. You should also verify that the Hospital is part of the Anthem Blue Cross network.

J. Outpatient Surgery Centers Contracting Program

Outpatient Surgery Centers are freestanding outpatient surgical facilities that are primarily engaged in providing surgical services for ambulatory patients on an outpatient basis, where the patient is admitted to and discharged from the facility within 24 hours.

If you use a Contract Outpatient Surgery Center, the Plan will pay the Benefit Percentage Payable shown in the Schedule of Benefits in Part IV, and there is no $2,000 cap on what the Plan will pay.

If you use a Non-Contract Outpatient Surgery Center, the Plan will pay a maximum benefit of $2,000, and you will be responsible for your share of UCR, any charges in excess of UCR, and all charges incurred after the Fund has exceeded its $2,000 maximum
benefit. Additionally, any expense you incur at a Non-Contract Outpatient Surgery Center will not count towards your Coinsurance Limit. Physician and surgeon fees are not included in this $2,000 maximum.

The Benefit Percentage Payable for procedures performed at an Outpatient Surgery Center is shown in the Schedule of Benefits in Section IV.

For Example: Suppose you are enrolled in Plan 4 and you have a surgical procedure at an Outpatient Surgery Center. Assume that you have already satisfied the Deductible under Plan 4 for the calendar year, but not the applicable Coinsurance Limit. The Outpatient Surgery Center bills $10,000 for its services, which is within the Plan’s UCR allowance.

If you use a Non-Contract Outpatient Surgery Center, the Plan will pay 70% of Covered Charges until the Plan pays $2,000. You will pay 30% of Covered Charges until the Plan pays $2,000, then you will pay the remainder of the charges. In this example, you would be responsible for $8,000 (your $3,000 coinsurance plus the $5,000 remaining after the Plan reaches its $2,000 cap, i.e. $7,000-$2,000), and none of your expenses would apply to your Coinsurance Limit.

If you had used a Contract Outpatient Surgery Center, on the other hand, you would save considerable expense because the Plan would pay 90% of the Covered Charge, which is a negotiated contract amount, until you reach the Coinsurance Limit, when the Plan would pay 100% of Covered Charges. In this case, the Covered Charge for the Contract Outpatient Surgery Center may be only $5,000, in which case you would be responsible for only $500 (10% of the Covered Charges).

K. Contract Physician and Outpatient Facility Program

The Trust has entered into an agreement with Anthem Blue Cross’ network of Physicians and Outpatient Facilities. The Contract Physician and Outpatient Facility network consists of various Physicians, including primary care Physicians and a wide range of specialists, laboratories and radiology (x-ray) facilities. These Physicians and Outpatient Facilities have agreed to accept reduced rates for Plan Participants. In addition, when hospitalization is required, the Contract Physician will admit you to a Contract Hospital whenever possible. This may provide even further savings for both you and the Plan. All Physicians in the network are board-certified or board-eligible.

Contract Physician and Contract Outpatient Facility Charges (including but not limited to laboratory, radiology and Urgent Care Centers)

You have a free choice of Physicians and Outpatient Facilities. If you use a Non-Contract Physician or Non-Contract Outpatient Facility, however, your out-of-pocket costs will greatly increase. If, on the other hand, you use a Contract Physician or Contract Outpatient Facility:
1. The Plan pays the applicable Contract Provider Benefit Percentage Payable, subject to the Deductible;

2. The Contract Physician or Outpatient Facility will file your claim forms for you; and

3. You will not have to wait to be reimbursed for expenses.

Contract Physicians should refer you and your dependents to network Outpatient Facilities such as laboratory, radiology and when needed. It is your responsibility, however, to make sure that you are referred to an Anthem Blue Cross network affiliated laboratory or Outpatient Facility. So, do not hesitate to check with your Physician if you have any doubts.

**Non-Contract Physician and Non-Contract Outpatient Facility Charges (including laboratory, radiology, Urgent Care)**

If you use a Non-Contract Physician or Non-Contract Outpatient Facility, the Plan pays the applicable Non-Contract Provider Benefit Percentage Payable shown in the Schedule of Benefits, after the applicable Deductible has been met. You are responsible for the remainder, which includes any additional amount charged in excess of the UCR allowance.

**Contracting Program Exceptions**

There are three situations when you may use Non-Contract Physicians or Non-Contract Outpatient Facilities and still be reimbursed at the applicable Contract Provider Benefit Percentages Payable shown in the Schedule of Benefits:

1. **Emergencies:** Charges incurred for services rendered by a Non-Contracting Physician or Outpatient Facility in Emergency situations are payable at the applicable Contract Provider Benefit Percentage Payable.

2. **No Control:** If you are hospitalized in a Contract Hospital, and your attending Physician is a Contract Physician, and a Non-Contract laboratory or Physician is utilized over which you and your Doctor have no control, benefits for those services are paid at the applicable Contract Provider Benefit Percentage Payable.

3. **Out-Of-Area:** If there are no Contract Physicians or Outpatient Facilities within a 30-mile radius of where you live or work, benefits are paid at the applicable Contract Provider Benefit Percentage Payable.

**How to Use the Program** — To select a Contract Provider, check the Anthem Blue Cross website at [www.bluecrossca.com](http://www.bluecrossca.com) or check with your district office’s benefit department.
When you visit one of the Contract Physicians or Contract Outpatient Facilities, bring your Gold Coast Joint Benefits Trust identification card with you and tell the Physician that you are a Participant in the Trust’s Indemnity Medical Plan. You should also verify with the Physician’s office that the Physician is a participating provider in the Anthem Blue Cross network. You must authorize direct payment to the Physician and/or Outpatient Facility. The Trust’s claims department will know which provider is part of the network and will automatically adjust the bill to the reduced negotiated rate. You will be sent an Explanation of Benefits Statement (EOB) to notify you of the amount paid by the Plan and the amount you owe, if any. With the exception of the Calendar Year Deductible and the Coinsurance Percentage, you will not be liable for any difference between the Trust’s payment for Covered Expenses and the Contract Physician’s or Contract Outpatient Facility’s billed charges. If you do receive a bill for this amount, show the EOB to the Physician or Outpatient Facility and ask them to remove the indicated amount. If you still have problems, contact the Trust Administrator for assistance. Instead of billing you for the Deductible and Coinsurance Percentage that you owe, some Contract Physicians may ask that you pay, at the time of your visit, the Physician’s estimate of your Deductible and Coinsurance Percentage. The Trust does not corroborate this estimate. You should attempt to discuss the basis of the provider’s estimate prior to receiving any services.

L. Mental Illness and Substance Abuse Program & Employee Assistance Program

1. Mental Illness and Substance Abuse Program

   Plan 2 Retirees and Voluntary Self Pay Retirees are not eligible for the following program.

   Only Plan 4 Indemnity Medical Plan Participants, not including Voluntary Self Pay Retirees, are eligible to receive benefits under this program.

   The Trust covers the treatment of Mental Illness and Substance Abuse through the Contract Provider network of US Behavioral Health Plan California (USBHPC). Any treatment must be authorized in advance by USBHPC. If you or your dependents receive treatment or services from someone other than a USBHPC Contract Provider, or the treatment/services has not been authorized in advance, no benefits will be payable.

   All benefits paid as Covered Expenses are counted towards and are subject to the Lifetime Maximum of $2,000,000, but are not subject to the Calendar Year Deductible.

   For example, if your first treatment during the year is for Substance Abuse, you do not have to pay any Deductible before the Plan will pay your Covered Expenses.
Benefits Payable by the Plan

If you or your eligible dependents incur Covered Expenses for Medically Necessary treatment, the Plan will pay as follows:

**Inpatient Treatment –**

In the case of inpatient Mental Illness treatment and Substance Abuse care:

The Plan will pay 90% of Covered Expenses for inpatient Mental Illness or Substance Abuse treatment received in a USBHPC Contract Hospital and authorized in advance by USBHPC. Mental Illness and Substance Abuse Treatment are subject to a combined maximum benefit of 30 days per calendar year and 90 days per lifetime. Inpatient detoxification benefits are payable under Major Medical Benefits as Hospital benefits. No benefits will be paid if:

a. You are covered under Plan 2 or you are a Voluntary Self-Pay Retiree in Plan 4; or

b. You are admitted to a Hospital that is not a USBHPC Contract Hospital; or

c. USBHPC does not authorize your treatment in advance.

**Outpatient Treatment –**

In the case of outpatient Mental Illness treatment:

After the required per visit copayment shown below, the Plan will pay 100% of Covered Expenses for treatment received from Contract Providers that has been authorized in advance by USBHPC:

a. Visits 1 through 5 — No copayment (includes EAP, see Section VII. L.1.).

b. Visits 6 through 20 — $10 per visit.

c. Visits 21 through 52 — $25 per visit.

The Plan will pay up to a maximum of 52 visits per calendar year (including visits under EAP for Plan 4 Indemnity Medical Plan Participants). No benefits will be paid if:

a. You use a Non-Contract Provider; or
b. **USBHPC does not authorize your treatment in advance.**

Call 1 (866) 358-8291 to obtain inpatient and outpatient pre-certifications any time, 24 hours a day, seven days a week. You pay the Contract Provider a copayment at each visit. The Contract Provider may not require any additional charges other than your copayment. There are no other charges to pay or claim forms to file. *If you wish to continue to see the counselor after USBHPC no longer certifies any further visits, you may continue to do so at your own cost.* Your cost, however, will be based on the reduced contract rate negotiated by USBHPC.

In order to obtain benefits for Mental Illness or Substance Abuse treatment, you must contact **USBHPC**. Through **USBHPC**, the Trust has entered into contracts with selected facilities in California to provide Substance Abuse treatment programs. These facilities include acute care Hospitals and residential treatment facilities that offer services ranging from inpatient to outpatient care.

**Inpatient Mental Illness Emergencies**

Inpatient care for Mental Illness treatment must be certified by **USBHPC** prior to Hospital admission, except in Emergencies. The Plan will also pay 90% of the Covered Expenses for Emergency treatment if **USBHPC** is contacted within 48 hours after an Emergency admission and certifies the Emergency admission.

**Mental Illness and Substance Abuse Limits on Benefits**

Benefits for inpatient and outpatient treatment of Substance Abuse are provided only if treatment is coordinated by **USBHPC**.

Expenses for detoxification are covered under Major Medical Benefits as a Hospital benefit.

The maximum benefit payable for all inpatient Mental Illness and Substance Abuse treatment combined is 30 days per calendar year and 90 days per lifetime per Participant.

No benefits will be paid for any Mental Illness and Substance Abuse treatment obtained from Non-Contract Providers or facilities, or treatment not authorized in advance by **USBHPC**. In addition no benefits are payable on behalf of Participants enrolled in Plan 2 or to Voluntary Self-Pay Retirees in Plan 4.

If you have any questions or need to obtain authorization in advance for treatment, call **USBHPC** at 1 (866) 358-8291.
The Directors have the authority to change the Mental Illness and Substance Abuse network at their discretion.

2. **Employee Assistance Program (EAP) – Available Only to Plan 4 Participants**
   (including Indemnity & HMO Enrollees), but excluding Voluntary Self Pay Retirees.

   *Plan 2 Retirees and Voluntary Self Pay Retirees in Plan 4 are not eligible for this program.*

   **Benefits under the EAP are available to active employees and District Paid Retirees in Plan 4, whether they are enrolled in the Indemnity Medical Plan or in a Trust-sponsored HMO.**

   The Employee Assistance Program (EAP) administered by USBHPC. The EAP provides five (5) therapeutic visits per family member per calendar year at no fee. The EAP is strictly private and confidential. EAP is available to you if you want mental health counseling but are unsure if you need treatment for a Mental Illness.

   In order to access the EAP, you or your eligible dependent must call USBHPC at 1 (866) 358-8291 anytime, 24 hours a day, 7 days a week. Your call will be answered by a qualified, experienced intake counselor who will ask you your name, address, telephone number, and why you are calling. The intake counselor will arrange for you to meet with a licensed counselor who is part of the USBHPC network.

   The EAP staff is knowledgeable about the world of work and the pressures of personal relationships, family life, parental responsibilities, personal crises and drug, alcohol or medication abuse. Sessions with a psychiatrist are not covered under the EAP.

   For Plan 4 Indemnity Medical Plan Participants only: if, after completing the 5 free EAP visits, you and your counselor agree to additional treatment, the Plan will pay Covered Expenses as described in the Mental Illness and Substance Abuse Program Section VII.K.1, subject to the copayment and treatment limits (i.e., all EAP visits will be applied towards the annual maximum of 52 visits under the outpatient Mental Illness benefit). **You must continue to use the USBHPC network for the treatment plan agreed to by your counselor and USBHPC.**

M. **Chiropractic Program**

   The Trust covers chiropractic care in and out of the state of California, so long as it is obtained through the Chiropractic Health Plan of California (CHPC), a managed care chiropractic provider with California and national networks. The Plan will pay benefits for chiropractic services received in or outside of the state of California, **but only** if you or your dependent use a **CHPC Contract Provider** and a **treatment plan has been**
authorized in advance by CHPC, except in the case of an Emergency as explained below under Limited Chiropractic Emergency Benefit.

Please refer to the Schedule of Benefits in Section IV for the applicable copayment and maximum number of annual visits. No benefits are provided if you use a Non-Contract Provider or for any services that are not Medically Necessary.

To find a chiropractic Contract Provider in the state of California, call 1 (800) 995-2442, or check the listing at your district office. To access a chiropractic Contract Provider outside the state of California, call 1 (800) 680-9997. It is important to remember that you must use a Contract Provider and have a treatment plan authorized by CHPC in advance before the Plan will pay for the services received — this rule applies to every geographic location in the United States.

**HOW TO USE THE PROGRAM** — When you visit one of the Contract Providers, bring your Gold Coast Joint Benefits Trust identification card with you and be sure to tell the chiropractor that you are an eligible Participant in the Trust’s Indemnity Medical Plan. After your first visit, the Contract Provider must submit a treatment plan to CHPC for review and certification. A new treatment plan must be submitted for each new illness or injury. If the Contract Provider does not submit the treatment plan, or if the treatment plan is not approved, no benefits will be payable. Any additional visits, in excess of the initial authorized treatment plan, must be pre-certified by CHPC.

Because chiropractic services are provided only through Contract Providers, no claim forms are required. The Trust’s claims department will know which provider is part of the network and will automatically adjust the bill to the reduced negotiated rate. Assuming your treatment plan has been approved by CHPC, your chiropractor is not allowed to charge you more per visit than the copayment shown in the Schedule of Benefits. If your chiropractor attempts to charge you more, please contact either CHPC or the Trust Administrator. Your chiropractic benefits are not subject to the Calendar Year Deductible.

**Limited Chiropractic Emergency Benefit** — The Plan provides for a limited Emergency benefit. The Plan will pay a maximum of two (2) consecutive visits per Emergency if during the Emergency:

1. You are treated by a Non-Contract Provider; and

2. A Contract Provider (CHPC) is not available or reasonably accessible.

The Emergency visit will be charged against the maximum number of chiropractic visits allowed per Participant per calendar year.

Reimbursements to the Participant for Emergency chiropractic care will be limited to the Contract Provider rate (CHPC), less the appropriate copayment, regardless of the network status of the chiropractor providing the service.
If the Non-Contract Provider charges more than the amount allowed under the network schedule of payments, you will be responsible for any remaining balance due to the provider. Reimbursement for Emergency chiropractic services are subject to the review and approval of CHPC. **If CHPC determines that the care provided by a Non-Contract Provider was not an Emergency and/or a Contract Provider was reasonably accessible to provide the care, the Plan will not pay the provider or reimburse any charges to the Participant.**

Any benefits paid for covered chiropractic expenses are counted towards and are subject to the Lifetime Maximum of $2,000,000.

N. **Prescription Drug Program**

1. **Walk-In Pharmacies**

Through a service agreement with Medco Health Solutions, the Plan provides you with Prescription Drug coverage at Medco-affiliated pharmacies. No benefits are payable for prescriptions filled by Non-Contract Providers or for prescriptions that are not Medically Necessary. After you pay the required copay shown in the Schedule of Benefits in section IV, the Plan pays the remainder of the retail price for the prescription or refill for up to a 30-day supply.

If the full retail price is less than minimum copayment shown per Plan, your copayment will be the retail price. You must pay your copayment to the pharmacy at the time you purchase the prescription or refill.

“Brand or brand name” Drugs are Prescription Drugs protected by a patent, and “generic” Drugs are Prescription Drugs which are therapeutically equivalent to “brand” Drugs. A “formulary” is a list of preferred brand name Drugs, which have lower copayment than the brand name Drugs placed on the non-formulary (also called “non-preferred brand” Drugs).

You and your Physician select whether a generic, preferred brand or nonpreferred brand Drug is medically best for you. Your choice may result in higher copayments. Medco (and not the Trust’s Board of Directors) determines which Drugs are placed on the formulary. In compiling the formulary, Medco, in consultation with an outside group of Physicians and Pharmacists, selects Drugs from among virtually all therapeutic types — based upon such factors as effectiveness, cost, quality, safety and potential side effects. The list of preferred brand Drugs on the formulary is extensive and is updated frequently.

Medco-affiliated pharmacies will automatically substitute a generic equivalent Drug for the brand name Drug unless your Physician indicates otherwise. If your Physician prescribes a preferred or non-preferred brand Drug, you may want to discuss whether a generic Drug may be substituted in place of the brand name Drug and if not, why not.
Be sure to take your Medco Prescription Drug identification card with you whenever you have a prescription filled or refilled at a Medco-affiliated pharmacy. If you need to replace your identification card or locate a Medco-affiliated pharmacy, you can do so by calling Medco Member Services at 1 (800) 711-0917.

If you and your spouse are both covered Employees and you wish to be reimbursed for Prescription Drug copayments, you must submit a claim to the Trust Administrator to be reimbursed under the dependent portion of your coverage. Your claim is subject to the applicable Calendar Year Deductible and Coinsurance Limit and will be paid at the applicable rates as specified under the “All-Other-Covered Expenses” section of the Schedule of Benefits.

**Benefit Limitations** — The amount of Prescription Drugs that are Covered Expenses at walk-in pharmacies is limited to the amount normally prescribed by a Physician. However, this amount cannot exceed a 30-day supply.

2. **Mail Order Program**

The Trust’s mail-order Prescription Drug program allows you to obtain maintenance medication by mail at reduced rates, and the Trust requires you to utilize this service as described below. The program is administered by Medco Health Home Delivery Service. Maintenance Drugs are provided up to a 90-day supply and require a copayment for each prescription or refill, as shown in the Schedule of Benefits.

**Mandatory Mail Order Program**

To be covered under the Plan, you may only purchase maintenance medications at a retail pharmacy twice, and then the third fill of a prescription must be purchased through Medco Health’s Home Delivery Service (mail order). Mail order forms can be obtained at your school district’s benefits office or by visiting [www.medcohealth.com](http://www.medcohealth.com).

**How to Use the Program**

1. Ask your Physician for a written prescription for a 90-day supply of medication, plus refills if appropriate.

2. Complete the prescription order form and enclose the original (not a photocopy) written prescription. Also enclose a check, money order, or your credit card number for the required copayment for each prescription.

3. Your order will be mailed to you via UPS or First Class U.S. Mail. Please allow 14 days for delivery from the day you place your order. Reordering and refill information for your next order will be included with your prescription.
Unless your Physician specifies otherwise, your prescription will be filled with a generic equivalent when available and permissible by law.

If you have customer service questions, you may contact Medco Member Services at 1 (800) 711-0917 anytime, 24 hours a day, seven days a week.

3. **Covered Drugs for Walk-In and Mail Order Program**

Prescription Drugs which are a Covered Expense include the following:

1. Federal legend Drugs, state restricted Drugs, including insulin, diagnostic test tapes, over-the-counter diabetic supplies, and Medically Necessary needles and syringes (except monitors);

2. Compound medications of which at least one ingredient is a legend Prescription Drug;

3. Oral contraceptives and Norplant;

4. Retin A for Participants through age 30;

5. Legend prenatal vitamins;

6. Drugs to treat impotency (including injectables) for males only, age 18 and over, limited to 30 days or 8 units, whichever is less in quantity, per prescription — except Yohimbine;

7. Preven, limited to 30 days or 2 kits, whichever is less in quantity per prescription;

8. Relenza, for Participants age 7 and over, limited to 30 days or one inhaler/20 units, whichever is less in quantity per prescription; and

9. Tamiflu, for Participants age 12 and over, limited to 30 days or 10 capsules, whichever is less in quantity per prescription.

4. **General Exclusions**

Prescription Drugs which are not a Covered Expense include, but are not limited to, the following:

1. Non-legend Drugs, vitamins (except as listed above) and minerals;

2. Prescriptions which are covered by workers’ compensation laws, or other county, state or federal programs;
3. Drugs labeled “Caution: Limited by Federal Law to Investigational Use” or Experimental Drugs, even though a charge is made to the Participant;

4. Drugs dispensed or administered in an outpatient setting, including but not limited to outpatient Hospital facilities and Doctors’ offices;

5. Drugs administered while in an inpatient at a licensed Hospital, Skilled Nursing Facility, extended care facility, nursing home or similar facility;

6. Blood and blood-related products;

7. Oxygen;

8. Drugs obtained outside the United States;

9. Professional charges in connection with administering or injecting Drugs;

10. Weight loss control or management;

11. Devices, appliances and medical supplies;

12. Any prescription refilled in excess of the number of refills specified by the Physician, or any refill dispensed one year after the Physician’s original order;

13. Contraceptive jellies, creams, foams or devices;

14. Smoking deterrents;

15. Topical fluoride products;

16. Methadone;

17. Drugs whose sole purpose is to promote or stimulate hair growth (e.g., Rogaine, Propecia) or for cosmetic purposes only (e.g., Renova, Vanica); and

18. Allergy sera; and biologicals, immunization agents or vaccines.
A. Waiver of Coverage

If you decline coverage for yourself or your dependents within 30 days of the date you become first eligible, or you terminate coverage after becoming eligible, you will be required to “certify” this decision by completing a waiver of coverage form. Coverage for you and/or your dependents will be re-instated as follows:

1. You and your eligible dependents (assuming all other eligibility requirements have been satisfied) will be eligible to have your coverage reinstated if:
   a. You (the Employee) were enrolled in another employer provided health benefit plan and you lose coverage under that other plan as a result of:
      1. Termination of employment of the person through whom you were covered as a dependent; or
      2. Change in employment status of the person through whom you were covered as a dependent; or
      3. Termination of another plan’s coverage; or
      4. Cessation of an employer’s contribution toward an Employee’s or dependent’s coverage; or
      5. Death of the person through whom you were covered as a dependent; or
      6. Divorce from (or the termination, dissolution or nullification of a Domestic Partnership with) the person through whom you were eligible as a dependent; or
      7. Termination of No-Share-of-Cost Medi-Cal coverage; or
   b. A court has ordered that coverage be provided to your spouse (or Domestic Partner) or minor child under this Plan, and a request for such coverage is made to the Trust Administrator within 30 days after issuance of the court order; or
   c. Your dependent’s coverage under Medi-Cal terminates, and your written request for Plan coverage is made to the Trust Administrator within 30 days of: (1) any event listed in item 1.a. above; (2) the last day of COBRA coverage; or (3) the date of the court order. You will be allowed to enroll
on the first of the month following receipt by the Trust Administrator of your written request for coverage. Your dependent(s) will also be allowed to enroll, provided the dependent(s) requests enrollment within 30 days of the loss of Medi-Cal coverage. You may not enroll dependents under any circumstances if you are not enrolled for coverage.

2. You and your eligible dependents (assuming all other eligibility requirements have been satisfied) will be eligible on the first of the month following receipt by the Trust Administrator of your written request for Plan coverage if, prior to declining coverage, the Plan did not give you written notice in bold type of this Waiver of Coverage rule.

3. If you and/or your dependents who do not satisfy 1 or 2 above, you are not allowed to enroll in the Plan until the first day of the thirteenth month following receipt by the Trust Administrator of your written request for coverage, provided that at that date you satisfy all other eligibility requirements.

B. Family and Medical Leave Act (FMLA)

Under the Family and Medical Leave Act of 1993 (FMLA), an active Employee may be entitled to family or medical leave.

1. If an Employee is eligible to take and elects FMLA leave, coverage under this Plan will continue until the earlier of:
   a. The date the Employee notifies his or her district that he or she does not intend to return to work at the end of the FMLA leave; or
   b. The end of the FMLA leave.

2. Contributions will continue to be paid by the district on the Employee’s behalf while he or she is on FMLA leave.

3. The Employee must contact the district to determine his or her eligibility for FMLA leave.

C. Continuation of Coverage — Total Disability

Loss of eligibility under this Plan will immediately terminate all benefits. However, if you or a dependent were totally disabled on the date coverage terminated, and if expenses are thereafter incurred directly related to the injury or Sickness causing the disability, then benefits will be continued with respect to such expenses until the first of the following events occur:

1. The last day of the 12th month following the month in which your coverage terminated;
2. The date the maximum amount of benefits has been paid;

3. The date you or your dependent cease to be totally disabled; or

4. The date coverage for you or your dependent becomes effective under any replacement policy without limitation as to the disabling condition.

Benefits under this provision will not be payable with respect to any other injuries or Sicknesses.

D. Continuation of Coverage Under Federal Law — COBRA

As required by a federal law called the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), the Plan offers you and each of your eligible dependents the opportunity for a temporary extension of health coverage at group rates in certain instances when Plan coverage would otherwise end. Qualified beneficiaries must pay for this continuation coverage (called “COBRA coverage”) by sending premiums directly to the Trust Administrator. (See Section VIII.D.10. and 11.) Both you and your spouse or Domestic Partner should take the time to read this section carefully.

1. Benefits Available under COBRA Coverage

Those of you who are entitled to choose COBRA (i.e., you and separately your spouse or Domestic Partner and eligible dependents) are known under COBRA as “qualified beneficiaries.”

COBRA coverage is the same coverage that the Plan gives to other Plan Participants who are not receiving COBRA coverage. Each qualified beneficiary who elects COBRA coverage will have the same rights under the Plan as other Plan Participants, including open enrollment and special enrollment rights. If the Plan changes its benefits levels or health coverage for all Participants, your health coverage will be changed in the same manner. COBRA qualified beneficiaries are not, however, considered Plan “Participants” during COBRA coverage.

When you initially enroll in COBRA Coverage, you must continue in the same Plan (i.e., Plan 2, Plan 4, or the Voluntary Self-Pay Retiree Plan) and under the same medical plan (i.e., the Indemnity Medical Plan or HMO) under which you were covered on the day before the occurrence of the qualifying event. You will be offered a choice between two levels of coverage: (1) a Core Plan of Benefits, which consists of medical and Prescription Drug coverage; and (2) a Non-Core Plan of Benefits, which consists of medical, Prescription Drug, vision and dental coverage. Each qualified beneficiary need not elect the same level of coverage. Each qualified beneficiary will be allowed, however, to change medical plans on the same basis as eligible Employees (e.g., during open enrollment).
2. **How COBRA Coverage Becomes Available**

   **a. For an Employee**

   If you are an Employee, you have a right to choose COBRA coverage for yourself if you lose your coverage under the Plan due to any of the following “qualifying events:”

   - Your hours of employment are reduced; or
   - Your employment ends for any reason (such as layoff or retirement) other than your gross misconduct.

   **b. For the Spouse or Domestic Partner of an Employee**

   If you are the spouse or Domestic Partner of an Employee, you have a right to choose COBRA coverage for yourself if you lose your coverage under the Plan due to any of the following “qualifying events:”

   - The Employee dies;
   - The Employee’s hours of employment are reduced;
   - The Employee’s employment ends for any reason other than his or her gross misconduct;
   - You become divorced or legally separated from the Employee; or
   - Your Domestic Partnership with the Employee is terminated, dissolved, or nullified.

   **c. For the Dependent Children of an Employee**

   Your dependent children have the right to choose COBRA coverage for themselves if they lose coverage under the Plan due to any of the following “qualifying events:”

   - The parent-Employee dies;
   - The parent-Employee’s hours of employment are reduced;
   - The parent-Employee’s employment ends for any reason other than his or her gross misconduct;
   - The parents become divorced or legally separated;
• The parents’ Domestic Partnership is terminated, dissolved, or nullified); or

• The child stops being eligible for Plan coverage because the child no longer qualifies as a “dependent” as defined by the Plan.

d. **For Retirees in the Event of Bankruptcy**

If you are a retiree, you will have a right to choose COBRA coverage if your Plan coverage is lost on account of your employer filing for bankruptcy under Title 11 of the United States Code. Your spouse, Domestic Partner and dependent children will also have the right to choose COBRA coverage if the bankruptcy results in their loss of Plan coverage. Please contact the Trust Administrator for details.

3. **Notifying the Trust Administrator of a Qualifying Event**

The Plan will offer COBRA coverage to each qualified beneficiary only after the Trust Administrator has been notified that a qualifying event has occurred.

Your employer must notify the Trust Administrator within 30 days of the occurrence of the following qualifying events: (1) the end of employment or reduction of hours of employment; (2) death of the Employee; or (3) commencement of a bankruptcy proceeding by your employer.

**YOU MUST NOTIFY THE TRUST ADMINISTRATOR OF CERTAIN QUALIFYING EVENTS:**

You or a dependent (or a representative of either) must notify the Trust Administrator by calling 1-800-556-5918 within 60 days after the date Plan coverage is lost due to a qualifying event that is the Employee’s divorce or legal separation, the termination, dissolution of nullification of the Employee’s Domestic Partnership, or a child’s loss of eligibility under the Plan as a dependent child. When you call, you may be asked to provide some or all of the following information: (1) the Employee’s name; (2) the Employee’s social security number; (3) the name(s) and social security number(s) of all qualified beneficiaries; (4) relevant mailing addresses; and (5) the date and nature of the qualifying event. You may be required to provide supporting documentation (e.g., a divorce decree) to the Trust Administrator.

**COBRA coverage will be denied if you fail to give notice to the Trust Administrator of a divorce, legal separation, termination or dissolution of a Domestic Partnership, or child’s loss of eligibility as a dependent child under the Plan within 60 days after the date Plan coverage is lost due to one of these qualifying events.**
4. **ELECTING COBRA COVERAGE & NOTICE OF DENIAL OF COBRA COVERAGE**

After the Trust Administrator is timely notified of a qualifying event, it will send each qualified beneficiary a “Notice of Right to Continue Health Coverage under Federal Law (COBRA) and Election Form” (the “Election Form”) within 14 days of the date Plan coverage ends due to a qualifying event.

If you would like to elect COBRA coverage, you must return the completed and signed Election Form to the Trust Administrator within 60 days after the later of: (1) the date Plan coverage ends due to a qualifying event; or (2) the date the Trust Administrator mailed you an Election Form. An election is considered to be made on the date you send the completed and signed Election Form to the Trust Administrator.

Each qualified beneficiary has a separate right to elect COBRA coverage. For example, the Employee’s spouse or Domestic Partner may elect COBRA coverage, even if the Employee does not. COBRA coverage may be elected for only one, several, or for all dependent children. Employees may elect COBRA coverage on behalf of their spouses or Domestic Partners, and parents may elect COBRA coverage on behalf of their children. The Employee or the Employee's spouse or Domestic Partner can elect COBRA coverage on behalf of all of the qualified beneficiaries.

If you reject COBRA coverage before the date the Election Form is due, you may change your mind as long as you send the completed and signed Election Form to the Trust Administrator before the due date. However, if you change your mind after first rejecting COBRA coverage, your COBRA coverage will begin on the date you send your completed and signed Election Form to the Trust Administrator.

**Please note that the Plan is required by law to make a complete disclosure of your COBRA eligibility and election status to any health care provider, such as a Doctor, Hospital, or pharmacy, that requests information about your coverage during such a period.**

If the Trust Administrator receives a notice relating to a qualifying event or disability determination regarding an Employee, dependent or other person and determines that such person is not entitled to COBRA coverage, the Trust Administrator will, within 14 days of receiving such notice, send such person a Notice of Denial of COBRA Coverage containing the reason for such denial.

In considering whether to elect COBRA coverage, you should be aware that a failure to continue your group health coverage will affect your future rights under federal law. First, other group health plans may apply pre-existing condition exclusions to you if you have more than a 63-day gap in health coverage. Election of COBRA coverage may help you avoid such a 63-day gap. Second, you will lose the guaranteed right to purchase individual health insurance policies that do
not impose such pre-existing condition exclusions if you do not get COBRA coverage for the maximum time available to you. Finally, you should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse’s employer) within 30 days after your group health coverage ends because of a qualifying event. You will also have the same special enrollment right at the end of COBRA coverage.

5. **How Long COBRA Coverage Lasts**

COBRA coverage is a temporary continuation of coverage.

- When the qualifying event is the Employee’s death, divorce or legal separation, termination of Domestic Partnership status, or the loss of dependent child status under the terms of the Plan, COBRA coverage lasts for up to a total of 36 months.

- Where the Employee became entitled to Medicare benefits less than 18 months before the qualifying event and the qualifying event is the end of employment or reduction of the Employee's hours of employment, COBRA coverage for qualified beneficiaries other than the Employee lasts up until 36 months after the date of the Employee’s Medicare entitlement. For example, if an Employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA coverage for his dependent spouse or Domestic Partner and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months).

- When the qualifying event is the end of employment or reduction of the Employee’s hours of employment, COBRA coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA coverage can be extended (see Section VIII.D.6., below).

6. **Extending an 18-Month Period of COBRA Coverage**

   a. **Disability Extension of 18-Month Period of COBRA Coverage**

   An 11-month extension of COBRA coverage (for a total maximum of 29 months) may be available if the Social Security Administration (SSA) determines any qualified beneficiary to be disabled. The disability must have started at any time before the 60th day of COBRA coverage and must last at least until the end of the 18-month COBRA coverage period. Each qualified beneficiary who has elected COBRA coverage will be eligible for the disability extension if one of them qualifies. COBRA premiums are higher for the extra 11 months of coverage.
To obtain this extension, you must notify the Trust Administrator by calling 1-800-556-5918 within 60 days after the date of the SSA disability determination (or if the qualified beneficiary is already disabled, within 60 days after the date Plan coverage is lost due to the qualifying event), but before the end of the initial 18-month period of COBRA coverage. When you call, you may be asked to provide some or all of the following information: (1) the Employee’s name; (2) the Employee’s social security number; (3) the name(s) and social security number(s) of all qualified beneficiaries; (4) relevant mailing addresses; and (5) the date of the SSA disability determination. In addition, you will be required to provide the Trust Administrator with a copy of the SSA determination letter.

The disability extension will terminate early if the SSA determines that the individual is no longer disabled before the end of the 11-month extension. You or your dependent must notify the Trust Administrator by calling 1-800-556-5918 within 30 days of any such final determination that the individual is no longer disabled.

b. Second Qualifying Event Extension of 18-Month Period of COBRA Coverage

An 18-month period of COBRA coverage may be extended to a period of up to 36 months for an Employee’s spouse, Domestic Partner or dependent child, if a second qualifying event occurs during the first 18-month period. This extension may be available to the spouse, Domestic Partner and any dependent child receiving COBRA coverage if the Employee or former Employee dies, gets divorced or legally separated, the Employee’s Domestic Partnership is terminated, dissolved, or nullified, or if the child stops being eligible under the Plan as a dependent child, but only if the second event would have caused the spouse or child to lose coverage under the Plan had the first qualifying event not occurred. For example, if an Employee’s spouse is on COBRA coverage for 18 months due to the termination of the Employee’s employment, and during the 18-month period, the spouse and the former Employee get divorced, the spouse will be eligible to maintain his or her COBRA coverage for up to 36 months from the date coverage ended due to the first qualifying event. However, in no event will COBRA coverage extend beyond 36 months from the date coverage ends due to the first qualifying event, and it may end before the 18, or 36-month period expires, as explained under “When COBRA Coverage Terminates” (see Section VIII.D.8., below).

In order to obtain an extension because of a second qualifying event, you must notify the Trust Administrator by calling 1-800-556-5918 within 60 days following the later of the date of the second qualifying event or the termination of the initial 18-month COBRA coverage period. When you call, you may be asked to provide some or all of the following information: (1) the Employee’s name; (2) the Employee’s social security number; (3) the Employee’s social security number; (4) relevant mailing addresses; and (5) the date of the SSA disability determination.
number; (3) the name(s) and social security number(s) of all qualified beneficiaries; (4) relevant mailing addresses; and (5) the date and nature of the qualifying event. The Trust Administrator may require that supporting documentation (such as a divorce decree) be submitted.

7. **When COBRA Coverage Begins**

COBRA coverage begins on the date Plan coverage ends due to a qualifying event. If you received extended Plan coverage due to Total Disability pursuant to Section VIII.C., your COBRA coverage will begin on the first day of the month after the end of such period of extended coverage. In other words, months of extended Plan coverage due to Total Disability will not count against or reduce the 18-, 29-, or 36-month maximum COBRA coverage period.

8. **When COBRA Coverage Terminates**

COBRA coverage will end before the expiration of the 18-, 29- or 36- month maximum COBRA coverage period if:

- The Trust Administrator does not receive timely payment of the required COBRA premium;
- The Trust no longer provides group health coverage;
- A qualified beneficiary becomes covered under another group health plan that does not impose any pre-existing condition exclusion for a pre-existing condition of a qualified beneficiary;
- The 11-month disability extension terminates early because the SSA determines that the disabled qualified beneficiary is no longer disabled;
- A qualified beneficiary becomes entitled to Medicare benefits (under Part A, Part B, or both) after electing COBRA coverage (COBRA coverage for family members not covered by Medicare will not be affected), or
- Your employer ceases to make contributions to the Trust and provides other group health plan coverage for its Employees.

COBRA coverage may also be terminated for any reason the Plan would terminate coverage of a Participant not receiving COBRA coverage (such as fraud).

Termination of COBRA coverage will be effective on the first day of the month following the month in which any of the above-listed events occur. Once COBRA coverage ends for any reason, it will not be reinstated. Furthermore, any medical claims incurred after the COBRA coverage termination date will not be paid by the Plan.
If your COBRA coverage is terminated early, the Trust Administrator will send you a Notice of Early Termination of COBRA Coverage as soon as reasonably practicable after it determines that your COBRA coverage will end. This notice will contain the reason for such termination, the termination date, and any rights you may have under the Plan or under applicable law to elect alternative group or individual coverage, such as coverage under a conversion policy.

Depending on the reason for your COBRA coverage termination, if you are enrolled in an HMO, you may be allowed to convert to individual coverage. The conversion policy will not provide the same benefits as you provided under COBRA. For more information on your conversion options, please contact your HMO directly. **THERE IS NO CONVERSION RIGHT UNDER THE TRUST’S INDEMNITY MEDICAL PLAN.**

9. **Adding Dependents to COBRA Coverage**

You may add a spouse, Domestic Partner, or a child who is newly acquired during a period of COBRA coverage for the balance of your COBRA coverage period. To enroll your new dependent for COBRA coverage, you must submit written proof of their dependency to the Trust Administrator at the address shown below in Section 14 within 30 days of the date the dependent(s) was acquired. There may be an increase in your COBRA premium to cover the new dependent.

A spouse, Domestic Partner, or child who is acquired through marriage or formation of a Domestic Partnership during a period of COBRA coverage will not be treated as a qualified beneficiary. On the other hand, a child born to, or placed for adoption with, the Employee while receiving COBRA coverage will become a qualified beneficiary in his or her own right. Such child will have the right, for example, to elect a different medical plan than the qualified beneficiary parent during the next open enrollment period, and will be eligible for extended COBRA coverage if a second qualifying event or disability occurs during an 18-month maximum COBRA coverage period.

10. **The Cost of COBRA Coverage**

Each qualified beneficiary must pay the entire cost of COBRA coverage, which may not exceed 102 percent (or, in the case of an extension of COBRA coverage due to a disability, 150 percent) of the cost to the group health plan (including both employer and Employee contributions) for coverage of a similarly-situated Plan Participant who is not receiving COBRA coverage. Neither your employer nor the Trust will pay for any part of your COBRA coverage.

The cost of COBRA coverage is set by the Board of Directors and is determined once a year. You can contact the Trust Administrator to obtain current rates.
11. **Payment Rules for COBRA Coverage**

   a. **First Payment for COBRA Coverage**

   If you elect COBRA coverage, you do not have to send any payment with the Election Form. However, you must make your first payment for COBRA coverage not later than 45 days after the date of your election. (This is the date your completed and signed Election Form is post-marked, if mailed.) If you do not make your first payment for COBRA coverage in full within this 45-day period, you will lose all COBRA coverage rights under the Plan.

   You are responsible for making sure that the amount of your first payment is correct and includes premiums due for all calendar months between the date Plan coverage terminated and the calendar month ending immediately before the initial premium is paid. You may contact the Trust Administrator to confirm the correct amount of your first payment. COBRA coverage will not be effective until your payment is received.

   b. **Periodic Payments for COBRA Coverage**

   After you make your first payment for COBRA coverage, you will be required to make periodic payments for each subsequent coverage period. The amount due for each coverage period for each qualified beneficiary will be provided to you with the Election Form. The periodic payments must be made on a monthly basis and are due on the tenth (10th) day of the month of coverage. For example, the payment for COBRA coverage for the month of January is due on January 10th. If you make a periodic payment on or before the first day of the coverage period to which it applies, your COBRA coverage under the Plan will continue for that coverage period without any break. **The Trust Administrator will not send monthly bills or warning notices of payments due for these coverage periods. It is the responsibility of you or your dependents to send the required payments when due.**

   c. **Grace Periods for Periodic Payments**

   Although periodic payments are due on the dates shown above, you will be given a grace period of 31 days after the first day of the coverage period to make each periodic payment. Your COBRA coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment. **If you fail to make a periodic payment before the end of the grace period for that coverage period, you will lose all rights to COBRA coverage under the Plan.**
d. Where Should I Send My Payments?

All payments for COBRA coverage must be sent to the Trust Administrator at the address shown below in Section 14.

12. If You Have Questions

Questions concerning the Plan or your COBRA coverage rights should be addressed to the Trust Administrator at the address and telephone number shown below in Section 14.

For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the U.S. Department of Labor’s Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA’s website.)

13. Keep the Trust Administrator Informed of any Changes

In order to protect your and your family’s rights, you should keep the Trust Administrator informed of any changes in your address and the addresses of family members. Also, you should inform the Trust Administrator of any changes in marital or Domestic Partnership status. You should also keep a copy, for your records, of any notices you send to the Trust Administrator.

14. Contact Information

Please use the address and telephone number listed below for submitting required notices or documents or directing any questions you may have about your COBRA rights:

Gold Coast Joint Benefits Trust  
Trust Administrator  
c/o Delta Health Systems.  
P.O. Box 80  
Stockton, CA 95201  
1-800-556-5918

E. Continuation of Coverage under USERRA — Military Service

The Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) established requirements that employers and health plans must meet for certain employees who have left employment due to service in the uniformed services.1

1 “Uniformed services” means the Armed Forces, the Army National Guard, and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty (i.e.,
With one important exception, your rights under COBRA and USERRA are essentially the same. Any election that you make pursuant to COBRA will also be an election under USERRA, and COBRA and USERRA will both apply with respect to the continuation coverage elected. But in contrast to COBRA, which provides you and your dependents up to 18 months of coverage, USERRA provides you and your dependents up to 24 months of coverage.

**COBRA and USERRA coverage are concurrent for up to the first 18 months of coverage.** This means that COBRA coverage and USERRA coverage begin at the same time. As with COBRA, you are responsible for paying for USERRA coverage. The monthly premiums are the same. The cost of the USERRA premium is the same as it would be under COBRA.

Your USERRA coverage will terminate if one of the following events takes place before the end of the 24 months:

1. You fail to make a premium payment within the required time;

2. You fail to return to work within the time required under USERRA following the completion of your service in the uniformed services (the time for returning varies, please contact your employer for more details); or

3. You lose your rights under USERRA as a result of a dishonorable discharge or other conduct specified in USERRA.

You may lose coverage under COBRA and USERRA for different reasons. You could, therefore, lose coverage under COBRA but retain it under USERRA, or vice versa. For example, if you lose coverage under USERRA due to a dishonorable discharge, your COBRA coverage would continue as long as you were within the 18-month time limit (plus any extensions, if applicable) for COBRA.

**F. Enrollment in Medicare**

The Trust requires that you and your covered dependents enroll in Medicare Part A as soon as you or your dependent first become eligible.

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pursuant to orders issued under federal law), the commissioned corps of the Public Health Service, and any other category of persons designated by the President in time of war or national emergency.

“Service in the uniformed services” or “service” means the performance of duty on a voluntary or involuntary basis in the uniformed services under competent authority, including active duty, active duty for training, initial active duty for training, inactive duty training, full-time National Guard duty, a period for which a person is absent from employment for an examination to determine his or her fitness to perform any of these duties, and a period for which a person is absent from employment to perform certain funeral honors duty. It also includes certain service by intermittent disaster-response personnel of the National Disaster Medical System.
If you are a Retiree: You and your dependent must enroll in and pay for Medicare Part B when you retire on or after January 1, 1999, and you or your dependent become eligible for Medicare.

For Retirees: failure to enroll in both Medicare Parts A and B when you first become eligible will result in the following:

1. Members of the Voluntary Self-Pay Retiree Plan — coverage will be terminated.
2. Retirees whose benefits are paid for by their district — HMO members: coverage will be terminated.
3. Retirees whose benefits are paid for by their district — Indemnity Medical Plan members: the Plan will process claims as if Medicare is the primary payer and the Trust’s Plan is the secondary payer.

If you are an Employee: the Trust recommends that you and your dependent spouse enroll in and pay for Medicare Part B when you or your dependent first become eligible for Medicare. If you or your spouse decline to enroll in Medicare Part B when first eligible, Medicare typically adds a surcharge to the cost of the Part B Premium for late enrollment. Please contact Medicare about qualifying for a waiver of this surcharge if you or your spouse enroll later than when first eligible.

If you or your spouse becomes Medicare eligible while you are an Employee, you have the right to make your coverage under Medicare or this Plan primary. If you choose Medicare as your primary coverage, you will have no further coverage under this Plan. If you choose this Plan, the benefits payable for you as a Medicare eligible Employee and/or your Medicare eligible spouse under this Plan are the same as the benefits for those who are not eligible for Medicare.

G. Coverage for Retirees

The Trust provides coverage for retirees and their dependents as follows:

1. District-Paid Coverage

You may be entitled to district-paid retiree coverage, but only if provided for by the collective bargaining agreement covering you. You should contact your school district to determine under what circumstances and for how long you are entitled to such coverage.

2. Voluntary Self-Pay Retiree Plan

Upon retirement, or at the end of district-paid coverage, you have the option of continuing medical coverage for yourself and your dependents through the Voluntary Self-Pay Retiree Plan established by the Trust.
To qualify for coverage under this plan:

a. You must be retired per your participating district rules;

b. You and your dependents must each purchase Medicare Parts A and B upon turning 65 years old;

c. You and your dependents must respectively purchase Medicare Parts A and B, if either or both is under age 65 and disabled; and

d. You must elect coverage under the Voluntary Self-Pay Retiree Plan within 30 days of your retirement date or the date your district-paid coverage ends.

You and your dependents may only elect to continue coverage in those benefit options (medical, vision and/or dental) in which you were enrolled as an Employee immediately prior to your retirement or end of district-paid coverage. You may not add dependents who were not previously covered, and you and your dependents may not enroll in additional benefit options if not previously covered. Once you decline coverage, you may not subsequently re-enroll. For example, if you were enrolled in medical and dental, you may continue or decline coverage in either one or both, but you may not add vision. You may only change medical plans at the next open enrollment period (e.g., Indemnity Medical Plan vs. PacifiCare).

Coverage is provided at your own expense at rates set annually by the Board of Directors. Coverage under the Voluntary Self-Pay Retiree Plan will end on the earliest of:

a. The first of the month for which payment has not been received by its due date;

b. The date the Voluntary Self-Pay Retiree Plan is terminated by the Trust; or

c. The date your participating school district ceases to participate in the Trust.

Once your coverage under the Voluntary Self-Pay Retiree Plan is terminated for any reason, reinstatement will not be allowed in any other plan offered by the Trust.

The Board of Directors of the Trust has full and exclusive authority to modify or terminate the Voluntary Self-Pay Retiree Plan, establish self-pay rates, and/or change carriers and health care providers at its discretion. The Trust is not required to provide benefits for retirees for life or any other guaranteed period. The Trust’s modification and/or termination of the
Voluntary Self-Pay Retiree Plan is independent of any right or claim to health insurance that a retiree may have or assert against his or her former employer.

Contact your district office or the Trust Administrator for full details concerning the Voluntary Self-Pay Retiree Plan.

3. **Surviving Spouse Benefit – For Retirees Only**

In the event of your death, coverage for your spouse and eligible dependents may be continued, provided your surviving spouse first elects COBRA coverage and then elects, without any interruption in coverage, to pay for the surviving spouse coverage provided by the Trust. Surviving spouse coverage will be provided after COBRA coverage ends for any reason.

In addition, your spouse must purchase Medicare Parts A and B upon turning 65 years old, or if he or she is under age 65 and disabled.

Coverage will cease on the last day of the month during which one of the following events first occurs:

a. Failure to remit the required contribution payment on time and in full;

b. Your spouse remarries;

c. Your spouse becomes covered under another group policy; or

d. The district ceases to provide any group health coverage through the Trust.

Coverage is provided under many of the same rules governing the Voluntary Self-Pay Retiree Plan. Your surviving spouse and any dependents may only elect to continue coverage in those benefit options (medical, vision, and/or dental) in which they were enrolled immediately prior to your death. Your surviving spouse may not add dependents who were not previously covered, and your surviving spouse and dependents may not enroll in additional benefit options if not previously covered. Once your surviving spouse declines coverage, he or she may not subsequently re-enroll. You may only change medical plans at the next open enrollment period (e.g., Indemnity Medical Plan vs. PacifiCare).

The Board of Directors of the Trust has full and exclusive authority to modify or terminate the surviving spouse coverage, establish rates and/or change carriers and health care providers at its discretion. The Trust is not required to provide benefits for your surviving spouse for life or any other guaranteed period.
4. **Certificated Retiree Continuation of Coverage Under State (Ed. Code 7000/AB 528)**

Upon retirement, an Employee and eligible spouse or Domestic Partner will have the option of continuing medical coverage provided under this Plan if the Employee was a certificated Employee of a participating school district prior to retirement and the Employee:

a. Retired under any public employee retirement system;

b. Gained permanent status while in the employment of the district;

c. Would currently be eligible for health and welfare benefits in the district if they were employed under the current conditions and in the same capacity as when permanency was gained;

d. Otherwise meet the requirements of Education Code Section 7000; and

e. Enrolls in the Trust’s Ed. Code Section 7000 plan within 30 days after losing active Employee or other Trust coverage.

If an individual is the surviving spouse or Domestic Partner of a retired certificated Employee, he/she is also eligible to continue coverage.

Coverage will be provided at the individual’s own expense, and premiums as set by the Trust must be paid by the individual for a minimum of three months coverage. A retiree or spouse (or Domestic Partner) who has elected coverage under Education Code Section 7000, and who subsequently voluntarily terminates that coverage for any reason, will be excluded from reobtaining coverage at any later date.

**H. Notice to Terminating Employees**

**California Health Services:** The California Department of Health Services will pay the cost of COBRA continuation coverage for certain persons losing employment under the following circumstances:

1. Persons eligible for Medi-Cal who qualify for the Health Insurance Premium Payment Program (HIPP). To enroll in HIPP or to inquire about requirements, call the California Department of Health Services at 1 (800) 952-5294 between 8:00 a.m. and 5:00 p.m., Monday through Friday.

2. Persons disabled by HIV/AIDS who under the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act of 1990, may qualify for the Health Insurance Continuation Program (CARE/HIPP). For additional information on CARE/HIPP contact the Northern California AIDS Hotline at 1 (800) 367-2437 or the Southern California AIDS Hotline at 1 (800) 922-2437.
Benefits are subject to the following Coordination of Benefits provisions.

“Coordination” means that if you or your eligible dependents are entitled to benefits under any health plan other than the Indemnity Medical Plan that will pay part or all of the expenses incurred for medical services, medical supplies, Prescription Drugs, or any benefit that would also be payable by this Plan, the amount of the benefits payable by this Plan will be coordinated so that the aggregate amount paid will not exceed 100% of the Allowable Expense, as defined below. This Plan’s payment will not exceed the amount that would have been paid if there were no other plan involved. Additionally this Plan will not pay benefits for any treatment, service, or supply that is not otherwise covered by this Plan.

The term “health plan,” as used in this Section IX. only, means any health plan other than the Indemnity Medical Plan that provides benefits or services for or by reason of medical treatment, which benefits or services are provided by: (1) group, blanket or franchise insurance coverage; (2) service plan contracts, group practice, individual practice and other prepayment coverage; (3) any coverage under a labor-management trustee plan, union welfare plan, employer organization plan, or employee benefit organization plan; (4) any coverage under governmental programs; and (5) any coverage required or provided by any statute.

The term “Allowable Expense” means any necessary, reasonable and customary item of expense for medical care and services, at least a portion of which is covered under at least one of the plans covering the person for whom the claim is made. When a plan provides benefits in the form of service rather than cash payment, the reasonable cash value of each service rendered shall be deemed to be both an Allowable Expense and a benefit paid. In no event shall an Allowable Expense exceed the lesser of the UCR charges billed by a provider or the contractual rate for such expense under a contract between a Contract Provider and this Plan or between a provider and the plan with which this Plan is coordinating.

“Allowable Expense” shall not include out-of-pocket expenses incurred as the result of non-compliance with the Plan’s Hospital Contracting and Hospital Utilization Review and Pre-Certification Programs (see Sections VII.G. and VII.H.).

For Employees and dependents who may be covered under this Plan and under an HMO, this Plan will only reimburse the copayments required under the HMO, if such copayments are required of every person covered by that HMO. Other than the copayments specified above, this Plan will not pay expenses of eligible Employees and dependents covered by HMOs.

A copayment is the fixed dollar amount, as stipulated by a plan, that is payable at the time covered services and supplies are rendered.

Effect on Benefits — If the COB provisions reduce the benefits payable under more than one plan provision, each benefit will be reduced proportionately. Only the amount will be charged against any benefit limit in those plan provisions.
The Coordination of Benefits provisions of this plan determine the order of payments when more than one plan covers the same individual. The order of payment rules are as follows:

1. The plan which covers the person as an employee pays before the plan which covers the person as a dependent.

2. The plan which covers the person as an active employee or dependent of an active employee pays before a plan which covers a person as a retired or laid off employee or dependent of such person. If either plan does not have a provision regarding laid off or retired employees and it results in each plan determining its benefits after the other, then this provision shall not apply.

3. For dependent children:
   a. If a dependent child lives with both parents, the plan which covers the parent whose birthday (month and day) falls earlier in the year will pay before the plan which covers the parent whose birthday (month and day) occurs later in the year. If one of the plans involved has not yet adopted this “birthday rule,” that plan’s coordination of benefits provision will determine the order of benefit payment.
   b. When the parents are divorced or separated, benefits for the child are determined in this order:
      1. The plan of the parent with custody pays first.
      2. If the parent with custody has remarried, the plan of the spouse of the parent with custody pays second.
      3. The plan of the parent not having custody pays next.
      4. If there is a court decree which establishes financial responsibility for the health care expenses of the child, the plan which covers the child as a dependent of the parent with such responsibility pays before any other plan covering the child.

4. If none of the above rules determines the order of benefit payments, the plan which covered the person longer pays before the plan which covered the person for the shorter time.

5. Exceptions to items 1 through 4 above are as follows:
   a. The benefits of a plan which covers the claimant as an active employee or dependent of an active employee shall be determined before the benefits of the plan which covers such person as a COBRA beneficiary.
b. The benefits of a plan which covers the claimant as a natural, adopted or foster dependent child shall be determined before the benefit of a plan which covers such person as a step-child, except as provided in 3(b) above.

In order to administer this Coordination of Benefits provision, the Trust has the right to:

1. Obtain or release any information needed to determine the benefits payable under this provision; and

2. Reimburse any person, organization or plan any amount that should have been paid by this Plan; and

3. Recover any amount paid to a claimant or organization in excess of the amount that is required by this provision.
A. Appeals Procedure

If your claim for benefits is denied, in whole or in part, you will receive a written notice of denial which will contain the following information:

1. The specific reason for the denial with reference to the pertinent Plan provisions on which the denial is based;

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

3. A description of the Plan’s claims appeal procedure.

The notice of denial shall be given within 90 days after the claim is filed, unless special circumstances require an extension of time for processing the claim. If such an extension is required, you will be sent written notice within 90 days of the time the claim is filed, stating the special circumstances requiring the extension. The final date for the decision will not be more than 180 days from the date the claim was filed. If such notice of denial is not given within the time required, you may proceed to the next review stage as though the claim had been denied.

Within 60 days of receipt of the written notification of denial, you or your duly authorized representative may request a review of the claim by filing a written appeal with the Board of Directors. An appeal must state the reasons you disagree with the notice of denial and should include any evidence supporting the appeal not previously provided to the Trust Administrator.

Appeals should be submitted to Delta Health Systems, the Trust Administrator, at:

DHS
P.O. Box 1931
Stockton, California 95201
1 (800) 556-5918

If you do not request a review of your claim within 60 days of the receipt of the written notification of denial, you will have waived your right to have your claim reconsidered. The Board at its discretion may consider a late appeal, if it concludes that there was reasonable cause for the delay in filing.
As part of the review procedure, you or your duly authorized representative may review pertinent documents and submit issues and comments in writing. When an appeal for review is received, the claim and its denial will receive a full and fair review by the Board of Directors.

After consideration of your appeal, the Board shall issue a written notice of its decision and will state the specific reasons for the decision. Reference to specific Plan provisions will be included in the notice. The decision will be made promptly and, unless special circumstances arise which require an extension of time for processing, you will ordinarily receive a determination letter within 60 days following the receipt of your appeal. In no case will the decision take longer than 120 days from the receipt of the appeal. If circumstances do exist which require an extension of time for processing, you will be furnished with a written notice of the extension before the extension period begins.

The Board possesses full discretion to decide benefit appeals and to interpret the terms of the Trust Agreement, the Plan Document and any other documents relevant to the claim.

If you are dissatisfied with the Board’s decision, the disputed claim must be submitted to binding arbitration, which is your exclusive remedy, unless the claim is less than the jurisdictional limit of the small claims court, in which case your exclusive remedy is to file an action in small claims court.

B. Arbitration Procedures

1. Any dispute with or claim against the GOLD COAST JOINT BENEFITS TRUST (“Trust”) and/or its directors, agents, independent contractors or their employees (“respondents”), regarding a denial of benefits, irrespective of the legal theories upon which the claim is asserted, will be determined by submission to binding arbitration and not by a lawsuit or resort to court process, except as California law provides for judicial review of arbitration proceedings. This arbitration requirement applies to claims asserted by a Participant, a Participant’s heir or personal representative, or any person claiming that a duty to him or her arises from a Participant’s relationship to one or more respondents.

2. A Participant or other claimant may request arbitration by submitting a written demand for arbitration to the Trust. The demand for arbitration must be received by the Trust within one year from the date the denial of an appeal is mailed to the Participant at the address provided by the Participant. All claims based on the same incident, transaction, or related circumstances must be arbitrated in one proceeding.

3. The arbitration will be conducted according to the labor arbitration rules of the American Arbitration Association. Each party will be responsible for the expenses of the arbitration in accordance with the labor arbitration rules. Under those rules, the Participant and the Trust are required to evenly split the following costs: an initial administrative fee, the arbitrator’s fees, and the cost of the court reporter’s transcript (if requested by the arbitrator). The Trust cannot provide you with an
estimate of how much the arbitration will cost, since there are too many variables involved. For more information, please refer to the labor arbitration rules of the American Arbitration Association available at “www.adr.org” or contact the Trust Administrator. The arbitrator will have no authority to amend or modify the Plan. The parties will have the right to conduct discovery in accordance with California Code of Civil Procedures Section 1283.05, or amendments thereto. The decision of the arbitrator is final and binding upon all parties, including the Participant and all persons claiming through the Participant, and judgment on the award may be entered in any court having jurisdiction.

4. Before you may commence an arbitration you must timely appeal all denied claims. If a claim is not timely appealed, or if a demand for arbitration is not timely, such claim will be waived and forever barred, and no judicial proceedings may be instituted with respect to such claim.

5. Notwithstanding the foregoing, if a claim is for less than the jurisdictional limit of small claims court, the Participant’s exclusive remedy is to file an action in small claims court.

By participating in this Plan, you are agreeing to have any dispute with the Trust and/or its directors, agents, independent contractors or their employees regarding a claim for benefits decided by neutral arbitration, giving up your right to a jury or court trial, and agreeing to a reduced period of limitations in which to initiate your claim.
XI. THIRD PARTY LIABILITY EXCLUSION

If a Participant incurs a Sickness, injury, disease or other condition (hereinafter “injury”) for which a third party may be liable or legally responsible, the Trust will be reimbursed from any proceeds received by way of judgment, settlement or otherwise in connection with, or arising out of, any claim for damages by such Participant or his heirs, parents or legal guardians (referred to collectively in this Section XI. as “Participant”), in an amount equal to the payments made or to be made by the Trust in connection with, or arising out of, such injury for which recovery is obtained from a third party.

The Trust will have a lien on all amounts paid or to be paid by or on behalf of any third party as a result of the exercise of any rights of recovery by the Participant against the third party for any injury sustained by the Participant for which the Trust has made payment. The Trust will be entitled to reimbursement and/or payment in satisfaction of its lien, even through the total amount of the Participant’s recovery is less than the actual loss suffered by the Participant. The proceeds of any recovery obtained by a Participant on account of the injury shall first be applied to satisfy the Trust’s lien or other rights under this Section.

The Participant will do whatever is necessary or appropriate to secure the above rights of the Trust, including: (1) the execution of any assignments, liens, Agreement to Reimburse, acknowledgements, or other documentation requested by the Trust; and (2) notifying Participant’s attorney of the Trust’s lien. The Participant will do nothing to prejudice such rights. A Participant’s failure to sign such an assignment or acknowledgement of lien will not defeat the Trust’s right to reimbursement and/or any other of its rights as set forth in this Section. The Participant will hold in trust for the benefit of the Trust all amounts received from or on account of a third party. If any action or proceeding is commenced or any claim is asserted against any third party for the injury or death of a Participant, or if any settlement agreement is made with the third party, the Participant or his or her representative or heir instituting an action or claim or participating in a settlement will promptly notify the Trust. The failure of the Participant to give such notice to the Trust, to cooperate with the Trust, or to sign the Agreement to Reimburse constitutes a material breach under the Plan and will result in the Participant being personally responsible to reimburse the Trust.

Notice of the rights of the Trust, including the above mentioned lien rights, may be filed by the Trust with any person having a material interest in the existence of such rights, including, but limited to, the court in which an action is filed, the attorney for the Participant, the third party responsible for the Participant’s injury, and the third party’s insurer.

The Trust’s reimbursement, lien and trust rights will be limited to the recovery by the Trust of the amounts it has paid in connection with such injury.

The Trust has the authority to reduce third party liens in consideration of attorneys fees and costs of litigation incurred to procure the recovery, loss of earnings, out-of-pocket expenses,
anticipated unreimbursed future medical expenses, the permanence of the injuries and the impact of the same on future employment.

The Trust’s lien applies to all amounts received or to be received by the injured party regardless of the source of payment, except that no lien shall apply to any amount received from any uninsured motorist or underinsured motorist coverage in any policy of insurance, provided that the injured party is a named insured in the policy.

Notwithstanding the foregoing, no reduction of any lien will be made (whether or not the injured party or the party’s attorney has been previously advised of a reduction) if:

1. The Trust brings any suit or other legal proceeding, or becomes involved in any suit or proceedings, to enforce its lien or to recover any amount owing thereunder, or to defend against any claim arising out of the same; or

2. In the opinion of the Board the injured party or the party’s attorney has attempted to evade or avoid the Trust’s lien. “Evade or avoid” includes, but is not limited to, the failure to advise the Trust that the injuries were caused by a third party, the failure to execute the written acknowledgment of the lien, or the failure to timely notify the Trust Administrator of any recovery.
1. **Name of Plan** — Gold Coast Joint Benefits Trust

2. **Name and Address of Board of Directors:**

   Board of Directors  
   Gold Coast Joint Benefits Trust  
   P.O. Box 7051  
   San Francisco, CA 94120

3. **EIN & Plan Number** — The Employer Identification Number assigned by the IRS to the Plan Sponsor is 95-4286060. The Plan Number is 001.

4. **Type of Plan** — The Plan is a welfare plan providing medical, dental, mental health, chiropractic and vision benefits to eligible Employees and dependents under a self-funded arrangement. Dental and vision benefits are described in separate brochures.

5. **Type of Administration** — The Board of Directors has engaged Delta Health Systems (DHS) to perform the routine administration of the Trust as Trust Administrator and claims payer.

6. **Name, Address and Telephone Number of Administrator:**

   Delta Health Systems  
   P.O. Box 80  
   Stockton, CA 95201  
   1 (800) 556-5918

7. **Name and Address of Agent for Legal Service:**

   Delta Health Systems  
   1234 W. Oak Street  
   Stockton, CA 95203

   Service of legal process may also be made upon the Board of Directors at the above address or upon any member of the Board of Directors.

8. **Name, Title and Business Address of the Plan Directors:**

   There are 14 Directors (7 Employer Directors and 7 Employee Directors) serving on the Board at any one time. A listing of the current Board of Directors, and their mailing addresses, may be obtained from the Trust Administrator.
9. **Description of the Relevant Provisions of any Applicable Collective Bargaining Agreement:**

   The program is maintained pursuant to various collective bargaining agreements. Copies of the collective bargaining agreements are available for inspection at the Trust Administrator’s office during regular business hours and will be furnished by mail upon written request to the Trust Administrator.

10. **Requirements regarding Eligibility for Participation and Benefits:**

   The Plan’s requirements with respect to eligibility for the Indemnity Medical Plan are shown in the Eligibility Provisions section of this booklet.

11. **Source of Contributions:** Contributions to the Trust are made by the participating public agencies in accordance with the collective bargaining agreements on behalf of active full-time Employees, part-time Employees and retirees.

12. ** Sufficiency of Contributions:**

   The benefits established by the Plan have been adopted by the Board of Directors based on the best information available to them as to the cost of benefits and the contributions which they anticipate receiving under the applicable collective bargaining agreements. The Board of Directors reserve the right to modify benefits at any time, or to reduce or even eliminate benefits if necessary to maintain the financial soundness of the Plan.

13. **Plan Year:**

   For purposes of maintaining Plan records, the fiscal year of the Plan is the twelve-month period ending each June 30.