

# SAN JOSE UNIFIED SCHOOL DISTRICT

PRESENTS THE

## **FOUNDATION PLAN**

July 2010

ADMINISTERED BY:

*UNITED ADMINISTRATIVE SERVICES, INC.*

*1120 SOUTH BASCOM AVENUE*

*P.O. BOX 5057*

*SAN JOSE, CALIFORNIA 95150*

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## **GENERAL INFORMATION**

### **ELIGIBILITY**

All school district employees, working half time (.500 FTE) or more which is at least 20 hours per week, their legal married husband/wife or domestic partner and unmarried children under 19 years of age are eligible for coverage under this plan. The waiting period for coverage is the first of the month following at least one half month of employment. Applications for enrollment must be received within 30 days of hire. For those enrolled in Medicare Parts A and B, total health protection will not be less than set forth in the Agreement. Family members must enroll within 31 days of birth or marriage. Coverage for a child born under this program begins at birth; however, application must be received within 31 days of birth, and additional subscription charges, if any, must be paid for coverage to continue. A subscriber or family member who does not enroll when first eligible or a new spouse who does not enroll within 31 days of marriage may only enroll during the Open Enrollment period as defined in this Agreement.

Retirees and their eligible dependents as defined in this Agreement are eligible for coverage under this plan.

At age 19 unmarried children may be included to age 25 if the child is attending school full-time at an accredited high school, trade school, college or university and primarily dependent upon the employee for support. If your dependent child(ren) loses eligibility between age 19 and 25 and subsequently becomes a full-time student as noted above, they will become eligible to re-enroll in the plan upon proof of full-time status. A Child is the Employee's child, stepchild, your adopted child from the moment of placement in your home, or a child under your legal guardianship, but only if this child depends on You for support and maintenance and if the child lives with You in a parent-child relationship. The term child does not include a foster child who is eligible for benefits provided by any governmental program or law, unless such inclusion is required by the laws of state. Proof of full-time status will be required annually from the school, college or university. Coverage also extends beyond age 19 for children who are mentally or physically incapacitated and incapable of self-support.

Note: During an approved leave of absence, a member may retain this protection, provided continued payment is made through the School District Payroll/Benefits Office (refer to COBRA section).

### **Special Enrollment Periods**

This *Plan* provides special enrollment periods that allow you to enroll in the *Plan*, even if you declined enrollment during an initial or subsequent eligibility period.

### **Additional Special Enrollment Rights**

*Employees* and *dependents* who are eligible but not enrolled are entitled to enroll under the following circumstances:

- The *employee's* or *dependent's* Medicaid or State Child Health Insurance Plan (i.e. CHIP) coverage has terminated as a result of loss of eligibility and the *employee* requests coverage under the *Plan* within 60 days after the termination; or
- The *employee* or *dependent* becomes eligible for a premium assistance subsidy under Medicaid or a State Child Health Insurance Plan (i.e. CHIP), and the *employee* requests coverage under the *Plan* within 60 days after eligibility is determined.

## **TERMINATION OF COVERAGE**

Coverage ceases:

1. When the Agreement between the District and the Foundation terminates, or
2. If subscription charges are not paid, or
3. On the first day following the period subscription, charges are paid either:
  - a. After receipt of your written request to terminate, or
  - b. The member fails to qualify for coverage under this Agreement under specific circumstances of loss of coverage, the coverage may be continued for a period of time under the COBRA Law (refer to COBRA section) with the subscriber paying the premium. Further information may be obtained through the School District Payroll/Benefits Office. While on leave of absence coverage may continue for the period set by the Agreement.

Unless otherwise provided in the Agreement, termination of your coverage automatically terminates coverage for your family members.

If a bed patient and eligible for hospital or skilled nursing facility benefits at the time coverage terminates, benefits will be paid until discharged, care is not required, or maximum benefits are paid, whichever occurs first.

## **COBRA BENEFITS (CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT OF 1985)**

Federal law requires most employers sponsoring group health plans, to offer employees and their families the opportunity for a temporary extension of health coverage (called "Continuation Coverage"), at group rates in certain instances where coverage under the plan would otherwise end, (e.g., dependent children beyond age 19 or full-time students at age 25). Employees and their dependents should read the COBRA section carefully.

Additional benefits for retirees and/or surviving spouses are detailed in the COBRA Section.

## **CERTIFICATE OF FORMER COVERAGE**

If you or your dependents lose coverage under the Plan, you will be furnished with a certificate of former plan coverage. You may need the certificate if your new plan excludes coverage for pre-existing conditions. If you are entitled to COBRA coverage, the certificate will be mailed when a notice for a qualifying event under COBRA is required, and after COBRA coverage stops. You may also request a certificate within 24 months after losing coverage.

## **FAMILY AND MEDICAL LEAVE ACT OF 1993 (FMLA)**

The FMLA law became effective August 5, 1993. One of the provisions of the FMLA states that Group Health Benefits must be continued by the employer while the employee is on an approved FMLA leave of absence. COBRA coverage is available after the end of the period that the district must continue coverage during a FMLA leave of absence. Please contact Human Resources for additional information.

## **UNIFORM SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT OF 1994 (USERRA)**

If an employee is absent from employment due to a qualifying military service under 38 U.S.C. 4301 et. seq., and notifies Human Resources of his or her entrance into such military service, then the employee has the right to continue coverage for himself or herself and his or her qualifying dependents for the periods stated under COBRA.

Coverage under the employer's coverage will be reinstated after discharge from active military duty if and when the employee returns to work for the employer, provided the employee returns within 90 days of discharge.

## **MICHELLE'S LAW**

“**Michelle's Law Notification**” means the extension of coverage to full-time student *dependents* at postsecondary educational institutions who experience a *medically necessary leave of absence*, for up to one year, if both of the following conditions are met:

- The *Plan* receives written certification from the *dependent's* treating *physician* certifying that:
  - The *dependent* is suffering from a serious *illness* or *injury*; and
  - The *leave of absence* from the postsecondary institution is a *medically necessary leave of absence*.
- The loss of student status would cause a loss of health coverage under the terms of the *Plan* without the application of *Michelle's Law*.

The one-year period begins with the first day of the *medically necessary leave of absence* and may end before the year ends, if the *dependent's* coverage under the *Plan* would terminate for any reason.

#### **SOURCE OF RATE CONTRIBUTION**

Information about your contribution to this program, if any, may be obtained from the District Payroll - Employee Benefits Office.

#### **RELATIONSHIP BETWEEN PLAN AND HEALTH CARE PROVIDERS**

No health care provider is an agent or representative of the Plan. The plan does not control or direct the provision of health care services and/or supplies to plan participants and beneficiaries by anyone. The plan makes no representation or guarantee of any kind that any provider will furnish health care services or supplies that are malpractice-free.

The foregoing statement applies to any and all health care providers, including both preferred and non-preferred providers under the terms of the plan. The statement also applies to all entities (and their agents, employees and representatives) which contract with the plan to offer preferred provider networks, or health-related services or supplies to participants and beneficiaries.

Nothing in this plan affects the ability of a provider to disclose alternative treatment options to a participant or beneficiary.

**HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)  
REQUIRED INFORMATION**

In accordance with the disclosure requirements of the Health Insurance Portability and Accountability Act, we are providing you the name and address of all Health Providers for the San Jose Unified School District Foundation Plan.

Health Providers

United Administrative Services  
1120 South Bascom Avenue  
San Jose, CA 95128  
*Contract Administrator*

CVS/Caremark  
P.O. Box 52116  
Phoenix, AZ 85072-2116  
*Prescription drug benefits*

Anthem Blue Cross  
BC Life and Health Insurance Company  
Prudent Buyer Network  
21555 Oxnard Street  
Woodland Hills, CA 91367  
*Provider  
Network/Utilization Review/Case Management*

American Health Holdings  
100 West Old Wilson Bridge Road,  
Third Floor  
Worthington, OH 43085-6016  
*Claim Review*

**HIPAA COVERAGE AND CONVERSION**

If your coverage for medical benefits under this plan ends, you may be eligible to enroll for coverage with any carrier or health plan that offers individual medical coverage.

**HIPAA Coverage**

The Health Insurance Portability and Accountability Act (HIPAA) is a federal law that provides an option for individual coverage when coverage under the employer's group plan ends. To be eligible for **HIPAA** coverage, you must meet all of the following requirements:

1. You must have a minimum of 18 months of continuous health coverage, most recently under an employer-sponsored health plan, and have had coverage within the last 63 days.
2. Your most recent coverage was not terminated due to nonpayment of subscription charges or fraud.
3. If continuation of coverage under the employer plan was available under COBRA, CalCOBRA, or a similar state program including PostCOBRA, such coverage must have been elected and exhausted.
4. You must not be eligible for Medicare, Medi-Cal, or any group medical coverage and cannot have other medical coverage.

You must apply for HIPAA coverage within 63 days of the date your coverage under the employer's plan ends. Any carrier or health plan that offers individual medical coverage must make HIPAA coverage available to qualified persons without regard to health status.

## **GENERAL PROVISIONS**

**Providing of Care.** We are not responsible for providing any type of *hospital*, medical or similar care, nor are we responsible for the quality of any such care received.

**Independent Contractors.** Our relationship with providers is that of an independent contractor. *Physicians*, and other health care professionals, *hospitals*, *skilled nursing facilities* and other community agencies are not our agents nor are we, or any of our employees, an employee or agent of any *hospital*, medical group or medical care provider of any type.

**Non-Regulation of Providers.** The benefits of this *plan* do not regulate the amounts charged by providers of medical care, except to the extent that rates for covered services are regulated with *participating providers*.

### **Terms of Coverage**

1. In order for you to be entitled to benefits under the agreement, both the agreement and your coverage under the agreement must be in effect on the date the expense giving rise to a claim for benefits is incurred.
2. The benefits to which you may be entitled will depend on the terms of coverage in effect on the date the expense giving rise to a claim for benefits is incurred. An expense is incurred on the date you receive the service or supply for which the charge is made.
3. The *agreement* is subject to amendment, modification or termination according to the provisions of the *agreement* without your consent or concurrence.

**Protection of Coverage.** We do not have the right to cancel your coverage under this *plan* while: (1) this *plan* is in effect; (2) you are eligible; and (3) your subscription charges are paid according to the terms of the *agreement*.

**Free Choice of Provider.** This *plan* in no way interferes with your right as a *member* entitled to *hospital* benefits to select a *hospital*. You may choose any *physician* who holds a valid *physician* and surgeon's certificate and who is a member of, or acceptable to, the attending staff and board of directors of the *hospital* where services are received. You may also choose any other health care professional or facility which provides care covered under this *plan*, and is properly licensed according to appropriate state and local laws. However, your choice may affect the benefits payable according to this *plan*.

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

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

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

**Expense in Excess of Benefits.** We are not liable for any expense you incur in excess of the benefits of this *plan*.

**Benefits Not Transferable.** Only the *member* is entitled to receive benefits under this *plan*. The right to benefits cannot be transferred.

**Notice of Claim.** You or the provider of service must send properly and fully completed claim forms to us within 90 days of the date you receive the service or supply for which a claim is made. Services received and charges for the services must be itemized, and clearly and accurately described. If it is not reasonably possible to submit the claim within that time frame, an extension of up to 12 months will be allowed. We are not liable for the benefits of the *agreement* if you do not file claims within the required time period. Claim forms must be used; canceled checks or receipts are not acceptable.

**Payment to Providers.** We will pay the benefits of this *plan* directly to *contracting hospitals*, *participating providers*, *COE* and medical transportation providers. Also, we will pay *non-contracting hospitals* and other providers of service directly when you assign benefits in writing. If you are a MediCal beneficiary and you assign benefits in writing to the State Department of Health Services, we will pay the benefits of this *plan* to the State Department of Health Services. These payments will fulfill our obligation to you for those covered services.

**Right of Recovery.** When the amount we paid exceeds our liability under this *plan*, we have the right to recover the excess amount. This amount may be recovered from you, the person to whom payment was made or any other plan.

**Plan Administrator - COBRA.** United Administrative Services is the Plan Administrator and is contracted by San Jose Unified School District to provide claim payment services based on the plan design contained in this Summary Plan Description. The term "plan administrator" refers either to the group or to a person or entity other than San Jose Unified School District, engaged by the group to perform or assist in performing administrative tasks in connection with the group's health plan. The group is responsible for satisfaction of notice, disclosure and other obligations of administrators. In providing notices and otherwise performing under the CONTINUATION OF COVERAGE section of this booklet, the group is fulfilling statutory obligations imposed on it by federal law and, where applicable, acting as your agent.

**Workers' Compensation Insurance.** The *agreement* does not affect any requirement for coverage by workers' compensation insurance. It also does not replace that insurance.

**Prepayment Fees.** Your employer is responsible for paying subscription charges to the Administrator for all coverage provided to you and your family members. Your employer may require that you contribute all or part of the costs of these subscription charges. Please consult your employer for details.

**Renewal Provisions.** Your employer's health plan agreement with us is subject to renewal at certain intervals.

**Confidentiality and Release of Medical Information.** We will use reasonable efforts, and take the same care to preserve the confidentiality of the member's medical information. We may use data collected in the course of providing services hereunder for statistical evaluation and research. If such data is ever released to a third party, it shall be released only in aggregate statistical form without identifying the member.

Medical information may be released only with the written consent of the *member* or as required by law. It must be signed, dated and must specify the nature of the information and to which persons and organizations it may be disclosed. *Members* may access their own medical records.

We may release your medical information to professional peer review organizations and to the *group* for purposes of reporting claims experience or conducting an audit of our operations, provided the information disclosed is reasonably necessary for the *group* to conduct the review or audit.

A statement describing our policies and procedures for preserving the confidentiality of medical records is available and will be furnished to you upon request.

## **HIPAA PRIVACY RULE**

### **Notice of Privacy Practices for Personal Health Information**

This notice of Privacy Practices describes San Jose Unified School District Foundation Plan's practices for safeguarding personal health information. The terms of this Notice apply to members and their dependents with medical and prescription drug coverage. This notice is effective April 14, 2003.

We are required by law to maintain the privacy of our Members' and their Dependents' personal health information and to provide notice of our legal duties and privacy practices with respect to personal health information. We are required to abide by the terms of this Notice as long as it remains in effect. We reserve the right to change the terms of this Notice as necessary and to make the new Notice effective for all personal health information maintained by us. You have a right to request a copy of the Notice.

### **Uses and Disclosures of Your Personal Health Information**

**Authorization.** Except as explained below, we will not use or disclose your personal health information for any purpose unless you have signed a form authorizing a use or disclosure. Unless we have taken any action in reliance on the authorization, you have the right to revoke an authorization if the request for revocation is in writing and sent to: Privacy Officer, United Administrative Services, P.O. Box 5057, San Jose, CA 95150-5057.

**Disclosures for Treatment.** We may disclose your personal health information as necessary for your treatment. For instance, a doctor or health care facility involved in your care may request your personal health information in our possession to assist in your care.

**Uses and Disclosures for Payment.** We will use and disclose your personal health information as necessary for payment purposes. For instance, we may use your personal health information to process or pay claims, for subrogation, to perform a hospital admission review to determine whether services are for medically necessary care or to perform prospective reviews. We may also forward information to another health plan in order for it to process or pay claims on your behalf.

**Uses and Disclosures for Health Care Operations.** We will use and disclose your personal health information as necessary for health care operations. For instance, we may use or disclose your personal health information for quality assessment and quality improvement, credentialing health care providers, premium rating, conducting, or arranging for medical review or compliance. We may also disclose your personal health information to another health plan, health care facility or health care provider for activities such as quality assurance or case management. We may contact your health care providers concerning prescription drug treatment alternatives.

**Other Health-Related Uses and Disclosures.** We may also contact you to provide information about treatment alternatives; other health related programs, products or services that may be available to you.

**Business Associate.** Certain aspects and components of our services are performed by outside people or organizations pursuant to agreements or contracts. It may be necessary for us to disclose your personal health information to these people or organizations that perform services on our behalf. We require them to appropriately safeguard the privacy of your personal health information.

**Family, Friends and Personal Representatives.** With your approval, we may disclose to family members, friends or another person you identify, your personal health information relevant to their involvement with your care or paying for your care. If you are unavailable, incapacitated or involved in an emergency situation, and we determine that a limited disclosure is in your best interests, we may disclose your personal health information without your approval. We may also disclose your personal health information to public or private entities to assist in disaster relief efforts.

**Other Uses and Disclosures.** We are permitted or required by law to use or disclose your personal health information, without your authorization, in the following circumstances:

- For any purpose required by law;
- For public health activities (for example, reporting of disease, injury, birth, death or suspicion of child abuse or neglect);
- To a governmental authority if we believe an individual is a victim of abuse, neglect or domestic violence;
- For health oversight activities (for example, audits, inspections, licensure actions or civil, administrative or criminal proceedings or actions);
- For judicial or administrative proceedings (for example, pursuant to a court order, subpoena or discovery request);
- For law enforcement purposes (for example, reporting wounds or injuries or for identifying or locating suspects, witnesses or missing people);
- To coroners and funeral directors;
- For compliance with workers' compensation programs.

We adhere to all state and federal laws or regulations that provide additional privacy protections. We will only use or disclose AIDS/HIV – related information, genetic testing information and information pertaining to your mental condition or any substance abuse problems as permitted by state and federal law or regulation.

**Your Rights.** If you believe that your privacy rights have been violated, you may complain to the Plan in care of our Privacy Officer at United Administrative Services, P.O. Box 5057, San Jose, CA 95150-5057. There will be no retaliation for filing a complaint. You also may send a written complaint to the Secretary of the U.S. Department of Health and Human Services.

You have the right to request restrictions on how we use or disclose your personal health information for treatment, payment, or health care operations. You also have the right to request restrictions on disclosures to family members or others who are involved in your care of the paying of your care. To request a restriction, you must send a written request to our Privacy Office, listed above. You have the right to request communications regarding your personal health information from us by alternative means, or at alternate locations. We will accommodate reasonable requests.

**Disclosure of Protected Health Information (“PHI”) to the Plan Sponsor for Plan Administration Purposes**

In order that the *Plan Sponsor* may receive and use *PHI* for *Plan Administration* purposes, the *Plan Sponsor* agrees to:

- Notify *participants* of any *PHI* use or disclosure that is inconsistent with the uses or disclosures provided for of which the *Plan Sponsor*, or any *Business Associate* of the *Plan Sponsor* becomes aware, in accordance with the *health breach notification rule* (16 CFR Part 18);
- Notify the Federal Trade Commission of any *PHI* use or disclosure that is inconsistent with the uses or disclosures provided for of which the *Plan Sponsor*, or any *Business Associate* of the *Plan Sponsor* becomes aware, in accordance with the *health breach notification rule* (16 CFR Part 18);

**Disclosure of Electronic Protected Health Information (“Electronic PHI”) to the Plan Sponsor for Plan Administration Functions**

To enable the *Plan Sponsor* to receive and use *Electronic PHI* for *Plan Administration* functions (as defined in 45 CFR § 164.504(a)), the *Plan Sponsor* agrees to:

- Notify *participants* of any *PHI* Security Incident of which the *Plan Sponsor*, or any *Business Associate* of the *Plan Sponsor* becomes aware, in accordance with the *health breach notification rule* (16 CFR Part 18); and
- Notify the Federal Trade Commission of any *PHI* Security Incident of which the *Plan Sponsor*, or any *Business Associate* of the *Plan Sponsor* becomes aware, in accordance with the *health breach notification rule* (16 CFR Part 18).

## **FOUNDATION PLAN**

The Foundation allows the option of obtaining treatment from an Anthem Blue Cross Prudent Buyer Network Provider or a provider who does not participate in the Prudent Buyer Network. All claims, payments, and questions are handled by United Administrative Services (UAS), the claims administrator for the district.

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

You may access coverage under either level of coverage. The applicable deductibles and out-of-pocket amounts will be applied depending which provider you utilize.

You may obtain treatment from any Prudent Buyer Network participating doctor or hospital anywhere in California and receive the benefits of the Foundation Plan. To you, this means that these doctors and hospitals have agreed to accept the Prudent Buyer Network allowances as full payment for covered services. Refer to the Schedule of Benefits for deductible, co-payments and maximums.

This Master Agreement sets forth in detail your rights and obligations under the District Plan. In addition to the Hospital, Medical and Surgical benefits, this book describes your Hospital Preadmission Certification and Concurrent Review Requirements, Foundation Plan, Hospital Self-Check Plan and Personal Case Management Program.

## **HOW TO USE YOUR PROGRAM**

### **Always Show Your Identification Card**

Within 6 months after you have incurred expenses, the itemized charges and dates of service must be filed with United Administrative Services. (Refer to *How to Submit a Claim*)

### **Hospital, Medical-Surgical and Special Benefits**

Bills for services listed in this plan book should be sent to United Administrative Services. When you receive medical care, ask if the provider will bill for you. Usually hospitals will bill United Administrative Services, and most doctors and laboratories have the Health Insurance Claim Form for reporting their services.

For those providers who do not bill directly, you must use the Members Claim Form if you submit the bills yourself. Forms are available from all District Sites and Departments, Human Resources, and United Administrative Services.

The Member Claim Form is designed to give you faster, more efficient service, and to keep administrative costs as low as possible. The form must be used each time you submit a bill, and a separate form must be used for each member and each provider of service.

## **COVERAGE**

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

The plan pays an amount equal to the Prudent Buyer Network Allowance depending upon which provider is utilized for medical treatment received, subject to the deductible and co-payments. Refer to the Schedule of Benefits for deductible, co-payment and maximums. The deductible is reapplied once each calendar year per covered person. However, any expenses applied toward the deductible in the last 90 days of a calendar year will also be applied toward the deductible for the next calendar year.

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

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

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

## **CHOICE OF PROVIDERS**

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

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

Before using a new doctor or hospital, you should always inquire whether the provider is a Prudent Buyer Network member, or check the provider website at [www.bluecrossca.com](http://www.bluecrossca.com). A list of Prudent Buyer Network physicians and hospitals can be obtained from United Administrative Services at (408) 288-4400.

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

**AVOID PHYSICIAN OVER-CHARGES**

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

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

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

### **SUMMARY OF BENEFIT LEVELS**

**Level One:** The deductible and the out-of-pocket maximum is the lowest for this level of coverage. If you choose a Prudent Buyer Network provider to receive services, you will receive the highest level of benefits. The Prudent Buyer Network Providers offer a substantial discount, which provides the greatest benefits. The deductible is \$100 per individual or \$300 per family per calendar year and the plan pays 80% of the first \$5,000 of covered expenses per person and then 100% thereafter each calendar year. By using a Prudent Buyer Network Provider, you will only be responsible for a \$15 Office Visit Copay.

**Level Two:** This level allows you to seek medical coverage from any medical provider, but the benefits you will receive are considerably lower. Your out-of-pocket expense is considerably increased if you choose Level Two benefits. The deductible is \$200 per individual or \$600 per family per calendar year and the plan pays 60% of the Usual, Customary and Reasonable Rate for covered expenses for the remainder of the calendar year.

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

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

SAN JOSE UNIFIED SCHOOL DISTRICT FOUNDATION PLAN

		LEVEL ONE	LEVEL TWO
		ANTHEM BLUE CROSS PROVIDERS	OUT OF NETWORK
Deductible Individual		\$100	\$200
Deductible Family		\$300	\$600
Annual Out-of-Pocket Maximum		After deductible, plan pays 80% for first \$5,000 of covered expenses and 100% thereafter for each calendar year.	After deductible, plan pays 60%* of covered expenses for each calendar year.
Lifetime Maximum		\$1,500,000 per member	\$1,500,000 per member
		<b>BENEFITS FOR COVERED SERVICES</b>	<b>BENEFITS FOR COVERED SERVICES</b>
<b>Physician Services</b>			
Office visits		\$15	60% *
Hospital/Skilled Nursing visits		80%	60% *
Specialist Office Visits		\$15	60% *
Surgeon/Asst. Surgeon		80%	60% *
Anesthesiologist		80%	60% *
Diagnostic X-ray & Labs		80%	60% *
<b>Hospital/Surgical Services</b>			
Inpatient		80%	60% *
Outpatient		80%	60% *
<b>Emergency Services</b>			
Ambulance		80%	60% *
Emergency Room		80% after \$75 copay, waived if life threatening or admitted	60% * after \$75 copay, waived if life threatening or admitted
<b>Maternity Services</b>			
Hospital Benefits – Delivery		80%	60% *
Outpatient Physician Services		\$15	60% *
Surgical Services		80%	60% *
<b>Prescription Drugs</b>			
Generic or Brand		80%	80%
<b>Mail Order</b>			
Generic		\$10 copay, 90 day supply	\$10 copay, 90 day supply
Brand		\$20 copay, 90 day supply	\$20 copay, 90 day supply
<b>Chiropractic Services</b>			
		\$15	60% *
<b>Continued Care Services</b>			
Skilled Nursing Facility		80%	60% *
		Following discharge from an acute care facility, plan pays 80%.	Following discharge from an acute care facility, plan pays 60% *.
<b>Physical Therapy</b>			
		80%	60% *
<b>Speech Therapy</b>			
		80%	60% *

\* If an Anthem Blue Cross Prudent Buyer Network provider is not available in the area where treatment is received, the plan will pay 80% of the covered expense amount.

### **\$15 OFFICE VISIT COPAY**

You will be responsible to pay \$15 for each office visit. Previously, you were responsible to pay 20% of the office visit charge. A \$15 Office Visit Copay would apply to all covered services, billed as an office visit, provided in an office by a San Jose Unified Prudent Buyer Network Physician. Any ancillary covered charges (ie: Lab, X-ray, Diagnostic Testing) would continue to be subject to the deductible and coinsurance percentage.

There are no changes in covered benefits. For example, cosmetic procedures performed in an office are currently not covered. Charges for a visit for cosmetic procedures would not be subject to the \$15 Copay, they would remain the patient's responsibility in full.

#### Frequently Asked Questions

**1. Does the \$15 Copay apply to all physicians?**

The \$15 Copay applies to all San Jose Unified Prudent Buyer Network physicians. This includes Family Practice, Internal Medicine, Pediatricians, and specialists like Dermatologists, Cardiologists, Urologists, Oncologists, etc.

**2. Do I pay the 20% coinsurance in addition to the \$15 Copay?**

No, once you have paid your \$15 Copay for your office visit, the remainder of the charges for a network physician are covered at 100%.

**3. Will I only pay \$15 if I go to a non-network physician?**

No, if you seek services from a non-network physician, your visit will be covered at the 60% level. The out-of-network benefit has not changed.

**4. Will the \$15 Copay apply to services currently not covered by the Plan?**

No, the \$15 Copay will not cover services that are currently excluded under the plan.

**5. What do I need to do when I go to the Doctor's office?**

When you visit a network physician, you need to inform them that you have a \$15 Office Visit Copay. The remainder of the charges will be billed to the San Jose Unified Foundation Plan by the Doctor's office. If the Doctor's office has any questions about your benefits, they can call the Foundation Plan at 408-288-4440.

**6. What paperwork do I need to complete because of the \$15 Copay?**

There is no additional paperwork for you to complete if you visit a network physician. They will bill the San Jose Unified Foundation Plan directly for any charges above the \$15 Copay.

**7. Will the Copay apply to my deductible?**

No, the \$15 Copay will not apply to your deductible.

**8. What will apply to my deductible?**

Any charges that are not incurred as part of an office visit will apply to your deductible. Some examples of these charges are: lab work, x-rays, hospitalization, and skilled nursing facility charges.

**HOW TO SUBMIT A CLAIM**

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

1. Obtain a claim form from your District Site or Department, Human Resources, or United Administrative Services.
2. Answer every question on your part of the claim form. **BE SURE TO SIGN YOUR NAME.**
3. Have your doctor complete the reverse side of the claim form, or
  - a. Submit an itemized statement that shows the name of the patient and physician and indicates a diagnosis, either written or with an International Classification of Disease Code.
  - b. The physician may want to submit his/her form, which is perfectly acceptable. Many participating Prudent Buyer Network doctors will bill United Administrative Services directly. By law, they must bill Medicare for retirees.
4. Attach all other medical bills to the claim form (or a sheet of paper showing your name, social security number and SJUSD Foundation Medical Plan) and mail them separately to United Administrative Services. Usually only one doctor will have to complete a claim for each illness. The anesthesiologist, assistant surgeon and or consulting doctor do not need to complete a claim form; just send their itemized bills.

5. Be sure that your medical bills are itemized for each type of expense and that dates of all doctors visits are shown.
6. If claims are filed for more than one person, the bills must indicate the expenses for each person and a separate form must be filed for each person (per calendar year).
7. All participating hospitals will bill United Administrative Services (UAS) directly. For retirees, they also will bill Medicare directly.
8. For retirees with Medicare (over age 65):
  - a. Obtain a copy of your bill from your doctor at the time of your visit. The doctor's office will bill Medicare for you.
  - b. Wait for your copy of the Medicare payment for that doctor's visit.
  - c. When you receive the Medicare statement, attach the original copy of doctor's bill and claim form (or a sheet of paper showing your name, social security number and SJUSD Foundation Medical Plan), and mail to United Administrative Services.
  - d. Most Prudent Buyer Network doctors will bill United Administrative Services for you.
9. **The EOB form from UAS for each service will tell you how much you should pay (employee responsibility) for that service to your doctor.**
10. In order to receive payment for out-of-state or out-of-the-country medical services, just follow the procedure listed under #3 and #4. In case of emergency outpatient hospital services, please submit an itemized billing with a copy of the emergency room report. Itemized bills must be in English and converted to U.S. Dollars.
11. For verification of coverage always carry your District ID card.
12. Written proof of claim satisfactory to the plan must be submitted within 6 months after the date of the event for which the claim is made. If proof of claim is not sent within the time required, the claim will not be reduced or denied if it was not possible to send proof within this time. However, the proof must be sent as soon as reasonably possible. In any case, the proof required must be sent to the plan no later than one year following the 6 month period specified, unless the Insured Person was legally incapacitated.

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

## **CLAIMS PROCEDURES**

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

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

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

## **CLAIMS REVIEW PROCEDURE**

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

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

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

There are four (4) categories of Claims, each with somewhat different claim and appeal rules based on the type of Claim involved. The primary difference is the timeframe within which Claims and appeals must be determined. It is very important to follow the requirements that

apply to your particular type of Claim. If you have any questions regarding what type of Claim and/or what Claims Procedure to follow, contact your Claims Administrator.

The definitions of the types of Claims are:

**Pre-Service Claim**

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

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

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

**Urgent Care Claim**

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

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

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

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

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

**Post-Service Claim**

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

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

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

**Concurrent Care Claim**

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

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

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

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

**Notice to claimant of adverse benefit determinations**

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

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

**Appeals**

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

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

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

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

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

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

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

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

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

The review shall take into account all comments, documents, records, and other information submitted by the Claimant relating to the Claim, without regard to whether such information was submitted or considered in the initial benefit determination. The review will not afford deference to the initial adverse benefit determination and will be conducted by a fiduciary of the Plan who is neither the individual who made the adverse determination nor a subordinate of that individual.

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

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

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

#### **Voluntary appeals through arbitration**

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

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

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

The Plan will provide to the Claimant, at no cost and upon request, sufficient information about arbitration to enable the claimant to make an informed judgment about whether to submit a benefit dispute to arbitration. This information will include a statement that the decision will have no effect on the Claimant's rights to any other benefits under the Plan; will list the rules of the appeal; state the Claimant's right to representation; enumerate the process for selecting the

decision maker; and give circumstances, if any, that may affect the impartiality of the decision maker.

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

Arbitration is not mandatory.

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

**DEFINITIONS**

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

of them have a separate place somewhere else. Even if one of them leaves the place they share, they still live together as long as the one who left intends to return.

\*\* **Basic living expenses** means the cost of basic food and shelter. It also includes any other expense which is paid by a benefit that the employee or domestic partner gets because of the partnership. For example, if the employee or domestic partner gets health insurance from their job and the insurance covers the partner they will be responsible for medical bills which the insurance does not pay. The employee and domestic partner don't have to split basic living expenses to be domestic partners; they just have to agree to provide these things for their partner if he or she can't provide for him or herself.

7. A **Family Member** is the employee's enrolled spouse or domestic partner and each enrolled eligible child.
8. A **Member** is the employee or family member.
9. The **Agreement Date** is the date this plan comes into effect.
10. The **Effective Date** is the date the member's coverage under this plan begins.
11. An **Open Enrollment Period** is held each school year from May 1<sup>st</sup> to June 1<sup>st</sup> for an effective date of July 1<sup>st</sup> for employees who wish to enroll, change medical plans, or modify dependent coverage.
12. **Medically Necessary** services or supplies are those which meet all of the following criteria, as determined by the plan administrator:
  - A. Appropriate and necessary for the symptoms and diagnosis or treatment of a medical condition covered by the plan, and
  - B. Provided for the diagnosis or direct care and treatment of the medical condition, and
  - C. Within standard of good medical practice within the organized medical community, and
  - D. Not primarily for the convenience of the member, the member's physician or another provider, and
  - E. The most cost effective, adequate and safe level of service or supplies which can appropriately be provided. For hospital stays, this means that acute care as a bed patient is needed due to the kind of services the member is receiving or the severity of the member's condition, and that safe and adequate care cannot be received as an outpatient or in less intensified medical setting.

13. A **Hospital** is a facility which provides diagnosis, treatment and care of persons who need acute care inpatient hospital care under the supervision of physicians. It must be licensed as a general acute care hospital according to state and local laws. It must also be registered as a general hospital by the American Hospital Association and meet accreditation standards of the Joint Commission on Accreditation of Hospitals.
14. An **Outpatient Surgical Center** is a facility other than a medical or dental office, whose main function is performing surgical procedures on an outpatient basis. It must be licensed as a general acute care hospital according to state and local laws. It must also be registered as a general hospital by the American Hospital Association and meet accreditation standards of the Joint Commission on Accreditation of Hospitals.
15. A **Skilled Nursing Facility** is an institution that provides continuous skilled nursing services. It must be licensed according to state and local laws and be recognized as a skilled nursing facility under Medicare.
16. **Home Health Agencies and Visiting Nurse Associations** are home health care providers which are licensed according to state and local laws to provide skilled nursing and other services on a visiting basis in the member's home. They must be recognized as home care providers under Medicare.
17. A **Physician or Surgeon** means:
  - A. A doctor of medicine (M.D.) or a doctor of osteopathy (D.O.) who is licensed to practice medicine or osteopathy where the care is provided, or
  - B. One of the following providers, but only when the provider is licensed to practice where the care is provided, is rendering a service within the scope of that license, is providing a service for which benefits are specified in this agreement, and when benefits would be payable if the services were provided by a physician as defined in A. above:
    1. A dentist (D.D.S.)
    2. A podiatrist or chiropodist (D.P.M., D.S.P. or D.S.C.)
    3. A certified acupuncturist (C.A.)\*
    4. A chiropractor (D.C.)
    5. A physical therapist (P.T. or R.P.T)\*
    6. A speech pathologist\*
    7. An audiologist

8. An occupational therapist (O.T.R.)\*
9. An optometrist (O.D.)
10. A dispensing optician
11. A psychologist
12. A clinical social worker (C.S.W. or L.C.S.W.)\*
13. A marriage, family and child counselor (M.F.C.C.)\*

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

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

18. A **Year** is a twelve month period starting each January 1 at 12:01 a.m. Pacific Standard Time.
19. **Custodial Care** is care provided primarily to meet the personal needs of the member. This includes help in walking, bathing or dressing. It also includes preparing food or special diets, feeding, administration of medicine which is usually self-administered or any other care which does not require continuing services of medical personnel.
20. **Special Care Units** are special areas of a hospital which have highly skilled personnel and special equipment for acute conditions that require constant treatment and observation.
21. **Experimental Procedures** are all procedures not generally provided as treatment by the organized medical community in California, and those that are mainly limited to laboratory and/or animal research.
22. **Investigative Procedures** are experimental procedures that have progressed to limited use on humans, but which are not widely accepted as proven and effective procedures within the organized medical community in California.
23. **Mental or Nervous Disorders** are any mental disease or disorder, whether the cause is organic, physical, mental or environmental, or any combination thereof, or whether the symptoms are physical, mental or a combination thereof.

Any condition meeting this definition is included in it regardless of whether it produces only emotional symptoms or only physical symptoms such as headaches, sweats, trembling,

nausea, or hysterical paralysis, or a combination of both. Plan limitations or exclusions of treatment of mental disease or disorder apply to the treatment of all conditions meeting this definition.

Examples of mental diseases or disorders include (but are not limited to) those which fall within the diagnosis Code 290 through 290.9 or 293 through 301.9 or 306 through 316 as listed in the "International Classification of Diseases," 9th Revision, Clinical Modification, Volumes 1 and 2, such as: schizophrenia, manic depression, and other conditions usually classified in the medical community as psychosis, depressive, phobic, manic and anxiety conditions (including panic disorders); bipolar affective disorders including mania and depression; obsessive compulsive disorders; autism; hypochondria; personality disorders (including paranoid, schizoid, dependent, antisocial and borderline); dementia and delirious states; post traumatic stress disorder; cumulative trauma syndrome; organic brain syndrome; hyperkinetic syndromes (including attention deficit disorders); adjustment reactions; reactions to stress; anorexia nervosa and bulimia.

**Severe mental disorders** include the following psychiatric diagnoses specified in California Health and Safety Code section 1374.72: schizophrenia, schizoaffective disorder, bipolar disorder, major depression, panic disorder, obsessive-compulsive disorder, pervasive developmental disorder or autism, anorexia, and bulimia.

"Severe mental disorders" also includes serious emotional disturbances of a child as indicated by the presence of one or more mental disorders as identified in the Diagnostic and Statistical Manual (DSM) of Mental Disorders, other than primary substance abuse or developmental disorder, resulting in behavior inappropriate to the *child's* age according to expected developmental norms. The child must also meet one or more of the following criteria:

1. As a result of the mental disorder, the child has substantial impairment in at least two of the following areas: self-care, school functioning, family relationships, or ability to function in the community and is at risk of being removed from the home or has already been removed from the home or the mental disorder has been present for more than six months or is likely to continue for more than one year without treatment.
  2. The child is psychotic, suicidal, or potentially violent.
  3. The child meets special education eligibility requirements under California law (Government Code Section 7570).
24. **Accidental Injury** is physical harm or disability which is the result of a specific unexpected incident caused by an outside force. The physical harm or disability must have occurred at an identifiable time and place. Accidental injury does not include illness or infection, except infection of a cut or wound.

25. A **Totally Disabled Member** is one who, because of illness or injury, is unable to work for income in any job for which he or she is qualified or for which he or she becomes qualified by training or experience, and who is in fact unemployed. A totally disabled family member is one who is unable to perform all activities usual for a person of that age.
26. **Administrator** is United Administrative Services.
27. **District** is the San Jose Unified School District.
28. **Plan** is the San Jose Unified School District Foundation Plan.
29. A **Retiree**:
  - A. Must have completed ten (10) full-time years during which time a District contribution has been made to a group plan;
  - B. Must have continuous (no breaks) service (exceptions are such conditions as medical leave and layoff) for the last ten (10) years **or** have been employed by SJUSD 20 or more years; and
  - C. Must be retiring from active service (service retirement).
  - D. The Human Resources office will make final eligibility approval.
  - E. Retirees have the same option as regular employees during the Open Enrollment period with the exception of enrollment.
30. **Coinsurance Amount** is the percentage amount payable by this plan, constituting benefits for covered expenses.
31. **Hospice** means an agency licensed or certified by the state in which it is located to provide hospice care.
32. **Hospice Care** means medically necessary and/or palliative treatment administered to a terminally ill person. Such treatment may include short-term care as an inpatient in a hospice unit or care in the person's home. All services must be planned, implemented and evaluated by an interdisciplinary team of trained volunteers and professionals, including at least a physician, registered nurse, clergy/counselors and other staff who have expertise in providing hospice care.
33. **Well Baby Care** is routine examinations and immunizations for eligible dependent children from birth to age two.
34. **Medical Emergency** is defined as medical services that are immediately required to treat a sudden, serious or unexpected illness or injury, or to provide medical services to alleviate

severe pain associated with a sudden, serious or unexpected illness or injury. Examples of medical emergencies are; uncontrollable bleeding; loss of consciousness or confusion, especially after a head injury; severe shortness of breath or difficulty breathing; apparent heart attack symptoms; and broken bones.

35. **Usual, Customary and Reasonable Charge** payments are based on the services received, specialty and geographical area of service.

### **COVERED EXPENSES**

The benefits described below are provided for covered services received for treatment of a covered illness, injury or condition. These benefits are subject to all provisions of this Agreement, which may limit benefits or result in benefits not being payable.

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

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

- a. Oxygen and carbon dioxide, including equipment and administration thereof.
- b. Intravenous injection and solutions, such as glucose and serum.
- c. Prescription drugs and biologicals.
- d. Whole blood and blood derivatives, and administration and processing of same by the hospital, but not including blood procurement charges or charges for maintenance of a blood bank.
- e. Dressings, splints, and casts, but not including special braces.
- f. Diagnostic services; the following procedures to diagnose a condition, in response to specific symptoms, ordered or performed by a physician or other Licensed Health Care Professional licensed to render the services:
  - (1) Radiology, ultrasound and nuclear medicine services.
  - (2) Laboratory and pathology services.

- (3) Electrocardiogram, electroencephalogram, ultrasound and other diagnostic procedures.
- g. Anesthesia, including continuous epidural anesthesia when used for control of chronic, intractable pain due to terminal cancer or when used for control of acute post-operative pain following select procedures.  
Anesthesia services are not available in connection with care which is not a Benefit.
- 3. Outpatient hospital: surgical procedure, accidental injuries and medical emergencies (shock, acute poisoning, hemorrhaging, etc.) Emergency room treatment that is not considered a medical emergency will require a \$50.00 co-payment that is in addition to the annual plan deductible. The deductible will be waived if the treatment is considered a medical emergency.
- 4. Ambulatory Surgical Center.
- 5. Radiation therapy, chemotherapy and hemodialysis treatment.
- 6. Skilled Nursing Facility or Rehabilitation Facility Treatment:
  - a. For confinement in skilled nursing or rehabilitation facility which immediately follows at least three days of hospital confinement. Includes ambulance service for transfer from hospital. Charges of a hospital for services and supplies rendered during confinement except that charges for room and board shall not exceed the hospital's semi-private room rate.
  - b. The services must be consistent with the illness, injury, degree of disability and medical needs of the patient. Benefits are only provided for the number of days required to treat the member's illness or injury. Services must be those which are regularly provided and billed by a Skilled Nursing Facility.
  - c. The patient must remain under the active medical supervision of a Physician. The Physician must be treating the illness or injury for which the patient is confined in the Skilled Nursing Facility.
- 7. Surgeon's Charges by a Physician for the performance of surgical procedures.
- 8. Anesthesia Charges and its administration when these are not covered as Hospital charges.
- 9. Physician's Charges for medical care and treatment including;
  - a. emergency room visits at hospital or clinics.

- b. inpatient hospital visits during a covered inpatient stay (except those relating to surgery), limited to one a day unless additional visits are needed due to the member's medical condition.
- c. extra time spent when the physician is detained to treat a member in critical condition who requires constant care.
- d. services of a physician at his/her office or in your home for treatment of illness or disease.
- e. Consultations requested by the attending Physician for a covered illness, injury or condition. This includes one psychiatric consultation during each illness to determine whether that illness is functional or organic.

10. Preventive Care Benefits:

The Plan will pay for 100% of charges by an Anthem Blue Cross Prudent Buyer Network Provider (no deductible applies) for routine check-ups, limited to one physical exam for Eligible Persons in a calendar year. Not more than \$300 will be paid in preventive care benefits for each person in a calendar year.

Preventive care and diagnostic procedures are covered at a Physician's direction as follows:

- Office visits for the evaluation of medical problems (subject to a \$15 copay)
- Laboratory tests and x-rays
- Immunizations for general use for both adults and children. For participants over age 18, the Plan covers only those immunizations recommended by the American Academy of Family Physicians. Immunizations for hepatitis B are covered only for your eligible dependent children under age 19. Covered expenses do not include immunizations for the sole purpose of travel, occupation, or residence in a foreign country.
- Sigmoidoscopy: Once every three Calendar Years for men and women age 45 and above
- Screening and Diagnosis of Prostate Cancer: Tests and procedures for the screening and diagnosis of prostate cancer, including but not limited to, prostate-specific antigen testing when Medically Necessary and consistent with good professional practice.

11. Nursing, Physiotherapy, and Occupational Therapy Charges for:

- a. private duty nursing care by an R.N. or L.P.N.;
- b. treatment by a licensed physiotherapist; and
- c. treatment by a licensed occupational therapist.

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

12. Radiological and Laboratory Charges for diagnostic purposes and preventive screening tests that the physician determines to be medically necessary based on family medical history:
  - a. x-rays;
  - b. radiological treatment;
  - c. diagnostic laboratory tests;
  - d. low-dose mammography screening;
  - e. an annual cervical cancer screening test (pap smear); and
  - f. endoscopy and arthroscopy.
13. Charges for routine mammographic examinations as diagnostic screening procedures, as specified;
  - a. A baseline mammogram for covered females ages 35 to 39;
  - b. For covered females age 40 to 49 a mammogram each 2 years unless recommended more frequently by her attending physician; and
  - c. For covered females age 50 and over a mammogram annually.
14. Cosmetic Surgery and related charges is covered only:
  - a. within 12 months after and as a result of an injury sustained while insured under this plan;
  - b. for replacement of diseased tissue surgically removed while insured under this plan;
  - c. for the initial reconstruction of a breast after a mastectomy for which the patient was insured under this plan for the mastectomy; and
  - d. repair of bodily damage covered by disease and/or radiation treatment while insured under this plan.
15. Women's Health and Cancer Rights Act of 1998

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

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

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

16. Ambulance and Air Ambulance are allowed at the prevailing reasonable and customary charges and subject to the following:

- a. Professional ambulance service when used to transport the insured person directly from the place where he/she is injured or becomes ill to the hospital(s) where treatment is given. Upon reaching the Hospital, the member must be admitted as an inpatient or receive emergency outpatient care as stated above.
- b. Professional ambulance service when also used to transport insured member from general hospital or emergency room to hospitals of specialty treatment, or to home hospital area.
- c. Transportation by air ambulance from one hospital to another will be allowed when certified by the attending physician as being medically necessary by reason of the severity of the insured person's condition. This also includes transportation to the United States from a foreign country.
- d. Services must be provided by an air ambulance, a licensed ambulance company, by professional non-air ambulance or on a regularly scheduled flight on a commercial airline when:
  - (1) special and unique Covered Hospital Services are required which are not provided by a local Hospital;
  - (2) transportation is medically necessary as deemed by the Administrator; and
  - (3) transportation is to the nearest Hospital equipped to furnish the services.
- e. Base charge, mileage and non-reusable supplies of a licensed ambulance or ambulance company.
- f. Monitoring, electrocardiograms (EKG'S or ECG'S), cardiac defibrillation, cardio-pulmonary resuscitation (CPR) and administration of oxygen and intravenous (IV) solutions in connection with ambulance service. An appropriately licensed person must render the services.

17. Home Health Care by approved home health care agency as recommended by physicians; does not include custodial care. Pays for covered charges for one visit a day from any of the following (up to a combined total of 60 visits in a 12 month period): registered nurse; medical social worker; occupational, speech and physical therapists; and health aide. Does not provide for housekeeping services, hemodialysis, or maintenance therapy.
18. Physical therapy. This must be given by a qualified therapist.
19. Injections and allergy testing and treatments.
20. Dental treatment necessitated by accidental bodily injuries occurring while the covered person is insured hereunder and within 6 months of the date of injury.
21. Pregnancy and Maternity Care

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

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

22. Organ and Tissue Transplants

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

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

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

Services in connection with a non-investigative organ or tissue transplant for:

- a. An enrolled member who receives the organ or tissue, and
- b. An enrolled member who donated the organ or tissue, and
- c. An organ or tissue donor who is not an enrolled member, if the organ or tissue recipient is an enrolled member. Benefits are reduced by any amounts paid or payable by that donor's own coverage.

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

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

- a. affixed to the body externally;
- b. required to replace all or any part of any limb or eye;
- c. required to support or correct a defect or form or function of a permanently inoperative or malfunctioning limb or eye.

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

The first pair of contact lenses and the first pair of eyeglasses when required as a result of eye surgery.

24. Charges for casts, splints, trusses, crutches and braces (except dental braces);
25. Rental or purchase of dialysis equipment, dialysis supplies and rental or purchase of other medical equipment and supplies which are:
- a. ordered by a physician;
  - b. of no further use when medical need ends;
  - c. usable only by the patient;
  - d. not primarily for the Member's comfort or hygiene;
  - e. not for environmental control;
  - f. not for exercise;
  - g. manufactured specifically for medical use;
  - h. approved as effective and usual and customary treatment of a condition as determined by the Plan; and
  - i. not for prevention purposes.

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

26. Prescription Drugs: Please refer to the end of this section titled Foundation Prescription Coverage (FRX).
27. Charges for blood and blood plasma, except when replaced.
28. Charges for acupuncture treatment by an acupuncturist.
29. Charges for Podiatric treatment (except shoe lifts and arch supports).
30. Chiropractic Care except for vitamin supplements, lumbar supports, pillows, massage therapy, or maintenance therapy. Progress report required after 20th visit.
31. Routine physical exams are included as a benefit only for eligible dependent children from birth to age two, which includes well baby care.
32. Charges for oxygen and rental of equipment for the giving of oxygen.
33. **Additional Accident Benefit**  
Pays up to \$500 each accident for hospital and medical-surgical expenses incurred within 90 days of the accident and in excess of other benefits described above.

**Accident Provision**

If more than one covered family member is injured in the same accident only one family member need satisfy the deductible.

34. **Personal Case Management** is conducted by a designated medical consultant who:
  - a. Identifies cases involving participants in a clinical situation, with the potential for catastrophic claims;
  - b. Assesses such cases for the appropriateness of the level of patient care and the setting in which it is received;
  - c. Develops, introduces and implements viable Alternate Treatment Plans for such cases, that maintain or enhance the quality of patient care; and
  - d. Provides cost controls through implementation of the agreed upon Alternate Treatment Plan.
35. **Hospital “Self-Check” Benefits**  
“Self-Check” is a program that involves you in helping to contain costs for both you and the District Self Funded Medical Plan. “Self-Check” involves you by checking to make sure that the bills for hospital services are for the supplies and services actually received. When errors exist and you correct them, you share in the money saved.

You must review the Explanation of Benefits you receive from United Administrative Services. Also obtain a copy of the hospital-itemized bill upon discharge and check it for accuracy.

If you find a discrepancy you should advise the hospital. When the hospital refunds United Administrative Services you will receive 50% of the savings provided the total amount saved is at least \$200.00.

### **EXCLUSIONS AND LIMITATIONS**

Benefits are NOT provided for the following:

1. Care which is not medically necessary, care which is experimental care, investigational care or obsolete care, and inpatient care which is not consistent with the diagnosis and treatment of the condition requiring hospitalization, in each case as determined by the Claims Administrator. The Claims Administrator will have the sole discretion to determine whether care is medically necessary, experimental care, investigational care, obsolete care, or inpatient care which is not consistent with the diagnosis and treatment of the condition requiring hospitalization. The fact that care has been recommended, provided, prescribed, or approved by a Physician or other provider shall not establish that care is medically necessary, is neither experimental care, investigational care nor obsolete care, or is consistent with the diagnosis or treatment of the condition requiring hospitalization.
2. Services received before the Member's Effective Date or during an inpatient stay that began before the Member's Effective Date. Services received after the Member's coverage ends except as specifically stated under Extension of Benefits.
3. Care received by the participant prior to his or her return to active employment if the participant was not actively at work due to illness or injury on his or her enrollment date. Also, care received by an enrolled dependent who was an inpatient on his or her enrollment date, until the day after the dependent is discharged from the hospital.
4. Care which is not prescribed, performed or directed by a Physician or other licensed health care professional licensed to perform, direct or prescribe the care.
5. Care which the provider cannot legally provide or for which he cannot legally bill.
6. Care provided and billed by a licensed health care professional who is in training.
7. Any amounts in excess of the Usual, Customary and Reasonable Rate for professional services of non-Prudent Buyer Network providers except for dual coverage.
8. Services not specifically listed in this Agreement as covered services.

9. Care for complications arising out of or from care which is not a benefit, care for conditions for which no benefits are available, and care for complications of conditions for which no benefits are available.
10. Services for which the Member is not legally obligated to pay. Services for which no charge is made to the Member. Services for which no charge is made to the Member in the absence of insurance coverage, except services received at a non-governmental charitable research Hospital. Such a Hospital must meet the following guidelines:
  - a. It must be internationally known as being devoted mainly to medical research;
  - b. At least ten percent of its yearly annual expenditure must be spent on research not directly related to patient care;
  - c. At least one-third of its gross income must come from donations or grants other than gifts or payments for patient care;
  - d. It must accept patients who are unable to pay; and
  - e. Two-thirds of its patients must have conditions directly related to the Hospital's research.
11. Telephone consultations, charges for failure to keep a scheduled visit, charges for completion of a claim form and late payment charges.
12. Work-related conditions if benefits are recovered or can be recovered, either by adjudication, settlement or otherwise, under any workers' compensation, employer's liability law or occupational disease law, even if the Member does not claim those benefits.
13. Care for any condition suffered as a result of any act of war or while on active or reserve military duty. Conditions caused by release of nuclear energy, whether or not the result of war.
14. Charges resulting from commission of a crime or self-inflicted wounds.
15. Any service provided by a local, state or federal government agency.
16. Care available in whole or part under the laws of the United States or any state or political subdivision thereof, unless the participant would legally be required to pay the charge for such care in the absence of this Plan Document or any policy or plan of another company. This exclusion applies to the extent that benefits are provided or would have been provided had the participant enrolled for, applied for, or maintained eligibility for such benefits under any such law.

17. Any services to the extent that the Member is entitled to receive Medicare benefits for those services, whether or not Medicare benefits are actually paid. Any services for which payment may be obtained from any other local, state or federal government agency (except Medi-Cal).
18. Professional services received from a person who lives in the Member's home or who is related to the Member by blood or marriage.
19. Inpatient room and board charges in connection with a hospital stay primarily for environmental change, physical therapy or treatment of chronic pain. Custodial care or rest cures. Services provided by a rest home, a home for the aged, a nursing home or any similar facility. Services provided by a Skilled Nursing Facility, except as specifically stated in Skilled Nursing Facility under Covered Expenses.
20. Custodial care, domiciliary care or rest cures; care rendered and billed for by a hotel, health resort, convalescent home, rest home, nursing home or other extended care facility, home for the aged, infirmary, school infirmary, institution providing education in special environments, or any similar facility or institution. The Claims Administrator will have the sole discretion to determine whether care is custodial care, domiciliary care, a rest cure, or otherwise excluded.

The fact that care has been recommended, provided, prescribed or approved by a Physician or other provider shall not establish that the care is a benefit.

21. Travel, whether or not recommended or prescribed by a physician or other licensed health care professional.
22. Inpatient room and board charges in connection with a hospital stay primarily for diagnostic tests or therapy which could have been performed safely on an outpatient basis.
23. Treatment for hyperkinetic syndromes, learning disabilities, or behavioral problems.
24. Growth hormone therapy for (1) the treatment of Turner's syndrome, and, (2) other conditions characterized by short stature, unless there is unequivocal evidence of pituitary gland failure as determined by the Claims Administrator.
25. Braces, other orthodontic appliances or orthodontic services.
26. Charges for the procurement of blood or blood plasma, and blood donor expenses.
27. Dental plates, bridges, crowns, caps or other dental prostheses (prosthodontics), oral orthotics, palatal expanders, dental services, extraction of teeth, or treatment to the teeth or gums, except as specifically stated under Covered Expenses. Cosmetic dental surgery or other services for beautification.

28. Hospital care when dental services (as distinguished from oral surgery) are rendered, except when a concurrent hazardous condition exists or covered oral Surgery services are concurrently required as a result of bodily injury.
29. Hearing aids or examinations for the prescription or fitting of hearing aids.
30. Optometric services, eye exercises including orthoptics, routine eye exams and routine eye refractions. Eyeglasses or contact lenses, except as specifically stated under Covered Expenses.
31. Outpatient occupational therapy, except following surgery, injury, or non-congenital organic disease.
32. Outpatient speech therapy, except following surgery, injury or non-congenital organic disease.
33. Hypnosis and continuous epidural anesthesia when used for control of chronic pain (except that associated with terminal cancer) or for control of acute post-operative pain (except when used following certain select procedures, as determined by the Claims Administrator). Anesthesia services are not allowed in connection with care which is not a Benefit.
34. Charges in connection with Cosmetic Surgery are covered only if:
  - a. within 12 months after and as the result of an injury sustained while insured under this plan;
  - b. for replacement of diseased tissue surgically removed while insured under the plan;
  - c. repair of bodily damage covered by disease and/or radiation treatment while insured under this plan;
  - d. functional congenital anomalies; or
  - e. nonfunctional congenital anomalies while the participant is less than 12 years of age or after said age if medical necessity for delaying the procedure is clearly established.
35. Cosmetic surgery or other services to the member for beautification.
36. Services primarily for weight reduction or treatment of obesity. This exclusion will not apply to surgical treatment of obesity if:
  - a. surgical treatment of obesity is necessary to treat another life-threatening condition involving obesity; and

- b. it has been documented that non-surgical treatments of obesity have failed.
- 37. Wigs, hairpieces and hair implants, for any reason.
- 38. Procedures or treatments to change characteristics of the body to those of the opposite sex.
- 39. Surgery for psychological or emotional reasons.
- 40. Care for sexual dysfunction unrelated to organic disease.
- 41. Sterilization reversal, treatment of infertility, artificial insemination and in vitro fertilization, including implantation of fertilized egg embryo or gamete transfer procedures and related care.
- 42. Personal and other drugs used for the induction of ovulation; ultrasound monitoring for the evaluation or treatment of infertility.
- 43. Birth control treatment unless related to a medical condition.
- 44. Coverage for foot care is limited to coverage for: consultations/office visits for podiatric diagnosis physical therapy when appropriate for treatment of arthritis and other rheumatologic problems, sprains and strains. Orthotics covered when arthritis, rheumatologic, neuropathic and entrapment related foot problems are present.
- 45. Orthopedic shoes (except when joined to braces) or shoe inserts, air purifiers, air conditioners, humidifiers, exercise equipment and supplies for comfort, hygiene or beautification. Educational services, nutritional counseling or food supplements. Telephone consultations.
- 46. Special braces.
- 47. Any eye surgery solely for the purpose of correcting refractive defects of the eye such as near sightedness (myopia) and astigmatism.
- 48. Medical or surgical termination of an intact, intrauterine pregnancy prior to viability.
- 49. Hysterectomy to terminate pregnancy.
- 50. Expenses incurred for or related to elective abortions.
- 51. Under the Newborns' and Mothers' Health Protection Act of 1996, group health plans and health insurance issuers generally may not restrict benefits for any *hospital* length of stay in connection with childbirth for the mother or newborn *child* to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting

with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a *provider* obtain authorization from the *Plan* or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). In no event will an “attending provider” include a plan, hospital, managed care organization, or other issuer.

Benefits are payable in the same manner as for medical or *surgical* care of an *illness*, shown in the “Schedule of Benefits” and this section, and subject to the same maximums.

52. Ultrasound tests are limited to one during each normal pregnancy.
53. Amniocentesis, except in connection with activity related to the survival of the fetus and for patients age 35 and older.
54. Insertion of Laminaria, except to initiate labor care of intrauterine death of the fetus.
55. Care in a self-care unit, apartment or similar facility operated by or connected with a hospital.
56. Physical fitness equipment, hot tubs, heated spas, pools, or memberships to health clubs.
57. Air conditioners, furnaces, humidifiers, electronic air filters, and similar equipment.
58. Heating pads, hot water bottles, ice packs and personal hygiene and convenience items such as but not limited to, devices and equipment used for environmental control or to enhance the environmental setting.
59. Organ transplants considered experimental or investigational.
60. Music therapy, remedial reading, recreational or activity therapy, all forms of special education, and supplies or equipment used therefore.
61. Psychological testing; psychoanalysis; counseling with relatives about a patient with mental illness and substance abuse; marital counseling.
62. Hospital stays exclusively required for the purpose of administering general anesthesia.

#### **COORDINATION OF BENEFITS**

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

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

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

"Plan" means benefits or services provided by:

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

"Plan" does not include:

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

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

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

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

1. The plan covering **the patient directly, rather than as employee's dependent**, is primary and **others are secondary**.
2. When this Plan and another plan cover the same child as a dependent of different persons, called "parents":

- a. the benefits of the plan of the parent whose birthday falls earlier in the year are determined before those of a plan of the parent whose birthday falls later in that year; but
  - b. if both parents have the same birthday, the benefits of the plan which covered the other parent longer are determined before those of the plan which covered the other parent for a shorter period of time.
3. In the case of a child of separated or divorced parents, the benefits of the plan covering the child as a dependent will be determined as follows:
- a. the plan of the natural parent having legal custody of the child;
  - b. the plan of the current spouse, if any, of the natural parent, having legal custody of the child; and
  - c. the plan of the natural parent not having legal custody of the child.
4. The plan covering a person as an active employee is primary to the plan covering the person as a retired or laid-off employee or any dependent thereof.
5. If 1, 2, 3 or 4 do not apply, the plan covering the patient longest is primary.

### **Coordination with Prepaid Plans**

Regardless of whether this Plan may be considered primary or secondary under its coordination of benefits provisions, in the event an Eligible Individual (i) has coverage under the indemnity program of this Plan, and (ii) has coverage under a prepaid program under another Group Plan (regardless of whether the Eligible Individual must pay a portion of the premium for such plan), and (iii) incurs expenses normally covered under the prepaid program, then this Plan will only reimburse the co-payments required of the Eligible Individual under the prepaid plan, and only if such co-payments are required of every person covered by that program. Except for the co-payments specified above, the Plan will not pay expenses of eligible employees or dependents covered by prepaid programs of other plans. For purposes of this Plan, the term “prepaid program” shall include health maintenance organizations, individual practice associations, and other programs that the District in its sole discretion deems to be essentially similar to such prepaid arrangements.

### **Medicare Coordination Of Benefits**

This plan is the primary payer for active duty employees covered by Medicare, and for retired employees under the age of 65. Since Medicare Benefits will, in large measure, duplicate the benefits provided under the plan described in this booklet, medical coverage under this plan for

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

### **HOSPITAL PREADMISSION CERTIFICATION AND CONCURRENT REVIEW**

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

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

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

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

Preadmission review requires you to instruct your physician to notify United Administrative Services at least **THREE WORKING DAYS BEFORE ANY SCHEDULED NON-EMERGENCY ADMISSION** to the hospital. The telephone number to do so is printed on your ID card. The doctor does all the rest.

### **HOSPITAL AND PHYSICIAN PREFERRED PROVIDER PLAN**

As mentioned, your Foundation Plan includes a Hospital and Physician feature. A list of participating hospitals and doctors will be provided to you upon request. You may call United Administrative Services if you have any questions regarding status of specific hospitals and doctors at (408) 288-4400 or you may check the provider website at [www.bluecrossca.com](http://www.bluecrossca.com).

**THIRD PARTY LIABILITY AND ACCIDENTS**

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

1. The plan shall be entitled to full extent of its payment for benefits for such sickness or injury, to the proceeds of any settlement or judgment that may result from the exercise of any rights or recovery of the covered employee or dependent against such person, firm or corporation.
2. The covered employee or dependent shall hold such rights of recovery in trust for the Plan, but only to the extent of its payment for such benefits.
3. The covered employee or dependent shall execute and deliver to the Plan such instruments and papers submitted by the Plan as may be appropriate to secure the rights and obligations of the Plan and the employee or dependent established by this provision. The execution of an agreement to hold recovery proceeds in trust for the Plan shall be a condition precedent to the furnishing of benefits for such sickness or injury by the Plan.
4. The Plan shall pay out of such proceeds actually recovered a proportional share (based on the amount of recovery) of the fee incurred by the covered employee or covered dependent for attorney services in collecting from such person, firm or corporation, or its insurer.

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

**RIGHT OF RECOVERY**

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

**EXTENSION OF BENEFITS**

1. If a member is Totally Disabled when coverage ends and is under the treatment of a Physician, benefits may continue to be provided for services treating the totally disabling illness or injury. No benefits are provided for services treating any other illness, injury or condition.
2. A member confined as an inpatient in a hospital or skilled nursing facility is considered Totally Disabled as long as the inpatient stay is medically necessary and no written certification of the total disability is required.

3. A member not confined as an inpatient who wishes to apply for total disability benefits must submit written certification by the physician of the total disability. The administrator must receive this certification within 90 days of the date coverage ends under this agreement. At least once every 90 days while benefits are extended, the administrator must receive proof that the member's total disability is continuing.
4. Benefits are provided until one of the following occurs:
  - a. the member is no longer Totally Disabled; or
  - b. the maximum lifetime benefits are paid; or
  - c. the member becomes covered under another group health plan that provides coverage without limitation for the disabling illness or injury; or
  - d. the date 12 months following the date in which the disabled member's coverage ended.

## **FOUNDATION PRESCRIPTION PLAN COVERAGE**

San Jose Unified School District provides prescription coverage to employees, retirees and their eligible dependents who are enrolled in the Foundation Plan.

FOR ELIGIBILITY REFER TO GENERAL INFORMATION SECTION

### **PRESCRIPTION COVERAGE**

Prescription Drugs that are FDA approved medication prescribed by a physician are covered and subject to the following:

1. **Prescriptions Filled at Your Local Pharmacy through Caremark**

An important part of your medical insurance program is the Caremark Retail prescription drug plan. Your prescription benefit is managed by Caremark – the nation’s largest independent provider of health improvement services. Under this plan, the Foundation Plan pays for a large part of the cost of medically necessary drugs and medicines. You and your dependents can buy the prescriptions you need to preserve your health.

You may fill your prescription at any of more than 50,000 pharmacies in the United States who transmit claim information via the Caremark Electronic System. Because of this technology, you will receive fast, accurate pharmacy service. Also, you will rarely need to submit a written claim form.

Getting Started is Easy! Fill your prescriptions in three simple steps:

- Select a pharmacy**
- Present your benefit card to your pharmacist**
- Pay your portion of the medication cost**

Over 90% of all pharmacies are Caremark members. However, there may be a rare occasion when you might not utilize a member pharmacy. Under these circumstances, you will have to submit a claim form for reimbursement. These forms can be obtained at the District Office or from UAS at 408-288-4400.

Your out of pocket costs at the retail pharmacy is 20% of the cost for Generic Prescriptions and Brand Name Prescriptions for a 34 day supply. Your local pharmacy is a good choice for short term or one time prescriptions. You may also use your local pharmacy for the first 90 days of long term medication.

2. **Mail Service Pharmacy – Caremark.com**

Employees may save time and money by obtaining their prescription medication through the Mail Service Pharmacy. Up to a 90 day supply of medication may be obtained for a \$10 copayment for generic medications and \$20 for Brand Name Medications. The medication

is mailed directly to your home. The Mail Service Pharmacy is designed mainly for maintenance type medication for treatment of chronic or long term conditions such as diabetes, arthritis, heart conditions, and high blood pressure, but may be used for any prescription medication, including oral contraceptives.

The Mail Service Pharmacy is through **Caremark.com**, a **home RX delivery from Caremark**. Order envelopes may be obtained through school secretaries, the Benefits Department or from UAS at 408-288-4400. Order envelopes contain complete information about this service.

Once you have sent in your doctor's prescription and the Mail Service order form, refills may be ordered over the telephone by calling 1-800-552-8159, or on line at [www.Caremark.com](http://www.Caremark.com).

Using the Mail Service Pharmacy not only saves you time and money, but also yields significant savings to your health benefit plan, due to the lower cost of prescriptions obtained through the Mail Service Pharmacy.

### **Bringing 90 Day Prescriptions to CVS Retail Pharmacies**

Effective 7/1/2010, you will be able to fill your 90 day prescriptions at a CVS pharmacy of your choice. This program is known as **CVS-90**.

United Administrative Services negotiated this 90 day offering, at the 7,000 plus CVS pharmacies nationwide, to enhance your prescription benefit and provide more options for receiving your long-term medications.

### **More Member Choices**

Simply take your 90 day prescription to a CVS pharmacy and they will fill your prescription on site.

You will still have the option of using the Caremark Mail Service Pharmacy benefit as you do today. No change in this regard if you prefer this method of filling your 90 day prescriptions.

You will still have the option of filling your 30 day prescriptions at any in-network pharmacy (any of the current Caremark network pharmacies you have used or use today).

### **Best-in-Class Experience**

We have developed simple processes to help members decide whether obtaining their 90 day medication at a local CVS pharmacy or from Caremark Mail Service Pharmacy best fits their lifestyle and preferences. Our goal is for every member to have best-in-class experience when obtaining his or her long-term medications.

For areas with no CVS pharmacy presence, members will continue to receive their long-term medication supply from the Caremark Mail Service Pharmacy.

Now with **CVS-90** you can have more options, convenience, flexibility and access to fill your prescriptions.

**How to Transfer a Prescription**

A Plan Participant can call the phone number on their CVS Caremark mail prescription bottle and request their prescription be transferred to their local CVS/pharmacy store. Customer Care will work with an internal team to facilitate this type of transfer.

CVS/pharmacy stores were also provided a special phone number they can call to request the transfer as well.

**3. Mail Service Coordination of Benefits**

The Retail and Mail Service Pharmacy is to be used only for the employee and eligible dependents with Foundation as their primary coverage. It should not be used for dependents having primary coverage under another medical plan. Under both the Retail and the Mail Service program your copayments will not be credited to the annual medical deductible.

**4. Prescription Exclusions**

Non-Prescription drugs, vitamins, minerals and nutritional supplements.

Experimental substances and/or treatments not approved by the Food and Drug Administration, or investigative drugs or substances labeled “Caution - limited by Federal law to investigational use,” even though a charge is made to the individual. Upon approval by the Food and Drug Administration they will be considered covered expenses from that time on.

Non-legend or over the counter drugs other than insulin.

All contraceptive items including; diaphragms, contraceptive jellies, foams or devices. Therapeutic devices or appliances, support garments and other non-medicinal substances regardless of intended use.

Rogaine or any medication targeting hair growth.

Prescriptions which are covered by workers’ compensation laws, or other county, state or federal programs.

Drugs dispensed or administered in an outpatient setting, including but not limited to outpatient hospital facilities and doctors’ offices.

Oxygen.

Immunization agents, biological sera, blood or blood plasma.

Medication that is to be taken by or administered to an individual, in whole or in part, while he or she is a patient in a licensed hospital, rest home, sanitarium, extended care facility, convalescent hospital, nursing home or similar institution which operates on its premises, or allows to be operated on its premises, a facility for dispensing pharmaceuticals.

Any prescription refill in excess of the number specified by the physician, or any refill dispensed after one year from the physician's original order.

Each prescription is limited to the amount normally prescribed by the physician but not to exceed a 34-day supply or 100-unit dose, whichever is greater.

Drugs obtained outside the United States.

Professional charges in connection with administering or injecting drugs.

Devices, appliances and medical supplies.

Medications for weight loss.

Medications for cosmetic purposes are not covered with the exception of Retin-A with a diagnosis of acne.

Smoking cessation products.

#### **COORDINATION WITH PREPAID PLANS**

Regardless of whether this Plan may be considered primary or secondary under its coordination of benefits provisions, in the event an Eligible Individual (i) has coverage under the indemnity portion of this Plan, and (ii) has coverage under a prepaid program under another Group Plan (regardless of whether the Eligible Individual must pay a portion of the premium for such plan), and (iii) incurs expenses normally covered under the prepaid program, then this Plan will only reimburse the co-payments required of the Eligible Individual under the prepaid plan, and only if such co-payments are required of every person covered by that program. Except for the co-payments specified above, the Plan will not pay expenses of eligible employees or dependents covered by prepaid programs of other plans. For purposes of this Plan, the term "prepaid program" shall include health maintenance organizations, individual practice associations and other programs that the District in its sole discretion deems to be essentially similar to such prepaid arrangements.