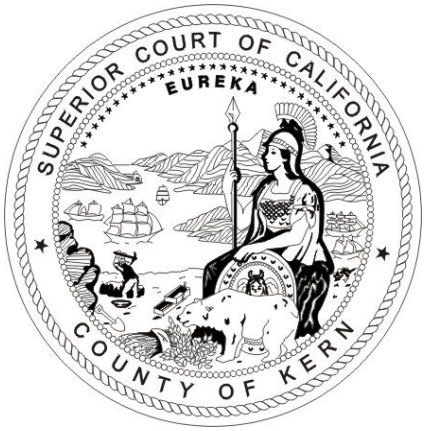

PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION FOR

THE SUPERIOR COURT OF CALIFORNIA, COUNTY OF KERN HEALTH CARE PLAN

Effective January 1, 2020

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INTRODUCTION

This document is a description of The Superior Court of California, County of Kern Health Care Plan (the Plan). No oral interpretations can change this Plan. The Plan described is designed to protect Plan Participants against certain catastrophic health expenses.

Coverage under the Plan will take effect for an eligible Employee and designated Dependents when the Employee and such Dependents satisfy the Waiting Period and all eligibility requirements of the Plan.

The Employer fully intends to maintain this Plan indefinitely. However, it reserves the right to terminate, suspend, discontinue or amend the Plan at any time and for any reason.

Changes in the Plan may occur in any or all parts of the Plan including benefit coverage, deductibles, maximums, copayments, exclusions, limitations, definitions, and eligibility. A reduction or loss of coverage may happen at any time, even after retirement.

Failure to follow the eligibility or enrollment requirements of this Plan may result in delay of coverage or no coverage at all. Reimbursement from the Plan can be reduced or denied because of certain provisions in the Plan, such as coordination of benefits, subrogation, exclusions, timeliness of COBRA elections, utilization review or other cost management requirements, lack of Medical Necessity, lack of timely filing of claims or lack of coverage. These provisions are explained in summary fashion in this document; additional information is available from the Plan Administrator at no extra cost.

The Plan will pay benefits only for the expenses incurred while this coverage is in force. No benefits are payable for expenses incurred before coverage began or after coverage terminated. An expense for a service or supply is incurred on the date the service or supply is furnished.

If the Plan is terminated, amended, or benefits are eliminated, the rights of Covered Persons are limited to Covered Charges incurred before termination, amendment or elimination.

It is the intent of this Plan and the Plan Administrator to comply with all applicable Federal and State laws and regulations. In the event of non-compliance with any such law or regulation, the Plan Document will be deemed amended to comply with said law or regulation as of its effective date, and the remainder of the Plan Document will remain in full force and effect. Similarly, in the event a law or regulation applicable will be deemed included in this Plan Document as of its effective date and without the necessity of an amendment to this Plan Document.

This document sets forth the Plan rights and benefits for covered Employees and their Dependents and is divided into the following parts:

Eligibility, Funding, Effective Date and Termination. Explains eligibility for coverage under the Plan, funding of the Plan and when the coverage takes effect and terminates.

Schedule of Benefits. Provides an outline of the Plan reimbursement formulas as well as payment limits on certain services.

Benefit Descriptions. Explains when the benefit applies and the types of charges covered.

Cost Management Services. Explains the methods used to curb unnecessary and excessive charges.

> **This part should be read carefully since each Participant is required to take action to assure that the maximum payment levels under the Plan are paid.**

Defined Terms. Defines those Plan terms that have a specific meaning.

Plan Exclusions. Shows what charges are **not** covered.

Claim Provisions. Explains the rules for filing claims.

Coordination of Benefits. Shows the Plan payment order when a person is covered under more than one plan.

Third Party Recovery Provision. Explains the Plan's rights to recover payment of charges when a Covered Person has a claim arising out of an accidental illness or injury, including but not limited to worker's compensation claims.

Continuation Coverage Rights Under COBRA. Explains when a person's coverage under the Plan ceases and the continuation options which are available.

Verification of Eligibility (800) 442-7247

Call this number to verify eligibility for Plan benefits **before** the charge is incurred.

MEDICAL BENEFITS

All benefits described in this Schedule are percentages paid by the Plan and are subject to the exclusions and limitations described more fully herein including, but not limited to, the Plan Administrator's determination that: care and treatment is Medically Necessary; charges are Recognized Charges; services, supplies and care are not Experimental and/or Investigational. The meanings of these capitalized terms are in the Defined Terms section of this document.

Note: The following services must be pre-certified or reimbursement from the Plan may be reduced.

Inpatient Hospitalizations
Skilled Nursing Facility stays
Home Health Care
Hospice Care
In-Network Outpatient Surgical Procedures included in the Anthem Blue Cross Standard Prior Authorization Requirements.*
All weight reduction surgical procedures
Durable Medical Equipment over $500
Air-Ambulance Transportation
Non-Emergency facility-to-facility Transportation
Transgender Services

*The Anthem Blue Cross Standard Prior Authorization Requirements are subject to change. Prior authorization should be requested on all outpatient surgical procedures but will only be required for those on the Anthem Blue Cross Standard Prior Authorization Requirements at the time of the procedure.

Please see the Cost Management section in this booklet for details.

The attending Physician does not have to obtain precertification from the Plan for prescribing a maternity length of stay that is 48 hours or less for a vaginal delivery or 96 hours or less for a cesarean delivery.

This Plan has entered into an agreement with certain Hospitals, Physicians and other health care providers, which are called Network Providers. Because these Network Providers have agreed to charge reduced fees to persons covered under the Plan, the Plan will reimburse a higher percentage of their fees when a Covered Person uses a Network Provider than when a Non-Network Provider is used. It is the Covered Person's choice as to which Provider to use.

Under the following circumstances, the higher Network payment will be made for certain Non-Network services:

If a Covered Person has no choice of Network Providers in the specialty that the Covered Person is seeking within the PPO service area.

If a Covered Person is out of the PPO service area and has a Medical Emergency requiring immediate care.

If a Covered Person receives professional services of an emergency room physician, radiologist, pathologist or anesthesiologist when services are rendered in a Network facility.

Additional information about this option, as well as website access to a list of Network Providers, will be given to Plan Participants, at no cost, and updated as needed.

Deductibles/Copayments payable by Plan Participants

Deductibles/copayments are dollar amounts that the Covered Person must pay before the Plan pays.

A deductible is an amount of money that is paid once a Calendar Year per Covered Person. Typically, there is one deductible amount per Plan and it must be paid before any money is paid by the Plan for any Covered Charges. Each January 1st, a new deductible amount is required.

A copayment is the amount of money that is paid each time a particular service is used. Typically, there may be copayments on some services and other services will not have any copayments.

MEDICAL BENEFITS SCHEDULE

COVERED CHARGES	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
MAXIMUM LIFETIME BENEFIT AMOUNT	NONE	
DEDUCTIBLE, PER CALENDAR YEAR		
Per Covered Person	$0	$250
Per Family Unit	$0	$500
COPAYMENTS		
MAXIMUM OUT-OF-POCKET AMOUNT, PER CALENDAR YEAR – Network and Non-Network Out-of-Pocket maximums are NOT combined. **MEDICAL**		
Per Covered Person	$1,500	$2,500
Per Family Unit	$3,000	$5,000
PRESCRIPTION DRUGS (through Express Scripts)		
Per Covered Person	$6,650	n/a
Per Family Unit	$13,300	n/a
The Plan will pay the designated percentage of Covered Charges until out-of-pocket amounts are reached, at which time the Plan will pay 100% of the remainder of Covered Charges for the rest of the Calendar Year unless stated otherwise.		
The following charges do not apply toward the out-of-pocket maximum and are never paid at 100%. Non-Network copayments Cost containment penalties Spinal manipulation/chiropractic charges Amounts over UCR Expenses not covered by the Plan		
COVERED CHARGES		
Note: The maximums listed below are the total for Network and Non-Network expenses. For example, if a maximum of 60 days is listed twice under a service, the Calendar Year maximum is 60 days total which may be split between Network and Non-Network providers.		
Kern Medical Center Inpatient	100% after $150 copayment per day up to $750 copayment Calendar Year maximum	
Percentage Payable – unless otherwise stated	100%	70% after deductible
Hospital Services – Certain procedures require prior authorization. See pages 4 and 28-30 for requirements.		
Inpatient - the semiprivate room rate	100% after $150 copayment per day up to a $750 copayment Calendar Year maximum	70% after deductible
Outpatient Services	90%	70% after deductible
Ambulatory/Outpatient Surgery	100% after $100 copayment	70% after deductible/$1,000 per surgery maximum
Emergency Room Visit – including professional services	100% after $100 copayment; copayment waived if admitted	100% after $100 copayment; copayment waived if admitted (deductible waived)
Urgent Care Services – including professional services	100% after $20 copayment;	70% after deductible
Skilled Nursing Facility - the facility's semiprivate room rate	90% 120 days Calendar Year maximum	70% after deductible 120 days Calendar Year maximum
Physician Services		
Inpatient visits	100%	70% after deductible
Office visits	100% after $20 copayment	70% after deductible
Specialist office visits	100% after $30 copayment	70% after deductible
A Specialist is other than the following Physician types: Family Practice, General Practice, Internal Medicine and/or Pediatrics.		
Second Surgical Opinion	100% after $30 copayment	70% after deductible
Surgery	100%	70% after deductible

COVERED CHARGES	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
Allergy injections, serum and testing	100% after $20 copayment	70% after deductible
Pregnancy (global)	100% after $200 copayment	70% after deductible
Diagnostic Testing, X-ray & Lab	90%	70% after deductible
Hearing Aids (including exams and fittings) (Up to $3,000 per 3-year period)	90%	70%; after deductible
Home Health Care	90% 40 visits Calendar Year maximum	70% after deductible 40 visits Calendar Year maximum
Hospice Care	100%	70% after deductible $7,500 Lifetime maximum
Bariatric Surgery – including complications resulting from such surgery	$15,000 Lifetime maximum	70% after deductible $15,000 Lifetime maximum
Ambulance Service		
Air Transport	100% (Pre-certification required on all air transportation)	100% of negotiated pricing
Ground Transport		
Pre-authorized facility-to-facility transport	100%	100% of billed charges
Emergency transport	100%	100% of billed charges
Non-emergency transport	Not Covered	Not Covered
Wig After Chemotherapy	100% $150 Calendar Year maximum	70% after deductible $150 Calendar Year maximum
Occupational, Physical and Speech Therapies **Note: Occupational, Speech and Physical Therapy visits are combined.**	100% after $20 copayment 60 visits Calendar Year maximum	70% after deductible 60 visits Calendar Year maximum
Diabetic Education - (4 visit lifetime maximum)	100% after $25 copayment	70% after deductible
Durable Medical Equipment	100% (Pre-certification required if over $500)	70% after deductible (Pre-certification required if over $500)
Prosthetics	100%	70% after deductible
Foot Orthotics – for the prevention of complications associated with diabetes.	100%	70% after deductible
Spinal Manipulation Chiropractic	100% up to $20 per visit 30 visits Calendar Year maximum	100% up to $20 per visit 30 visits Calendar Year maximum
Mental Disorders and Substance Abuse		
Inpatient	100% after $150 copayment per day up to a $750 copayment Calendar Year maximum	70% after deductible
Outpatient	100% after $20 copayment	70% after deductible
Preventive Care - (see pages 35-40 for a list of applicable preventive services)		
Routine Well Adult Care	100%	Not Covered
Includes: office visits, routine physical examination, x-rays, laboratory tests and immunizations/flu shots.		
Gynecological Exam and Pap Smear	100%	Not Covered
Mammogram	100%	Not Covered
Contraceptive Methods	100%	70% after deductible

COVERED CHARGES	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
Prostate Screening	100%	Not Covered
Colorectal Cancer Screenings	100%	Not Covered
Routine Well Child Care – to age 19.	100%	70% after deductible
Includes: office visits, routine physical examination, laboratory tests, x-rays and immunizations.		
Organ Transplants	Same as any other illness.	Same as any other illness.
Lodging and Travel – when the recipient resides more than 50 miles from the facility	100% up to $50 per day for one person or up to $100 per day for all family members. $10,000 combined Lifetime maximum for recipient and companion(s) in connection with all transplant procedures.	

PRESCRIPTION DRUG BENEFIT SCHEDULE

PRESCRIPTION DRUG BENEFIT (through Express Scripts)	
Pharmacy Option (30 Day Supply)	
Generic Drugs	$10 copayment (waived for oral contraceptives)
Formulary Brand Name Drugs*	$20 copayment
Non-Formulary Brand Name Drugs*	$40 copayment
Mail Order Option (90 Day Supply)	
Generic Drugs	$20 copayment (waived for oral contraceptives)
Formulary Brand Name Drugs*	$40 copayment
Non-Formulary Brand Name Drugs*	$80 copayment
Refer to the Prescription Drug Section for details on the Prescription Drug benefit.	
***If an FDA approved Generic equivalent is available, and the Brand is still requested, you will be responsible for the difference in cost between the Brand and Generic in addition to the brand copayment.**	

DENTAL CARE BENEFIT SCHEDULE

Please read the Alternate Treatment section in the Dental Plan. You will need to follow this section or reimbursement from the Plan may be reduced.

	NETWORK BENEFIT	NON-NETWORK BENEFIT
Dental Care Calendar Year Deductible (Network and Non-Network deductibles are combined)	$50 per individual/$150 per family (3 family members must meet $50)	
Calendar Year Deductible only applies to these classes of services: **Class B Basic Services and Class C Major Services**		
MAXIMUM BENEFIT AMOUNT (Network and Non-Network Maximum Benefit Amounts are combined)		
For Class A - Preventive, Class B - Basic and Class C - Major Services	$1,750 Per Covered Person per Calendar Year	
COVERED CHARGES		
Dental Percentage Payable		
Class A Services - Preventive	90%	70%
Class B Services - Basic	90%	70%
Class C Services - Major	90%	70%
Class D – Orthodontia - $3,000 Per Covered Person Lifetime maximum		
Initial Exam – includes preliminary study, including x-rays, diagnostic casts and treatment plan	100% after $50 copayment	
Active Treatments and Retention Appliance	Children to age 19 - 100% after $2,600 copayment Adults ages 19 and above - 100% after $2,400 copayment	
Additional information on Dental Care can be found in the Dental Benefits section of this document.		

A Plan Participant should contact the Plan Administrator to obtain additional information, free of charge, about Plan coverage of a specific benefit, particular drug, treatment, test or any other aspect of Plan benefits or requirements.

ELIGIBILITY

Eligible Classes of Employees. The following Classes of Employees:

(1) All active Employees of the Employer.

Eligibility Requirements for Employee Coverage. A person is eligible for Employee coverage from the first day that he or she satisfies all of the following:

(1) all employees who work in a probationary, permanent, or extra help capacity and are assigned to work 30 or more scheduled hours per week.

(2) is in a class eligible for coverage.

(3) completes the employment Waiting Period of 30 consecutive days as an Active Employee.

A "Waiting Period" is the time between the first day of employment as an eligible Employee and the first day of coverage under the Plan.

Eligible Classes of Retirees:

(1) is an Employee of the Employer who has taken either a service retirement or a disability retirement on or after September 1, 2008.

(2) is an Employee of the Employer who has taken either a service retirement or a disability retirement between January 1, 2001 and August 31, 2008 AND who was covered by the County of Kern's self-insured Point-of-Service PPO medical plan on December 31, 2010.

Service retirement means:

(a) An Employee has 10 years of service retirement credit and are age 50 or older; or

(b) An Employee has 30 years of retirement service credit; or

(c) An Employee is age 70, regardless of your years of service credit.

Disability retirement means an Employee is disabled and permanently unable to perform normal job duties and that the disability has been approved by, and meets the requirements of, the Board of Directors of KCERA.

Eligible Classes of Dependents. A Dependent is any one of the following persons:

(1) A covered Employee's Spouse and children from birth to the limiting age of 26 years. When the child reaches the limiting age, coverage will end on the child's birthday.

Individuals whose coverage ended, or who were denied coverage (or were not eligible for coverage), because the availability of dependent coverage of children ended before attainment of age 26 are eligible to enroll in The Superior Court of California, County of Kern Health Care Plan. Individuals may request enrollment for such children for 30 days from the date of notice. Enrollment will be effective retroactively to January 1, 2011. For more information contact The Superior Court of California, County of Kern, 1415 Truxtun Avenue, Room 212, Bakersfield, California, 93301.

The term "Spouse" shall mean a person who is legally married to the eligible employee in their state of primary residency. The Plan Administrator may require documentation proving a legal marital relationship.

The term "Spouse" shall also mean the person who is currently registered with the Employer as the domestic partner of the Employee, this includes opposite sex (if 62 or older and on Social Security) and same sex couples. An individual is a domestic partner of an Employee if that individual and the Employee meet each of the following requirements:

(a) The Employee and the individual are 18 years of age or older and are mentally competent to enter into a legally binding contract.

(b) The Employee and the individual are not married to anyone and not a member of another domestic partnership with someone else.

(c) The Employee and the individual are not related by blood to a degree of closeness that would prohibit legal marriage between individuals of the opposite sex in the state in which they reside.

(d) The Employee and the individual share the same principal residence(s), the common necessities of life, the responsibility for each other's welfare, are financially interdependent with each other and have a long-term committed personal relationship in which each partner is the other's sole domestic partner. Each of the foregoing characteristics of the domestic partner relationship must have been in existence for a period of at least twelve (12) consecutive months and be continuing during the period that the applicable benefit is provided. The Employee and the individual must have the intention that their relationship will be indefinite.

(e) The Employee and the individual have common or joint ownership of a residence (home, condominium, or mobile home), motor vehicle, checking account, credit account, mutual fund, joint obligation under a lease for their residence or similar type ownership.

To obtain more detailed information or to apply for this benefit, the Employee must contact the Plan Administrator, The Superior Court of California, County of Kern, 1415 Truxtun Avenue, Room 212, Bakersfield, California, 93301.

In the event the domestic partnership is terminated, either partner is required to inform The Superior Court of California, County of Kern of the termination of the partnership.

The Plan Administrator may require documentation proving a legal marital and/or domestic partner relationship.

The term "children" shall include natural children of the Employee or domestic partner or adopted children. Step-children who reside in the Employee's household may also be included as long as a natural parent remains married to the Employee and also resides in the Employee's household.

If a covered Employee or domestic partner is the Legal Guardian of a child or children, these children may be enrolled in this Plan as covered Dependents.

(2) A covered Dependent child who reaches the relevant limiting age and is Totally Disabled, incapable of self-sustaining employment by reason of mental or physical handicap, primarily dependent upon the covered Employee for support and maintenance and unmarried. The Plan Administrator may require, at reasonable intervals during the two years following the Dependent's reaching the relevant limiting age, subsequent proof of the child's Total Disability and dependency.

After such two-year period, the Plan Administrator may require subsequent proof not more than once each year. The Plan Administrator reserves the right to have such Dependent examined by a Physician of the Plan Administrator's choice, at the Plan's expense, to determine the existence of such incapacity.

These persons are excluded as Dependents: other individuals living in the covered Employee's or Retiree's home, but who are not eligible as defined; the legally separated or divorced former Spouse of the Employee or Retiree; any person who is on active duty in any military service of any country; any former domestic partner of the Employee; Foster Children; or any person who is covered under the Plan as an Employee or Retiree.

If a person covered under this Plan changes status from Employee to Dependent or Dependent to Employee, and the person is covered continuously under this Plan before, during and after the change in status, credit will be given for deductibles and all amounts applied to maximums.

(1) If both mother and father or domestic partner are Employees, their children will be covered as Dependents of the mother or father or domestic partner, but not of both.

No one shall be eligible as a dependent, in the Superior Court of California, County of Kern Employee Health Care Plan, if they are denied enrollment in their employer-sponsored medical plan and alternatively required to be covered by his or her employer's Medical Expense Reimbursement Plan (MERP) or other plan whose design shifts all comprehensive medical plan coverage to the Superior Court of California, County of Kern Employee Health Care Plan and which does not have standard coordination of benefits (COB) rules.

Eligibility Requirements for Dependent Coverage. A family member of an Employee will become eligible for Dependent coverage on the first day that the Employee is eligible for Employee coverage and the family member satisfies the requirements for Dependent coverage.

At any time, the Plan may require proof that a Spouse, domestic partner, or a child qualifies or continues to qualify as a Dependent as defined by this Plan.

FUNDING

Funding for benefits covered by this Plan is derived from the funds of the Employer and contributions made by covered Plan members. All contributions are governed by the MOU and KCERA.

The level of any Employee contributions is set by the Plan Administrator. The Plan Administrator reserves the right to change the level of Employee contributions.

ENROLLMENT

Enrollment Requirements. An Employee must enroll for coverage by filling out and signing an enrollment application along with any appropriate payroll deduction authorization.

Enrollment Requirements for Newborn Children.

A newborn child of a covered Employee is not automatically enrolled in this Plan. If the newborn child is not enrolled in this Plan on a timely basis, as defined in the section "Timely Enrollment" following this section, there will be no payment from the Plan.

If the child is not enrolled within 31 days of birth, the enrollment will be considered a Late Enrollment.

TIMELY OR LATE ENROLLMENT

(1) **Timely Enrollment** - An enrollment is "timely" if the completed form is received by the Plan Administrator no later than 31 days after the person becomes eligible for coverage, either initially or under a Special Enrollment Period.

If two Employees (husband and wife or domestic partner) are covered under the Plan and the Employee who is covering the Dependent children terminates coverage, the Dependent coverage may be continued by the other covered Employee with no Waiting Period as long as coverage has been continuous.

(2) **Late Enrollment** - An enrollment is "late" if it is not made on a "timely basis" or during a Special Enrollment Period. Late Enrollees and their Dependents who are not eligible to join the Plan during a Special Enrollment Period may join only during open enrollment.

If an individual loses eligibility for coverage as a result of terminating employment or a general suspension of coverage under the Plan, then upon becoming eligible again due to resumption of employment or due to resumption of Plan coverage, only the most recent period of eligibility will be considered for purposes of determining whether the individual is a Late Enrollee.

The time between the date a Late Enrollee first becomes eligible for enrollment under the Plan and the first day of coverage is not treated as a Waiting Period. Coverage begins on January 1 next following or coincident with the Late Enrollment.

SPECIAL ENROLLMENT RIGHTS

Federal law provides Special Enrollment provisions under some circumstances. If an Employee is declining enrollment for himself or his dependents (including their spouse) because of other health insurance or group health plan coverage, there may be a right to enroll in this Plan if there is a loss of eligibility for that other coverage (or if the employer stops contributing towards the other coverage). However, a request for enrollment must be made within 31 days after the coverage ends (or after the employer stops contributing towards the other coverage).

In addition, in the case of a birth, marriage, adoption or placement for adoption, there may be a right to enroll in this Plan. However, a request for enrollment must be made within 31 days after the birth, marriage, adoption or placement for adoption.

The Special Enrollment rules are described in more detail below.

ENROLLMENT RIGHTS under STATE CHILD HEALTH INSURANCE PROGRAM (SCHIP)

If an Employee has declined enrollment in the Plan for him or herself or his or her dependents (including a spouse) because of coverage under Medicaid or the State Children's Health Insurance Program, there may be a right to enroll in this Plan if there is a loss of eligibility for the government-provided coverage. However, a request for enrollment must be made within 60 days after the government-provided coverage ends.

In addition, if an Employee has declined enrollment in the Plan for him or herself or his or her dependents (including a spouse), and later becomes eligible for state assistance through a Medicaid or State Children's Health Insurance Program which provides help with paying for Plan coverage then there may be a right to enroll in this Plan. However, a request for enrollment must be made within 60 days after the determination of eligibility for the state assistance.

If you have any questions regarding the application of these provisions or to request Special Enrollment, contact the Plan Administrator, The Superior Court of California, County of Kern, 1415 Truxtun Avenue, Room 212, Bakersfield, California, 93301.

SPECIAL ENROLLMENT PERIODS

The Enrollment Date for anyone who enrolls under a Special Enrollment Period is the first date of coverage. Thus, the time between the date a special enrollee first becomes eligible for enrollment under the Plan and the first day of coverage is not treated as a Waiting Period.

(1) **Individuals losing other coverage creating a Special Enrollment right.** An Employee or Dependent who is eligible, but not enrolled in this Plan, may enroll if loss of eligibility for coverage is due to any of the following conditions:

(a) The Employee or Dependent was covered under a group health plan or had health insurance coverage at the time coverage under this Plan was previously offered to the individual.

(b) If required by the Plan Administrator, the Employee stated in writing at the time that coverage was offered that the other health coverage was the reason for declining enrollment.

(c) The coverage of the Employee or Dependent who had lost the coverage was under COBRA and the COBRA coverage was exhausted, or was not under COBRA and either the coverage was terminated as a result of loss of eligibility for the coverage or because employer contributions towards the coverage were terminated.

The Employee or Dependent requests enrollment in this Plan not later than 31 days after the date of exhaustion of COBRA coverage or the termination of non-COBRA coverage due to loss of eligibility or termination of employer contributions, described above. Coverage will begin the first day after the loss of coverage.

(d) For purposes of these rules, a loss of eligibility occurs if:

(i) The Employee or Dependent has a loss of eligibility on the earliest date a claim is denied that would meet or exceed a lifetime limit on all benefits.

(ii) The Employee or Dependent has a loss of eligibility due to the plan no longer offering any benefits to a class of similarly situated individuals (i.e., part-time employees).

(iii) The Employee or Dependent has a loss of eligibility as a result of legal separation, divorce, cessation of dependent status (such as attaining the maximum age to be eligible as a dependent child under the plan), death, termination of employment, or reduction in the number of hours of employment or contributions towards the coverage were terminated.

(iv) The Employee or Dependent has a loss of eligibility when coverage is offered through an HMO, or other arrangement, in the individual market that does not provide benefits to individuals who no longer reside, live or work in a service area (whether or not within the choice of the individual).

(v) The Employee or Dependent has a loss of eligibility when coverage is offered through an HMO, or other arrangement, in the group market that does not provide benefits to individuals who no longer reside, live or work in a service area (whether or not within the choice of the individual), and no other benefit package is available to the individual.

If the Employee or Dependent lost the other coverage as a result of the individual's failure to pay premiums or required contributions or for cause (such as making a fraudulent claim or an

intentional misrepresentation of a material fact in connection with the plan), that individual does not have a Special Enrollment right.

(2) **Dependent beneficiaries.** If:

(a) The Employee is a participant under this Plan (or has met the Waiting Period applicable to becoming a participant under this Plan and is eligible to be enrolled under this Plan but for a failure to enroll during a previous enrollment period), and

(b) A person becomes a Dependent of the Employee through marriage, registration of domestic partnership, birth, adoption or placement for adoption,

then the Dependent (and if not otherwise enrolled, the Employee) may be enrolled under this Plan. In the case of the birth or adoption of a child, the Spouse or domestic partner of the covered Employee may be enrolled as a Dependent of the covered Employee if the Spouse or domestic partner is otherwise eligible for coverage. If the Employee is not enrolled at the time of the event, the Employee must enroll under this Special Enrollment Period in order for his eligible Dependents to enroll.

The Dependent Special Enrollment Period is a period of 31 days and begins on the date of the marriage, birth, adoption or placement for adoption. To be eligible for this Special Enrollment, the Dependent and/or Employee must request enrollment during this 31-day period.

The coverage of the Dependent and/or Employee enrolled in the Special Enrollment Period will be effective:

(i) in the case of marriage, as of the date of marriage; or

(ii) in the case of a Dependent's birth, as of the date of birth; or

(iii) in the case of a Dependent's adoption or placement for adoption, the date of the adoption or placement for adoption.

EFFECTIVE DATE

Effective Date of Employee Coverage. An Employee will be covered under this Plan as of the first day of the pay period coincident with or next following the date that the Employee satisfies all of the following:

(1) The Eligibility Requirement.

(2) The Active Employee Requirement.

(3) The Enrollment Requirements of the Plan.

(4) The employment Waiting Period of 30 consecutive days as an Active Employee.

Active Employee Requirement.

An Employee must be an Active Employee (as defined by this Plan) for this coverage to take effect.

Effective Date of Dependent Coverage. A Dependent's coverage will take effect on the day that the Eligibility Requirements are met; the Employee is covered under the Plan; and all Enrollment Requirements are met.

TERMINATION OF COVERAGE

When coverage under this Plan stops, Plan Participants will receive a certificate that will show the period of Creditable Coverage under this Plan. The Plan maintains written procedures that explain how to request this certificate. Please contact the Plan Administrator for a copy of these procedures and further details.

The Employer or Plan has the right to rescind any coverage of the Employee and/or Retiree and/or Dependents for cause, making a fraudulent claim or an intentional material misrepresentation in applying for or obtaining coverage, or obtaining benefits under the Plan. The Employer or Plan may either void coverage for the Employee and/or covered Retirees and/or covered Dependents for the period of time coverage was in effect, may terminate coverage as of a date to be determined at the Plan's discretion, or may immediately terminate coverage. The employer will refund all contributions paid for any coverage rescinded; however, claims paid will be offset from this amount. The employer reserves the right to collect additional monies if claims are paid in excess of the Employee's and/or Retiree's and/or Dependent's paid contributions.

When Employee Coverage Terminates. Employee coverage will terminate on the earliest of these dates (except in certain circumstances, a covered Employee may be eligible for COBRA continuation coverage. For a complete explanation of when COBRA continuation coverage is available, what conditions apply and how to select it, see the section entitled Continuation Coverage Rights under COBRA):

(1) The date the Plan is terminated.

(2) The date the covered Employee's Eligible Class is eliminated.

(3) The end of the last pay period in which the covered Employee ceases to be in one of the Eligible Classes. This includes death or termination of Active Employment of the covered Employee. (See the section entitled Continuation Coverage Rights under COBRA.) It also includes an Employee on disability, leave of absence or other leave of absence, unless the Plan specifically provides for continuation during these periods.

(4) The earliest date the Employee has a claim that is denied in whole or in part because the Employee has met or exceeded a lifetime limit on all benefits.

(5) If an Employee commits fraud or makes a material misrepresentation in applying for or obtaining coverage, or obtaining benefits under the Plan, then the Employer or Plan may either void coverage for the employee and covered Dependents for the period of time coverage was in effect, may terminate coverage as of a date to be determined at the Plan's discretion, or may immediately terminate coverage.

Continuation During Periods of Employer-Certified Disability, Leave of Absence or Layoff. A person may remain eligible for a limited time if Active, full-time work ceases due to disability, leave of absence or layoff. This continuance will end as follows:

For disability leave only: the date the Employer ends the continuance.
For leave of absence or layoff only: the date the Employer ends the continuance.

While continued, coverage will be that which was in force on the last day worked as an Active Employee. However, if benefits reduce for others in the class, they will also reduce for the continued person.

Rehiring a Terminated Employee. A terminated Employee who is rehired will be treated as a new hire and be required to satisfy all Eligibility and Enrollment requirements.

Employees on Military Leave. Employees going into or returning from military service may elect to continue Plan coverage as mandated by the Uniformed Services Employment and Reemployment Rights Act (USERRA) under the following circumstances. These rights apply only to Employees and their Dependents covered under the Plan immediately before leaving for military service.

(1) The maximum period of coverage of a person and the person's Dependents under such an election shall be the lesser of:

(a) The 24 month period beginning on the date on which the person's absence begins; or

(b) The day after the date on which the person was required to apply for or return to a position of employment and fails to do so.

(2) A person who elects to continue health plan coverage must pay up to 102% of the full contribution under the Plan, except a person on active duty for 30 days or less cannot be required to pay more than the Employee's share, if any, for the coverage.

(3) An exclusion or Waiting Period may not be imposed in connection with the reinstatement of coverage upon reemployment if one would not have been imposed had coverage not been terminated because of service. However, an exclusion or Waiting Period may be imposed for coverage of any Illness or Injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of uniformed service.

If the Employee wishes to elect this coverage or obtain more detailed information, contact the Plan Administrator The Superior Court of California, County of Kern, 1415 Truxtun Avenue, Room 212, Bakersfield, California, 93301. The Employee may also have continuation rights under USERRA. In general, the Employee must meet the same requirements for electing USERRA coverage as are required under COBRA continuation coverage requirements. Coverage elected under these circumstances is concurrent not cumulative. The Employee may elect USERRA continuation coverage for the Employee and their Dependents. Only the Employee has election rights. Dependents do not have any independent right to elect USERRA health plan continuation.

When Dependent Coverage Terminates. A Dependent's coverage will terminate on the earliest of these dates (except in certain circumstances, a covered Dependent may be eligible for COBRA continuation coverage. For a complete explanation of when COBRA continuation coverage is available, what conditions apply and how to select it, see the section entitled Continuation Coverage Rights under COBRA):

(1) The date the Plan or Dependent coverage under the Plan is terminated.

(2) The date that the Employee's coverage under the Plan terminates for any reason including death. (See the section entitled Continuation Coverage Rights under COBRA.)

(3) The date a covered Spouse loses coverage due to loss of dependency status. (See the section entitled Continuation Coverage Rights under COBRA.)

(4) On the first date that a Dependent child ceases to be a Dependent as defined by the Plan. (See the section entitled Continuation Coverage Rights under COBRA.)

(5) The end of the period for which the required contribution has been paid if the charge for the next period is not paid when due.

(6) The earliest date the Dependent has a claim that is denied in whole or in part because it meets or exceeds a lifetime limit on all benefits.

(7) If a Dependent commits fraud or makes a material misrepresentation in applying for or obtaining coverage, or obtaining benefits under the Plan, then the Employer or Plan may either void coverage for the Dependent for the period of time coverage was in effect, may terminate coverage as of a date to be determined at the Plan's discretion, or may immediately terminate coverage.

OPEN ENROLLMENT

OPEN ENROLLMENT

At a time established by the Plan Administrator, the annual open enrollment period will be held and covered Employees will be able to change some of their benefit decisions based on which benefits and coverages are right for them.

At a time established by the Plan Administrator, the annual open enrollment period will be held and Employees and their Dependents who are Late Enrollees will be able to enroll in the Plan.

Benefit choices made during the open enrollment period will become effective January 1 and remain in effect through the following December 31 unless there is a Special Enrollment event or a change in family status during the year (birth, death, marriage, divorce, adoption) or loss of coverage due to loss of a Spouse's employment. To the extent previously satisfied, coverage Waiting Periods will be considered satisfied when changing from one benefit option under the Plan to another benefit option under the Plan.

Benefit choices for Late Enrollees made during the open enrollment period will become effective January 1.

A Plan Participant who fails to make an election during open enrollment will automatically retain his or her present coverages.

Plan Participants will receive detailed information regarding open enrollment from the Plan Administrator.

MEDICAL BENEFITS

Medical Benefits apply when Covered Charges are incurred by a Covered Person for care of an Injury or Sickness while the person is covered for these benefits under the Plan.

DEDUCTIBLE

Deductible Amount. This is an amount of Covered Charges for which no benefits will be paid. Before benefits can be paid in a Calendar Year a Covered Person must meet the deductible shown in the Schedule of Benefits.

Family Unit Limit. When the maximum amount shown in the Schedule of Benefits has been incurred by members of a Family Unit toward their Calendar Year deductibles, the deductibles of all members of that Family Unit will be considered satisfied for that year.

BENEFIT PAYMENT

Each Calendar Year, benefits will be paid for the Covered Charges of a Covered Person that are in excess of the deductible and any copayments. Payment will be made at the rate shown under reimbursement rate in the Schedule of Benefits. No benefits will be paid in excess of the Maximum Benefit Amount or any specific Plan limit.

OUT-OF-POCKET LIMIT

Covered Charges are payable at the percentages shown each Calendar Year until the out-of-pocket limit shown in the Schedule of Benefits is reached. Then, Covered Charges incurred by a Covered Person will be payable at 100% (except for ineligible charges) for the rest of the Calendar Year. The Prescription Drug Program (through Express Scripts) has a separate out-of-pocket limit.

When a Family Unit reaches the out-of-pocket limit, Covered Charges for that Family Unit will be payable at 100% (except for ineligible charges) for the rest of the Calendar Year.

MAXIMUM BENEFIT AMOUNT

The Maximum Benefit Amount is shown in the Schedule of Benefits. It is the total amount of benefits that will be paid under the Plan for all Covered Charges incurred by a Covered Person. The Maximum Benefit applies to all benefit options offered under the Plan.

COVERED CHARGES

Covered Charges are the Recognized Charges that are incurred for the following items of service and supply. These charges are subject to the benefit limits, exclusions and other provisions of this Plan. A charge is incurred on the date that the service or supply is performed or furnished.

(1) **Hospital Care.** The medical services and supplies furnished by a Hospital or Ambulatory Surgical Center or a Birthing Center. Covered Charges for room and board will be payable as shown in the Schedule of Benefits. After 23 observation hours, a confinement will be considered an inpatient confinement.

Room charges made by a Hospital having only private rooms will be paid at 80% of the average private room rate.

Charges for Intensive Care Unit stays are payable.

(2) **Coverage of Pregnancy.** The Recognized Charges for the care and treatment of Pregnancy are covered the same as any other Sickness.

Group health plans generally may not, under Federal law, 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).

(3) **Skilled Nursing Facility Care.** The room and board and nursing care furnished by a Skilled Nursing Facility will be payable if and when:

(a) the patient is confined as a bed patient in the facility; and

(b) the attending Physician certifies that the confinement is needed for further care of the condition that caused the Hospital confinement; and

(c) the attending Physician completes a treatment plan which includes a diagnosis, the proposed course of treatment and the projected date of discharge from the Skilled Nursing Facility.

Covered Charges for a Covered Person's care in these facilities are payable as described in the Schedule of Benefits.

(4) **Physician Care.** The professional services of a Physician for surgical or medical services.

Charges for **multiple surgical procedures** will be a Covered Charge subject to the following provisions:

(a) If bilateral or multiple surgical procedures are performed by one (1) surgeon, benefits will be determined based on the Recognized Charge that is allowed for the primary procedures; 50% of the Recognized Charge will be allowed for each additional procedure performed through the same incision. Any procedure that would not be an integral part of the primary procedure or is unrelated to the diagnosis will be considered "incidental" and no benefits will be provided for such procedures;

(b) If multiple unrelated surgical procedures are performed by two (2) or more surgeons on separate operative fields, benefits will be based on the Recognized Charge for each surgeon's primary procedure. If two (2) or more surgeons perform a procedure that is normally performed by one (1) surgeon, benefits for all surgeons will not exceed the Recognized Charge percentage allowed for that procedure; and

(c) If an assistant surgeon is required, the assistant surgeon's Covered Charge will not exceed 25% of the surgeon's Recognized Charge allowance.

(5) **Private Duty Nursing Care.** The private duty nursing care by a licensed nurse (R.N., L.P.N. or L.V.N.). Covered Charges for this service will be included to this extent:

(a) **Inpatient Nursing Care.** Charges are covered only when care is Medically Necessary or not Custodial in nature and the Hospital's Intensive Care Unit is filled or the Hospital has no Intensive Care Unit.

(b) **Outpatient Nursing Care.** Outpatient private duty nursing care is not covered.

(6) **Home Health Care Services and Supplies.** Charges for home health care services and supplies are covered only for care and treatment of an Injury or Sickness when Hospital or Skilled Nursing Facility confinement would otherwise be required. The diagnosis, care and treatment must be certified by the attending Physician and be contained in a Home Health Care Plan.

Benefit payment for nursing, home health aide and therapy services is subject to the Home Health Care limit shown in the Schedule of Benefits.

A home health care visit will be considered a periodic visit by either a nurse or therapist, as the case may be, or four hours of home health aide services.

(7) **Hospice Care Services and Supplies.** Charges for hospice care services and supplies are covered only when the attending Physician has diagnosed the Covered Person's condition as being terminal, determined that the person is not expected to live more than six months and placed the person under a Hospice Care Plan.

Covered Charges for Hospice Care Services and Supplies are payable as described in the Schedule of Benefits.

(8) **Other Medical Services and Supplies.** These services and supplies not otherwise included in the items above are covered as follows:

(a) Local Medically Necessary professional land or air **ambulance** service. A charge for this item will be a Covered Charge only if the service is to the nearest Hospital or Skilled Nursing Facility where necessary treatment can be provided unless the Plan Administrator finds a longer trip was Medically Necessary.

(b) **Anesthetic**; oxygen; blood and blood derivatives that are not donated or replaced; intravenous injections and solutions. Administration of these items is included.

(c) **Cardiac rehabilitation** as deemed Medically Necessary provided services are rendered (a) under the supervision of a Physician; (b) in connection with a myocardial infarction, coronary occlusion or coronary bypass surgery; (c) initiated within 12 weeks after other treatment for the medical condition ends; and (d) in a Medical Care Facility as defined by this Plan.

(d) Radiation or **chemotherapy** and treatment with radioactive substances. The materials and services of technicians are included.

(e) Coverage for participation in an ‘’approved **clinical trial**” must be provided for any Covered Person who is eligible to participate according to the clinical trial protocol, so long as the Covered Person provides information establishing why his or her participation in the clinical trial is appropriate, or a referring health care provider that is a network provider concludes that the Covered Person’s participation in the clinical trial is appropriate.

An “approved clinical trial” is a phase I, phase II, phase III or phase IV clinical trial conducted in relation to the prevention, detection or treatment of cancer or another life-threatening disease or condition that is likely to result in death unless the course of the condition is interrupted. In addition, the clinical trial must be a study or investigation conducted under a new drug application reviewed by the Food and Drug Administration (or be exempt from having such an investigational new drug application) or the clinical trial must be approved or funded by specified government agencies.

(f) Initial **contact lenses** or glasses required following cataract surgery.

(g) Services and products for FDA approved **contraceptive methods** and management including, but not limited to, implants, intrauterine devices (IUDs), and birth control shots.

This <u>does not include</u> oral contraceptives, condoms, sponges, foam or jelly.

(h) **Dental Care.** Medical facility, anesthesia charges or any fees associated with treatment that is determined to be medically necessary will be covered under the medical plan. Following are some examples of medical necessity:

(i) The patient is a child (up to 6 years old) with a dental condition that requires repairs of significant complexity (e.g., multiple restorations, pulpal therapy, extractions);

(ii) Patients with certain physical, intellectual or medically compromising conditions (e.g., mental retardation, cerebral palsy, epilepsy, cardiac problems, hyperactivity verified by appropriate medical documentation);

(iii) Extremely uncooperative, fearful, unmanageable, anxious or uncommunicative patients with substantial dental needs and no expectation that behavior will improve soon;

(iv) Patients with dental restorative or surgical needs for whom local anesthesia is ineffective (such as due to acute infection, anatomic variations or allergy);

(v) Patients who have sustained extensive orofacial or dental trauma, for which treatment under local anesthesia would be ineffective or compromised.

(i) **Diabetic Education** services limited as stated in the Schedule of Benefits.

(j) **Diabetic supplies** include, but are not limited to, blood glucose monitors, podiatric (foot) appliances for prevention of complications associated with diabetes (in accordance with Medicare guidelines), insulin pumps and insulin pump supplies.

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

(k) Coverage for **dialysis** includes dialysis treatment at a dialysis center, hemodialysis and training in operating of dialysis equipment, including supplies for and maintenance of dialysis equipment used in a Covered Person's home.

(l) Rental of **durable medical or surgical equipment** if deemed Medically Necessary. These items may be bought rather than rented, with the cost not to exceed the fair market value of the equipment at the time of purchase, but only if agreed to in advance by the Plan Administrator.

(m) **Laboratory studies.** Covered Charges for diagnostic and preventive lab testing and services.

(n) Treatment of **Mental Disorders and Substance Abuse**.

Psychiatrists (M.D.), psychologists (Ph.D.), counselors (Ph.D.) or Masters of Social Work (M.S.W.) may bill the Plan directly. Other licensed mental health practitioners must be under the direction of and must bill the Plan through these professionals.

(o) Injury to or care of **mouth, teeth and gums**. Charges for Injury to or care of the mouth, teeth, gums and alveolar processes will be Covered Charges under Medical Benefits only if that care is for the following oral surgical procedures:

Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth.

Apicoectomy (excision of tooth root without excision of the tooth), in lieu of a successful root canal procedure.

Osseous surgery.

Emergency repair due to Injury to sound natural teeth.

Surgery needed to correct accidental injuries to the jaws, cheeks, lips, tongue, floor and roof of the mouth.

Treatment of fractures of facial bones

Excision of benign bony growths of the jaw and hard palate.

External incision and drainage of cellulitis.

Incision of sensory sinuses, salivary glands or ducts.

No charge will be covered under Medical Benefits for dental and oral surgical procedures involving orthodontic care of the teeth, periodontal disease and preparing the mouth for the fitting of or continued use of dentures.

(p) **Occupational therapy** by a licensed occupational therapist. Therapy must be ordered by a Physician, result from an Injury or Sickness and improve a body function. Covered Charges do not include recreational programs, maintenance therapy or supplies used in occupational therapy.

(q) **Organ transplant** limits. Charges otherwise covered under the Plan that are incurred for the care and treatment due to an organ or tissue transplant are subject to these limits:

The transplant must be performed to replace an organ or tissue.

Charges for obtaining donor organs or tissues are Covered Charges under the Plan when the recipient is a Covered Person. When the donor has medical coverage, his or her plan will pay first. The benefits under this Plan will be reduced by those payable under the donor's plan. Donor charges include those for:

evaluating the organ or tissue;

removing the organ or tissue from the donor; and

No benefits are payable for a Covered Person who donates an organ or tissue, unless the recipient is a Covered Person under this Plan.

The following transplant travel and lodging benefit will be payable, subject to pre-arrangement by the designated transplant coordinator and any maximums stated in the Schedule of Benefits:

The plan pays reasonable and necessary expenses for lodging and meals for the patient (while not confined) and one companion.

Travel and lodging expenses are available only if the transplant recipient resides more than 50 miles from the approved transplant site.

If the patient is a covered Dependent minor child, the transportation expenses of two companions will be covered and lodging and meal expenses will be reimbursed up to the maximum as stated in the Schedule of Benefits.

The overall Lifetime maximum, as stated in the Schedule of Benefits, is combined for all transportation; lodging and meal expenses incurred by the transplant recipient and donor and companion(s) and reimbursed under this Plan in connection with all transplant procedures.

(r) The initial purchase, fitting and repair of **orthotic appliances** such as braces, splints or other appliances which are required for support for an injured or deformed part of the body as a result of a disabling congenital condition or an Injury or Sickness. Foot appliances are only covered as indicated under diabetic supplies.

(s) **Physical therapy** by a licensed physical therapist to restore the loss or impairment of motor functions resulting from illness, disease or injury. Coverage ends once maximum medical recovery has been achieved and further treatment is primarily for maintenance purposes. Benefits are limited to the maximum as stated in the Schedule of Benefits.

(t) **Pre-admission testing.**

(u) Inpatient **Prescription** Drugs.

(v) Routine **Preventive Care.** Covered Charges under Medical Benefits are payable for routine Preventive Care as described in the Schedule of Benefits.

Charges for Routine Well Adult Care. Routine well adult care is care by a Physician that is not for an Injury or Sickness.

Charges for Routine Well Child Care. Routine well child care is routine care by a Physician that is not for an Injury or Sickness.

(w) The initial purchase, fitting and repair of fitted **prosthetic devices** which replace body parts.

(x) **Reconstructive Surgery.** Correction of abnormal congenital conditions and reconstructive mammoplasties will be considered Covered Charges.

This mammoplasty coverage will include reimbursement for:

(i) reconstruction of the breast on which a mastectomy has been performed,

(ii) surgery and reconstruction of the other breast to produce a symmetrical appearance, and

(iii) coverage of prostheses and physical complications during all stages of mastectomy, including lymphedemas,

in a manner determined in consultation with the attending Physician and the patient.

(y) **Speech therapy** by a licensed speech therapist. Therapy must be ordered by a Physician and follow either: (i) surgery for correction of a congenital condition of the oral cavity, throat or nasal complex (other than a frenectomy) of a person; (ii) an Injury; or (iii) a Sickness that is other than a learning or Mental Disorder.

(z) **Spinal Manipulation/Chiropractic services** by a licensed M.D., D.O. or D.C.

(aa) **Sterilization** procedures.

(bb) **Surgical dressings**, splints, casts and other devices used in the reduction of fractures and dislocations.

(cc) Covered services and supplies recognized as effective and appropriate by the medical or dental profession as necessary to treat **temporomandibular joint (TMJ) dysfunction**, myofacial pain dysfunction syndromes and other associated disorders.

(dd) **Transgender Services**

Services and supplies provided in connection with gender transition will be covered, when you have been diagnosed with gender identity disorder or gender dysphoria by a physician. This coverage is provided according to the terms and conditions of the Plan that apply to all other covered medical conditions, including medical necessity requirements, utilization management, and exclusions (e.g. cosmetic services).

Coverage includes medically necessary services related to gender transition such as:

- Transgender surgery (also known as gender reassignment surgery);
- Continuous hormone replacement therapy (hormones of the desired gender);
- Laboratory testing to monitor the safety of continuous hormone therapy;
- Diagnosis of, and psychotherapy for, gender identity disorders/dysphoria and associated co-morbid psychiatric diagnoses.

Coverage is provided and payable according to the Plan benefits that applies to that specific service. For example, transgender surgery, if medically necessary and meeting the guidelines of the Plan, would be covered on the same basis as any other covered, medically necessary surgery; hormone therapy would be covered under the plan's prescription drug benefits; psychotherapy would be covered under the mental health benefit. If coverage for a specific service, such as face lift is not included, the service will not be covered.

Not all charges are eligible. For example, services that are not medically necessary and or services considered cosmetic are excluded. Examples of cosmetic services or non-covered expenses include, but are not limited to:

1. Blepharoplasty
2. Breast augmentation
3. Breast implants
4. Drugs for hair loss or hair growth
5. Drugs for sexual performance or cosmetic purposes
6. Facial bone reconstruction
7. Face Lift
8. Hair removal/hairplasty
9. Liposuction
10. Lip reduction/enhancement
11. Puberty suppression therapy
12. Rhinoplasty

13. Sperm or gamete procurement for future infertility or storage of sperm, gametes or embryos
14. Treatment received outside the United States
15. Transportation, meals, lodging or similar expenses
16. Voice therapy and voice modification surgery

Surgery related to transgender services (including transgender surgery/gender reassignment surgery) are subject to prior authorization in order for coverage to be provided. Transgender surgeries not preauthorized by the Plan will not be covered.

(ee) Coverage of **Well Newborn Nursery/Physician Care**.

Charges for Routine Nursery Care. Routine well newborn nursery care is care while the newborn is Hospital-confined after birth and includes room, board, circumcision and other normal care for which a Hospital makes a charge.

This coverage is only provided if the newborn child is an eligible Dependent and a parent (1) is a Covered Person who was covered under the Plan at the time of the birth, or (2) enrolls himself or herself (as well as the newborn child if required) in accordance with the Special Enrollment provisions with coverage effective as of the date of birth.

The benefit is limited to Recognized Charges for nursery care for the newborn child while Hospital confined as a result of the child's birth.

Charges for covered routine nursery care will be applied toward the Plan of the parent.

Group health plans generally may not, under Federal law, 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).

Charges for Routine Physician Care. The benefit is limited to the Recognized Charges made by a Physician for the newborn child while Hospital confined as a result of the child's birth.

Charges for covered routine Physician care will be applied toward the Plan of the parent.

If the baby is ill, suffers an injury, premature birth, congenital abnormality or requires care other than routine care, benefits will be provided on the same basis as for any other eligible expense provided coverage is in effect.

(ff) Charges associated with the initial purchase of a **wig after chemotherapy**.

Charges for wig after chemotherapy are subject to the limits as described in the Schedule of Benefits.

(gg) Diagnostic **x-rays**.

COST MANAGEMENT SERVICES

Cost Management Services Phone Number

Please refer to the Employee ID card for the Cost Management Services phone number.

Any reduced reimbursement due to failure to follow cost management procedures will not accrue toward the 100% maximum out-of-pocket payment.

UTILIZATION REVIEW

Utilization review is a program designed to help insure that all Covered Persons receive necessary and appropriate health care while avoiding unnecessary expenses.

The program consists of:

(a) Precertification of the Medical Necessity for the following non-emergency services before Medical and/or Surgical services are provided:

Inpatient Hospitalizations
Skilled Nursing Facility stays
Home Health Care
Hospice Care
In-Network Outpatient Surgical Procedures included in the Anthem Blue Cross Standard Prior Authorization Requirements.*
All weight reduction surgical procedures
Durable Medical Equipment over $500
Air-Ambulance Transportation
Non-Emergency facility-to-facility Transportation
Transgender Services

(b) Retrospective review of the Medical Necessity of the listed services provided on an emergency basis;

(c) Concurrent review, based on the admitting diagnosis, of the listed services requested by the attending Physician; and

(d) Certification of services and planning for discharge from a Medical Care Facility or cessation of medical treatment.

*The Anthem Blue Cross Standard Prior Authorization Requirements are subject to change. Prior authorization should be requested on all outpatient surgical procedures but will only be required for those on the Anthem Blue Cross Standard Prior Authorization Requirements at the time of the procedure.

The purpose of the program is to determine what charges may be eligible for payment by the Plan. This program is not designed to be the practice of medicine or to be a substitute for the medical judgment of the attending Physician or other health care provider.

If a particular course of treatment or medical service is not certified, it means that either the Plan will not pay for the charges or the Plan will not consider that course of treatment as appropriate for the maximum reimbursement under the Plan. The patient is urged to find out why there is a discrepancy between what was requested and what was certified before incurring charges.

The attending Physician does not have to obtain precertification from the Plan for prescribing a maternity length of stay that is 48 hours or less for a vaginal delivery or 96 hours or less for a cesarean delivery.

In order to maximize Plan reimbursements, please read the following provisions carefully.

Here's how the program works.

Before a Covered Person enters a Medical Care Facility on a non-emergency basis or receives other listed medical services, the utilization review administrator will, in conjunction with the attending Physician, certify the care. Precertification does not confirm or verify eligibility for coverage, nor is it a guarantee of payment. A non-emergency stay in a Medical Care Facility is one that can be scheduled in advance.

The utilization review program is set in motion by a telephone call from the Covered Person. Contact the utilization review administrator at the telephone number on your ID card before services are scheduled to be rendered with the following information:

- The name of the patient and relationship to the covered Employee
- The name, Social Security number and address of the covered Employee
- The name of the Employer
- The name and telephone number of the attending Physician
- The name of the Medical Care Facility, proposed date of admission, and proposed length of stay
- The diagnosis and/or type of surgery
- The proposed rendering of listed medical services

If there is an **emergency** admission to the Medical Care Facility, the patient, patient's family member, Medical Care Facility or attending Physician must contact the utilization review administrator **within** 48 hours or as soon as reasonably possible given the facts and circumstances of the emergency admission.

The utilization review administrator will determine the number of days of Medical Care Facility confinement or use of other listed medical services authorized for payment. **Failure to follow this procedure may result in a denial of benefits.**

> If the Covered Person does not receive precertification as explained in this Section, the benefit payment may be denied. This denial applies to all services related to the procedure requiring precertification.

Concurrent review, discharge planning. Concurrent review of a course of treatment and discharge planning from a Medical Care Facility are parts of the utilization review program. The utilization review administrator will monitor the Covered Person's Medical Care Facility stay or use of other medical services and coordinate with the attending Physician, Medical Care Facilities and Covered Person either the scheduled release or an extension of the Medical Care Facility stay or extension or cessation of the use of other medical services.

If the attending Physician feels that it is Medically Necessary for a Covered Person to receive additional services or to stay in the Medical Care Facility for a greater length of time than has been pre-certified, the attending Physician must request the additional services or days.

SECOND AND/OR THIRD OPINION PROGRAM

Certain surgical procedures are performed either inappropriately or unnecessarily. In some cases, surgery is only one of several treatment options. In other cases, surgery will not help the condition.

In order to prevent unnecessary or potentially harmful surgical treatments, the second and/or third opinion program fulfills the dual purpose of protecting the health of the Plan's Covered Persons and protecting the financial integrity of the Plan.

Benefits will be provided for a second (and third, if necessary) opinion consultation to determine the Medical Necessity of an elective surgical procedure. An elective surgical procedure is one that can be scheduled in advance; that is, it is not an emergency or of a life-threatening nature.

The patient may choose any board-certified specialist who is not an associate of the attending Physician and who is affiliated in the appropriate specialty.

While any surgical treatment is allowed a second opinion, the following procedures are ones for which surgery is often performed when other treatments are available.

Cataract surgery	Hysterectomy	Surgery to knee, shoulder, elbow or toe
Cholecystectomy (gall bladder removal)	Mastectomy surgery	Tonsillectomy and adenoidectomy
Deviated septum (nose surgery)	Prostate surgery	Tympanotomy (inner ear)
Hemorrhoidectomy	Salpingo-oophorectomy (removal of tubes/ovaries)	
Hernia surgery	Spinal surgery	

CASE MANAGEMENT

Case Management. The Plan may elect, in its sole discretion, when acting on a basis that precludes individual selection, to provide alternative benefits that are otherwise excluded under the Plan. The alternative benefits, called "Case Management," shall be determined on a case-by-case basis, and the Plan's determination to provide the benefits in one instance shall not obligate the Plan to provide the same or similar alternative benefits for the same or any other Covered Person, nor shall it be deemed to waive the right of the Plan to strictly enforce the provisions of the Plan.

A case manager consults with the patient, the family and the attending Physician in order to develop a plan of care for approval by the patient's attending Physician and the patient. This plan of care may include some or all of the following:

-- personal support to the patient;

-- contacting the family to offer assistance and support;

-- monitoring Hospital or Skilled Nursing Facility;

-- determining alternative care options; and

-- assisting in obtaining any necessary equipment and services.

Case Management occurs when this alternate benefit will be beneficial to both the patient and the Plan.

The case manager will coordinate and implement the Case Management program by providing guidance and information on available resources and suggesting the most appropriate treatment plan. The Plan Administrator, attending Physician, patient and patient's family must all agree to the alternate treatment plan.
Once agreement has been reached, the Plan Administrator will direct the Plan to reimburse for Medically Necessary expenses as stated in the treatment plan, even if these expenses normally would not be paid by the Plan.

Note: Case Management is a voluntary service. There are no reductions of benefits or penalties if the patient and family choose not to participate.

Each treatment plan is individually tailored to a specific patient and should not be seen as appropriate or recommended for any other patient, even one with the same diagnosis.

The following terms have special meanings and when used in this Plan will be capitalized.

Active Employee is an Employee who is on the regular payroll of the Employer and who has begun to perform the duties of his or her job with the Employer on a full-time basis.

Allowable charge is a charge which is either the network Provider's reduced fee or the Recognized charge for a service or supply.

Ambulatory Surgical Center is a freestanding outpatient surgical facility. It must be licensed as an outpatient clinic according to state and local laws and must meet all requirements of an outpatient clinic providing surgical services. It must also meet accreditation standards of the Joint Commission on Accreditation of Health Care Organizations or the Accreditation Association of Ambulatory Health Care.

Birthing Center means any freestanding health facility, place, professional office or institution which is not a Hospital or in a Hospital, where births occur in a home-like atmosphere. This facility must be licensed and operated in accordance with the laws pertaining to Birthing Centers in the jurisdiction where the facility is located.

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

Brand Name means a trade name medication.

Calendar Year means January 1st through December 31st of the same year.

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

Cosmetic Dentistry means dentally unnecessary procedures.

Covered Charge(s) means those Medically Necessary services or supplies that are covered under this Plan.

Covered Person is an Employee, Retiree or Dependent who is covered under this Plan.

Creditable Coverage includes most health coverage, such as coverage under a group health plan (including COBRA continuation coverage), HMO membership, an individual health insurance policy, Medicaid, Medicare or public health plans.

Creditable Coverage does not include coverage consisting solely of dental or vision benefits.

Creditable Coverage does not include coverage that was in place before a significant break of coverage of 63 days or more. With respect to the Trade Act of 2002, when determining whether a significant break in coverage has occurred, the period between the trade related coverage loss and the start of the special second COBRA election period under the Trade Act, does not count.

Custodial Care is care provided primarily to meet your personal needs. This includes help in walking, bathing or dressing. It also includes: Preparing food or special diets; feeding by utensil, tube or gastrostomy; suctioning and administration of medicine which is usually self-administered or any other care which does not require continuing services of medical personnel.

If Medically Necessary, benefits will be provided for feeding (by tube or gastrostomy) and suctioning.

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

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

Emergency Care
This means the treatment given in a hospital's emergency room to evaluate and treat medical conditions of recent onset and severity including, (but not limited to) severe pain that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that his or her condition, sickness or injury is of such a nature that failure to get immediate medical care could result in:

- Placing the person's health in serious jeopardy, or
- Serious impairment to bodily function, or
- Serious dysfunction of a body part or organ, or
- Serious jeopardy to the health of the fetus (in the case of a pregnant woman).

Emergency Condition
This means a recent and severe medical condition including, (but not limited to) severe pain that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that his or her condition, sickness or injury is of such a nature that failure to get immediate medical care could result in:

- Placing the person's health in serious jeopardy, or
- Serious impairment to bodily function, or
- Serious dysfunction of a body part or organ, or
- Serious jeopardy to the health of the fetus (in the case of a pregnant woman).

Employee means a person who is an Active, regular Employee of the Employer, regularly scheduled to work for the Employer in an Employee/Employer relationship.

Employer is The Superior Court of California, County of Kern.

Enrollment Date is the first day of coverage or, if there is a Waiting Period, the first day of the Waiting Period.

Experimental procedures are those that are mainly limited to laboratory and/or animal research**.**

Drugs are considered Experimental if they are not commercially available for purchase and/or they are not approved by the Food and Drug Administration for treatment of the Covered Person's condition.

Family Unit is the covered Employee or Retiree and the family members who are covered as Dependents under the Plan.

Formulary means a list of prescription medications of safe, effective therapeutic drugs specifically covered by this Plan.

Generic drug means a Prescription Drug which has the equivalency of the brand name drug with the same use and metabolic disintegration. This Plan will consider as a Generic drug any Food and Drug Administration approved generic pharmaceutical dispensed according to the professional standards of a licensed pharmacist and clearly designated by the pharmacist as being generic.

Genetic Information means information about genes, gene products and inherited characteristics that may derive from an individual or a family member. This includes information regarding carrier status and information derived from laboratory tests that identify mutations in specific genes or chromosomes, physical medical examinations, family histories and direct analysis of genes or chromosomes.

Home Health Care Agency is a home health care provider which is licensed according to state and local laws to provide skilled nursing and other services on a visiting basis in your home, and recognized as home health providers under Medicare and/or accredited by a recognized accrediting agency such as the Joint Commission on the Accreditation of Healthcare Organizations.

Home Health Care Plan must meet these tests: it must be a formal written plan made by the patient's attending Physician which is reviewed at least every 30 days; it must state the diagnosis; it must certify that the Home Health Care is in place of Hospital confinement; and it must specify the type and extent of Home Health Care required for the treatment of the patient.

Home Health Care Services and Supplies include: part-time or intermittent nursing care by or under the supervision of a registered nurse (R.N.); part-time or intermittent home health aide services provided through a Home Health Care Agency (this does not include general housekeeping services); physical, occupational and speech therapy; medical supplies; and laboratory services by or on behalf of the Hospital.

Home infusion therapy provider is a provider licensed according to state and local laws as a pharmacy and must be either certified as a home health care provider by Medicare, or accredited as a home pharmacy by the Joint Commission on Accreditation of Health Care Organizations.

Hospice Agency is an agency or organization providing a specialized form of interdisciplinary health care that provides palliative care (pain control and symptom relief) and alleviates the physical, emotional, social, and spiritual discomforts of a terminally ill person, as well as providing supportive care to the primary caregiver and the patient's family. A hospice must be: currently licensed as a hospice pursuant to Health and Safety Code section 1747 or a licensed home health agency with federal Medicare certification pursuant to Health and Safety Code section 1726 and 1747.1.

Hospice Care Plan is a plan of terminal patient care that is established and conducted by a Hospice Agency and supervised by a Physician.

Hospice Care Services and Supplies are those provided through a Hospice Agency and under a Hospice Care Plan and include inpatient care in a Hospice Unit or other licensed facility, home care, and family counseling during the bereavement period.

Hospice Unit is a facility or separate Hospital Unit, which provides treatment under a Hospice Care Plan and admits at least two unrelated persons who are expected to die within six months.

Hospital is a facility which provides diagnosis, treatment and care of persons who need acute 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 Health Care Organizations.

For limited purpose of inpatient care, the definition of hospital also includes: (1) psychiatric health facilities (only for the acute phase of a mental or nervous disorder or substance abuse), and (2) residential treatment centers.

Illness means a bodily disorder, disease, physical sickness or Mental Disorder. Illness includes Pregnancy, childbirth, miscarriage or complications of Pregnancy.

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

In-Network Provider means Hospitals, Physicians, Dentists and other health care providers who have entered into an agreement with the Plan's Preferred Provider Networks (Kern Medical Center is considered an In-Network provider).

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

Investigative procedures or medications are those that have been progressed to limited use on

humans, but which are not widely accepted as proven and effective within the organized medical community.

Late Enrollee means a Plan Participant who enrolls under the Plan other than during the first 31-day period in which the individual is eligible to enroll under the Plan or during a Special Enrollment Period.

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

Lifetime is a word that appears in this Plan in reference to benefit maximums and limitations. Lifetime is understood to mean while covered under this Plan. Under no circumstances does Lifetime mean during the lifetime of the Covered Person.

Medical Care Facility means a Hospital, a facility that treats one or more specific ailments or any type of Skilled Nursing Facility.

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

Medical Non-Emergency Care means care which can safely and adequately be provided other than in a Hospital.

Medically Necessary procedures, supplies, equipment or services are those we determined to be:

(1) Appropriate and necessary for the diagnosis or treatment of the medical condition;

(2) Provided for the diagnosis or direct care and treatment of the medical condition;

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

(4) Not primarily for our convenience, or for the convenience of your physician or another provider; and

(5) The most appropriate procedure, supply, equipment or service which can safely be provided. The most appropriate procedure, supply, equipment or service must satisfy the following requirements:

   (a) there must be valid scientific evidence demonstrating that the expected health benefit from the procedure, supply, equipment or service are clinically significant and produce a greater likelihood of benefit, without a disproportionately greater risk of harm or complications, for you with the particular medical condition being treated than other possible alternatives; and

   (b) generally accepted forms of treatment that are less invasive have been tried and found to be ineffective or are otherwise unsuitable; and

   (c) for hospital stays, acute care as an inpatient is necessary due to the kind of services you are receiving or the severity of your condition, and safe and adequate care cannot be received by you as an outpatient or in a less intensified medical setting.

The Plan Administrator has the discretionary authority to decide whether care or treatment is Medically Necessary, and whether an exception to the Medical Necessity requirement is available.

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

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

No-Fault Auto Insurance is the basic reparations provision of a law providing for payments without determining fault in connection with automobile accidents.

Non-Network Provider means Hospitals, Physicians, Dentists and other health care providers who have not entered into an agreement with the Plan's Preferred Provider Networks (this provision does not apply to Kern Medical Center).

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

Pharmacy means a licensed establishment where covered Prescription Drugs are filled and dispensed by a pharmacist licensed under the laws of the state where he or she practices.

Physician means a Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Doctor of Podiatry (D.P.M.), Doctor of Chiropractic (D.C.), Audiologist, Certified Nurse Anesthetist, Licensed Professional Counselor, Licensed Professional Physical Therapist, Master of Social Work (M.S.W.), Midwife, Occupational Therapist, Doctor of Dental Surgery (D.D.S.), Physiotherapist, Psychiatrist, Psychologist (Ph.D.), Speech Language Pathologist and any other practitioner of the healing arts who is licensed and regulated by a state or federal agency and is acting within the scope of his or her license.

Plan means The Superior Court of California, County of Kern Health Care Plan, which is a benefits plan for certain Employees of The Superior Court of California, County of Kern and is set forth in this document.

Plan Participant is any Employee, Retiree or Dependent who is covered under this Plan.

Plan Year is the 12-month period beginning on either the effective date of the Plan or on the day following the end of the first Plan Year which is a short Plan Year.

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

Prescription Drug means any of the following: a Food and Drug Administration-approved drug or medicine which, under federal law, is required to bear the legend: "Caution: federal law prohibits dispensing without prescription"; injectable insulin; hypodermic needles or syringes, but only when dispensed upon a written prescription of a licensed Physician. Such drug must be Medically Necessary in the treatment of a Sickness or Injury.

Preventive Services - The plan covers, under Preventive Care, any recommended preventive services the Plan is required to cover under the Affordable Care Act. Preventive care, as defined by the Affordable Care Act has certain limitations. Some of the eligible preventive care services include:

Covered Preventive Services for Adults	***Special Notes***
Abdominal Aortic Aneurysm screening (for men)	A one-time screening for abdominal aortic aneurysm (AAA) by ultrasonography in men aged 65 to 75 who have ever smoked.
Anemia Screening (for pregnant women)	Screening for iron deficiency anemia in asymptomatic pregnant women.
Annual Well-Woman Visits	Gynecological Exam, Pap Smear, and Mammogram.

Alcohol Misuse screening and counseling	Screening and behavioral counseling interventions to reduce alcohol misuse by adults, in primary care settings.
Aspirin	Use for adults ages 50-59 with increased cardiovascular risk
Bacteriuria Urinary Tract or Other Infection screening (for women)	Screening for asymptomatic bacteriuria with urine culture for pregnant women at 12 to 16 weeks gestation or at the first prenatal visit, if later.
Blood Pressure screening	Screening for high blood pressure in adults aged 18 and older.
BRCA counseling (for women)	Genetic counseling and evaluation for BRCA testing for women whose family history is associated with an increased risk for deleterious mutations in BRCA1 or BRCA2 genes.
Breast Cancer Chemoprevention counseling (for women)	Counseling for women at high risk for breast cancer and at low risk for adverse effects of chemoprevention. Clinicians should inform patients of the potential benefits and harms of chemoprevention.
Breast Cancer Mammography screenings (for women)	Mammography screening for women with or without clinical breast examination (CBE), every 1-2 years for women aged 40 and older.
Breast Feeding interventions (for women)	Interventions during pregnancy and after birth to promote and support breastfeeding.
Breast Feeding Support	Supplies and counseling
Cervical Cancer screening (for women)	Screening for cervical cancer in women who have been sexually active.
Chlamydia Infection screening (for women)	Screening for chlamydial infection for all sexually active non-pregnant young women aged 24 and younger and for older non-pregnant women who are at increased risk and for all pregnant women aged 24 and younger and for older pregnant women who are at increased risk.
Cholesterol screening	For adults with increased risk of coronary heart disease.
Colorectal Cancer screening	Screening for colorectal cancer (CRC) using fecal occult blood testing, sigmoidoscopy, or colonoscopy, in adults, aged 50 and older. Coverage also provided if proctoscopy is used for this screening.
Contraceptive Methods	Services and products for FDA approved contraceptive methods including, but not limited to, implants, intrauterine devices (IUDs), and birth control shots. This does not include oral contraceptives, condoms, sponges, foam or jelly.
Depression screening	Screening adults for depression when staff-assisted depression care supports are in place to assure accurate diagnosis, effective treatment, and follow-up.
Diabetes (Type 2) screening	Screening for type 2 diabetes in asymptomatic adults with sustained blood pressure (either treated or untreated) greater than 135/80 mm Hg.

Diet counseling	Behavioral dietary counseling for adult patients with hyperlipidemia and other known risk factors for cardiovascular and diet-related chronic disease. Counseling can be delivered by primary care clinicians or by referral to other specialists, such as nutritionists or dietitians.
Domestic Violence	Interpersonal screening and counseling.
Folic Acid	Supplements for women who may become pregnant.
Gestational Diabetes	Screening.
Gonorrhea screening (for women)	Screening of all sexually active women, including those who are pregnant, for gonorrhea infection if they are at increased risk for infection (that is, if they are young or have other individual or population risk factors).
Gynecological Examination	Coverage provided for routine gynecological examinations.
Hearing screening	Coverage provided for routine hearing screenings.
Hepatitis B screening (for women)	The USPSTF strongly recommends screening for hepatitis B virus (HBV) infection in pregnant women at their first prenatal visit.
HIV screening & counseling	The USPSTF strongly recommends that clinicians screen for human immunodeficiency virus (HIV) all adolescents and adults at increased risk for HIV infection.
HPV DNA Testing	For women 30 years and older.
Immunization Vaccines (Standard)	Hepatitis A, Hepatitis B, Herpes Zoster (Shingles), Human Papillomavirus, Influenza, Measles, Mumps, Rubella, Meningococcal, Pneumococcal, Tetanus, Diphtheria, Pertussis, Varicella (Chickenpox)
Obesity screening	Screening of adult patients for obesity and counseling and behavioral interventions to promote sustained weight loss for obese adults.
Oral Contraceptives	Generic oral contraceptives.
Osteoporosis screening (for women)	Screening beginning at age 60 for women at increased risk for osteoporotic fractures and routinely for women aged 65 and older.
Ovarian Cancer screening (for women)	Coverage provided for Cancer Antigen-125 (CA-125) blood test and transvaginal ultrasound screenings for ovarian cancer when ordered or provided by a physician in accordance with the standard practice of medicine.
Physical Examination	Coverage provided for annual routine physical examinations.
Prostate Cancer screening	Coverage provided for men 40 years of age or over who are symptomatic or in a high-risk category and for all men 50 years of age or older. The screening consists of a Prostate Specific Antigen (PSA) blood test and a Digital Rectal Examination (DRE).

Rh Incompatibility screening and follow-up testing (for women)	Rh (D) blood typing and antibody testing for all pregnant women during their first visit for pregnancy-related care. The USPSTF recommends repeated Rh (D) antibody testing for all unsensitized Rh (D)-negative women at 24-28 weeks gestation, unless the biological father is known to be Rh (D)-negative.
Sexually Transmitted Infection (STI) prevention counseling	Behavioral counseling to prevent sexually transmitted infections (STIs) for all sexually active adolescents and for adults at increased risk for STIs.
Syphilis screening	Screening for all pregnant women or other women at increased risk for syphilis infection.
Tobacco use screening	Screening of all adults about tobacco use and provide tobacco cessation interventions for those who use tobacco products. Expanded counseling for pregnant tobacco users.

Covered Preventive Services for Children	*Special Notes*
Alcohol and Drug Use assessments	Alcohol and drug use assessments for adolescents.
Autism screening	Autism screening for children at 18 and 24 months.
Behavioral assessments	Behavioral assessments for children of all ages.
Blood Pressure screening	Screening for all children.
Cervical Dysplasia screening	Screening for cervical dysplasia in females who have been sexually active and have a cervix.
Congenital Hypothyroidism	Screening for newborns.
Depression screening	Screening of adolescents (12-18 years of age) for major depressive disorder (MDD) when systems are in place to ensure accurate diagnosis, psychotherapy (cognitive-behavioral or interpersonal), and follow-up.
Developmental screening	Developmental screening for children under age 3, and surveillance throughout childhood.
Dyslipidemia screening	Dyslipidemia screening for children at higher risk of lipid disorders.
Fluoride Chemoprevention supplements	Primary care clinicians may administer (or prescribe) oral fluoride supplementation at currently recommended doses to preschool children older than 6 months of age whose primary water source is deficient in fluoride. Coverage is only available when administered by the physician.
Gonorrhea preventive medication	Prophylactic ocular topical medication for all newborns against gonococcal ophthalmia neonatorum. Coverage is only available when administered by the physician.
Hearing screening	Screening for hearing loss in all newborn infants. Coverage also provided for routine hearing screenings for children of all ages.
Height, Weight and Body Mass Index measurements	Height, weight and body mass index measurements for children.
Hematocrit or Hemoglobin screening	Hematocrit or hemoglobin screening for children.
Hemoglobinopathies screening	Screening for sickle cell disease in newborns.
HIV screening	Screening for human immunodeficiency virus (HIV) all adolescents at higher risk.

Hypothyroidism screening	Screening for congenital hypothyroidism (CH) in newborns.
Immunizations Vaccines (Standard)	Hepatitis A, Hepatitis B, Herpes Zoster (Shingles), Human Papillomavirus, Influenza, Measles, Mumps, Rubella, Meningococcal, Pneumococcal, Tetanus, Diphtheria, Pertussis, Varicella (Chickenpox), for children from birth to age 18.
Iron Supplements	For children ages 6 to 12 months, that are at risk for anemia.
Lead screening	Lead screening for children at risk of exposure.
Medical History	Medical history for all children throughout development.
Obesity screening and counseling	Screening for children aged 6 years and older for obesity and offer them or refer them to comprehensive, intensive behavioral interventions to promote improvement in weight status.
Oral Health Risk assessment	Oral health risk assessment for young children.
Phenylketonuria (PKU) screening	Screening for genetic disorder in newborns.
Physical (Well Child Care) Examination	7 exams in first 12 months of life; 3 exams from 13 to 24 months; 1 exam every calendar year thereafter to age 18
Sexually Transmitted Infection (STI) prevention counseling	Behavioral counseling to prevent sexually transmitted infections (STIs) for all sexually active adolescents at increased risk for STIs.
Tuberculin testing	Tuberculin testing for children at higher risk of tuberculosis.
Vision screening	Visual Acuity screening to detect amblyopia, strabismus, and defects in visual acuity in all children.

Recognized Charge is the lower of:

(1) The provider's usual charge to provide a service or supply, or

(2) The charge the Claims Administrator determines to be the recognized charge percentage for the service or supply, or

(3) The charge the Claims Administrator determines to be appropriate, based on factors such as:

(a) The cost of supplying the same or similar service or supply, and

(b) The manner in which the charges for the service or supply are made.

(c) The complexity of the service or supply,

(d) The Degree of skill needed to provide it,

(e) The provider's specialty, and

(f) The Recognized Charge in other areas.

Retired Employee is an Employee who has taken either a service retirement or a disability retirement on or after September 1, 2008.

Service retirement means:

(1) An Employee has 10 years of service retirement credit and are age 50 or older; or

(2) An Employee has 30 years of retirement service credit; or

(3) An Employee is age 70, regardless of your years of service credit.

Disability retirement means an Employee is disabled and permanently unable to perform normal job duties and that the disability has been approved by, and meets the requirements of, the Board of Directors of KCERA.

Sickness is a person's Illness, disease or Pregnancy (including complications).

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.

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

Substance Abuse is regular excessive compulsive drinking of alcohol and/or physical habitual dependence on drugs. This does not include dependence on tobacco and ordinary caffeine-containing drinks.

Total Disability (Totally Disabled) means: In the case of a Dependent child, the complete inability as a result of Injury or Sickness to perform the normal activities of a person of like age and sex in good health.

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

The Plan will reimburse the actual charge billed if it is less than the Recognized Charge.

The Plan Administrator has the discretionary authority to decide whether a charge is Usual and Reasonable.

PLAN EXCLUSIONS

Note: Exclusions related to Prescription Drugs are shown in the Prescription Drug Plan. Contact your Prescription Drug vendor for details.

Note: All exclusions related to Dental are shown in the Dental Plan.

For all Medical Benefits shown in the Schedule of Benefits, a charge for the following is not covered:

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

(2) **Acupuncture.**

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

(4) **Alcohol.** Services, supplies, care or treatment to a Covered Person for an Injury or Sickness which occurred as a result of that Covered Person's illegal use of alcohol. The responding officer's determination of inebriation will be sufficient for this exclusion. Expenses will be covered for Injured Covered Persons other than the person illegally using alcohol and expenses will be covered for Substance Abuse treatment as specified in this Plan. This exclusion does not apply if the Injury resulted from an act of domestic violence or a medical (including both physical and mental health) condition.

(5) **Bereavement counseling.**

(6) **Biofeedback.**

(7) **Complications of non-covered treatments.** Care, services or treatment required as a result of complications from a treatment not covered under the Plan are not covered. Complications from a non-covered abortion are covered.

(8) **Contraceptives.** Oral contraceptives, condoms, sponges, foam or jelly.

(9) **Cosmetic surgery.** Cosmetic surgery unless the surgery is necessary for:

(a) repair or alleviation of damage resulting from an accident;

(b) because of infection or Sickness; or

(c) because of congenital disease, developmental condition or anomaly of a covered Dependent child which has resulted in a functional defect.

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

(a) its primary purpose is to beautify; or

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

(10) **Custodial care.** Services or supplies provided mainly as a rest cure, maintenance or Custodial Care.

(11) **Educational or vocational testing.** Services for educational or vocational testing or training.

(12) **Excess charges.** The part of an expense for care and treatment of an Injury or Sickness that is in excess of the Recognized Charge.

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

(14) **Experimental or not Medically Necessary.** Care and treatment that is either Experimental/Investigational or not Medically Necessary.

(15) **Eye care.** Radial keratotomy or other eye surgery to correct refractive disorders. Also, routine eye examinations, including refractions, lenses for the eyes, exams for their fitting, orthoptics and/or visual therapy. This exclusion does not apply to aphakic patients and soft lenses or sclera shells intended for use as corneal bandages.

(16) **Foot care.** Treatment of weak, strained, flat, unstable or unbalanced feet, metatarsalgia or bunions (except open cutting operations), and treatment of corns, calluses or toenails (unless needed in treatment of a metabolic, peripheral-vascular disease or diabetes).

(17) **Foreign travel.** Care, treatment or supplies out of the U.S. if travel is for the sole purpose of obtaining medical services.

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

(19) **Government coverage.** Care, treatment or supplies furnished by a program or agency funded by any government. This does not apply to Medicaid or when otherwise prohibited by law.

(20) **Hair loss.** Care and treatment for hair loss including wigs, hair transplants or any drug that promises hair growth, whether or not prescribed by a Physician, except for wigs after chemotherapy.

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(22) **Holistic care.** Except as specified under benefits for spinal manipulation treatment.

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

(24) **Illegal acts.** Charges for services received as a result of Injury or Sickness occurring directly or indirectly, as a result of the Covered Person's commission of or attempt to commit a Serious Illegal Act, or a riot or public disturbance. For purposes of this exclusion, the term "Serious Illegal Act" shall mean any act or series of acts that, if prosecuted as a criminal offense, a sentence to a term of imprisonment in excess of one year could be imposed. It is not necessary that criminal charges be filed, or, if filed, that a conviction result, or that a sentence of imprisonment for a term in excess of one year be imposed for this exclusion to apply. Proof beyond a reasonable doubt is not required. This exclusion does not apply if the Injury or Sickness resulted from an act of domestic violence or a medical (including both physical and mental health) condition.

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

(26) **Marital or pre-marital counseling.** Care and treatment for marital or pre-marital counseling.

(27) **Massage therapy.** Charges for massage therapy are not covered even when recommended or prescribed by a physician.

(28) **No charge.** Care and treatment for which there would not have been a charge if no coverage had been in force.

(29) **No obligation to pay.** Charges incurred for which the Plan has no legal obligation to pay.

(30) **No Physician recommendation.** Care, treatment, services or supplies not recommended and approved by a Physician; or treatment, services or supplies when the Covered Person is not under the regular care of a Physician. Regular care means ongoing medical supervision or treatment which is appropriate care for the Injury or Sickness.

(31) **Non-compliance.** All charges in connection with treatments or medications where the patient either is in non-compliance with or is discharged from a Hospital or Skilled Nursing Facility against medical advice.

(32) **Non-emergency Hospital admissions.** Care and treatment billed by a Hospital for non-Medical Emergency admissions on a Friday or a Saturday. This does not apply if surgery is performed within 24 hours of admission.

(33) **Not specified as covered.** Non-traditional medical services, treatments and supplies which are not specified as covered under this Plan.

(34) **Weight Control:** Services or supplies for obesity, weight reduction or dietary control, except when provided for morbid obesity that has persisted for at least five years, defined as either:

(a) BMI exceeding 40; or BMI greater than 35 in conjunction with any of the following severe comorbidities: coronary heart disease, type 2 diabetes, clinically significant obstructive sleep apnea or hypertension; and

(b) Patient has completed growth (18 years of age or documentation of completion of bone growth); and

(c) Patient has attempted weight loss in the past without successful long-term weight reduction; and

(d) Patient has participated in a physician-supervised nutrition and exercise program documented in the medical record. This physician-supervised nutrition and exercise program must meet ALL of the following criteria:

- Must be supervised and monitored by a physician working in cooperation with dieticians and/or nutritionists; and
- Must be six months or longer in duration; and
- Must occur within the two years prior to surgery; and
- Must be documented in the medical record by an attending physician who does not perform bariatric surgery.

Charges for surgical procedures to treat morbid obesity performed on or after October 1, 2010 and charges for complications resulting therefrom, are limited to a Lifetime maximum of $15,000. The Lifetime maximum does not apply to charges for complications resulting from surgical procedures to treat morbid obesity performed before October 1, 2010.

(35) **Occupational.** Care and treatment of an Injury or Sickness that is occupational -- that is, arises from work for wage or profit including self-employment. This exclusion may apply even if the expenses for the illness or injury are not paid by Worker's Compensation or similar employer's liability insurance.

(36) **Orthoptics and/or Visual Therapy.**

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

(38) **Plan design excludes.** Charges excluded by the Plan design as mentioned in this document.

(39) **Private duty nursing.** Charges in connection with outpatient care, treatment or services of a private duty nurse.

(40) **RAST testing.** Reactive Allergy Skin Testing (RAST), provocative and neutralization testing for allergies.

(41) **Relative giving services.** Professional services performed by a person who ordinarily resides in the Covered Person's home or is related to the Covered Person as a Spouse, parent, child, brother or sister, whether the relationship is by blood or exists in law.

(42) **Replacement braces.** Replacement of braces of the leg, arm, back, neck, or artificial arms or legs, unless there is sufficient change in the Covered Person's physical condition to make the original device no longer functional.

(43) **Self-Inflicted.** Any loss due to an intentionally self-inflicted Injury. This exclusion does not apply if the Injury resulted from an act of domestic violence or a medical (including both physical and mental health) condition.

(44) **Services before or after coverage.** Care, treatment or supplies for which a charge was incurred before a person was covered under this Plan or after coverage ceased under this Plan.

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

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

(47) **Surgical sterilization reversal.** Care and treatment for reversal of surgical sterilization.

(48) **Travel or accommodations.** Charges for travel or accommodations, whether or not recommended by a Physician, except for ambulance and organ transplant charges as defined as a Covered Charge.

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

(50) **War.** Any loss that is due to a declared or undeclared act of war.

(51) **Non-emergency transportation.** Charges to or from any location for treatment, services, supplies or consultation. This does not apply to ambulance services associated with a medical emergency or for facility-to-facility ambulance services for non-emergency transport when directed by the attending physician and pre-authorized by the Plan.

Pharmacy Drug Charge

Participating pharmacies have contracted with the Plan to charge Covered Persons reduced fees for covered Prescription Drugs.

Copayments

The copayment is applied to each covered pharmacy drug or mail order drug charge and is shown in the schedule of benefits. The copayment amount is not a Covered Charge under the medical Plan. Any one pharmacy prescription is limited to a 30-day supply. Any one mail order prescription is limited to a 90-day supply.

If a drug is purchased from a non-participating pharmacy, or a participating pharmacy when the Covered Person's ID card is not used, the amount payable in excess of the amounts shown in the schedule of benefits will be the ingredient cost and dispensing fee.

Mail Order Drug Benefit Option

The mail order drug benefit option is available for maintenance medications (those that are taken for long periods of time, such as drugs sometimes prescribed for heart disease, high blood pressure, asthma, etc.). Because of volume buying, the mail order pharmacy is able to offer Covered Persons significant savings on their prescriptions.

Covered Prescription Drugs

(1) All drugs prescribed by a Physician that require a prescription either by federal or state law. This includes oral contraceptives, but excludes any drugs stated as not covered under this Plan.

(2) All compounded prescriptions containing at least one prescription ingredient in a therapeutic quantity.

(3) Insulin and other diabetic supplies when prescribed by a Physician.

(4) Injectable drugs or any prescription directing administration by injection.

Limits To This Benefit

This benefit applies only when a Covered Person incurs a covered Prescription Drug charge. The covered drug charge for any one prescription will be limited to:

(1) Refills only up to the number of times specified by a Physician.

(2) Refills up to one year from the date of order by a Physician.

Expenses Not Covered

This benefit will not cover a charge for any of the following:

(1) **Administration.** Any charge for the administration of a covered Prescription Drug.

(2) **Appetite suppressants.** A charge for appetite suppressants, dietary supplements or vitamin supplements, except for prenatal vitamins requiring a prescription or prescription vitamin supplements containing fluoride.

(3) **Consumed on premises.** Any drug or medicine that is consumed or administered at the place where it is dispensed.

(4) **Devices.** Devices of any type, even though such devices may require a prescription. These include (but are not limited to) therapeutic devices, artificial appliances, braces, support garments, or any similar device.

(5) **Drugs used for cosmetic purposes.** Charges for drugs used for cosmetic purposes, such as anabolic steroids, Retin A or medications for hair growth or removal.

(6) **Experimental.** Experimental drugs and medicines, even though a charge is made to the Covered Person.

(7) **FDA.** Any drug not approved by the Food and Drug Administration.

(8) **Immunization.** Immunization agents or biological sera.

(9) **Impotence.** A charge for impotence medication.

(10) **Infertility.** A charge for infertility medication.

(11) **Inpatient medication.** A drug or medicine that is to be taken by the Covered Person, in whole or in part, while Hospital confined. This includes being confined in any institution that has a facility for the dispensing of drugs and medicines on its premises.

(12) **Investigational.** A drug or medicine labeled: "Caution - limited by federal law to investigational use."

(13) **Medical exclusions.** A charge excluded under Medical Plan Exclusions.

(14) **No charge.** A charge for Prescription Drugs which may be properly received without charge under local, state or federal programs.

(15) **No prescription.** A drug or medicine that can legally be bought without a written prescription. This does not apply to injectable insulin.

(16) **Refills.** Any refill that is requested more than one year after the prescription was written or any refill that is more than the number of refills ordered by the Physician.

(17) **Smoking cessation.** A charge for Prescription Drugs, such as nicotine gum or smoking deterrent patches, for smoking cessation.

DENTAL BENEFITS

This benefit applies when covered dental charges are incurred by a person while covered under this Plan.

DEDUCTIBLE

Deductible Amount. This is an amount of dental charges for which no benefits will be paid. Before benefits can be paid in a Calendar Year, a Covered Person must meet the deductible shown in the Schedule of Benefits.

Family Unit Limit. When the dollar amount shown in the Schedule of Benefits has been incurred by members of a Family Unit toward their Calendar Year deductibles, the deductibles of all members of that Family Unit will be considered satisfied for that year.

BENEFIT PAYMENT

Each Calendar Year benefits will be paid to a Covered Person for the dental charges in excess of the deductible amount if applicable. Payment will be made at the rate shown under Dental Percentage Payable in the Schedule of Benefits. No benefits will be paid in excess of the Maximum Benefit Amount.

MAXIMUM BENEFIT AMOUNT

The Maximum dental benefit amount is shown in the Schedule of Benefits.

DENTAL CHARGES

Dental charges are the Recognized Charges made by a Dentist or other Physician for necessary care, appliances or other dental material listed as a covered dental service.

A dental charge is incurred on the date the service or supply for which it is made is performed or furnished. However, there are times when one overall charge is made for all or part of a course of treatment. In this case, the Claims Administrator will apportion that overall charge to each of the separate visits or treatments. The pro rata charge will be considered to be incurred as each visit or treatment is completed.

COVERED DENTAL SERVICES

Class A Services:
Preventive and Diagnostic Dental Procedures

The limits on Class A services are for routine services. If dental need is present, this Plan will consider for reimbursement services performed more frequently than the limits shown.

(1) Routine oral exams. Limit of two per Covered Person every Calendar Year.

(2) Cleaning and scaling of teeth. Limit of two per Covered Person every Calendar Year, no more frequently than once every six months.

(3) One bitewing x-ray series once every Calendar Year.

(4) One full mouth x-ray or Panorex X-ray once every 36 months except when taken for diagnosis of third molars, cysts, or neoplasms.

(5) Extra-oral X-ray limited to two films per Calendar Year.

(6) Diagnostic casts limited to one time per 24 months.

(7) One fluoride treatment for covered Dependent children under age 16 years, up to two every Calendar Year.

(8) Sealants for Dependent children under age 16, once per first or second permanent molar, every five Calendar Years.

Class B Services:
Basic Dental Procedures

(1) Fillings. Allowed per surface once every three Calendar Years.

(2) Pin retention, limited to two pins per tooth; not covered in addition to cast restoration.

(3) Space maintainers for covered Dependent children under age 16, to replace primary teeth, once Lifetime maximum.

(4) Endodontics (root canals). Once per site Lifetime maximum.

(5) Post and cores are covered only for teeth that have had root canal therapy.

(6) Root Planing per quadrant once every 24 months.

(7) Periodontal surgery once every 36 months per site.

(8) Periodontal maintenance limited to two times per 12 months following active and adjunctive periodontal therapy.

(9) Scaling and root planing once per quadrant every 24 months.

(10) Osseous grafts, with or without restorable or non-restorable GTR membrane placement in once every 36 months per quadrant or surgical site.

(11) Full mouth debridement once every 36 months.

(12) Oral surgery. Oral surgery is limited to removal of teeth, including impacted wisdom teeth, preparation of the mouth for dentures and removal of tooth-generated cysts of less than 1/4 inch.

(13) Extractions. This service includes local anesthesia and routine post-operative care.

(14) Emergency palliative treatment for pain. Covered as a separate benefit only if no other service, other than exam and radiographs, were done during the visit.

(15) General anesthetics when required for patients under 6 years of age or patients with behavioral problems or physical disabilities.

(16) Drugs and medications when they are dispensed and utilized in the dental office during the patient visit.

Class C Services:
Major Dental Procedures

(1) Inlays and onlays once every five Calendar Years.

(2) Installation of crowns once every five Calendar Years.

(3) Installing partial, full or removable dentures to replace one or more natural teeth once every five years. This service also includes all adjustments made during 6 months following the installation.

(4) Initial installation of fixed bridgework to replace one or more natural teeth once every five Calendar Years.

(5) Recementing bridges, crowns or inlays.

(6) Repair of crowns, bridgework and removable dentures. Limited to repairs or adjustments done more than 12 months after the initial insertion.

(7) Replacing retainers, habit appliances, and fixed or removable interceptive orthodontic appliances.

(8) Occlusal guards to control habitual grinding once every five Calendar Years.

(9) Replacing an existing removable partial or full denture or fixed bridgework; adding teeth to an existing removable partial denture; or adding teeth to existing bridgework to replace newly extracted natural teeth. However, this item will apply only if this test is met:

(a) The existing denture or bridgework was installed at least five years prior to its replacement, cannot currently be made serviceable and the member has been covered under this plan for 12 months. If the loss of a tooth requires the addition of a clasp, pontic, and/or abutment(s) within this 12 month period, the plan is responsible only for the procedures associated with the addition.

(10) Dental implants are covered up to $250 per calendar year.

Class D Services:
Orthodontic Treatment and Appliances

This is treatment to move teeth by means of appliances to correct a handicapping malocclusion of the mouth.

These services are available for covered Dependent children and adults and include preliminary study, including x-rays, diagnostic casts and treatment plan, active treatments and retention appliance.

ALTERNATE TREATMENT

Many dental conditions can be treated in more than one way. This Plan has an "alternate treatment" clause which governs the amount of benefits the Plan will pay for treatments covered under the Plan. If a patient chooses a more expensive treatment than is needed to correct a dental problem according to accepted standards of dental practice, the benefit payment will be based on the cost of the treatment which provides professionally satisfactory results at the most cost-effective level.

For example, if a regular resin composite filling is sufficient to restore a tooth to health, and the patient and the Dentist decide to use a gold filling, the Plan will base its reimbursement on the Recognized Charge for a resin composite filling. The patient will pay the difference in cost.

EXCLUSIONS

A charge for the following is not covered:

(1) **Administrative costs.** Administrative costs of completing claim forms or reports or for providing dental records. This Plan also excludes charges associated with failure to keep a scheduled appointment without giving the dental office 24 hours notice.

(2) **Attachments, semi-precision or precision attachments.** Attachments to conventional removable prostheses or fixed bridgework. This includes semi-precision or precision attachments associated with partial dentures, crown or bridge abutments, full or partial overdentures, any internal attachment associated with an implant prosthesis, and any elective endodontic procedure related to a tooth or root involved in the construction of a prosthesis of this nature.

(3) **Broken appointments.** Charges for broken or missed dental appointments.

(4) **Cosmetic procedures.** Any dental procedure performed solely for cosmetic/aesthetic reasons. (Cosmetic procedures are those procedures that improve physical appearance.)

(5) **Crowns.** Crowns for teeth that are restorable by other means or for the purpose of Periodontal Splinting.

(6) **Excluded under Medical.** Services that are excluded under Medical Plan Exclusions.

(7) **Hospitalization.** Charges associated with hospitalization or other facility charges.

(8) **Hygiene.** Oral hygiene, plaque control programs or dietary instructions.

(9) **Implants.** Placement of dental implants, implant-supported abutments and prostheses. This includes pharmacological regimens and restorative materials not accepted by the American Dental Association (ADA) Council on Dental Therapeutics.

(10) **Medical services.** Services that, to any extent, are payable under any medical expense benefits of the Plan.

(11) **Missing teeth replacement.** Benefits are not payable for the replacement of missing natural teeth lost prior to the becoming a Covered Person under this Plan unless coverage has been in effect for twelve months.

(12) **No listing.** Services which are not included in the list of covered dental services.

(13) **Orthognathic surgery.**

(14) **Periodontal stability.** Placement of fixed bridgework solely for the purpose of achieving periodontal stability.

(15) **Personalization.** Personalization of dentures.

(16) **Prior to effective date and after termination date.** Expenses for dental procedures begun prior to the Covered Persons effective date with this Plan or after coverage under this Plan has terminated.

(17) **Reconstructive surgery.** Charges for reconstructive surgery regardless of whether or not the surgery which is incidental to a dental disease, injury, or congenital anomaly when the primary purpose is to improve physiological functioning of the involved part of the body.

(18) **Replacement.** Replacement of lost or stolen appliances.

(19) **Splinting.** Crowns, fillings or appliances that are used to connect (splint) teeth, or change or alter the way the teeth meet, including altering the vertical dimension, restoring the bite (occlusion) or are cosmetic.

(20) **Temporomandibular joint (TMJ).** Services related to the temporomandibular joint (TMJ), either bilateral or unilateral, Upper and lower jaw bone surgery (including that related to the temporomandibular joint). No coverage is provided for orthognathic surgery, jaw alignment, or treatment for the temporomandibular joint.

(21) **Vertical dimension of occlusion (VDO).** Procedures related to the reconstruction of a patient's correct vertical dimension of occlusion (VDO).

HOW TO SUBMIT A CLAIM

Benefits under this Plan shall be paid only if a claim has been filed with the Plan Administrator and the Plan Administrator decides in its discretion that a Covered Person is entitled to them.

When a Covered Person has a Claim to submit for payment that person must:

(1) Obtain a Claim form from the Human Resources Office or the Plan Administrator.

(2) Complete the Employee portion of the form. ALL QUESTIONS MUST BE ANSWERED.

(3) Have the Physician or Dentist complete the provider's portion of the form.

(4) For Plan reimbursements, attach bills for services rendered. ALL BILLS MUST SHOW:

- Name of Plan
- Employee's name
- Name of patient
- Name, address, telephone number of the provider of care
- Diagnosis
- Type of services rendered, with diagnosis and/or procedure codes
- Date of services
- Charges

(5) Send the above to the Claims Administrator at this address:

HealthComp Administrators
P. O. Box 45018
Fresno, California 93718-5018
(800) 442-7247

WHEN CLAIMS SHOULD BE FILED

Claims should be filed with the Claims Administrator within 12 months of the date charges for the services were incurred. Benefits are based on the Plan's provisions at the time the charges were incurred. Claims filed later than that date may be declined or reduced unless:

(a) it's not reasonably possible to submit the claim in that time; and

(b) This one year period will not apply when the person is not legally capable of submitting the claim.

The Claims Administrator will determine if enough information has been submitted to enable proper consideration of the claim. If not, more information may be requested from the claimant. The Plan reserves the right to have a Plan Participant seek a second medical opinion.

A request for Plan benefits will be considered a claim for Plan benefits, and it will be subject to a full and fair review. If a claim is wholly or partially denied, the Claims Administrator will furnish the Plan Participant with a written notice of this denial. This written notice will be provided within 90 days after receipt of the claim. The written notice will contain the following information:

(a) the specific reason or reasons for the denial;

(b) specific reference to those Plan provisions on which the denial is based;

(c) a description of any additional information or material necessary to correct the claim and an explanation of why such material or information is necessary; and

(d) appropriate information as to the steps to be taken if a Plan Participant wishes to submit the claim for review.

A Plan Participant will be notified within 90 days of receipt of the claim as to the acceptance or denial of a claim and if not notified within 90 days, the claim shall be deemed denied.

If special circumstances require an extension of time for processing the claim, the Claims Administrator shall send written notice of the extension to the Plan Participant. The extension notice will indicate the special circumstances requiring the extension of time and the date by which the Plan expects to render the final decision on the claim. In no event will the extension exceed a period of 90 days from the end of the initial 90-day period.

CLAIMS REVIEW PROCEDURE

In cases where a claim for benefits payment is denied in whole or in part, the Plan Participant may appeal the denial. This appeal provision will allow the Plan Participant to:

(a) Request from the Plan Administrator a review of any claim for benefits. Such request must include: the name of the Employee, his or her Social Security number, the name of the patient and the Group Identification Number, if any.

(b) File the request for review in writing, stating in clear and concise terms the reason or reasons for this disagreement with the handling of the claim.

The request for review must be directed to the Plan Administrator or Claims Administrator within 60 days after the claim payment date or the date of the notification of denial of benefits.

A review of the denial will be made by the Plan Administrator and the Plan Administrator will provide the Plan Participant with a written response within 60 days of the date the Plan Administrator receives the Plan Participant's written request for review and if not notified, the Plan Participant may deem the claim denied. If, because of extenuating circumstances, the Plan Administrator is unable to complete the review process within 60 days, the Plan Administrator shall notify the Plan Participant of the delay within the 60 day period and shall provide a final written response to the request for review within 120 days of the date the Plan Administrator received the Plan Participant's written request for review.

The Plan Administrator's written response to the Plan Participant shall cite the specific Plan provision(s) upon which the denial is based.

A Plan Participant must exhaust the claims appeal procedure before filing a suit for benefits.

COORDINATION OF BENEFITS

Coordination of the benefit plans. Coordination of benefits sets out rules for the order of payment of Covered Charges when two or more plans -- including Medicare -- are paying. When a Covered Person is covered by this Plan and another plan, or the Covered Person's Spouse is covered by this Plan and by another plan, or the couple's covered children are covered under two or more plans, the plans will coordinate benefits when a claim is received.

The plan that pays first according to the rules will pay as if there were no other plan involved. The secondary and subsequent plans will pay the balance of eligible expenses due, up to 100% of the total Allowable Charges.

The Superior Court of California, County of Kern Employee Health Care Plan does not coordinate benefits with a Medical Expense Reimbursement Plan (MERP).

Benefit plan. This provision will coordinate the medical and dental benefits of a benefit plan. The term benefit plan means this Plan or any one of the following plans:

(1) Group or group-type plans, including franchise or blanket benefit plans.

(2) Blue Cross and Blue Shield group plans.

(3) Group practice and other group prepayment plans.

(4) Federal government plans or programs. This includes, but is not limited to, Medicare and Tricare.

(5) Other plans required or provided by law. This does not include Medicaid or any benefit plan like it that, by its terms, does not allow coordination.

(6) No Fault Auto Insurance, by whatever name it is called, when not prohibited by law.

Allowable Charge. For a charge to be allowable it must be a Recognized Charge and at least part of it must be covered under this Plan.

In the case of HMO (Health Maintenance Organization) or other in-network only plans: This Plan will not consider any charges in excess of what an HMO or network provider has agreed to accept as payment in full. Also, when an HMO or network plan is primary and the Covered Person does not use an HMO or network provider, this Plan will not consider as an Allowable Charge any charge that would have been covered by the HMO or network plan had the Covered Person used the services of an HMO or network provider.

In the case of service type plans where services are provided as benefits, the reasonable cash value of each service will be the Allowable Charge.

Automobile limitations. Automobile limitations. When medical payments are available under vehicle insurance, the Plan shall pay excess benefits only, without reimbursement for vehicle plan deductibles. This Plan shall always be considered the secondary carrier regardless of the individual’s election to file a claim under PIP (personal injury protection) coverage with the auto carrier.

Benefit plan payment order. When two or more plans provide benefits for the same Allowable Charge, benefit payment will follow these rules:

(1) Plans that do not have a coordination provision, or one like it, will pay first. Plans with such a provision will be considered after those without one.

(2) Plans with a coordination provision will pay their benefits up to the Allowable Charge:

(a) The benefits of the plan which covers the person directly (that is, as an employee, member or subscriber) ("Plan A") are determined before those of the plan which covers the person as a dependent ("Plan B").

(b) The benefits of a benefit plan which covers a person as an employee who is neither laid off nor retired are determined before those of a benefit plan which covers that person as a laid-off or retired employee. The benefits of a benefit plan which covers a person as a dependent of an employee who is neither laid off nor retired are determined before those of a benefit plan which covers a person as a dependent of a laid off or retired employee. If the other benefit plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule does not apply.

(c) The benefits of a benefit plan which covers a person as an employee who is neither laid off nor retired or a dependent of an employee who is neither laid off nor retired are determined before those of a plan which covers the person as a COBRA beneficiary.

(d) When a child is covered as a dependent and the parents are not separated or divorced, these rules will apply:

(i) The benefits of the benefit plan of the parent whose birthday falls earlier in a year are determined before those of the benefit plan of the parent whose birthday falls later in that year;

(ii) If both parents have the same birthday, the benefits of the benefit plan which has covered the parent for the longer time are determined before those of the benefit plan which covers the other parent.

(e) When a child's parents are divorced or legally separated, these rules will apply:

(i) This rule applies when the parent with custody of the child has not remarried. The benefit plan of the parent with custody will be considered before the benefit plan of the parent without custody.

(ii) This rule applies when the parent with custody of the child has remarried. The benefit plan of the parent with custody will be considered first. The benefit plan of the stepparent that covers the child as a dependent will be considered next. The benefit plan of the parent without custody will be considered last.

(iii) This rule will be in place of items (i) and (ii) above when it applies. A court decree may state which parent is financially responsible for medical and dental benefits of the child. In this case, the benefit plan of that parent will be considered before other plans that cover the child as a dependent.

(iv) If the specific terms of the court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child shall follow the order of benefit determination rules outlined above when a child is covered as a dependent and the parents are not separated or divorced.

(v) For parents who were never married to each other, the rules apply as set out above as long as paternity has been established.

(f) If there is still a conflict after these rules have been applied, the benefit plan which has covered the patient for the longer time will be considered first.

When there is a conflict in coordination of benefit rules, the Plan will never pay more than 50% of Allowable Charges when paying secondary.

(3) Medicare will pay primary, secondary or last to the extent stated in federal law. If a Plan Participant is Medicare entitled, this Plan will base its payment upon benefits that would have been paid by Medicare under Parts A, B and D, regardless of whether or not the person was enrolled under any of these parts.

(4) If a Plan Participant is under a disability extension from a previous benefit plan, that benefit plan will pay first and this Plan will pay second.

(5) The Plan will pay primary to Tricare to the extent required by federal law.

Claims determination period. Benefits will be coordinated on a Calendar Year basis. This is called the claims determination period.

Right to receive or release necessary information. To make this provision work, this Plan may give or obtain needed information from another insurer or any other organization or person. This information may be given or obtained without the consent of or notice to any other person. A Covered Person will give this Plan the information it asks for about other plans and their payment of Allowable Charges.

Facility of payment. This Plan may repay other plans for benefits paid that the Plan Administrator determines it should have paid. That repayment will count as a valid payment under this Plan.

Right of recovery. This Plan may pay benefits that should be paid by another benefit plan. In this case this Plan may recover the amount paid from the other benefit plan or the Covered Person. That repayment will count as a valid payment under the other benefit plan.

Further, this Plan may pay benefits that are later found to be greater than the Allowable Charge. In this case, this Plan may recover the amount of the overpayment from the source to which it was paid.

THIRD PARTY RECOVERY PROVISION

RIGHT OF SUBROGATION AND REFUND

When this provision applies. The Covered Person may incur medical or dental charges due to Injuries which may be caused by the act or omission of a Third Party or a Third Party may be responsible for payment. In such circumstances, the Covered Person may have a claim against that Third Party, or insurer, for payment of the medical or dental charges. Accepting benefits under this Plan for those incurred medical or dental expenses automatically assigns to the Plan any rights the Covered Person may have to Recover payments from any Third Party or insurer. This Subrogation right allows the Plan to pursue any claim which the Covered Person has against any Third Party, or insurer, whether or not the Covered Person chooses to pursue that claim. The Plan may make a claim directly against the Third Party or insurer, but in any event, the Plan has a lien on any amount Recovered by the Covered Person whether or not designated as payment for medical expenses. This lien shall remain in effect until the Plan is repaid in full.

The payment for benefits received by a Covered Person under the Plan shall be made in accordance with the assignment of rights by or on behalf of the Covered Person as required by Medicaid.

In any case in which the Plan has a legal liability to make payments for benefits received by a Covered Person, to the extent that payment has been made through Medicaid, the payment for benefits under the Plan shall be made in accordance with any state law that has provided that the state has acquired the rights of the Covered Person to the payments of those benefits.

The Covered Person:

(1) automatically assigns to the Plan his or her rights against any Third Party or insurer when this provision applies; and

(2) must repay to the Plan the benefits paid on his or her behalf out of the Recovery made from the Third Party or insurer.

Amount subject to Subrogation or Refund. The Covered Person agrees to recognize the Plan's right to Subrogation and Refund. These rights provide the Plan with a 100%, first dollar priority over any and all Recoveries and funds paid by a Third Party or insurer to a Covered Person relative to the Injury or Sickness, including a priority over any claim for non-medical or dental charges, attorney fees, or other costs and expenses, even if the Covered Person's Recovery is less than the amount claimed, and, as a result, the Covered Person is not made whole. The Covered Person further specifically agrees and acknowledges that the "made whole doctrine" and "common fund" doctrine are completely abrogated under this Plan, and will not affect the Plan's right to 100% Subrogation or Refund for any and all benefits paid. Accepting benefits under this Plan for those incurred medical or dental expenses automatically assigns to the Plan any and all rights the Covered Person may have to recover payments from any responsible third party or insurer. Further, accepting benefits under this Plan for those incurred medical or dental expenses automatically assigns to the Plan the Covered Person's Third Party Claims and/or the Covered Person's claims under any other policy of insurance, including, but not limited to, underinsured or uninsured motorist coverage.

Notwithstanding its priority to funds, the Plan's Subrogation and Refund rights, as well as the rights assigned to it, are limited to the extent to which the Plan has made, or will make, payments for medical or dental charges as well as any costs and fees associated with the enforcement of its rights under the Plan. The Plan reserves the right to be reimbursed for its court costs and attorneys' fees if the Plan needs to file suit in order to Recover payment for medical or dental expenses from the Covered Person.

When a right of Recovery exists, the Covered Person will execute and deliver all required instruments and papers as well as doing whatever else is needed to secure the Plan's right of Subrogation as a condition to having the Plan make payments. In addition, the Covered Person will do nothing to prejudice the right of the Plan to Subrogate.

Conditions Precedent to Coverage. The Plan shall have no obligation whatsoever to pay medical or dental benefits to a Covered Person if a Covered Person refuses to cooperate with the Plan's reimbursement and Subrogation rights or refuses to execute and deliver such papers as the Plan may require in furtherance of its reimbursement and Subrogation rights. Further, in the event the Covered Person is a minor, the Plan shall have no obligation to pay any medical or dental benefits incurred on account of Injury or Sickness caused by a responsible Third Party until after the Covered Person or his authorized legal representative obtains valid court recognition and approval of the Plan's 100%, first dollar reimbursement and Subrogation rights on all Recoveries, as well as approval for the execution of any papers necessary for the enforcement thereof, as described herein.

Defined terms: "Covered Person" means anyone covered under the Plan, including minor dependents.

"Recover," "Recovered," "Recovery" or "Recoveries" means all monies paid to the Covered Person by way of judgment, settlement, or otherwise to compensate for all losses caused by the Injury or Sickness, whether or not said losses reflect medical or dental charges covered by the Plan. "Recoveries" further includes, but is not limited to, recoveries for medical or dental expenses, attorneys' fees, costs and expenses, pain and suffering, loss of consortium, wrongful death, lost wages and any other recovery of any form of damages or compensation whatsoever.

"Refund" means repayment to the Plan for medical or dental benefits that it has paid toward care and treatment of the Injury or Sickness.

"Subrogation" means the Plan's right to pursue and place a lien upon the Covered Person's claims for medical or dental charges against the other person.

"Third Party" means any Third Party including another person or a business entity.

Recovery from another plan under which the Covered Person is covered. This right of Refund also applies when a Covered Person Recovers under an uninsured or underinsured motorist plan (which will be treated as Third Party coverage when reimbursement or Subrogation is in order), homeowner's plan, renter's plan, medical malpractice plan or any liability plan.

Rights of Plan Administrator. The Plan Administrator has a right to request reports on and approve of all settlements.

CONTINUATION COVERAGE RIGHTS UNDER COBRA

Under federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), certain Employees and their families covered under The Plan will be entitled to the opportunity to elect a temporary extension of health coverage (called "COBRA continuation coverage") where coverage under the Plan would otherwise end. This part of the Plan sets forth the rights and obligations of the Plan Participants and beneficiaries under the continuation coverage provisions of COBRA, as amended and reflected in final and proposed regulations published by the Department of the Treasury.

The Plan Administrator is The Superior Court of California, County of Kern, 1415 Truxtun Avenue, Room 212, Bakersfield, California, 93301. COBRA continuation coverage for the Plan is administered by HealthComp Administrators, P. O. Box 45018, Fresno, California 93718-5018, (800) 442-7247. Complete instructions on COBRA, as well as election forms and other information, will be provided by the Plan Administrator or its designee to Plan Participants who become Qualified Beneficiaries under COBRA.

What is COBRA continuation coverage? COBRA continuation coverage is the temporary extension of group health plan coverage that must be offered to certain Plan Participants and their eligible family members (called "Qualified Beneficiaries") at group rates. The right to COBRA continuation coverage is triggered by the occurrence of a life event that results in the loss of coverage under the terms of the Plan (the "Qualifying Event"). The coverage must be identical to the Plan coverage that the Qualified Beneficiary had immediately before the Qualifying Event, or if the coverage has been changed, the coverage must be identical to the coverage provided to similarly situated active employees who have not experienced a Qualifying Event (in other words, similarly situated non-COBRA beneficiaries).

Who can become a Qualified Beneficiary? In general, a Qualified Beneficiary can be:

(1) Any individual who, on the day before a Qualifying Event, is covered under the Plan by virtue of being on that day either a covered Employee, the Spouse of a covered Employee, or a Dependent child of a covered Employee. If, however, an individual who otherwise qualifies as a Qualified Beneficiary is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the Plan coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.

(2) Any child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage, and any individual who is covered by the Plan as an alternate recipient under a qualified medical support order. If, however, an individual who otherwise qualifies as a Qualified Beneficiary is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the Plan coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.

(3) A covered Employee who retired on or before the date of substantial elimination of Plan coverage which is the result of a bankruptcy proceeding under Title 11 of the U.S. Code with respect to the Employer, as is the Spouse, surviving Spouse or Dependent child of such a covered Employee if, on the day before the bankruptcy Qualifying Event, the Spouse, surviving Spouse or Dependent child was a beneficiary under the Plan.

The term "covered Employee" includes not only common-law employees (whether part-time or full-time) but also any individual who is provided coverage under the Plan due to his or her performance of services for the employer sponsoring the Plan (e.g., self-employed individuals, independent contractor, or corporate director). However, this provision does not establish eligibility of these individuals. Eligibility for Plan Coverage shall be determined in accordance with Plan Eligibility provisions.

An individual is not a Qualified Beneficiary if the individual's status as a covered Employee is attributable to a period in which the individual was a nonresident alien who received from the individual's Employer no earned income that constituted income from sources within the United States. If, on account of the preceding reason, an individual is not a Qualified Beneficiary, then a Spouse or Dependent child of the individual will also not be considered a Qualified Beneficiary by virtue of the relationship to the individual. A registered domestic partner is treated as a Qualified Beneficiary. This gives the registered domestic partner the contractual rights outlined in this document but does not extend statutory provisions to the registered domestic partner.

Each Qualified Beneficiary (including a child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage) must be offered the opportunity to make an independent election to receive COBRA continuation coverage.

What is a Qualifying Event? A Qualifying Event is any of the following if the Plan provided that the Plan participant would lose coverage (i.e.: cease to be covered under the same terms and conditions as in effect immediately before the Qualifying Event) in the absence of COBRA continuation coverage:

(1) The death of a covered Employee.

(2) The termination (other than by reason of the Employee's gross misconduct), or reduction of hours, of a covered Employee's employment.

(3) The divorce or legal separation of a covered Employee from the Employee's Spouse. If the Employee reduces or eliminates the Employee's Spouse's Plan coverage in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the divorce or legal separation may be considered a Qualifying Event even though the Spouse's coverage was reduced or eliminated before the divorce or legal separation.

(4) A covered Employee's enrollment in any part of the Medicare program.

(5) A Dependent child's ceasing to satisfy the Plan's requirements for a Dependent child (for example, attainment of the maximum age for dependency under the Plan).

(6) A proceeding in bankruptcy under Title 11 of the U.S. Code with respect to an Employer from whose employment the covered Employee retired at any time.

If the Qualifying Event causes the covered Employee, or the covered Spouse or a Dependent child of the covered Employee, to cease to be covered under the Plan under the same terms and conditions as in effect immediately before the Qualifying Event (or in the case of the bankruptcy of the Employer, any substantial elimination of coverage under the Plan occurring within 12 months before or after the date the bankruptcy proceeding commences), the persons losing such coverage become Qualified Beneficiaries under COBRA if all the other conditions of COBRA are also met. For example, any increase in contribution that must be paid by a covered Employee, or the Spouse, or a Dependent child of the covered Employee, for coverage under the Plan that results from the occurrence of one of the events listed above is a loss of coverage.

What is the procedure for obtaining COBRA continuation coverage? The Plan has conditioned the availability of COBRA continuation coverage upon the timely election of such coverage. An election is timely if it is made during the election period.

What is the election period and how long must it last? The election period is the time period within which the Qualified Beneficiary must elect COBRA continuation coverage under the Plan. The election period must begin no later than the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event and ends 60 days after the later of the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event or the date notice is provided to the Qualified Beneficiary of her or his right to elect COBRA continuation coverage. If coverage is not elected within the 60 day period, all rights to elect COBRA continuation coverage are forfeited.

Note: If a covered employee who has been terminated or experienced a reduction of hours qualifies for a trade readjustment allowance or alternative trade adjustment assistance under a federal law called the Trade Act of 2002, and the employee and his or her covered dependents have not elected COBRA coverage within the normal election period, a second opportunity to elect COBRA coverage will be made available for themselves and certain family members, but only within a limited period of 60 days or less and only during the six months immediately after their group health plan coverage ended. Any person who qualifies or thinks that he and/or his family members may qualify for assistance under this special provision should contact the Plan Administrator for further information.

The Trade Act of 2002 also created a new tax credit for certain TAA-eligible individuals and for certain retired employees who are receiving pension payments from the Pension Benefit Guaranty Corporation (PBGC) (eligible individuals). Under the new tax provisions, eligible individuals can either take a tax credit or get advance payment of 65% of premiums paid for qualified health insurance, including continuation coverage. If you have questions about these new tax provisions, you may call the Health Coverage Tax Credit Consumer Contact Center toll-free at 1-866-628-4282. TTD/TTY callers may call toll-free at 1-866-626-4282. More information about the Trade Act is also available at www.doleta.gov/tradeact.

Is a covered Employee or Qualified Beneficiary responsible for informing the Plan Administrator of the occurrence of a Qualifying Event? The Plan will offer COBRA continuation coverage to Qualified Beneficiaries only after the Plan Administrator or its designee has been timely notified that a Qualifying Event has occurred. The employer (if the employer is not the Plan Administrator) will notify the Plan Administrator of the Qualifying Event within 30 days following the date coverage ends when the Qualifying Event is:

(1) the end of employment or reduction of hours of employment,

(2) death of the employee,

(3) commencement of a proceeding in bankruptcy with respect to the employer, or

(4) enrollment of the employee in any part of Medicare.

IMPORTANT:

For the other Qualifying Events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you or someone on your behalf must notify the Plan Administrator or its designee in writing within 60 days after the Qualifying Event occurs, using the procedures specified below. If these procedures are not followed or if the notice is not provided in writing to the Plan Administrator or its designee during the 60-day notice period, any spouse or dependent child who loses coverage will not be offered the option to elect continuation coverage. You must send this notice to the COBRA Administrator.

NOTICE PROCEDURES:

Any notice that you provide must be ***in writing***. Oral notice, including notice by telephone, is not acceptable. You must hand-deliver, mail or fax your notice to the person, department or firm listed below, at the following addresses or numbers:

HealthComp Administrators

Hand deliver to:
621 Santa Fe
Fresno, California 93721

Mail to:
P. O. Box 45018
Fresno, California 93718-5018

Fax to:
559-499-2464

If mailed, your notice must be postmarked no later than the last day of the required notice period. Any notice you provide must state:

- the **name of the plan or plans** under which you lost or are losing coverage,
- the **name and address of the employee** covered under the plan,
- the **name(s) and address(es) of the Qualified Beneficiary(ies)**, and
- the **Qualifying Event** and the **date** it happened.

If the Qualifying Event is a **divorce or legal separation**, your notice must include **a copy of the divorce decree or the legal separation agreement**.

Be aware that there are other notice requirements in other contexts, for example, in order to qualify for a disability extension.

Once the Plan Administrator or its designee receives *timely notice* that a Qualifying Event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each Qualified Beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage for their spouses, and parents may elect COBRA continuation coverage on behalf of their children. For each Qualified Beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date that plan coverage would otherwise have been lost. If you or your spouse or dependent children do not elect continuation coverage within the 60-day election period described above, the right to elect continuation coverage will be lost.

Is a waiver before the end of the election period effective to end a Qualified Beneficiary's election rights? If, during the election period, a Qualified Beneficiary waives COBRA continuation coverage, the waiver can be revoked at any time before the end of the election period. Revocation of the waiver is an election of COBRA continuation coverage. However, if a waiver is later revoked, coverage need not be provided retroactively (that is, from the date of the loss of coverage until the waiver is revoked). Waivers and revocations of waivers are considered made on the date they are sent to the Plan Administrator or its designee, as applicable.

Is COBRA coverage available if a Qualified Beneficiary has other group health plan coverage or Medicare? Qualified beneficiaries who are entitled to elect COBRA continuation coverage may do so even if they are covered under another group health plan or are entitled to Medicare benefits on or before the date on which COBRA is elected. However, a Qualified Beneficiary's COBRA coverage will terminate automatically if, after electing COBRA, he or she becomes entitled to Medicare or becomes covered under other group health plan coverage.

When may a Qualified Beneficiary's COBRA continuation coverage be terminated? During the election period, a Qualified Beneficiary may waive COBRA continuation coverage. Except for an interruption of coverage in connection with a waiver, COBRA continuation coverage that has been elected for a Qualified Beneficiary must extend for at least the period beginning on the date of the Qualifying Event and ending not before the earliest of the following dates:

(1) The last day of the applicable maximum coverage period.

(2) The first day for which Timely Payment is not made to the Plan with respect to the Qualified Beneficiary.

(3) The date upon which the Employer ceases to provide any group health plan (including a successor plan) to any employee.

(4) The date, after the date of the election, that the Qualified Beneficiary first becomes covered under any other Plan.

(5) The date, after the date of the election that the Qualified Beneficiary first enrolls in the Medicare program (either part A or part B, whichever occurs earlier).

(6) In the case of a Qualified Beneficiary entitled to a disability extension, the later of:

(a) (i) 29 months after the date of the Qualifying Event, or (ii) the first day of the month that is more than 30 days after the date of a final determination under Title II or XVI of the Social Security Act that the disabled Qualified Beneficiary whose disability resulted in the Qualified Beneficiary's entitlement to the disability extension is no longer disabled, whichever is earlier; or

(b) the end of the maximum coverage period that applies to the Qualified Beneficiary without regard to the disability extension.

The Plan can terminate for cause the coverage of a Qualified Beneficiary on the same basis that the Plan terminates for cause the coverage of similarly situated non-COBRA beneficiaries, for example, for the submission of a fraudulent claim.

In the case of an individual who is not a Qualified Beneficiary and who is receiving coverage under the Plan solely because of the individual's relationship to a Qualified Beneficiary, if the Plan's obligation to make COBRA continuation coverage available to the Qualified Beneficiary ceases, the Plan is not obligated to make coverage available to the individual who is not a Qualified Beneficiary.

What are the maximum coverage periods for COBRA continuation coverage? The maximum coverage periods are based on the type of the Qualifying Event and the status of the Qualified Beneficiary, as shown below:

(1) In the case of a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period ends 18 months after the Qualifying Event if there is not a disability extension and 29 months after the Qualifying Event if there is a disability extension.

(2) In the case of a covered Employee's enrollment in the Medicare program before experiencing a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period for Qualified Beneficiaries other than the covered Employee ends on the later of:

(a) 36 months after the date the covered Employee becomes enrolled in the Medicare program; or

(b) 18 months (or 29 months, if there is a disability extension) after the date of the covered Employee's termination of employment or reduction of hours of employment.

(3) In the case of a bankruptcy Qualifying Event, the maximum coverage period for a Qualified Beneficiary who is the covered retiree ends on the date of the retiree's death. The maximum coverage period for a Qualified Beneficiary who is the covered Spouse, surviving Spouse or Dependent child of the retiree ends on the earlier of the Qualified Beneficiary's death or 36 months after the death of the retiree.

(4) In the case of a Qualified Beneficiary who is a child born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage, the maximum coverage period is the maximum coverage period applicable to the Qualifying Event giving rise to the period of COBRA continuation coverage during which the child was born or placed for adoption.

(5) In the case of any other Qualifying Event than that described above, the maximum coverage period ends 36 months after the Qualifying Event.

Under what circumstances can the maximum coverage period be expanded? If a Qualifying Event that gives rise to an 18-month or 29-month maximum coverage period is followed, within that 18- or 29-month period, by a second Qualifying Event that gives rise to a 36-months maximum coverage period, the original period is expanded to 36 months, but only for individuals who are Qualified Beneficiaries at the time of and with respect to both Qualifying Events. In no circumstance can the COBRA maximum coverage period be expanded to more than 36 months after the date of the first Qualifying Event. The Plan Administrator must be notified of the second Qualifying Event within 60 days of the second Qualifying Event. This notice must be sent to the COBRA Administrator in accordance with the procedures above.

How does a Qualified Beneficiary become entitled to a disability extension? A disability extension will be granted if an individual (whether or not the covered Employee) who is a Qualified Beneficiary in connection with the Qualifying Event that is a termination or reduction of hours of a covered Employee's employment, is determined under Title II or XVI of the Social Security Act to have been disabled at any time during the first 60 days of COBRA continuation coverage. To qualify for the disability extension, the Qualified Beneficiary must also provide the Plan Administrator with notice of the disability determination on a date that is both within 60 days after the date of the determination and before the end of the original 18-month maximum coverage. This notice should be sent to the COBRA Administrator in accordance with the procedures above.

Does the Plan require payment for COBRA continuation coverage? For any period of COBRA continuation coverage under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage. Qualified beneficiaries will pay up to 102% of the applicable premium and up to 150% of the applicable premium for any expanded period of COBRA continuation coverage covering a disabled Qualified Beneficiary due to a disability extension. The Plan will terminate a Qualified Beneficiary's COBRA continuation coverage as of the first day of any period for which timely payment is not made.

Must the Plan allow payment for COBRA continuation coverage to be made in monthly installments? Yes. The Plan is also permitted to allow for payment at other intervals.

What is Timely Payment for payment for COBRA continuation coverage? Timely Payment means a payment made no later than 30 days after the first day of the coverage period. Payment that is made to the Plan by a later date is also considered Timely Payment if either under the terms of the Plan, covered employees or Qualified Beneficiaries are allowed until that later date to pay for their coverage for the period or under the terms of an arrangement between the Employer and the entity that provides Plan benefits on the Employer's behalf, the Employer is allowed until that later date to pay for coverage of similarly situated non-COBRA beneficiaries for the period.

Notwithstanding the above paragraph, the Plan does not require payment for any period of COBRA continuation coverage for a Qualified Beneficiary earlier than 45 days after the date on which the election of COBRA continuation coverage is made for that Qualified Beneficiary. Payment is considered made on the date on which it is postmarked to the Plan.

If Timely Payment is made to the Plan in an amount that is not significantly less than the amount the Plan requires to be paid for a period of coverage, then the amount paid will be deemed to satisfy the Plan's requirement for the amount to be paid, unless the Plan notifies the Qualified Beneficiary of the amount of the deficiency and grants a reasonable period of time for payment of the deficiency to be made. A "reasonable period of time" is 30 days after the notice is provided. A shortfall in a Timely Payment is not significant if it is no greater than the lesser of $50 or 10% of the required amount.

Is COBRA continuation coverage available to domestic partners and children of domestic partners? A domestic partner is treated as a Qualified Beneficiary. This gives the domestic partner the contractual rights outlined in this document but does not extend statutory provisions to the domestic partner.

IF YOU HAVE QUESTIONS

If you have questions about your COBRA continuation coverage, you should contact the COBRA Administrator. For more information about your rights under COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website at www.dol.gov/ebsa.

KEEP YOUR PLAN ADMINISTRATOR INFORMED OF ADDRESS CHANGES

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

RESPONSIBILITIES FOR PLAN ADMINISTRATION

PLAN ADMINISTRATOR. The Plan is the benefit plan of The Superior Court of California, County of Kern, the Plan Administrator, also called the Plan Sponsor. An individual may be appointed by The Superior Court of California, County of Kern to be Plan Administrator and serve at the convenience of the Employer. If the Plan Administrator resigns, dies or is otherwise removed from the position, The Superior Court of California, County of Kern shall appoint a new Plan Administrator as soon as reasonably possible.

The Plan Administrator shall administer this Plan in accordance with its terms and establish its policies, interpretations, practices, and procedures. It is the express intent of this Plan that the Plan Administrator shall have maximum legal discretionary authority to construe and interpret the terms and provisions of the Plan, to make determinations regarding issues which relate to eligibility for benefits, to decide disputes which may arise relative to a Plan Participant's rights, and to decide questions of Plan interpretation and those of fact relating to the Plan. The decisions of the Plan Administrator will be final and binding on all interested parties.

DUTIES OF THE PLAN ADMINISTRATOR.

(1) To administer the Plan in accordance with its terms.

(2) To interpret the Plan, including the right to remedy possible ambiguities, inconsistencies or omissions.

(3) To decide disputes which may arise relative to a Plan Participant's rights.

(4) To prescribe procedures for filing a claim for benefits and to review claim denials.

(5) To keep and maintain the Plan documents and all other records pertaining to the Plan.

(6) To appoint a Claims Administrator to pay claims.

(7) To delegate to any person or entity such powers, duties and responsibilities as it deems appropriate.

PLAN ADMINISTRATOR COMPENSATION. The Plan Administrator serves **without** compensation; however, all expenses for plan administration, including compensation for hired services, will be paid by the Plan.

CLAIMS ADMINISTRATOR IS NOT A FIDUCIARY. A Claims Administrator is **not** a fiduciary under the Plan by virtue of paying claims in accordance with the Plan's rules as established by the Plan Administrator.

COMPLIANCE WITH HIPAA PRIVACY STANDARDS. Certain members of the Employer's workforce perform services in connection with administration of the Plan. In order to perform these services, it is necessary for these employees from time to time to have access to Protected Health Information (as defined below).

Under the Standards for Privacy of Individually Identifiable Health Information (45 CFR Part 164, the "Privacy Standards"), these employees are permitted to have such access subject to the following:

(1) **General.** The Plan shall not disclose Protected Health Information to any member of the Employer's workforce unless each of the conditions set out in this HIPAA Privacy section is met. "Protected Health Information" shall have the same definition as set out in the Privacy Standards but generally shall mean individually identifiable health information about the past, present or future physical or mental health or condition of an individual, including information about treatment or payment for treatment.

(2) **Permitted Uses and Disclosures.** Protected Health Information disclosed to members of the Employer's workforce shall be used or disclosed by them only for purposes of Plan administrative functions. The Plan's administrative functions shall include all Plan payment and health care operations. The terms "payment" and "health care operations" shall have the same definitions as set out in the Privacy Standards, but the term "payment" generally shall mean activities taken with respect to payment of premiums or contributions, or to determine or fulfill Plan responsibilities with respect to coverage, provision of benefits, or reimbursement for health care. "Health care operations" generally shall mean activities on behalf of the Plan that are related to quality assessment; evaluation, training or accreditation of health care providers; underwriting, premium rating and other functions related to obtaining or renewing an insurance contract, including stop-loss insurance; medical review; legal services or auditing functions; or business planning, management and general administrative activities.

(3) **Authorized Employees.** The Plan shall disclose Protected Health Information only to members of the Employer's workforce, who are designated and are authorized to receive such Protected Health Information, and only to the extent and in the minimum amount necessary for these persons to perform duties with respect to the Plan. For purposes of this HIPAA Privacy section, "members of the Employer's workforce" shall refer to all employees and other persons under the control of the Employer.

(a) **Updates Required.** The Employer shall amend the Plan promptly with respect to any changes in the members of its workforce who are authorized to receive Protected Health Information.

(b) **Use and Disclosure Restricted.** An authorized member of the Employer's workforce who receives Protected Health Information shall use or disclose the Protected Health Information only to the extent necessary to perform his or her duties with respect to the Plan.

(c) **Resolution of Issues of Noncompliance.** In the event that any member of the Employer's workforce uses or discloses Protected Health Information other than as permitted by the Privacy Standards, the incident shall be reported to the privacy official. The privacy official shall take appropriate action, including:

(i) Investigation of the incident to determine whether the breach occurred inadvertently, through negligence, or deliberately; whether there is a pattern of breaches; and the degree of harm caused by the breach;

(ii) Applying appropriate sanctions against the persons causing the breach, which, depending upon the nature of the breach may include, oral or written reprimand, additional training, or termination of employment;

(iii) Mitigating any harm caused by the breach, to the extent practicable; and

(iv) Documentation of the incident and all actions taken to resolve the issue and mitigate any damages.

(4) **Certification of Employer.** The Employer must provide certification to the Plan that it agrees to:

(a) Not use or further disclose the Protected Health Information other than as permitted or required by the Plan documents or as required by law;

(b) Ensure that any agent or subcontractor, to whom it provides Protected Health Information received from the Plan, agrees to the same restrictions and conditions that apply to the Employer with respect to such information;

(c) Not use or disclose Protected Health Information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Employer;

(d) Report to the Plan any use or disclosure of the Protected Health Information of which it becomes aware that is inconsistent with the uses or disclosures hereunder or required by law;

(e) Make available Protected Health Information to individual Plan members in accordance with Section 164.524 of the Privacy Standards;

(f) Make available Protected Health Information for amendment by individual Plan members and incorporate any amendments to Protected Health Information in accordance with Section 164.526 of the Privacy Standards;

(g) Make available the Protected Health Information required to provide any accounting of disclosures to individual Plan members in accordance with Section 164.528 of the Privacy Standards;

(h) Make its internal practices, books and records relating to the use and disclosure of Protected Health Information received from the Plan available to the Department of Health and Human Services for purposes of determining compliance by the Plan with the Privacy Standards;

(i) If feasible, return or destroy all Protected Health Information received from the Plan that the Employer still maintains in any form, and retain no copies of such information when no longer needed for the purpose of which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information unfeasible; and

(j) Ensure the adequate separation between the Plan and member of the Employer's workforce, as required by Section 164.504(f)(2)(iii) of the Privacy Standards.

The following members of Employer's workforce are designated as authorized to receive Protected Health Information from the Plan in order to perform their duties with respect to the Plan: Privacy Officer, and other individuals trained and authorized by the Privacy Officer to receive Protected Health Information.

COMPLIANCE WITH HIPAA ELECTRONIC SECURITY STANDARDS. Under the Security Standards for the Protection of Electronic Protected Health Information (45 CFR Part 164.300 et. seq., the "Security Standards"), the Employer agrees to the following:

(1) The Employer agrees to implement reasonable and appropriate administrative, physical and technical safeguards to protect the confidentiality, integrity and availability of Electronic Protected Health Information that the Employer creates, maintains or transmits on behalf of the Plan. "Electronic Protected Health Information" shall have the same definition as set out in the Security Standards, but generally shall mean Protected Health Information that is transmitted by or maintained in electronic media.

(2) The Employer shall ensure that any agent or subcontractor to whom it provides Electronic Protected Health Information shall agree, in writing, to implement reasonable and appropriate security measures to protect the Electronic Protected Health Information.

(3) The Employer shall ensure that reasonable and appropriate security measures are implemented to comply with the conditions and requirements set forth in Compliance With HIPAA Privacy Standards provisions (3) Authorized Employees and (4) Certification of Employer described above.

FUNDING THE PLAN AND PAYMENT OF BENEFITS

The cost of the Plan is funded as follows:

For Employee Coverage: Funding is derived solely from the funds of the Employer.

For Dependent Coverage: Funding is derived from the funds of the Employer and contributions made by the covered Employees.

The level of any Employee contributions will be set by the Plan Administrator. These Employee contributions will be used in funding the cost of the Plan as soon as practicable after they have been received from the Employee or withheld from the Employee's pay through payroll deduction.

Benefits are paid directly from the Plan through the Claims Administrator.

PLAN IS NOT AN EMPLOYMENT CONTRACT

The Plan is not to be construed as a contract for or of employment.

CLERICAL ERROR

Any clerical error by the Plan Administrator or an agent of the Plan Administrator in keeping pertinent records or a delay in making any changes will not invalidate coverage otherwise validly in force or continue coverage validly terminated. An equitable adjustment of contributions will be made when the error or delay is discovered.

If, due to a clerical error, an overpayment occurs in a Plan reimbursement amount, the Plan retains a contractual right to the overpayment. The person or institution receiving the overpayment will be required to return the incorrect amount of money. In the case of a Plan Participant, if it is requested, the amount of overpayment will be deducted from future benefits payable.

GENERAL PLAN INFORMATION

TYPE OF ADMINISTRATION

The Plan is a self-funded group health Plan and the administration is provided through a Third Party Claims Administrator. The funding for the benefits is derived from the funds of the Employer and contributions made by covered Employees. The Plan is not insured.

PLAN NAME

The Superior Court of California, County of Kern Health Care Plan

TAX ID NUMBER: 77-0559433

PLAN EFFECTIVE DATE: September 1, 2008

PLAN YEAR ENDS: December 31

EMPLOYER INFORMATION

The Superior Court of California, County of Kern
1415 Truxtun Avenue, Room 212
Bakersfield, California 93301

PLAN ADMINISTRATOR

The Superior Court of California, County of Kern
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CLAIMS ADMINISTRATOR/COBRA ADMINISTRATOR

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