HEALTH CARE PLAN BOOKLET

Del Norte County Self-Funded Health Care Plan

April 2003

CONTACT INFORMATION/TECHNICAL ASSISTANCE

Delta Health Systems – Group Plan # 550
1234 W. Oak Street
P.O. Box 551
Stockton, CA 95201-0551
(209) 948-8483
(800) 422-6099

- To submit claims
- For questions regarding eligibility
- For questions regarding benefits described in this benefit booklet
- To obtain pre-determination of dental benefits

County of Del Norte
981 H Street, Suite 250
Crescent City, CA 95531
(707) 464-7213

- For interpretations and questions regarding this Plan
- To obtain claim forms
- For replacement ID cards

Delta TeamCare
P.O. Box 1147
Stockton, CA 95204-1147
(877) 464-1441

- To obtain pre-admission review
- To obtain outpatient surgery review
- To obtain information regarding second surgical opinions

Interplan
(209) 473-0811
(800) 444-4036
www.interplancorp.com

- To request enrollment of a doctor in the Participating Provider Network
- For latest additions of hospitals, physicians or labs to the Participating Provider Network

PCN – Group Plan # 00342
Pharmaceutical Care Network
9343 Tech Center Drive, Suite 200
Sacramento, CA 95826-2592
(800) 777-0074 – Customer Care

- To locate a participating pharmacy
- **For copayment information**
- To obtain prior authorization for specific medications
- To request replacement prescription cards
- To submit claims for prescriptions purchased outside of the network

PPS
Postal Prescription Services
P.O. Box 2718
Portland, OR 97208-2718
(800) 552-6694
www.ppsrx.com

- To transfer existing prescriptions from a different pharmacy
- To reorder medication(s) previously filled by PPS

Issued To: ______________________________ Effective Date: _______________

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Section A – General Provisions

INTRODUCTION

This booklet describes the medical, dental, and pharmacy benefits that are provided by Del Norte County. Material in this booklet is for informational purposes only and is not intended to serve as legal interpretation of benefits. This booklet replaces and supercedes all plan documents the enrollee may have previously received.

Benefit Coverage

- Medical
- Dental
- Prescription Drugs

Effective Date

September 1, 2002

Self-Funding

This Health Care Benefit Plan is established on a self-funded basis with the County of Del Norte assuming liability for payment of benefits. The benefits described herein are not guaranteed and may be modified or terminated. No agent, other than the plan administrator, has the authority to change the benefits of this plan or to waive any of its provisions. The Plan Administrator has the authority and discretionary power to interpret benefits and determine questions of eligibility.

Benefit Booklet

This booklet has been prepared to furnish you with a description of your benefits provided through this plan. We suggest that you review this booklet carefully so you will be familiar with the benefits available to you and your family. This booklet is intended to serve as the Summary Plan Description. Employees are responsible for confirming the availability or interpretation of any benefit described herein.

Identification Cards

Beginning in July 2003, a *Del Norte County Health Plan* Identification card will be issued to each participant. This card serves as both a medical, including dental, and prescription drug card. Information regarding medical benefits is provided on one side; prescription plan information on the other. The identification card is to be presented to the medical provider or pharmacy so that they may obtain needed information.

Any questions about the ID card, requests for replacement of lost cards, or to receive additional cards should be made to the Del Norte County Personnel Office. The provision of replacement or additional cards may be subject to a small fee.

DEFINITIONS/KEY PHRASES

Below is a listing of terms and key phrases that appear in this booklet. In order for you to have a better understanding of your benefits, it is recommended that you review these definitions.

- **Active Work/Actively at Work**
  The active performance of all of an employee's normal job duties at the employer's usual place or places of business.

Section A – General Provisions

- **Certification**
  Determination has been made by the Utilization Review Organization that a surgical procedure or hospitalization has been approved as medically necessary for a specified number of days.

- **Contract Provider**
  Hospital, physician or lab which has negotiated a contract with this Health Plan to provide a service or supply covered under the Plan at a pre-determined fee which will normally result in a savings to both the Plan and to the Plan participant.

- **Convalescent Hospital**
  An institution which: (a) meets the licensing requirement listed under the definition of Skilled Nursing Facility; (b) provides skilled nursing care under 24-hour a day supervision of a doctor or graduate Registered Nurse; (c) has available at all times the services of a doctor who is a staff member of a hospital; (d) provides 24 hour a day nursing services by a graduate Registered Nurse, Licensed Vocational Nurse or Skilled Practical Nurse and has a graduate Registered Nurse on duty at least 8 hours per day; (e) maintains a daily medical record for each patient; and (f) is not a place for rest, custodial care, for the aged, for drug addicts or alcoholics, nor is a hotel or similar institution.

- **Copayment**
  The portion of a provider's charge, after the Plan has made payment of maximum benefits, that is the Plan participant's responsibility to pay. This may also be referred to as the Plan participant's "share of cost".

- **Covered Expense**
  The amount allowed by the Plan for a particular service or supply, based on all Plan provisions.

- **Deductible**
  An annual amount that is required to be paid by the Plan participant before health plan benefits will begin to reimburse for services.

- **Dental Treatment Plan**
  The dentist's report of proposed treatment which: (a) lists the procedures proposed for the period of dental treatment; (b) shows the charges for each procedure; and (c) is accompanied by any diagnostic materials and x-rays that might be required.

- **Durable Medical Equipment**
  Equipment which meets all of the following criteria: (a) it can withstand repeated use; (b) it is designed and used only to treat bodily injury or sickness; (c) it is appropriate for medical treatment in the home; (d) it has no value to the patient or the patient's family in absence of the bodily injury or sickness being treated; (e) it is not an item commonly found in the household; and (f) it is not sporting or athletic equipment.

- **Effective Date**
  The date on which coverage for an eligible employee or his/her eligible dependents begin.

- **Expense Incurred**
  The fee or charge for covered medical or dental services or supplies that is usual and customary in a case of comparable nature and severity in the particular geographic area concerned. Expense is considered to be incurred on the date the service or supply is rendered or obtained. For a supply or service furnished by a Contract Provider, the term "expense

incurred" means only the pre-determined fee. The Contracted Provider is not entitled to payment for any amount in excess of the pre-determined fee.

- **Home Health Care Agency**
  A hospital, agency, or other service that is recognized by Medicare and certified by the proper authority of the state in which it is located to provide home health care services of a Home Health Aide, Certified Nursing Aide, Licensed Vocational nurse, Registered Nurse, Physical Therapist, Occupational Therapist, or Speech Therapist.

- **Hospital**
  An institution that is: (a) licensed as an acute care facility by the proper authority of the state in which it is located; (b) recognized as a hospital by the Joint Commission on Accreditation of Hospitals (JCAH); (c) a state licensed and JCAH recognized mental health or psychiatric facility or an alcoholic or drug treatment facility, provided that these facilities are providing a treatment program for these specific diagnosed conditions and are operating within the scope of their license; and (d) a state licensed birthing center. A hospital does not include any institution, or part thereof, that is used primarily as a convalescent home, rest home, home for the aged, nursing home, custodial care facility, training center, residential care facility or half-way house.

- **Medical Emergency**
  The sudden onset of severe medical symptoms that: (a) could not have been reasonably anticipated, and (b) require immediate medical treatment to prevent loss of life.

- **Medicare**
  Both Part A, or the basic hospital portion, and Part B, or the voluntary supplemental medical portion, of the U.S. Public Law-89-97, "Health Insurance for the Aged Act", including any future amendments.

- **Physician**
  A doctor licensed to practice medicine and perform surgery. The term also refers to a licensed dentist, podiatrist, chiropractor or psychologist. Physicians also include any other licensed or certified practitioner who, upon referral by a Doctor of Medicine or a Doctor of Osteopathy, performs services which are covered under the Plan and are within the scope of his or her license or certificate.

- **Plan**
  The Medical, Dental and Prescription expense covered, whose benefits are self-funded by the County of Del Norte. Medical and Dental claim administration services are performed by Delta Health Systems. Prescription Care Network (PCN) administers the Prescription portion of the Plan.

- **Plan Participant**
  Any eligible employee of the County of Del Norte, that is eligible for Medical, Dental, and Prescription expense covered under this Health Plan. Plan participant is also used to refer to retirees, and the employee's or retiree's eligible dependents that may be covered under this Plan.

- **Pre-Determined Fee**
  The payment amount that a Contract Hospital, Physician or Lab has negotiated and contractually agreed upon with the Plan to accept as payment for a service or supply covered under this Plan.

Section A – General Provisions

- **Reimbursement**
  The Plan's right to recover any medical expense payments: (a) made because of an injury caused by a third party; and (b) for which the Plan participant later recovers from the third party or the third party's insurer.

- **Retired Employee**
  An employee who is: (a) classified as such by the Employer; and (b) is not in the military service.

- **Skilled Nursing Facility**
  An institution that is: (a) licensed by the state in which it is located to provide skilled nursing care to resident patients for an illness or injury; (b) is approved by Medicare as a Skilled Nursing Facility; (c) recognized by the Joint Commission on Accreditation of Hospitals; and (d) provides staffing as services listed under the definition of Convalescent Hospital; and (e) is not a place for rest, custodial care, for the aged, for drug addicts or alcoholics, or is a hotel or similar institution.

- **Substance Abuse**
  Any diagnosed condition, confinement or treatment related to the chemical dependency on alcohol or drugs.

- **Third Party Liability (Subrogation)**
  Another person, organization or entity which has caused an injury to a Plan participant by some wrongful act or negligence and is liable or responsible to make a financial settlement or award to the Plan participant for any medical expense, suffering or damages.

- **Totally Disabled**
  A condition resulting from bodily injury or sickness which: (a) you or your dependent is confined to a hospital; (b) completely and continuously keeps you from performing your occupation or engaging in any work for wage or profit; or (c) keeps a dependent from performing the normal activities of a person in good health of the same age and sex.

- **Usual, Customary & Reasonable (UCR)**
  A fee or charge for a service or supply which reflects current statistical data of prevailing health care charges for each particular procedure billed in each geographical service area. In determining UCR, the complexity and nature of the services are considered.

- **Utilization Review**
  The review of hospital admissions and surgical procedures by an organization comprised of Physicians and Registered Nurses to determine the medical necessity and length of stay required for each specific hospitalization or surgery. Utilization Review includes Pre-admission Review, Concurrent Review, and Discharge Planning, and Outpatient Surgery Review.

- **Waiting Period**
  The period of time that must pass from the date of employment to the first day of coverage under the Plan. The waiting period counts toward any requirements under the Pre-Existing Condition Limitation, but does not count in determining breaks in coverage or creditable coverage.

Section A – General Provisions

ELIGIBILITY AND PLAN PARTICIPATION

Eligibility

To be eligible for coverage under this Plan, you must be a permanent full-time employee or a permanent part-time employee who receives compensation from the County. A full-time employee is defined as an employee who works at least 35 hours per week; a permanent part-time employee is defined as an employee who works at least 15 hours per week. Retired employees are also covered under this Plan.

Effective Date

You will be eligible for benefits on the first day of the month following the 120-day waiting period provided you fill out the necessary enrollment form for yourself and any eligible dependents, and sign the forms necessary to authorize payroll deduction or any required employee contribution to the Plan.

Waiting Period

There is a waiting period of 120 days of continuous service that must be satisfied before an employee will be eligible for benefits. Benefits are effective on the 1st day of the month following the waiting period.

Dependent Eligibility

Dependent means:

(a) the covered employee's spouse under a legally valid marriage to a member of the opposite sex; and

(b) the covered employee's unmarried children from birth, including step-children, legally adopted children, or children who are relatives by blood or marriage living with the employee in a parent-child relationship, to age nineteen (19) if the child continuously remains financially dependent upon the employee for more than 60% of his or her support; but extending to age twenty-three (23) when they are attending an accredited educational institution on a full-time basis and continuously remains financially dependent upon the employee for more than 60% of his or her support.

The term dependent shall not include any person who is in full-time military service, foster children, or any individual other than as stated above.

Proof of educational status and financial dependence will be required and may be requested annually. Failure to provide such proof will result in termination of coverage for that dependent.

If a husband and wife are both covered as employees of this plan, their children can be dependents of one parent only. In addition, no plan participant can be a dependent if he/she is eligible as an employee under this plan.

When an unmarried dependent child is incapable of self-sustaining employment because of mental retardation or physical handicap on the date coverage would otherwise terminate on account of age, satisfactory proof of his/her incapacity should be submitted by a physician within thirty-one (31) days prior to the date termination would occur. Extension of medical and dental benefits will be continued until the earliest of: (a) the date he/she ceases to be eligible for reasons other than age; (b) the date/she ceases to be incapacitated; or (c) the 61st day after we request additional proof of his/her incapacity if you fail to furnish such proof.

Dependent Effective Date

Coverage for your dependents will be in force under the same terms as your coverage. However, coverage for a newly acquired spouse or child through marriage will become effective on the day he/she becomes a dependent, but only if an application to enroll the new spouse or child has been filed within thirty (30) days of the marriage. Newborn infants or a legally adopted child will be automatically covered on the date the child becomes an eligible dependent. A newborn infant becomes an eligible dependent on the date of birth and a legally adopted child becomes an eligible dependent on the date the child is placed in physical custody of the employee for adoption. In order to have coverage continue beyond the first 31 days without lapse, a written application must follow within 31 days of birth or adoption of such dependent.

OPEN ENROLLMENT

Open enrollment is a designated time period in a benefit plan year that provides employees the option of making changes in benefits for themselves and/or their dependents (i.e. add/drop a dependent or dependents). An open enrollment period is the only time during the plan year that changes can be made except in the event of a qualifying circumstance. Coverage elected during these dates will continue and deductions maintained until the next open enrollment period, a qualifying circumstance arises or the plan is no longer available. Qualifying events include:

- Active duty in the military of a dependent
- Birth or adoption of a child
- Appointment as a legal guardian
- Dependent child no longer eligible because of age or exhaustion of COBRA coverage
- Marriage, divorce, annulment or legal separation
- Death of a dependent

For more information regarding open enrollment, please contact the Personnel Office.

TERMINATION OF BENEFITS

Your coverage under this Plan will cease on the earliest of the following dates: (a) the date the group Plan terminates; (b) the last day of the month in which you cease to be in an eligible status.

Coverage for all of your dependents will cease when any of the above conditions exist or when they cease to be your dependent as outlined in the conditions described under Dependent Eligibility.

For more information regarding continuation of coverage after termination of eligibility under this Plan, please refer to the section entitled *Continuation of Coverage/COBRA Benefits*.

Section B – Medical Coverage

AT A GLANCE

Maximum Benefits Payable for each Active Employee, Retiree and Covered Dependents under the Age of 65	
Medical Plan	$1,000,000 – Lifetime
Mental Health Outpatient Services	50 Visits – Calendar Year *
Alcohol & Substance Abuse Treatment	1 Treatment – Lifetime
Tobacco Cessation	1 Treatment @ 50% - Lifetime
Skilled Nursing Facility	120 Days Confinement – Calendar Year
Home Health Care	100 Visits – Calendar Year *
Dependent Child Learning Impairment	$1,500 – Calendar Year/$6,000 – Lifetime

Medical Benefits	**PPO Providers	Non-PPO Providers
Deductible *		
• Single	$300	
• Family Cumulative	$600	
• Emergency Room (waived if admitted)	$50 per visit	
Coinsurance Maximum (Plan pays 100% thereafter)		
• Single	$1,000	$3,000
• Family Cumulative	$2,000	$6,000
Hospital Inpatient		
• With Pre-Admission Review	85%	60%
• Without Pre-Admission Review	50% up to $500, then 85%	50% up to $500, then 60%
• Pre-Admission Testing within 7 days prior to hospital confinement as a bed patient.*	85%	60%
Outpatient Surgery*		
• With Pre-Admission Review	85%	60%
• Without Pre-Admission Review	50% up to $500, then 85%	50% up to $500, then 60%
• Pre-Admission Testing within 7 days prior to hospital confinement as a bed patient.*	85%	60%
Mental Health		
• Inpatient -		
With Pre-Admission Review	85%	60%
Without Pre-Admission Review	50% up to $500, then 85%	50% up to $500, then 60%
• Outpatient	80%	60%
Alcohol and Substance Abuse		
• Inpatient -		
With Pre-Admission Review	80%	60%
Without Pre-Admission Review	50% up to $500, then 80%	50% up to $500, then 60%
• Outpatient	80%	60%

* Deductible does not apply to covered expenses related to pre-admission testing; outpatient surgery or home health care visits.

** Preferred Provider Organization (PPO) is a group of providers who have agreed and contracted to accept a discounted amount for certain health care plans.

Section B – Medical Coverage

Medical Benefits	PPO Providers	Non-PPO Providers
Ambulance	80%	60%
Physician Office Visits	85%	60%
Other Physician/Medical Services	85%	60%
Second Opinion	85%	60%
Surgeon	85%	60%
Assistant Surgeon	85%	60%
Anesthesiology	85%	60%
Lab & X-ray	85%	60%
Prescription Drugs	85%	60%
Chiropractic Care	85%	60%
Home Health Care	85%	60%
Durable Medical Equipment	80%	60%
Speech Therapy	80%	60%
Occupational Therapy	85%	60%
Physical Therapy	85%	60%
Preventive Care		
• Immunization & Health Screens	90%	60%
• Routine PAP Tests	90%	60%
• Routine Prostate Screening	90%	60%
• Annual Flu Shot	100%	60%
• Mammography	90%	60%
Skilled Nursing Facility		
• 1st to 20th Day of Confinement	90%	60%
• 21st to 120th day of Confinement	80%	60%
Prosthetic Appliances	80%	60%
Tobacco Cessation	50%	50%

CONTACT INFORMATION/TECHNICAL ASSISTANCE

Delta Health Systems
1234 W. Oak Street
P.O. Box 551
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(209) 948-8483
(800) 422-6099

- To submit claims
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- To request enrollment of a doctor in the Participating Provider Network
- For latest additions of hospitals, physicians or labs to the Participating Provider Network

MEDICAL PLAN PROVISIONS

Medical Necessity

Medical Benefits are provided only for services which are medically necessary. These include only those which have been established as safe and effective and are furnished in accordance with generally accepted professional standards to treat an illness or injury, and which are determined to be: (a) consistent with the symptoms or diagnosis in treatment of the illness or injury; (b) not furnished primarily for the convenience of the patient, the attending physician, or other provider; and (c) are furnished at the most appropriate level which can be provided safely and effectively to the patient.

Delta Health Systems reserves the right to review all claims for medical necessity and may use the services of a Physician Consultant, or other consultants.

Benefit Maximum

This is the maximum amount of benefits that will be paid by this Plan as long as the employee or his/her dependents remain eligible and are covered under the Plan. The Lifetime Medical Benefit Maximum for each eligible Plan participant is $1,000,000. Certain Plan benefits have separate Benefit Maximums, however, they are all counted toward the Lifetime Medical Benefit Maximum. Please refer to the description of each benefit for the specific Benefit Maximum.

Deductible

For active employees and retirees under 65, the Plan requires that a deductible be met in any calendar year before the plan begins to pay for most benefits. There is a separate deductible requirement for the Dental Plan.

The calendar year deductible amount is shown in the *At A Glance* schedule at the beginning of this section. The deductibles indicated do not apply to Home Health Care visits.

It is not necessary to satisfy the deductible for each illness or injury – it is applied against an individual's eligible expenses for all illnesses and injuries during the year.

The deductible requirement is liberalized in the following instances, although the deductible amount must nevertheless be satisfied by expenses incurred within 12 consecutive months:

(a) Eligible medical expenses incurred and applied toward the deductible, but not satisfying that deductible, in the last 3 months of a calendar year may be applied towards the deductible for the next calendar year.

(b) When two or more covered members of a family are injured in the same accident, only one deductible applies to all eligible expenses resulting from the accident in that year.

(c) If all covered members of a family incur, during the same calendar year, eligible expenses to which the deductible applies, an amount equal to the family deductible shown in the *At a Glance* schedule at the beginning of this section, all covered members of that family are considered as having satisfied their deductible.

Percentage Payable

The Medical Benefit will pay at the specified percentage payable of covered medical expenses up to the coinsurance maximum, if applicable, then 100% thereafter for the remainder of the calendar year. These percentages are payable up to the amount allowed or the usual and customary and reasonable (UCR) amount for each service or supply. Please note the exceptions (below) of charges that do not apply toward the coinsurance maximum.

Exception

Charges in excess of the usual, customary and reasonable (UCR) rate or charges for services that are not covered do not apply toward the coinsurance maximum. Also, if Pre-admission Review is not obtained prior to any hospitalization or surgical procedure, any penalty imposed will not apply toward the coinsurance maximum. Any expense in excess of a Benefit Maximum is also excluded and will not count toward the coinsurance maximum.

In addition, prescription copayments and services related to dental coverage do not apply. Dental services are subject to a separate Benefit Maximum and reimburse at the specified rate as provided by the Plan.

Pre-Existing Condition Limitation

Benefits will not be paid for a pre-existing condition. A pre-existing condition is an illness, injury or other condition for which the employee or dependent previously received medical treatment, consultation, care or services including diagnostic measures, or took prescribed drugs three (3) months prior to the effective date of coverage. Benefits will not be paid for the pre-existing condition until the individual has received no treatment or prescribed drugs for that condition for three (3) consecutive months beginning after the effective date, or the employee has been covered under the Plan for six (6) consecutive months, or the dependent has been covered under the Plan for twelve (12) consecutive months.

Credit will be given for time the employee or dependent was covered under the Plan of a previous employer. This credit will reduce the limitation period for the pre-existing condition. However, the credit only applies as long as the participant is covered under this Plan within 90 days of loss of coverage on the prior plan. Proof of prior coverage is required and must be provided to Delta Health Systems. If there is no lapse in coverage (regular or COBRA) the pre-existing limitation does not apply. Credit for prior coverage can be applied if there is no lapse in previous coverage and county coverage is obtained within 120 days.

Hospital Review Program

All hospital review is administered by Delta TeamCare. Through various hospital review programs, Delta TeamCare can offer sound and practical alternatives to hospitalization that will

help determine the medical treatment most appropriate. For specific questions or concerns about proposed hospital procedures, contact Delta TeamCare for assistance.

Pre-Admission Review

The Pre-admission Review Program is designed to verify the need for non-emergency hospitalization or surgery before the admission or surgery takes place. Physicians and hospitals are familiar with these procedures, and normally request certification for surgical procedures and hospitalization on behalf of the patient; however, **it is ultimately the Plan participant's responsibility to ensure that the Pre-admission Review is obtained.**

In the case of an emergency surgery or emergency hospital admission, review must be obtained within seventy-two (72) hours following the admission or surgical procedure. An emergency admission is one that involves the sudden onset of severe medical symptoms that: (a) could not have been reasonably anticipated; (b) require immediate medical treatment; or (c) can be considered life-threatening.

Pre-Admission Review is not required for retirees or dependents who are 65 and older.

Penalty for Not Obtaining Pre-admission Review

Hospital Claims cannot be processed for payment without a certification from Delta TeamCare indicating that review requirements have been satisfied.

If prior authorization is not obtained as specified above, the benefits payable for all covered expenses incurred in connection with the hospital confinement or surgery will be 50% of the benefits that would be payable in the absence of this provision; however, benefits will not be reduced by more than $500. This penalty is in addition to the calendar year deductible. This penalty will be waived for emergency admissions or surgical procedures if Delta TeamCare is contacted within 72 hours of the admission or surgical procedure.

Concurrent Review

Once the hospital admission has taken place, Delta TeamCare assumes the responsibility for additional ongoing review. Ongoing review does not require any patient involvement. The Concurrent Review Program helps reduce medical expenses as well as assure the quality of care. This program provides for ongoing hospital review to monitor the medical necessity, appropriateness of treatment, and length of hospitalization to determine if a patient is receiving the level of care required.

Discharge Planning

At the time of discharge from the hospital, Delta TeamCare nursing staff and medical director will evaluate, coordinate and expedite the transfer from an inpatient, acute-care hospital to an alternate, more efficient setting if medically required and/or assess the need for home health care or other medically necessary services.

Outpatient Surgery Review

This program reviews all surgeries performed in outpatient hospital facilities or surgery centers. Delta TeamCare must be contacted prior to any proposed surgical procedures being performed. It is the responsibility of the Plan participant to obtain Outpatient Surgery Review for approval of all outpatient surgeries. Delta TeamCare will review for medical necessity and appropriateness of placement for the proposed surgery. Surgery being performed in the physician's office does not require Outpatient Surgery Review.

Please Note: The above Hospital Pre-Admission Review and Outpatient Surgery Review programs are designed not only to prevent unnecessary surgery, but also to properly manage health care dollars. If surgery is required, the patient can be assured that proposed medical or surgical procedures have been carefully reviewed for medical necessity.

Case Management

In the unfortunate circumstances where there is a catastrophic illness or injury, selected cases may require case management to provide ongoing review and coordination of medical care to ensure that the Plan participant is receiving optimum utilization of his/her medical benefits in the most cost effective manner. With the acceptance and cooperation of the Plan participant, case management will assist in the coordination of medical care and expenses from the time of case identification until the patient has achieved his/her maximum functional potential.

Payment Recommendation

Delta TeamCare only provides recommendations regarding the medical necessity of health care services. This medical review or certification of hospital services does not approve or deny payment for those medical services, nor does it determine the choice of treatment; however, their recommendations do influence determination for payment.

The decision regarding choice of treatment is made by the patient and the patient's physician. However, it will be the Plan participant's responsibility to pay for any services or days in the hospital that are not approved as medically necessary.

Independent Medical Examiner

Delta Health Systems reserves the right to have a Plan participant, whose medical expense is the basis for claim, examined by an independent physician chosen by Delta Health Systems. The Plan will pay for these independent medical examinations.

Delta TeamCare

To obtain Pre-Admission Review or Outpatient Surgery Review, or for questions regarding proposed hospitalization or procedures contact:

Delta TeamCare
P. O. Box 1147
Stockton, CA 95204-1147
(877) 464-1441

CONTRACT PROVIDERS

Interplan Provider Benefits

To receive maximum benefits, participants must use medical providers who have contracted with Interplan to provide services at a lower rate than that charged to the general public. The Plan has negotiated with Interplan to provide a network of hospitals, physicians and labs that provide services at a discounted rate.

If a Plan participant's current physician is not an Interplan participating provider, he/she may contact Interplan at (800) 444-4036 to apply for membership.

Interplan providers will not require payment at the time of service. They have agreed to file the medical claim forms on the patient's behalf. The patient is responsible for his/her portion of the expenses after the Plan pays its portion and sends out the Explanation of Benefits.

Use of Interplan providers is not required in order to receive benefits through the Plan; it is a personal choice. Keep in mind, however, that Interplan hospitals, physicians and labs bill at lower negotiated rates, which means fewer out-of-pocket expenses and a savings to the Plan.

Please reference the listing in *Appendix A* to locate local Interplan providers. This listing is complete as of publication and is subject to change. Updated listings and out-of-the-area providers can be obtained from the Personnel Office or at Interplan's website, www.interplancorp.com.

Savings

For maximum benefits, contracted facilities must be used. The share of cost will be significantly less at a Contract Hospital. In addition, there is no charge for routine newborn nursery services at Contract Hospitals. Also, most Contract Hospitals offer a discounted rate on outpatient services. Depending upon the Contract Hospital's reduced rate and the services received, the savings could be substantial. In addition to personal savings, tremendous savings can be passed on to the Health Plan by utilizing a Contract Hospital when in need of hospital services.

Emergencies

For emergencies requiring immediate care, use the most convenient treatment facility or readily available medical help regardless of whether or not it is a Contract Hospital. The higher Contract Hospital payment rate will apply if there is no choice of facilities because you are admitted to a hospital on an **emergency basis for a condition which requires immediate treatment to prevent loss of life.**

Delta TeamCare must be notified within 72 hours of any emergency admission or surgical procedure or a penalty will be imposed. If the emergency admission was to a non-Contract Hospital, the higher rate will continue only until such time as the doctor verifies the patient's condition is stable, and that the patient is recovering and is no longer life threatening. At that time, if the patient elects to be moved to a Contract Hospital at the Plan's expense, the higher rate will continue for the duration of the authorized hospital confinement. If the patient elects not to be moved, the payment rate will be reduced to the non-Contract Hospital rate.

Contract Hospital Listing

To locate a hospital, please refer to the listing of Contract Hospitals in *Appendix B*. This listing is complete as of its publication, however, it is subject to change. The listing of Contract Hospitals is for information only. It is not intended to be a recommendation of any particular hospital, as the choice of which hospital to use is a decision made by a patient and his/her physician. For updated Contract Hospitals, contact Interplan.

Contract Facilities are also available for treatment of chemical dependency and alcoholism. These treatment facilities range from acute care hospital type facilities to free-standing non-hospital based setting as well as outpatient treatment programs.

A complete listing of California hospitals is available at the Personnel Office.

Section B – Medical Coverage

MEDICAL BENEFITS

This section is designed to describe the principal benefits which are covered under this Plan. The chart in the section entitled *At A Glance*, shows the deductibles and percentages payable for each benefit.

Inpatient Hospital Services

Hospital services for treatment of injury or illness, including the hospital's charges for room and board up to the semi-private room rate; actual charges are covered for intensive care when such services are medically necessary.

All inpatient hospitalizations require Pre-admission Review through Delta TeamCare. Please refer to the section entitled *Medical Plan Provisions* for details on Hospital Review Services.

A penalty will be imposed if Pre-Admission Review is not obtained.

Outpatient Hospital Services

Hospital outpatient services for medically necessary treatment of injury or illness are covered when provided in the outpatient facility of the hospital.

All outpatient surgical procedures require Outpatient Surgery Review through Delta TeamCare Please refer to the section entitled *Medical Plan Provisions* for details on Hospital Review Services.

A penalty will be imposed if Pre-Admission Review is not obtained.

Skilled Nursing Facility Benefit

Inpatient services for necessary medical care for the treatment of illness or injury at the usual customary and reasonable rate for a maximum of 120 days per confinement is provided.

Services are covered only when the patient has been referred to the facility by a physician. Any admission to a Skilled Nursing Facility requires Pre-admission Review by Delta TeamCare prior to admission. The patient must remain under the active supervision of a physician treating the illness or injury for which the patient was confined in the Skilled Nursing Facility.

Surgical Procedures

Medically necessary services by a Surgeon, Assistant Surgeon, Anesthesiologist, Consultant or Podiatrist. Elective sterilization procedures are covered. Elective abortions are covered if medically necessary to treat an illness or injury.

Focused Second Opinion or Outpatient Surgery Review is required. Please refer to the section entitled *Medical Plan Provisions* for details on Hospital Review Services.

A penalty will be imposed if Pre-Admission Review is not obtained.

Medical Services

Medically necessary professional services by a Physician, Anesthetist, Registered Nurse, Podiatrist, Speech Therapist or Occupational Therapist. Benefits will be provided for visits to the provider's office, patient's home, hospital or skilled nursing facility.

Speech Therapy and Physical Therapy treatment must be ordered by a physician.

Services of a Registered Nurse must be ordered by a physician and be pre-authorized by Delta TeamCare.

Outpatient X-Ray & Lab

Diagnostic x-ray services and clinical laboratory services when provided to diagnose illness or injury.

Preventative Care

Charges for routine Pap tests and mammograms; annual flu shot; and routine prostate screening.

Mammograms and Pap tests are limited to once in a 24 month period or as recommended by a physician as the medical standard. Prostate screening is limited to once in a 24 month period or as recommended by a physician as the medical standard. Annual flu shots are covered at 100% and are not subject to the annual deductible.

Maternity Benefit

Medically necessary treatment and services for pregnancy and complications of pregnancy are covered the same as any illness.

Plan coverage for hospital stay in connection with childbirth following a normal vaginal delivery will be 48 hours for both the mother (if a covered person) and the newborn child unless a shorter stay is agreed to by both the mother and her attending physician. Plan coverage for a hospital stay in connection with childbirth following a cesarean section will be 96 hours for both the mother (if a covered person) and the newborn child unless a shorter stay is agreed upon by both the mother and her attending physician.

Home Health Care & Home Hospice Care Benefit

Medically necessary services of an approved Home Health Care Agency or Hospice Agency; including services of a Registered Nurse, Licensed Vocational Nurse, Licensed Physical Therapist, Occupational Therapist, Speech Therapist or Medical Social Service Worker. Benefits will be provided up to a maximum of 100 visits per person per calendar year.

Home Health Care or Home Hospice Care must be ordered by a physician and requires pre-authorization by Delta TeamCare.

Ambulance Benefit

Medically necessary ambulance services including the base charge, mileage and supplies to transport a patient to and from the hospital. Also, if special treatment, not locally available is required, transportation to the nearest hospital where special treatment can be given. This includes charges made by an ambulance service, railroad, or regularly scheduled airline.

Covered expenses will exclude charges for transportation when it is not within the United States or Canada, or undertaken to secure the services of a physician or group of physicians or institution of greater renown or degree of specialization.

Durable Medical Equipment Benefit

Rental or purchase of medical equipment and supplies, including dialysis, which are: (a) ordered by a physician; (b) usable only by the patient (c) not primarily for the patient's comfort or hygiene; (d) not for environmental control; (e) not primarily used for exercise; and (f) manufactured specifically for medical use. Rental charges that exceed the reasonable purchase price of the equipment are not covered.

Durable Medical Equipment that exceeds $500 should be pre-authorized by Delta TeamCare.

Prosthetic Benefit

Surgical implants, artificial limbs or eyes and the first pair of contact lenses or eyeglasses when required as a result of eye surgery. Penile implants are covered only for documented irreversible vascular or neuralgic disease that prevents normal male sexual function.

Re-Constructive Surgery Benefit

Medically necessary treatment to repair or alleviate bodily damage caused by illness or injury. Breast implants are covered only following a medically necessary mastectomy. Breast reduction surgery is covered only when medically necessary and after all other conventional non-surgical therapies have been exhausted.

Benefits for mastectomy include: reconstruction of the breast on which the mastectomy was performed; surgery and reconstruction of the other breast to produce a symmetrical appearance; and prosthesis and physical complications for all stages of mastectomy, including lymphedemas.

Services require pre-authorization by Delta TeamCare. Focused Second Opinion or Outpatient Surgery Review may also be required. Please refer to the section entitled *Medical Plan Provisions* for details on Hospital Review Services.

A penalty will be imposed if Pre-admission Review is not obtained.

Chiropractic Benefit

Services by a Chiropractor, including examinations, office visits, spinal manipulations, and physical therapy modalities and procedures for the treatment of an injury or illness. Routine or maintenance treatments are not covered.

Organ & Tissue Transplant Benefit

Services provided in connection with surgery for organ and tissue transplants. Coverage is provided for: (a) a Plan participant who receives the organ or tissue; (b) a Plan participant who donates the organ or tissue; or (c) an organ or tissue donor who is not a Plan participant, if the organ or tissue recipient is a Plan participant. The above benefits are reduced by any amounts paid or payable by the non-participant's own insurance coverage.

Dental Injury & Illness Benefit

Services of a dentist or an oral surgeon treating tumors of the gums or accidental injury to natural teeth and their dependent tissues.

Other Medical Benefit

Charges for Radiation Therapy, Chemotherapy, and Hemodialysis treatment. Blood Transfusions, including blood processing and the cost of un-replaced blood and blood products.

Inpatient Mental Health Benefit

Inpatient hospital services and treatment for mental or nervous conditions are covered the same as any other illness. Psychiatric Hospitals must be licensed by the State to provide treatment in each specialty.

All inpatient hospitalizations require Pre-admission Review through Delta TeamCare. Please refer to the section entitled *Medical Plan Provisions* for details on Hospital Review Services.

A penalty will be imposed if Pre-admission Review is not obtained.

Outpatient Mental Health Benefit

Treatment can be provided by a Psychiatrist, Psychologist, Licensed Clinical Social Worker (L.C.S.W.), or Licensed Marriage Family and Child Counselor (M.F.C.C.). Psychological testing is a covered benefit. Counseling for marital problems, family problems or behavioral problems is provided only upon referral by a medical doctor.

Outpatient mental health services are limited to fifty (50) visits per person in a calendar year.

Services by practitioners other than a Licensed Psychologist require the referral of a medical doctor.

Inpatient Alcohol & Substance Abuse Benefit

Inpatient hospital services and treatment for alcohol and substance abuse are covered the same as any illness. Substance Abuse Facilities must be licensed by the State to provide treatment.

Inpatient alcohol and substance abuse rehabilitation is limited to one treatment per person per lifetime.

All inpatient hospitalizations require Pre-admission Review through Delta TeamCare. Please refer to the section entitled *Medical Plan Provisions* for details on Hospital Review Services.

A penalty will be imposed if Pre-admission Review is not obtained.

Tobacco Cessation Benefit

Examinations and prescriptions for tobacco cessation treatment are covered at 50%. Group or individual counseling sessions are not covered services. Benefit is limited to one treatment per person per lifetime.

DEPENDENT CHILD LEARNING IMPAIRMENT EXPENSE BENEFIT

If, while covered for this benefit a Dependent child necessarily incurs treatment charges (as defined below) in connection with a Treatment Plan, the Plan will pay the benefit shown below for the Treatment Charges. Payment is subject to all the terms of the Plan.

No other benefits are payable under the Plan for charges incurred in connection with a Treatment Plan.

Definitions

"Benefit Period" means a 6 consecutive month period which starts on the day a covered dependent child first incurs a treatment charge. This charge must not belong to a prior Benefit Period. A charge will be deemed incurred when the treatment is performed or supplies are purchased. If a charge is made for total treatment or services given over a specific period of time, the charges will be prorated to determine a daily charge for the treatments and service.

"Educational Therapy" means applying therapeutic training exercises and multi-sensory teaching techniques to a child with a learning impairment. This therapy must be meant to reduce the degree of impairment not to teach specific subject-matter knowledge.

"Remedial Clinic" means a legally authorized institution (not owned or run by a national or state government) used mainly as a facility for education or training through Educational Therapy. It must: (a) be supervised 24 hours a day by a Doctor of Medicine (M.D.) or a graduate registered nurse (R.N.); (b) have a Doctor of Medicine's service available at all time; and (c) be staffed with a legally qualified psychiatrist or psychologist and physical and educational therapists as may be needed to make up and carry out Treatment Plans.

"Treatment Plan" means a program, made up and carried out by a Remedial Clinic. It must be meant to both (a) cure or improve any condition (whether functional or organic) which causes or contributes to a learning impairment, and (b) overcome, improve or make up for the learning impairment.

Amount of Benefit

The benefit will be 80% of the Treatment Charges defined in (a) below and 50% of the Treatment Charges defined in (b), (c) and (d) below. But, not more than $1,500 of benefits will be payable for all Treatment Charges incurred in any Benefit Period. And, not more than $6,000 of benefits will be payable for all Treatment Charges incurred by a dependent child in his lifetime.

Treatment Charges

Treatment Charges are any of the following made by a Remedial Clinic in connection with a Treatment Plan for the dependent child:

(a) Charges up to $200 for an initial series of physical, neurological, mental, associative memory, lateral dominance and similar standard tests made by a Remedial Clinic to (a) determine the nature and extent of a learning impairment and (b) devise a Treatment Plan for it.

(b) Charges for room and board furnished by a Remedial Clinic on its own premises for a child treated on a resident basis.

(c) Charges for Educational Therapy.

(d) Charges for periodic administration of standard achievement tests to determine the child's progress under the Treatment Plan.

Exclusions & Limitations

Benefits will not be payable for charges:

(a) to the extent they exceed the customary and reasonable charge for the service, supply or treatment in the geographical area where the charge is incurred.

(b) which the Covered Person is not legally required to pay.

(c) for tutoring in specific subjects.

(d) for the purchase or rental of books, tools, equipment, implements, eye glasses, contact lenses, hearing aids or supplies of any kind.

(e) or related to travel or sports, hobbies, camping and other activities which are mainly recreational (whether or not such travel and activities are deemed part of Treatment Plan).

Extended Benefit

If a dependent child is in a Benefit Period when his or her coverage for this benefit ends, the provisions of this benefit will still apply, but only until the end of that Benefit Period.

MEDICAL EXCLUSIONS & LIMITATIONS

General Exclusions & Limitations

The following items are not considered as covered expense under this Plan:

1. Charges for services received prior to the date coverage is effective under this Plan or after coverage is terminated, except as specifically provided. Please reference the section entitled *Continuation of Coverage/COBRA Benefits* for details.

2. Charges in excess of the usual, customary and reasonable fee (UCR) or the amount of covered expense as determined by the geographical area.

3. Charges for services for which no actual fee is billed or for which the Plan participant is not required to pay, nor would have been billed except for the fact that he/she has "insurance". This includes services furnished by the United States Government or one of its agencies and there is no legal requirement to pay for such services or supplies.

4. Charges for professional services received from a person who lives in the Plan participant's home or who is related to the Plan participant or his/her dependent by blood or marriage.

5. Charges for a service or supply that is not prescribed by a physician or charges for treatment by a doctor which is not within the scope of his/her license.

6. Charges for a condition, injury, or disability resulting from any involvement in an illegal occupation or attempt to commit an illegal act and any complication therefrom.

7. Charges resulting from an act of war, whether declared or undeclared and any complication therefrom.

8. Charges for any confinement, treatment, or service that results from an injury, condition or illness covered by Workers' Compensation.

9. Charges for intentionally self-inflicted injuries whether sane or insane.

10. Charges for any illness, injury, disease or other condition for which a third party may be liable or legally responsible by reason of negligence, an intentional act or breach of any legal obligation on the part of such third party. Nevertheless, benefits will be advanced subject to compliance with provisions stated in the section entitled *Subrogation*.

11. Charges for any services or supplies to the extent that the Plan participant is eligible for coverage under Medicare for end-stage renal disease.

Medical Exclusions

The following items are not considered covered Medical expense:

1. Charges not medically necessary for the diagnosis and treatment of an illness, injury or pregnancy, or charges not recommended or prescribed by a physician, except as specifically listed in the Preventive Care Benefits.

2. Charges for any services related to complications resulting from any surgery, medical service or procedure that is not covered by this Plan.

3. Charges for inpatient room and board, if hospitalization is for any service that could have been performed safely on an outpatient basis including, but not limited to, primarily diagnostic tests, physical therapy, medical observation, convalescent or rest care, or treatment of chronic pain.

4. Charges for services provided by a rest home, home for the aged, nursing home, residential care facility, or any other similar facility that is primarily for custodial care. (This exclusion is not intended to omit medically necessary services at a transitional living center.)

5. Charges for any form of transportation, except as specified in the ambulance benefit.

6. Charges for the preparation of medical reports or itemized billings.

7. Charges for non-medical services or personal comfort items even if prescribed by a physician. This would include training, education or instruction materials, air conditioners, purifiers, humidifiers or dehumidifiers, corrective shoes, heating pads, whirlpools, hot tubs, waterbeds, hot water bottles and any other clothing or equipment whose sole purpose is not for the therapeutic treatment of a medical illness or injury.

8. Charges for the purchase of hearing aids, batteries or repairs; charges for hearing examinations, except for those charges that are medically necessary and incurred for treatment of an injury suffered while covered. Treatment must begin within 90 days of the injury and must be incurred within 24 months of the injury.

9. Charges for the purchase or fitting of eyeglasses, contact lenses and related examination of the eyes for the purpose of prescribing corrective lenses for refractive error; radial keratotomy or keratomoleusis or any other surgery to correct refractive defects of the eye.

10. Charges for services related to the restoration of fertility or the promotion of conception, including but not limited to, the reversal of a tubal ligation or vasectomy, tuboplasty, in-vitro fertilization, artificial insemination, sperm or sperm bank charges, embryo transplantation and any complication therefrom. Also excluded are charges for infertility drugs or any drug with the primary purpose of promoting conception.

11. Charges for any procedures, services, and supplies related to sexual dysfunction or inadequacy except for documented irreversible vascular or neurologic disease that prevents normal male sexual function; or for surgery primarily to transfer the characteristics of the body to those of the opposite sex and any complication therefrom.

12. Charges for dietary control, or surgery or any other treatment of obesity; including, but not limited to food and food supplements, vitamins, nutritional counseling, laboratory tests in association with weight reduction programs, gastric bubble, gastric stapling, intestinal by-pass or other similar procedures and any complication therefrom.

13. Charges for inpatient or outpatient eating disorder programs.

14. Charges for the services of dietitian or nutritional counseling for conditions other than diabetes.

15. Charges for Orthognathic Surgery or treatment of Temporomandibular Joint Dysfunction (TMJ) abnormalities caused by malocclusion, structural jaw abnormalities and conditions unrelated to an external traumatic episode. Charges for other dental cosmetic surgery or services performed primarily for the purpose of beautification.

16. Charges for routine foot care including, but not limited to, removal or reduction of corns and calluses, hallux valgus, clipping of toenails, flat feet, weak or fallen arches, and chronic foot strain.

17. Charges for cosmetic or re-constructive surgery primarily for the purpose of beautification, except implants incident to a medically necessary mastectomy or unless medically necessary for the correction of a medical condition that impairs normal body function. Breast reduction surgery is covered only after all other conventional non-surgical therapies have been exhausted.

18. Charges for services provided for acupuncture, biofeedback, aversion therapy and hypnosis therapy.

19. Massage therapy except when prescribed by a health care provider for treatment of an injury or illness.

20. Charges for service related to illness or injury due to the release of nuclear materials.

21. Charges for confinement, treatment, or services for psychological evaluations or testing, or developmental disorders including learning disabilities, mental retardation or autistic disease of childhood. Charges for telephone psychiatric consultations.

22. Charges for educational books or programs, instructional materials or activities for weight reduction, physical fitness, or smoking cessation programs.

23. Charges for medical equipment, supplies, prescribed drugs, procedures, or treatment which are experimental or investigational in nature and have not been established as safe or effective; or are not in accordance with generally accepted professional standards to treat a specifically diagnosed illness or injury.

24. Charges for drugs, medicines and supplies that can be purchased without a prescription from a physician, including vitamins, minerals, food supplements, digestive enzymes, bacterial or viral substances or homeopathic preparations.

25. Charges for an intra-uterine device (IUD), diaphragm, or any examination, consultation, treatment or service in connection with the prescription, insertion, or removal of an intra-uterine device or diaphragm, and any complication therefrom.

26. Charges for sales tax except where required by state statute for medical expenses.

27. Charges for treatment of a pre-existing condition, except as specifically listed.

28. Charges for failure to keep a scheduled visit with a physician, dentist or therapist.

29. Charges for services not specifically listed in this Benefit Booklet as covered services.

CLAIMS PROCEDURES

Delta Health Systems will provide claim forms to assist in filing claims. Claim forms may also be obtained at the Personnel Office. These claim forms provide essential information and can make processing a claim more efficient; however they are not required. Any claim can be submitted with complete information, including the participant's name and current address, Plan identification number as specified on his/her Identification Card, the patient name and relationship, date of birth, the Provider's name, address and Federal Income Tax ID number, and a completed billing indicating dates of service, diagnosis, procedure numbers of services performed, and individual charges for each procedure. The claim should also indicate if the services were rendered as a result of an automobile accident, work related illness or injury, or other accidental injury. A separate form and claim should be completed and submitted for each patient and for each provider. It is recommended that a photocopy be taken of any claim submitted for personal and tax records before submitting it for processing.

Completed claim forms and itemized billings should be submitted within ninety (90) days after the date services or treatment has been rendered or as soon as is reasonably possible, and except in the absence of legal capacity of the claimant, not later than one year after the end of the ninety (90) day period.

Claims should be submitted to:

Delta Health Systems
P.O. Box 551
Stockton, CA 95201-0551

Claims are processed for payment or denial based upon information submitted with the claim; therefore to avoid unnecessary delay, it is very important that the claim be complete. Failure to supply necessary information to enable Delta Health Systems to properly evaluate the Plan's liability on a claim may result in the denial of that claim. Payment will be determined after the claim is received and reviewed for eligibility, dental necessity, and Plan exclusions and limitations. Payment or denials will be based on the Benefits, Coverages, Limitations and Exclusions as outlined in this Benefit Booklet and will be subject to any applicable deductible, percentage payable, and Benefit Maximum as set forth herein.

If any information is given to you over the telephone or in writing by any of the Claims Department staff or your Employer which is not in accordance with the language of this Benefit Booklet, the provisions in this Benefit Booklet supersede and will stand as your verification of benefit coverage.

Section C – Dental Coverage

AT A GLANCE

Maximum Benefits Payable for each Active Employee, Retiree and Covered Dependent	
Dental Plan	$2,000 – Calendar Year
Non-Surgical TMJ	$500 - Lifetime
Orthodontia	$1,500 - Lifetime

Dental Benefits	
Deductible	$50 per Individual
Percentage Payable	
• Preventative	100%
• Restorative	80%
• Prosthodontic	50%
• Non-Surgical TMJ	50%
Orthodontia Limited to dependents under the age of 18 who have been continuously covered for a minimum of two years	50%

CONTACT INFORMATION/TECHNICAL ASSISTANCE

Delta Health Systems
1234 W. Oak Street
P.O. Box 551
Stockton, CA 95201-0551
(209) 948-8483
(800) 422-6099

- To submit claims
- For questions regarding eligibility
- For questions regarding benefits described in this benefit booklet
- To obtain pre-determination of dental benefits

County of Del Norte
981 H Street, Suite 250
Crescent City, CA 95531
(707) 464-7213

- For interpretations and questions regarding this Plan
- To obtain claim forms

DENTAL PLAN PROVISIONS

Dental benefits are provided for necessary expenses incurred for covered dental services when provided by a licensed dentist, physician, denturist, or dental hygienist and must be for preventive care or the treatment of dental illness, defect or injury.

Section C – Dental Coverage

Dental Treatment Necessity

Covered services include only those which have been established as safe and effective and are furnished in accordance with generally accepted professional standards to treat a dental disease, defect, or injury, and which are determined to be consistent with the symptoms or diagnosis in treatment of dental disease, defect or injury; not furnished primarily for the convenience or cosmetic appearance of the patient; and furnished at the most appropriate, cost effective level which can be provided safely and effectively to the patient. It may be necessary to submit dental x-rays and pocket-depth charts or other necessary information to Delta Health Systems in order to make payment determination.

***Delta Health Systems reserves the right to review all claims for their necessity of treatment and services and may use the services of a Dental Consultant or other consultants*.**

Benefit Maximum

There is a $2,000 per person per calendar year Benefit Maximum on the Dental Plan.

Deductible

Before the Plan begins to pay benefits in any calendar year, a deductible of $50 per person is required to be paid toward the covered expense.

Percentage Payable

The Dental Benefit will pay at the percentage specified in *At A Glance* at the beginning of this section. These percentages are payable up to the amount allowed or the usual, customary and reasonable (UCR) amount for each service. The percentage not paid by the Plan is considered share of cost or copayment amount.

Pre-Determination of Benefit

When a dentist recommends dental treatment which is expected to cost more than $200, it is recommended that the dentist request a pre-determination of dental benefits. Pre-determination requires submission of a treatment plan and fees as outlined by the dentist for Delta Health Systems to evaluate prior to actual treatment. It is not an "authorization" to perform services; it establishes what the benefits will be, based on provisions of the Dental Plan, and verifies eligibility at the time of the request.

Pre-determination of benefits permits both the patient and the dentist to learn in advance what the benefit payments will be according to the Dental Plan and provides the opportunity for them to discuss how the balance of expense not covered under the Plan will be handled or, if necessary, to give consideration to an alternate, less expensive plan of treatment that will safely and satisfactorily meet the patient's dental needs. For claims involving extensive dental services or for certain dental procedures, it will be necessary for your dentist to submit full-mouth diagnostic x-rays, periodontic charting and clinical findings for the Dental Consultant to review. After the dental treatment plan has been reviewed, Delta Health Systems will respond with a pre-determination of benefits that will be paid based on all Plan provisions and limitations. This pre-determination will be valid for ninety (90) days providing there is no change in dental condition and eligibility remains in force.

Independent Dental Examination

Delta Health Systems reserves the right to have a Plan participant whose dental expense is the basis for claim, examined by an independent dentist chosen by Delta Health Systems. The Plan will pay for these independent dental examinations.

Extension of Dental Expense Benefit

If a covered person's coverage ends while he/she is receiving treatment for which covered expenses were incurred while he/she was covered for this benefit, benefits will continue to be paid for such treatment completed within 30 days after his/her coverage ends.

No benefits will be provided for any treatment which is completed after the Plan ends for any person who is covered or eligible to become covered under another group policy or plan which provides similar benefits.

DENTAL BENEFITS

This section is designed to describe the principal benefits which are covered under this Plan. The services which are excluded from coverage are listed in "General Exclusions & Limitations" in the Medical Coverage section and "Dental Exclusions & Limitations" under the Dental Plan.

Preventative

Services include visits and consultations, emergency treatment, diagnostic procedures, dental x-rays, scaling, and space maintainers.

Diagnostic exams, prophylaxis, polishing, bite-wing x-rays and fluoride treatment can be performed once every six months. Full mouth diagnostic x-rays are covered once every three years.

Topical fluoride treatments and sealants are limited to participants under the age of 16.

All services subject to a $2,000 calendar year Dental Benefit Maximum.

Restorative

Services include oral and dental surgery, fillings, endodontics, including pupal therapy and root canal fillings, periodontics, procedures for treating gums and bones supporting the teeth, and antibiotic injections.

Scaling and root planing is limited to twice per area of the mouth per 12 consecutive months.

All services subject to a $2,000 calendar year Dental Benefit Maximum.

Prosthodontics

Services include preparation and installation of bridges, crowns, gold inlays, gold on-lays and porcelain and gold restorations, the preparation and installation of partial or full dentures and non-surgical TMJ (Temporomandibular Joint Dysfunction) Treatment.

Replacement of full or partial dentures is limited to once every five (5) years as necessary. Adjustment or relining of a prosthesis within six (6) months of the initial placement of the prosthesis is considered as part of the original fee and no additional benefits will be paid.

All services subject to a $2,000 calendar year Dental Benefit Maximum.
TMJ (Temporomandibular Joint Dysfunction) Treatment is limited to a maximum of $500 per person per lifetime.

Orthodontia

Orthodontia services are covered for dependents under the age of 18 who have been continuously enrolled in the Plan for a minimum of two years. Covered services include, orthodontic work-up, including x-rays, diagnostic casts, treatment plan, active treatment by month, and retention applicances.

All orthodontia benefits will cease, including work in progress, when the member reaches the age of 19.

It is recommended that all dental services in excess of $200 be submitted for pre-determination of benefits. Please refer to the section entitled Dental Plan Provisions for details.

DENTAL EXCLUSIONS & LIMITATIONS

The following items are not considered as covered Dental expense:

1. Charges incurred where any of the exclusions or limitations listed in the section entitled "General Exclusions and Limitations" of the Medical Plan would apply.

2. Charges for prosthetic devices, including crowns, bridges, partials, dentures, and the fitting thereof which were ordered prior to the effective date of coverage.

3. Charges for a dental treatment plan that began prior to termination of coverage, subject to the Extension of Dental Benefits provision.

4. Charges for full mouth diagnostic x-rays more often than once every three (3) years, unless there is a demonstrated dental need for additional x-rays other than bite-wing x-rays.

5. Charges for preventive or diagnostic exams, bite-wing x-rays, fluoride treatment, polishing, or prophylaxis more often than once every six (6) months.

6. Charges for sealants or topical fluoride for participants age sixteen (16) and over.

7. Charges for dentures, partials or bridges to replace those lost or stolen, or to replace existing dentures, partials or bridge which are, or can be made, satisfactory.

8. Charges for dentures more often than once every five (5) years. Charges for partials, bridges, inlays or crowns replaced more often than once every five (5) years will require documented evidence of necessity by the dentist.

9. Charges for relining or adjusting a denture or prosthesis within six (6) months of its initial placement.

10. Charges for temporary full prosthesis.

11. Charges for Orthognathic Surgery or treatment of Temporomandibular Joint Dysfunction (TMJ) abnormalities caused by malocclusion, structural jaw abnormalities and conditions unrelated to an external traumatic episode in excess of $500 maximum per person per lifetime. Charges for other dental cosmetic surgery or services primarily for the purpose of beautification.

12. Charges for Nitrous Oxide, or IV Sedation, or other sedative drugs. General Anesthesia is covered only for extraction of impacted wisdom teeth or when medically necessary to perform certain oral surgical procedures.

13. Charges for the following items and services: an athletic mouth-guard, specialized appliances, precision or semi-precision attachments, dental duplications, artificial implants or myofunctional therapy.

14. Charges for treatment of fractures of facial bones, biopsy, excision of tumors, cysts or foreign bodies, removal of salivary stones or other procedures that are covered under the Plan's Medical Benefits.

15. Charges for dietary planning, oral hygiene instruction or training in preventive dental care.

16. Charges for photographs.

CLAIMS PROCEDURES

For information regarding claim submittal, please refer to *Claims Procedures* at the end of the Medical Coverage Section.

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Section D – Prescription Coverage

AT A GLANCE

Prescription Benefits for Active Employees, Retirees and Covered Dependents	
Prescription Type/Quantity	**Copayment per Prescription ***
Retail – up to a 30-day supply	
• Generic	$15
• Formulary (Preferred)	$25
• Non-Formulary (Non-Preferred)	$40
Mail Order – up to a 90-day supply	
• Generic	$20
• Formulary (Preferred)	$35
• Non-Formulary (Non-Preferred)	$55

* ***If the total cost of a prescription is less than the copayment amount, the actual cost of the medication will be charged.***

CONTACT INFORMATION/TECHNICAL ASSISTANCE

PCN
Pharmaceutical Care Network
9343 Tech Center Drive, Suite 200
Sacramento, CA 95826-2592
(800) 777-0074 – Customer Care

- To locate a participating pharmacy
- **For copayment information**
- To obtain prior authorization for specific medications
- To submit claims for prescriptions purchased outside of the network

PPS
Postal Prescription Services
P.O. Box 2718
Portland, OR 97208-2718
(800) 552-6694
www.ppsrx.com

- To transfer existing prescriptions from a different pharmacy
- To reorder medication(s) previously filled by PPS

PRESCRIPTION PLAN PROVISIONS

Pharmaceutical Care Network (PCN)

PCN is a network of pharmacies providing prescription drugs at a reduced cost to the Plan. All local pharmacies currently participate in the network. For additional providers, contact PCN Customer Service.

Section D – Prescription Coverage

Participating Pharmacies

Most pharmacies participate in PCN's program. For prescriptions filled at participating pharmacies, the Plan participant will only be charged the applicable copayment. A pharmacy that is not a member of the network will charge the full price of the drug and the member must submit a claim form to PCN for applicable reimbursement.

Mail Order

Prescriptions for a maintenance medication (a drug that is taken for an extended period) have the option of being filled by mail order. Prescriptions filled by mail order have a significantly smaller copayment than that of retail. Members can receive up to a 90-day supply of a medication for one copayment. PCN's affiliated mail order provider is Postal Prescription Services (PPS).

PRESCRIPTION BENEFITS

This benefit covers most drugs and medicines, up to a maximum of a 90-day supply per prescription, including contraceptives, which can be lawfully purchased only with a written prescription by a physician. A copayment is required for each prescription.

Tiered Copayment Structure

PCN maintains a recommended drug list of medications for covered illnesses and conditions. It is used to identify the safest and most effective medications for its members while attempting to maintain affordable pharmacy benefits.

The list is broken down into 3 tiers. Each level, as listed below, has an applicable copayment as indicated in *At A Glance* at the beginning of this section.

- **Tier I – Generic**

  A generic drug is made with the same active ingredient as found in the brand-name product. All generics must meet the same manufacturing testing standards as a brand name drug.

- **Tier II – Formulary (Preferred)**

  A formulary is a comprehensive list of drugs expected to meet the needs of most patients based on their safety, effectiveness, quality, and (all else being equal) cost. These medications are also commonly referred to as "preferred" drugs.

  Formularies are used as a way to provide cost effective prescription drugs to its members at a lower copayment due to their known effectiveness.

  Formularies were created to enhance the quality of medical and psychiatric care by identifying the best medicines from among the thousands of drugs now available. They are also a tool to help resist the trend towards rocketing prescription drug costs.

- **Tier III – Non-formulary**

  Non-formulary drugs are offered at a higher copayment level due to the high cost of the medication and/or the availability of lower cost comparable drugs such as generics or those included in the formulary.

Section D – Prescription Coverage

Prior Authorization

Certain prescription drugs (or the prescribed quantity of a particular drug) may require prior authorization of benefits. Prior authorization helps promote appropriate utilization and enforcement guidelines for prescription drug benefit coverage. At the time a prescription is filled, the network pharmacist is informed of the prior authorization requirement through the pharmacy's computer system. For information regarding the prior authorization process, contact PCN Customer Service.

Medications requiring Prior Authorization

- Niacin
- Retin-A
- Depigmenting Agents
- All Injectables and Self-injectables
- Zyban, Nicotine Inhalers and Sprays
- Hematopoetic Growth Factors
- Enbrel
- Growth Hormones
- Interferons
- Low Molecular Weight Heparins
- Rebetron Kit
- Androgens and Anabolic Steroids
- Pre-filled Insulin Syringes
- Gleevec
- Cox-2 Inhibitors
- Frova

PRESCRIPTION LIMITATIONS & EXCLUSIONS

Medications with Limits

The following medications are considered as a covered prescription expense, however, prior authorization is required once the limit is reached:

- Medications for Attention Deficit Disorder, prior authorization required for members over the age of 18.

- Preven Kits and Plan B are limited to 2 prescriptions in 25 days or 4 fills a year.

- Migraine medications:
  (a) Migranal limited to 4ml (1 kit) per month.
  (b) Imitrex injectables limited to 4 kits or 8 injections per month.
  (c) Imitrex tablets 25mg and 50mg – max 18 per month; 100mg – max 9 per month.
  (d) Nasal spray limited to 6 bottles every 3 weeks.
  (e) Amerge 1mg and 2.5mg limited to 18 per month.
  (f) Maxalt & Maxalt MLT 5mg & 10mg limited to 24 per month.
  (g) Zomig & Zomig ZMT 2.5mg & 5mg limited to 18 per month.
  (h) Stadol limited to 2 units of 3ml per month.
  (i) Axert is limited to 12 per month.

Exclusions

Charges for drugs, medicines, and supplies that can be purchased without a prescription from a physician, including vitamins, minerals, food supplements, digestive enzymes, bacterial or viral substances or homeopathic preparations are not considered as a covered prescription expense. These include, but are not limited to:

- OTC (Over the Counter) Products
- Prescription (legend) medications with OTC equivalents
- Drugs obtained outside the United States
- Drugs labeled "Caution: Limited by Federal Law to Investigational Use."
- Vitamins
- Erectile Dysfunction Medications
- Cosmetic Drugs
- Dental Products and Devices (Except Peridex)
- Nicotine gum and transdermal patches
- Devices, appliances and medical supplies
- Diabetic Monitors, Pumps and Alcohol Swabs
- Norplant, IUD's and Mifiprex
- Weight Loss Medications
- Infertility Medications

CLAIMS PROCEDURES

Because a copayment is charged for each prescription filled at a participating pharmacy, it is not necessary to submit a claim form.

If a prescription is filled at a pharmacy that is not a participating provider, the full price of the medication will charged. A claim form can then be submitted to PCN for applicable reimbursement. Claim forms are available at the Personnel Office.

Section E – Continuation of Coverage/COBRA Benefits

CONTINUATION OF COVERAGE

Continuation of Dependent Coverage after employee Death

If an employee's dependent coverage would end because the employee has died, such dependent coverage will continue as to Medical Care Benefits without further contribution of payments. Coverage so continued for any dependent will end on the first of these occur: a) the end of a (2) two year period following the date the employee dies; b) the date the dependent spouse remarries; c) the date the dependent ceases to be a covered dependent as defined in the Plan; d) the date the Plan ends or is changed to end dependent coverage on the employee's class; or e) the date the dependent becomes covered under any other group policy or Plan or under an individual policy of medical care coverage offered to him or her under any "Conversion Privilege" provision. Retirees' dependents may continue at the end of the two-year period following the death of the retiree with payment at the retiree status.

Extension of Benefits

If a covered person is totally disabled when his or her coverage for this Plan ends, the Major Medical Benefits provisions will still apply to covered expenses he or she incurs in connection with the cause of, and during the unbroken continuance of, the disability. But these provisions will only continue to apply until the end of one year after the date the covered person's coverage ends.

An employee must be so disabled that he or she can perform no duty of his /her occupation. A dependent must be so disabled that he/she can engage in none of his usual activities.

Any restoration provision in the Plan will not be in force after the covered person's coverage for this benefit ends.

This one year extension will end when the covered person is otherwise entitled to or: a) becomes covered under any policy available through the Sponsor which provides medical care expenses; or b) is covered, or is eligible to become covered, under any group or franchise policy, or any other insured or uninsured program which provides medical care expenses.

COBRA

The Consolidated Omnibus Budget Reconciliation Act of 1985 (Public Law 99-272, Title X), entitled COBRA, requires that this Plan offer Plan participants the opportunity for a temporary extension of health coverage (Continuation of Coverage) at group rates in certain instances where coverage under this Plan would otherwise terminate.

Legislation relating to COBRA occasionally changes. This Plan will remain in compliance with all applicable laws or any future IRS guidance, even if it conflicts with Plan provisions.

You have a right to choose Continuation of Coverage for you and/or your covered dependents if you lose your group health coverage because of certain qualifying events.

If your Medical and/or Dental Health Plan would otherwise terminate for you or your eligible dependents, coverage may be continued if the required contribution is self-paid. You may continue to make payments and receive coverage unless one of the following happens: (a) You do not pay the required premiums on time and in full; (b) You become eligible, as an employee or dependent, under another group health plan that does not exclude coverage for pre-existing conditions; or (c) You are entitled to Medicare; or (d) Your employer stops providing group health coverage to any of its employees.

Section E – Continuation of Coverage/COBRA Benefits

Qualified Persons & Qualifying Events

A Plan participant may qualify for continued coverage for up to eighteen (18) months after coverage would otherwise terminate due to: (a) termination of employment for any reason other than gross misconduct; or (b) any reduction in work hours causing a loss of Plan eligibility.

A Plan participant may qualify for continued coverage for up to twenty-nine (29) months if the employee and/or dependent is disabled at the time of the qualifying event. This information is clarified in the "COBRA" letter sent from Delta Health Systems. This determination can only be made by the Social Security Administration. Notice of the disability award must be provided to your employer within sixty (60) days after it is issued and within the initial eighteen (18) month period of COBRA eligibility. There will be an increased contribution rate for this extended period of coverage.

An eligible spouse or dependent children of a covered employee may continue coverage for up to thirty-six (36) months if they would otherwise lose coverage due to: (a) the death of an employee; (b) divorce or legal separation; (c) the covered employee's election to drop out of the group health plan upon his or her entitlement to Medicare; or (d) a child ceases to be a dependent as defined in this Benefit Booklet.

Any qualified person who acquires a new dependent while continuing coverage will be permitted to cover that dependent for the balance of that period as stated above. Coverage for that dependent is subject to the enrollment requirements described in the *General Provisions* section of this booklet.

Notice to Employees

If a dependent qualifies for COBRA due to divorce, legal separation, or ceasing to be a dependent child, either you or the dependent must notify Delta Health Systems. This notice should be given before the qualifying event, or as soon as possible thereafter. Notice given more than sixty (60) days after the qualifying event will not be accepted.

Notice to Qualified Person

Delta Health Systems must give you written notice of your continuation rights, obligations, and contribution costs within fourteen (14) days after receipt of the notice described above, or within fourteen (14) days after any other qualifying event (termination of employment, death of the employee, etc.) becomes known by Delta Health systems.

Written Election by Qualified Person

You or a qualified dependent must make written election within sixty (60) days after the later of: (a) the date coverage would otherwise terminate; or (b) the date of Delta Health Systems' written notice.

The election form must be returned within this 60-day period; otherwise, the self-pay option for coverage under COBRA expires. You must pay for your COBRA continuation coverage retroactive to the date coverage would have terminated. It is requested that the initial contribution be included with the election form. No payment is due for forty-five (45) days after the initial election; however, no benefit claim will be honored unless the required payment has been received for the period in which the claim was incurred.

Monthly Cost

The Covered Person must pay the monthly cost to Del Norte County Personnel. Usually the monthly cost will not exceed 102% of the total average monthly cost (determined on an actuarial basis) as for coverage of a similarly situated covered person whose coverage has not terminated. However, when a disabled covered person continues beyond 18 months, the monthly cost can increase to 150% of that total average monthly cost.

If you do not choose Continuation of Coverage under COBRA, coverage under this Plan will terminate. No other extended benefits are provided, whatever the reason for termination of coverage.

Section F – Other Provisions

SUBROGATION

A third party may be defined as another person, organization, or entity which has caused an injury to a Plan participant by some wrongful act or negligence and is liable or responsible to make a financial settlement or award to the Plan participant for any medical expense, suffering, or damages.

If a Plan participant or dependent is injured or disabled by a third party who may be thereby liable to the Plan participant, the benefits of this Plan shall be provided subject to the following conditions obliging the Plan participant or dependent as follows:

1. If any damages are recovered from a third party or uninsured or underinsured motorist coverage on account of such injury or disability, the Plan shall be reimbursed by the Plan participant or dependent immediately upon collection, whether by action at law, settlement or otherwise; and

2. To the extent of benefits provided herein, the Plan shall have a lien upon any third party recovery, or uninsured or underinsured motorist recovery by the Plan participant or dependent.

3. The Plan participant or dependent will not take any action which would prejudice these reimbursement rights and will cooperate in doing whatever is reasonably necessary to assist in any recovery of funds.

COORDINATION OF BENEFITS

Intent

The intent of coordination of benefits (COB) is to coordinate the benefits provided by this Plan with similar benefits payable under any other health plan. If a covered person has any other health plan coverage, benefits will be coordinated so that not more than 100% of the covered expense will be paid or reimbursed. Covered expense will be interpreted to be the allowed amount or the usual, customary and reasonable amount for a particular claim; therefore, a claim may not necessarily be paid in full by receiving benefits through more than one health plan.

Effect on Benefits

The effect on benefits is that the amount of covered expense that would otherwise be payable under this Plan will be reduced by the amount of benefits payable under any other plan for the same expenses.

Payment Determination

If a person is covered under this Plan and under one or more other plans, the following rules apply:

1. the primary plan pays benefits without regard to any other plan that also may cover the same claim;

2. the secondary plan calculates its benefits as if no other plan existed. This calculation is of the maximum benefit amount that can be paid;

3. the secondary plan subsequently ascertains the amount the primary plan did not pay on the claim, and reimburses to the extent that the combined benefits do not exceed the maximum amount payable by the secondary plan.

Section F – Other Provisions

Key Guideline

- **Employee/Dependent Rule**. The plan covering an individual as an employee is primary, and the plan covering an individual as a dependent is always secondary.

- **Birthday Rule**. For dependent children of parents who are not separated or divorced, the plan of a parent whose birth-date (month and day, not year) falls earlier in the calendar year is primary; the plan of the parent whose birthday falls later is secondary.

- **Children of Separated/Divorced Parents Rule**. For dependent children of parents who are separated or divorced, the plan of the parent with custody is the primary plan; the plan of a stepparent (spouse of parent with custody) is the secondary plan; and the plan of the parent without custody is the tertiary plan. In cases where dependent children of separated/divorced parents are subject to joint custody (and neither parent is designated as specifically responsible for health care expenses), the birthday rule is applied.

- **Active/Inactive Rule**. The plan covering an individual who is an active employee (or a dependent of an active employee) is primary, and the plan covering an individual as an inactive employee (such as a retired or laid-off individual or a dependent of an inactive employee) is secondary.

- **Continuation of Coverage**. For individuals with COBRA continuation coverage, the primary plan is the plan covering the individual as an employee or member (or as that person's dependent). Benefits under the continuation coverage are secondary only if the other group health plan contains limitations on pre-existing conditions. Only those services which are excluded as pre-existing will be eligible charges for coordination of benefits.

- **Longer/Shorter Rule**. For situations *not* governed by the aforementioned rules, this rule provides that the plan which has covered the individual longer is the primary plan; and the plan which has covered the individual for less time is secondary.

- **Cost Containment**. The amount of benefits reduced under a primary plan (such as second surgical opinions or pre-certification), *if the covered individual did not comply with the plan's provisions*, are not considered to be allowable expenses.

- **No COB Provision**. If a plan has no COB provision, it is always considered the primary plan.

Coordination with Medicare

Medicare is the primary payer for retirees age 65 and older. Medicare is the secondary payer for: (a) active employees over age 65; (b) active employees' spouses who are age 65 or older; (c) covered employees and their dependents who are eligible for Medicare due to disability regardless of age; and (d) the first eighteen (18) months of treatment for end stage renal disease for employees and their dependents under age 65.

Coordination of Benefits – (PPO & HMO)

Preferred Provider Organizations (PPO): Where this Plan is coordinating benefits with another health plan which has entered into a Preferred Provider Agreement with a medical or hospital provider, in no event will this plan's covered expenses under these Coordination of Benefits provisions for benefits provided under another Plan's Preferred Provider Agreement exceed the lesser of UCR charges or the discounted rates charged to the other health plan under the Preferred Provider Agreement.

Health Maintenance Organizations (HMO): Where this Plan is coordinating benefits with a Health Maintenance Organization, this Plan will coordinate only on copayaments, and will not assume primary status when services are obtained from out of network providers.

Exchange of Information

Any Plan participant who claims primary benefits under this Plan must provide all information that is needed to coordinate benefits. In addition, all information that is needed to coordinate benefits may be exchanged with other companies, organizations, or persons only for this express purpose.

Facility of Payment

The Plan may reimburse any other plan if benefits were paid by that other plan but should have been paid under this Plan in accordance with the detailed provisions of this section. In such instances, the reimbursement amounts will be considered benefits paid under this Plan and, to the extent of those amounts, will discharge this Plan from liability.

Explanation of Benefits Required

When it is clearly indicated that a Plan participant has primary coverage under Medicare or another health plan, the claim submitted to Delta Health Systems must also have an Explanation of Benefits from the other health plan attached stating the exact amount of benefits paid. If this information is not attached, the claim will be denied as it will not be possible to determine liability under this Plan. Once the Explanation of Benefits is submitted for a claim, Delta Health Systems will then coordinate benefits and process the claim for payment of any covered expense allowed under this Plan.

APPEALS PROCEDURES

When a claim for benefits is submitted, Delta Health Systems will determine eligibility and the amount of benefits payable, if any. If it is determined that no benefits are payable, the following procedure applies:

Written Notice

Delta Health Systems will give written notice when the claim for benefits has been totally or partially denied based on eligibility status or the amount of benefits payable. This notice will include the following:

1. the specific reason or reasons for the denial of the claim;

2. a specific reference to the provisions of the benefit plan, a copy of which will be provided free of charge upon request, on which the denial of the claim is based; and

3. a description of any additional material or information that needs to be provided to Delta Health Systems so that the claim may be reviewed and reconsidered for possible payment.

A Plan participant is entitled to receive, free of charge upon request, reasonable access to copies of all documents, records and other information relevant to his/her claim for benefits.

Request for Appeal

This Plan allows for one full and fair review of an adverse benefit determination in compliance the Employee Retirement Income Security Act (ERISA) of 1974.

A participant, beneficiary, or a duly authorized representative may appeal any denial of a claim for benefits by filing a written request for Appeal to Delta Health Systems within 180 days after issue of the written notice. Proof that the claim is covered and payable under the Plan's provisions must be submitted, including:

1. all facts and theories supporting the claim;
2. a statement of the reason(s) for disagreement with the handling of the claim; and
3. any material/information that indicates that the claim does not fall within the referenced Plan provision.

The written appeal should be sent to:

Claim Appeal
c/o Delta Health Systems
PO Box 1931
Stockton CA 95201-1931

If the claimant provides the Plan with all information needed to address the appeal, the Plan will respond to the appeal not later than 60 days after receipt of the appeal. The decision, after review, shall be in writing and shall include specific reasons for the decision. This decision shall also include specific references to the pertinent Plan provisions as outlined in this Benefit Booklet, on which the decision was based.

Upon request the claimant can be provided free of charge with a complete description of the Plan's review procedures and the applicable time limits, by calling Delta Health Systems, (800) 422-6099.

If an adverse benefit determination is received following the appeal, civil action such as voluntary mediation can be taken against the Plan according to the provisions of Section 502(a) of ERISA.

ERISA INFORMATION

The following information is required by the Employee Retirement Income Security Act of 1974 (ERISA).

- **Name of Plan**
  County of Del Norte Group Health Plan.
- **Type of Plan**
  Employee Health and Welfare Plan
- **Effective Date**
  September 1, 1984
- **Description of Plan**
  This Plan is a Self-Funded Medical and Dental Plan with benefits paid directly by County of Del Norte. The Employer has authority to control and manage the operation and administration of the Plan.

Section F – Other Provisions

- **Plan Identification numbers**
  The Federal Identification Number is 94-2254126
  The Plan Identification Number is 501
  The Group Plan Designation Number is 550

- **Plan Year**
  Records of the Plan are kept on a plan year basis ending November 30th.

- **Plan Administrator & Agent for Services of Legal Process**
  County of Del Norte
  981 H Street, Suite 250
  Crescent City CA 95531
  (707) 464-7213

- **Benefits Administrator**
  Delta Health Systems
  1234 W. Oak Street
  P.O. Box 1147
  Stockton, CA 95201-1147

Statement of ERISA Rights

As a participant of this Plan a participant is entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA).

ERISA provides that all Plan participants shall be entitled to:

1. Examine, without charge, at the Plan administrator's office and at other specified locations all documents, including insurance contracts, and copies of all documents filed by the Plan with the U.S. Department of Labor, such as detailed annual reports and Plan Descriptions.

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

3. Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each Plan participant with a copy of this summary annual report.

Any questions about this statement or about rights under ERISA, contact the nearest office of the Pension and Welfare Benefits Administration , U.S. Department of Labor, listed in the telephone directory or the :

Division of Technical Assistance inquiries
Pension and Welfare Benefits Administration
U.S. Department of Labor
200 Constitution Avenue, N.W.
Washington, D.C. 20210

Continued Coverage

A Plan participant or his/her dependents can continue health care coverage if there is a loss of coverage under the plan as a result of a qualifying event. Information governing COBRA continuation coverage rights is provided in the preceding section.

A participant is entitled to a reduction or elimination of exclusionary periods of coverage for preexisting conditions under his/her health plan, if he/she has creditable coverage from another plan. Proof of creditable coverage can be obtained free of charge, from the group health plan or health insurance issuer when coverage under the plan is lost, when a participant becomes entitled to elect COBRA continuation coverage, when COBRA continuation coverage ceases, if it is requested before losing coverage, or if it is requested up to 24 months after losing coverage. Without evidence of creditable coverage, preexisting condition exclusions may be applicable for 12 months (18 months for late enrollees) after the enrollment date.

Material Reduction

A Summary of any material reduction in covered services or benefits provided under this Plan must be furnished to each Plan participant and beneficiary no later than 60 days after the adoption of the modification or change.

"Fiduciary" Responsibilities

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employees benefit plan. The people who operate the plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of the Plan participants and Plan participants beneficiaries. No one, including the employer or any other person, may terminate or otherwise discriminate against a participant in any way to prevent him/her from obtaining a welfare benefit or exercising his/her rights under ERISA. If a claim for a welfare benefit is denied in whole or part, a written explanation of the reason for the denial must be given. A Plan participant has the right to have the Plan review and reconsider the claim.

Steps to Enforce ERISA Rights

Under ERISA, there are steps that can be taken to enforce the above rights. For instance, if a request for materials from the Plan is made and not received within 30 days, suit can be filed in a federal court. In such a case, the court may require the Plan administrator to provide the materials and pay up to $100 a day until the requested materials are received, unless the materials were not sent because of reasons beyond the control of the administrator. If a claim for benefits is denied or ignored, in whole or in part, a suit may be filed in a state or federal court. The court will decide who should pay court costs and legal fees. If it should happen that fiduciaries misuse the Plan's money, or if a Plan participant is discriminated against for asserting his/her rights, assistance may be sought from the U.S. Department of Labor, or a suit may be filed in a federal court. The court will decide who should pay court costs and legal fees. If a participant is successful, the court may order the person who was sued to pay these costs and fees. If a participant loses, the court may order him/her to pay these costs and fees, if, for example, it finds that the claim is frivolous.

Additional Information

For any questions about the Plan, contact Delta Health Systems. Any questions about this statement or about rights under ERISA, contact the nearest Area Office of the U.S. Labor-Management Services Administration, Department of Labor.

NOTICE OF PRIVACY PRACTICES

Effective April 14, 2003 - This notice describes how medical information about you may be used and disclosed and how you can access this information. Please review it carefully.

Section F – Other Provisions

Your health care information is personal, and the Del Norte County Self-Funded Health Care Plan is committed to protecting it. Your medical information is also important to our ability to provide you with quality services. In addition to our own best practices, we are compliant with state and federal regulations governing the privacy and confidentiality of your health care information. This notice describes the Del Norte County Self-Funded Health Care Plan privacy practices, currently in effect, as required by law.

Under federal law, we must provide a copy of this notice when you participate in certain health plans administered or operated by the County. The Del Norte County Self-Funded Health Care Plan reserves the right to revise or change the terms of this notice, and to apply those changes to our policies and procedures regarding your medical information. You have the right to be notified of any changes to this notice and to receive a copy of those changes in writing. You can request an updated copy of this notice at any time by contacting the Del Norte County Personnel Division (contact information is listed at the end of this notice).

General Uses And Disclosures of Your Medical Information

In order to provide you with insurance coverage, we need medical information and other personal information about you, and we may obtain that information from many sources, including you, other insurers, HMOs or third-party administrators, and health care providers.

For Treatment: We may disclose medical information to doctors, hospitals and other health care providers to assist in your diagnosis and treatment. For example, we may disclose medical information so that your provider can offer you information about alternative treatments. We may also use medical information when communicating with providers regarding patient safety or for other treatment-related reasons.

For Payment: We may use and disclose your medical information in order to pay for your covered health expenses. For example, we might use your protected health information to process claims or be reimbursed by another insurer that may be responsible for payment. We may also share information with another health plan regarding treatment you are going to receive in order to obtain prior approval or to determine whether the other plan will cover treatment.

For Health Care Operations: In order to improve our services, we may use or disclose your medical information to evaluate the services we provide you and for administrative activities. These uses and disclosures are necessary to make sure that all of our plan participants receive quality care. For example, we may use medical information to review our services or to evaluate the performance of doctors providing treatment to you. We may combine medical information about many plan participants to decide what additional services we should offer, what services are not needed and whether certain new treatments are effective. The Del Norte County Self-Funded Health Care Plan may also use medical information for underwriting or determining premiums.

Right to Object to Uses and Disclosures of Medical Information

Unless you object, we may disclose your medical information to a friend or family member, your parent or any other person identified by you who is involved in your health care or payment for your health care. You may object to these disclosures in writing, specifying the individuals/organizations you do not want to receive your information, with the Del Norte County Personnel Division. We will not honor the objection in circumstances where doing so would expose you or someone else to danger, as determined by your treatment team.

Section F – Other Provisions

In the event of a disaster, we may disclose your medical information to a disaster relief agency such as the Red Cross, so that your family can be notified about your condition, status and location.

Authorization for Uses and Disclosures of Your Medical Information

Other uses and disclosures of your medical information not covered by this notice will be made only with your written authorization. If you authorize use or disclosure of your medical information, you may revoke that authorization, in writing, at any time. If you revoke your authorization, we will no longer use or disclose your medical information for the reasons covered by the authorization. We are, however, unable to take back any disclosures already made while the authorization was in effect.

Permitted or Required Uses and Disclosures

Del Norte County Self-Funded Health Care Plan may use and disclose your health care information, without providing you the opportunity to agree or object and without authorization, in the following cases:

- **As required by law:** We will use and disclose medical information when required to do so by state or federal law or regulation.

- **Public health activities:** We may use or disclose medical information for public health activities including the following:
  - Preventing or controlling injury, disease or disability;
  - Reporting abuse or neglect of children, elders and dependent adults;
  - To report reactions to medications or problems with products;
  - To notify people of recalls of products they may be using; or
  - To notify a person exposed to or at risk to contract or spread a disease or condition.

- **Mandated reporting of abuse, neglect or domestic violence:** We may use or disclose medical information when notifying the appropriate government authority if we believe you have been the victim of abuse neglect or domestic violence.

- **Health oversight activities:** As authorized by law, we may disclose medical information to federal or state health oversight agencies for the purpose of monitoring health care systems, government programs and compliance with civil rights laws.

- **Judicial and administrative proceedings:** We may disclose medical information in order to comply with judicial and administrative proceedings when compelled by court order, or in response to a subpoena, discovery request or other lawful process as allowed by law.

- **Law enforcement:** We may disclose medical information if asked to do so by law enforcement officials in any of the following circumstances:
  - In response to a court order, subpoena, warrant, summons or similar process;
  - To identify or locate a suspect, fugitive, material witness, or missing person;
  - In regards to the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's consent;
  - In regards to a death we believe may be the result of criminal conduct;
  - In regards to criminal conduct in any of our facilities; or
  - In emergency circumstances to report a crime, the location of a crime or crime victims, or the identity, description, description or location of a person who may have committed a crime.

- **To avert serious threats to the health and safety**: We may disclose medical information, when necessary, to prevent a serious threat to the health and safety of you or others.

- **Workers' compensation**: We may disclose medical information, to the minimum extent necessary, for workers' compensation or similar programs.

- **Research:** In certain circumstances, we may disclose medical information for research purposes, provided certain measures have been taken to protect your privacy. All research projects are subject to a special approval process before any disclosures will be made.

- **Special government functions:** We may disclose medical information as required by military authorities or to authorized federal officials for national security and intelligence activities.

Your Rights Regarding Your Medical Information

You have certain rights regarding your medical information maintained by Del Norte County Self-Funded Health Care Plan.

Right to Inspect and Obtain Copies: With certain exceptions, you have the right to inspect and obtain copies of your medical information from our records. Requests must be made in writing with the Del Norte County Personnel Division. We may charge a fee for the costs of fulfilling your request.

Del Norte County Self-Funded Health Care Plan may deny your request to inspect or obtain copies of certain portions of your medical information including certain types of mental health treatment/evaluation records and information involved in ongoing legal proceedings. If you are denied the right to access your medical information, you may appeal this decision and request a review of your request by another licensed health care professional, designated by Del Norte County Self-Funded Health Care Plan, who was not involved in the initial decision to deny your request. We will comply with the results of that review.

Right to Request an Amendment: If you feel that your medical record is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as we maintain your records. You must submit your request to the Del Norte County Personnel Division. Requests must be in writing and provide a reason supporting your request. Your request will become part of your record. Del Norte County Self-Funded Health Care Plan may deny requests if the information:

- Is accurate and complete;
- Was not created by the Del Norte County Self-Funded Health Care Plan;
- Is not medical information kept by or for Del Norte County Self-Funded Health Care Plan; or
- Is not information you are permitted to inspect and copy.

Right to an Accounting of Disclosures: With the exception of certain disclosures including those for treatment, payment and health care operations and those authorized by you, you have the right to request a list of the disclosures we have made of your medical information. You must submit your request in writing to the Del Norte County Personnel Division. Your request must state a time period, which may not be longer than six years and may not include dates before April 14, 2003.

Right to Request Restrictions: You have the right to request that we follow additional, special restrictions when using or disclosing your medical information. An example of such limitation

might be limits on disclosures we may make to your spouse. We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you with emergency treatment as determined by your doctor. You may submit your request to Del Norte County Personnel Division. Requests must be in writing and state:

- The information you want to limit;
- Type of limitation; and
- Persons/organizations the limitation should to apply to.

Right to Request Confidential Communications: You have the right to request that we communicate with you about matters related to your medical information in a specific way or at a specific location. For example, you can ask that we only contact you at work, or by mail at a post office box. You can submit your request to Del Norte County Personnel Division. Requests must be in writing and must specify how or where you wish to be contacted. We will accommodate reasonable requests.

Right to a Paper Copy of This Notice: You may ask us for a copy of this notice at any time. To obtain a copy, contact the Del Norte County Personnel Division.

Del Norte County Personnel Division
981 H Street, Suite 250
Crescent City, CA 95531
(707) 464-7213

Complaints

You have the right to file a complaint if you believe that the Del Norte County Self-Funded Health Care Plan has not complied with the practices outlined in this notice. All complaints must be submitted in writing. You will not be penalized in any way for filing a complaint. To file a complaint with the County of Del Norte, contact:

HIPAA Privacy Officer
County of Del Norte, Administration Office
981 H St., Suite 210
Crescent City, CA 95531
(707) 464-7214

Please contact the privacy officer listed above, if you want specific information for filing a complaint with the federal Health and Human Services or the Office for Civil Rights.

Appendix A – Contracted Providers

PPO CONTRACTING PROVIDERS

The following is a listing of local, including Brookings, Interplan Providers. This listing is complete as of publication and is subject to change. Updated listings and out-of-the-area providers can be obtained from the Personnel Office or at Interplan's website, www.interplancorp.com.

Specialty/Contracted Provider	Phone Number
Medical Group	
Crescent City Internal Medicine	(707) 465-8666
Del Norte Medical Clinic	(707) 464-4116
Brookings Harbor Medical Center	(541) 469-7401
Physical Therapy Group	
Function Junction	(707) 465-4003
Coastal Physical Therapy (Brookings)	(541) 469-7314
Radiology Group	
Crescent Imaging Medical Group	(707) 464-1989
Ear, Nose and Throat	
Douglas Hoffman	(707) 465-0191
Family/General Practice	
Matthew Baggett (Brookings)	(541) 412-3008
Kevin Caldwell	(707) 465-5566
Wayne Hawthorne	(707) 464-6700
James Morrow	(707) 464-6700
Donna Sund	(707) 465-5566
General Surgery	
Robert Dodson	(707) 465-0884
Thomas Polidore	(707) 465-0884
Internal Medicine	
Matthew Blundell	(707) 465-8666
Thomas Martinelli	(707) 465-8666
Donald Micheletti	(707) 465-8666
Marriage, Family & Child Counselor	
Becky Blatnick	(707) 464-8451
Gary Blatnick	(707) 464-8451
Susan Isaac	(707) 464-6966
Janice Miller	(707) 464-8451
Cheryl Simons	(707) 464-1545

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Appendix A – Contracted Providers

Specialty/Contracted Provider	Phone Number
Obstetrics/Gynecology	
John Tynes	(707) 464-8686
Orthopedics/Orthopedic Surgery	
Gregory Duncan	(707) 465-1126
Mark Lau	(707) 465-1126
Pediatrics	
Christopher Chang	(707) 464-3430
Physical Therapy	
Patrick Dodgen	(707) 465-6500
Ryan Farr	(707) 464-9958
Michael Zingg	(707) 464-9511
Podiatry	
A. James Fisher III	(707) 465-6624
John Fjerstad	(707) 464-1373
Psychiatry	
Ange Lobue	(707) 440-1111
Psychology	
Edwin Jenesky	(707) 464-6267
David Mandel	(707) 465-1585
Radiology	
Kathleen Adams	(707) 464-1989
Robert Tambeaux	(707) 464-1989

If your current physician/provider is not an Interplan participating provider, he/she may contact Interplan at (800) 444-4036 or www.interplancorp.com to apply for membership.

Appendix B – Contracted Hospitals

PPO CONTRACTING HOSPITALS

The following is a listing of the local Interplan hospital as well as those in the Eureka/Arcata and Medford, Oregon areas . This listing is complete as of publication and is subject to change. Updated listings and out-of-the-area providers can be obtained from the Personnel Office or at Interplan's website, www.interplancorp.com.

DEL NORTE COUNTY

Sutter Coast Hospital
800 E Washington Blvd.
Crescent City, CA 95531
(707) 464-8511

HUMBOLDT COUNTY

General Hospital
2200 Harrison Ave.
Eureka, CA 95501
(707) 445-5111

Mad River Hospital
3800 Janes Rd
Arcata, CA 95521
(707) 822-3621

Redwood Memorial Hospital
3300 Renner Drive
Fortuna, CA 95540
(707) 725-3361

St. Joseph Hospital
2700 Dobeer St.
Eureka, CA 95501
(707) 445-8121

JACKSON COUNTY

Rouge Valley Medical Center
2825 East Barnett Rd.
Medford, OR 97504-8332
(541) 608-4900
(800) 944-7073