County of Kern
Exclusive Provider Organization (EPO)
Retiree Medical Benefit Plan

Summary Plan Description

Effective March 1, 2008
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OVERVIEW

About this Booklet

This booklet describes the County of Kern Retiree Exclusive Provider Organization (EPO) Plan, which is available to all County of Kern retirees and their dependents, including retirees in the Ridgecrest area, who are eligible for County retiree health benefits. If there is a conflict between what is contained in this document and the County of Kern Retiree Exclusive Provider Organization (EPO) Plan, the Plan terms will prevail. You can visit the County Health Benefits office to examine the Plan and relevant documents such as those filed with the Internal Revenue Service or the Department of Labor.

Your Coverage is Self-Insured

The EPO Plan is a self-insured plan. This means that County of Kern pays the actual cost of any medical expenses you and your covered dependents have which are eligible for payment under the plan. Managed Care Systems, LLC (MCS), a health care plan administrator, administers the Plan on behalf of the County and processes the claims that you or your providers file. National Pharmaceutical Services (NPS) administers the prescription drug program, and pays benefits for formulary prescription drugs you purchase at NPS network pharmacies or through the IHMO mail order program. By using your medical plan wisely, you can help control the cost of claims and help keep health care coverage affordable for all retirees.

How the EPO Plan Works

The EPO Plan provides benefits for preventive medical services. It also covers expenses for treatment of non-occupational illnesses or injuries for you and your covered family members. You must receive all of your health care from providers in a network of health care providers especially set up for this Plan. If you receive emergency medical care from a non-network provider, you may submit a claim form to be considered for reimbursement.

Your share of the medical costs is lower when your primary care physician (PCP) manages all of your health care; that is, the PCP provides basic health care services, identifies when it’s appropriate to consult with a specialist, and refers you to other network specialists when necessary.

Chiropractic care is available through the MCS Chiropractic network. You don’t need a referral from your PCP to take advantage of this benefit. However, the EPO Plan pays chiropractic benefits only for care provided by MCS network chiropractic providers.

Prescription drug benefits are administered through NPS. You can purchase up to a 30-day supply of prescription drugs at NPS participating pharmacies. You may purchase up to a 90-day supply of maintenance prescription drugs through the IHMO mail order prescription drug program. The Plan covers drugs, which are prescribed by a dentist for dental care. The EPO Plan generally does not pay benefits for any prescription drugs that are prescribed by non-participating providers and/or purchased at non-participating pharmacies. However, if you need a prescription while you are out of the network’s area, you may submit a claim form to be considered for reimbursement.

What “Exclusive Provider Organization (EPO)” Means

The Plan is referred to as an exclusive provider organization (EPO for short) because you must receive care from a group of specially selected network providers.

The EPO Plan offers the County of Kern EPO Network. It includes the Golden Empire Managed Care (GEMCare) IPA and Delano Medical Group (DMG), as well as some independent specialty physicians. This Network, negotiated exclusively for County of Kern retirees, includes providers in the Ridgecrest area.

County of Kern EPO. The County of Kern EPO Network consists of primary care physicians (PCPs) and specialists in two physician groups (GEMCare and DMG) that operate in central California. Both groups operate similarly; however, providers in one network may be more convenient to your home or workplace.
Each covered family member must select a PCP to manage his or her care. Family members are not required to be enrolled in the same medical group and may select different PCPs. Family practitioners, general practitioners, internists, and pediatricians are all considered to be PCPs.

If you need to consult with a specialist, your PCP will refer you to one within the network. Specialist referrals will be limited to the physician group you have selected; your PCP will look at all appropriate County of Kern EPO Network specialists.

**Emergency Care.** This Plan will pay for emergency care when medically necessary – even if a non-network provider performs it. Although you do not need prior referral from your PCP in this situation, it is critical that you contact your PCP as soon as you can after receiving emergency services, regardless of whether the provider is in the network. Your PCP will evaluate your medical situation and make all necessary arrangements to assume responsibility for your continuing care. Once your medical condition is no longer an emergency, you must obtain services from a network provider or your care will not be covered.

**IMPORTANT: The Plan will not pay benefits for self-referrals to non-network providers.**

**Interpreting the Plan’s Provisions**

In order to equitably administer the provisions of this Plan, the County of Kern reserves the exclusive authority and discretion to determine eligibility for benefits, to interpret and apply the provisions of the Plan or any resolutions, administrative rules and regulations, contracts or writings that the County might adopt or enter into. In addition, the County reserves the right to resolve any and all claims and disputes regarding the rights and entitlements of individuals to participate in the Plan and to receive benefits and payments pursuant to the Plan.

Part or all of this authority and discretion might be delegated to other parties, as described more fully under the section **Important Information About your Rights and Responsibilities under the Plan** starting on page 20.
# Contact Information
This chart will help you get your questions answered quickly.

<table>
<thead>
<tr>
<th>For information or action on</th>
<th>Contact</th>
<th>Phone</th>
<th>Web/Email</th>
</tr>
</thead>
<tbody>
<tr>
<td>▶ Approved medical expenses</td>
<td>Managed Care Systems, LLC (MCS), the Claims Administrator</td>
<td>1-888-587-8810</td>
<td><a href="http://www.managedcaresystems.com">www.managedcaresystems.com</a></td>
</tr>
<tr>
<td>▶ Plan questions</td>
<td></td>
<td>1-661-716-7100</td>
<td></td>
</tr>
<tr>
<td>▶ Prior authorization of care, when required</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>▶ Claim filing, disputes and appeals</td>
<td></td>
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<tr>
<td>▶ Retail and mail order pharmacy program information</td>
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<tr>
<td>▶ Mail order pharmacy order form</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>▶ HIPAA privacy rights and privacy complaints</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>▶ Administrative matters</td>
<td>County Health Benefits office</td>
<td>1-661-868-3182</td>
<td><a href="http://www.co.kern.ca.us/cao/empbenefits">www.co.kern.ca.us/cao/empbenefits</a></td>
</tr>
<tr>
<td>▶ Eligibility and coverage rules</td>
<td></td>
<td>Fax: 1-661-868-3110</td>
<td></td>
</tr>
<tr>
<td>▶ Qualified Medical Child Support Order (QMCSO)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>▶ Addresses of dependents not living with you</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>▶ Benefit payment arrangement while on FMLA Leave</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>▶ HIPAA privacy complaint</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>▶ Mail order pharmacy order form</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>▶ Plan document review</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>▶ Participating retail pharmacies</td>
<td>National Pharmaceutical Services (NPS)</td>
<td>1-800-546-5677</td>
<td><a href="http://www.pti-nps.com">www.pti-nps.com</a></td>
</tr>
<tr>
<td>▶ Mail order pharmacy program</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>▶ Prior authorization of prescription drugs, when required</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>▶ Mail order pharmacy order form</td>
<td></td>
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</tbody>
</table>
GENERAL INFORMATION
Please refer to the County of Kern Health Benefits Eligibility Policy for Participants without Active Employee Medical Coverage for County policy and procedures about:

- Your and your dependents’ eligibility for coverage,
- How to enroll for coverage,
- When coverage begins,
- When coverage ends,
- Reinstatement of coverage,
- Continuation of coverage through COBRA,
- Leaves of absence, and
- Continuation of coverage during a Family and Medical Leave Act (FMLA) leave.

You may get a copy of the Eligibility Policy booklet from the County web site:
You may also request a copy from the County Health Benefits office.

For information about how the County enforces the Health Insurance Portability Act (HIPAA), please refer to the County of Kern HIPAA Policy.
HIGHLIGHTS OF THE COUNTY EPO PLAN BENEFITS

Out-of-Pocket Expenses
This section provides highlights of the main out-of-pocket expenses you will – and will not – have under the EPO Plan.

Deductible
There is no deductible under the EPO Plan.

Copayments
Copayments (or copays) are flat dollar amounts you pay for certain covered services. After you pay the required copayment for a particular covered service, the Plan will pay the remainder of the cost for that service.

The EPO Plan covers most services for no copayment, and almost all others for a small copay, as shown in the chart on page 6. If a married couple are both County retirees and cover each other under the EPO Plan, the Plan’s copayments are waived.

Coinsurance
The term coinsurance is a percentage of eligible expenses for which you are responsible. At this time, coinsurance is required only for infertility testing; you pay 50% of covered expenses.

Maximum Out-of-Pocket Limit
The term maximum out-of-pocket limit refers to the most you will have to pay in copayments for covered medical services during the calendar year. (It does NOT include prescription drug copayments or charges for health care services that are excluded from the Plan.) The maximum out-of-pocket limit is $1,000 per person. For families of three or more, the family’s maximum out-of-pocket limit is $3,000.

Lifetime Maximum Benefits
The EPO Plan has a $2 million lifetime maximum on the total benefits paid per member.

Coverage for Emergency Care
The Plan generally provides coverage for covered services that are provided in:

- An urgent care facility or
- A licensed hospital’s emergency room when there is a medical emergency.

A medical emergency occurs when a medical condition manifests itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in placing the participant’s health in serious jeopardy, serious impairment to bodily functions or serious dysfunction of any bodily part or organ. Generally, emergency health care services do not require prior authorization, although members should notify their PCP as soon as possible following any emergency treatment.

When Prior Authorization is Required
If a certain health care service requires prior authorization, your PCP or specialist is responsible for calling MCS to get the authorization.
Summary of Benefits

The following chart highlights, in general, the types of medical services, treatments, and care and prescription drugs covered under the County EPO Plan. Medical copayments are waived for married couples who are both County retirees and cover each other under the EPO Plan. For more details, refer to EPO Plan Covered Services & Supplies, starting on page 8. Remember also to review the Exclusions and Limitations section, starting on page 16, since coverage for some medical services, treatments, and care may be limited.

If you are unsure about a particular medical expense, be sure to contact MCS at 1-661-716-3450 or 1-888-587-8810 to verify benefit coverage.

<table>
<thead>
<tr>
<th>Physician Office Visits</th>
<th>You Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>PCP</td>
<td>$10/ visit</td>
</tr>
<tr>
<td>Specialist (all except OB/GYN need PCP referral)</td>
<td>$15/ visit</td>
</tr>
<tr>
<td>OB/GYN (for pregnancy)</td>
<td>$10/ visit</td>
</tr>
</tbody>
</table>

**Wellness and Preventive Care**

<table>
<thead>
<tr>
<th>Wellness and Preventive Care</th>
<th>You Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Well baby care (up to 2 yrs. of age)</td>
<td>$10/ visit</td>
</tr>
<tr>
<td>Well child care (2 through 17 yrs. of age)</td>
<td>$10/ visit</td>
</tr>
<tr>
<td>Adult Preventive Health Evaluations (18 yrs. of age &amp; over)</td>
<td>$10/ visit</td>
</tr>
<tr>
<td>Immunizations</td>
<td>Nothing (100% coverage)</td>
</tr>
<tr>
<td>Routine Pap smear &amp; Mammogram</td>
<td>Nothing (100% coverage)</td>
</tr>
<tr>
<td>Diagnostic lab and X-rays</td>
<td>Nothing (100% coverage)</td>
</tr>
<tr>
<td>Allergy injections and services (including serum)</td>
<td>Nothing (100% coverage)</td>
</tr>
<tr>
<td>Other covered services</td>
<td>Nothing (100% coverage)</td>
</tr>
</tbody>
</table>

**Hospital**

<table>
<thead>
<tr>
<th>Hospital</th>
<th>You Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient semi-private room and board</td>
<td>$100/day, up to a maximum of $500/calendar year</td>
</tr>
<tr>
<td>Outpatient surgery (facility)</td>
<td>$150/surgery</td>
</tr>
<tr>
<td>Emergency Room (for medical emergency)</td>
<td>$75/ visit (waived if admitted)</td>
</tr>
</tbody>
</table>

**Physician Services**

**Inpatient**

<table>
<thead>
<tr>
<th>Inpatient</th>
<th>You Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surgeon and surgical assistant</td>
<td>Nothing (100% coverage)</td>
</tr>
<tr>
<td>Anesthesiologist</td>
<td>Nothing (100% coverage)</td>
</tr>
<tr>
<td>Chemotherapy</td>
<td>Nothing (100% coverage)</td>
</tr>
</tbody>
</table>

**Outpatient**

<table>
<thead>
<tr>
<th>Outpatient</th>
<th>You Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surgeon and surgical assistant</td>
<td>Nothing (100% coverage)</td>
</tr>
<tr>
<td>Anesthesiologist</td>
<td>Nothing (100% coverage)</td>
</tr>
</tbody>
</table>

**Short-term Therapy**

<table>
<thead>
<tr>
<th>Short-term Therapy</th>
<th>You Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical, speech, respiratory, occupational, neuromuscular and rehabilitation therapy</td>
<td>Nothing (100% coverage); maximum of 60 days for all therapies combined</td>
</tr>
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**Patient Education**

<table>
<thead>
<tr>
<th>Patient Education</th>
<th>You Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Education to help patients manage health risks and/or conditions</td>
<td>Nothing (100% coverage)</td>
</tr>
</tbody>
</table>

**Mental Health and Chemical Dependency**

<table>
<thead>
<tr>
<th>Mental Health and Chemical Dependency</th>
<th>You Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient (mental health &amp; chemical dependency combined)</td>
<td>$15/ visit</td>
</tr>
<tr>
<td>Inpatient (mental health &amp; chemical dependency combined)</td>
<td>$100/day, up to a maximum of $500/calendar year</td>
</tr>
<tr>
<td><strong>Prescription Drugs</strong> (covered only when prescribed by a participating provider and purchased at a participating pharmacy or through the Plan’s mail order program, unless prescription is required while patient is out of the network’s area)</td>
<td></td>
</tr>
<tr>
<td>----------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td><strong>Participating retail pharmacy</strong> (30-day supply)</td>
<td><strong>Mail Order</strong> (90-day supply)</td>
</tr>
<tr>
<td>£ Generic</td>
<td>£ Generic</td>
</tr>
<tr>
<td>£ Preferred brand name</td>
<td>£ Preferred brand name</td>
</tr>
<tr>
<td>£ Non-preferred brand name</td>
<td>£ Non-preferred brand name</td>
</tr>
<tr>
<td>£ $5/prescription</td>
<td>£ $10/prescription</td>
</tr>
<tr>
<td>£ $10/prescription</td>
<td>£ $20/prescription</td>
</tr>
<tr>
<td>£ $25/prescription</td>
<td>£ $50/prescription</td>
</tr>
<tr>
<td><strong>Diabetic Supplies</strong> (30-day supply)</td>
<td><strong>Other Services</strong></td>
</tr>
<tr>
<td>£ Lancets</td>
<td><strong>Chiropractic</strong> (self-referral; covered only within MCS chiropractic network)</td>
</tr>
<tr>
<td>£ Strips</td>
<td><strong>Urgent Care Facility</strong></td>
</tr>
<tr>
<td><strong>Diabetic Supplies</strong> (30-day supply)</td>
<td><strong>Ambulance (ground or air)</strong></td>
</tr>
<tr>
<td>£ Lancets</td>
<td><strong>Ambulatory Surgical Center</strong></td>
</tr>
<tr>
<td>£ Strips</td>
<td><strong>Durable medical equipment (including oxygen and prosthetics/orthotics)</strong></td>
</tr>
<tr>
<td><strong>Other Services</strong></td>
<td><strong>Annual eye refraction</strong></td>
</tr>
<tr>
<td><strong>Chiropractic</strong> (self-referral; covered only within MCS chiropractic network)</td>
<td><strong>Hearing test</strong></td>
</tr>
<tr>
<td>£ Visits 1 – 30</td>
<td><strong>Home health care</strong></td>
</tr>
<tr>
<td>£ Visits after 30</td>
<td>£ Visits after 30</td>
</tr>
<tr>
<td><strong>Hospice care</strong></td>
<td><strong>Infertility testing</strong></td>
</tr>
<tr>
<td><strong>Skilled Nursing Facility</strong></td>
<td><strong>Skilled Nursing Facility</strong></td>
</tr>
<tr>
<td><strong>Bariatric surgery (requires Plan authorization and compliance with additional treatment programs)</strong></td>
<td><strong>Bariatric surgery (requires Plan authorization and compliance with additional treatment programs)</strong></td>
</tr>
</tbody>
</table>
EPO PLAN COVERED SERVICES & SUPPLIES
The Plan covers medically necessary services and supplies described below for treatment of non-occupational injuries or illnesses when authorized by your PCP. This section lists covered services and supplies in alphabetical order.

Any covered service or supply may require a copayment or have a benefit maximum. Please refer to the Summary Of Benefits chart starting on page 6 for details.

Certain limitations may apply. Be sure to read the Exclusions and Limitations section beginning on page 16 before obtaining care.

**Medical Coverage**

**Ambulance Services**
Air and ground ambulance services are covered.

**Blood and Blood Products**
Blood transfusions, including blood processing, the cost of blood, unreplaced blood, and blood products, are covered. Self-donated (autologous) blood transfusions, however, are covered only for surgery.

**Contraceptives**
Contraceptives, including vaginal diaphragms, implantable devices, injectable contraceptives, intra-uterine devices (IUDs), and cervical caps, are covered only when a network physician prescribes the device. The Plan also covers the removal of such devices.

**Dental Services and Supplies**
The Plan covers dental services and supplies only when provided by a physician in these specific circumstances:
- Emergency dental care to sound teeth following an accidental injury,
- Hospitalization and professional services for non-covered dental treatment that is deemed medically necessary by your PCP,
- Dental examination and treatment of gingival tissue (gums) performed for the diagnosis or treatment of a tumor.

**Diabetic Medical Equipment**
Diabetic supplies are covered and may include blood glucose monitors, insulin pumps and related supplies, pen delivery systems, and podiatric devices. Additional supplies may be covered. Refer to Prescription Drug Coverage starting on page 12.

Self-management training and education will be covered also.

**Disorders of the Jaw**
The Plan covers the following treatment of jaw disorders:
- Services to correct abnormally positioned or improperly developed bones of the upper or lower jaw, provided services are medically necessary due to a recent injury, the existence of cysts, tumors, or neoplasma, or a functional disorder, and
- Medical services to correct disorders of the temporomandibular jaw joint (also known as TMJ disorders) are covered if they are medically necessary. However, dental services such as crowns, inlays, onlays, bridgework, or other dental appliances are never covered under any circumstances.
**Durable Medical Equipment**

Durable medical equipment is covered and will be repaired or replaced when necessary. However, repair or replacement of equipment that has been misused or lost will not be covered.

**Health Evaluation**

For preventive health purposes, a periodic health evaluation and diagnostic preventive procedures are covered, based on recommendations published by the U.S. Preventive Services Task Force.

**Home Health Care**

The Plan covers services provided by a home health agency. These services are provided in a member’s home and are limited to part-time intermittent skilled nursing care and home health aide services, physical therapy, occupational therapy, speech-language therapy, medical social services, and other services as authorized.

The PCP is responsible for setting up a treatment plan describing the length, type, and frequency of the services to be provided. MCS may require authorization before home health care is initiated.

**Home Visits**

Visits by a network physician to a participant’s home are covered if the physician concludes that the visit is medically and otherwise reasonably warranted.

**Hospice Care**

Hospice care is available for covered individuals who have been diagnosed as terminally ill. To be considered terminally ill, the person must have a prognosis of six months or less to live. MCS must pre-authorize hospice care before it is initiated.

Hospice care includes physician services, counseling, medications, other necessary services and supplies, and homemaker services.

**Immunizations and Injections**

Immunizations and injections, professional services to inject the medication, and the medications that are injected (including any serum) are covered, except when provided for travel-related purposes.

**Inpatient Hospital Confinement**

Care in a semi-private room or in a licensed special treatment unit is covered. Benefits for a private room are limited to the hospital’s most common charge for a semi-private room, unless a private room is determined to be medically necessary.

**Laboratory and X-ray Services**

Laboratory and X-ray services and materials are covered on an inpatient and outpatient basis.

**Mental Health/Chemical Dependency Treatment**

*Outpatient:* The Plan covers outpatient treatment for crisis intervention, short-term evaluation, and substance abuse rehabilitation. Visits may include mental health consultations, medication management, and psychological testing.

*Inpatient:* The Plan provides benefits for inpatient treatment in a hospital setting or a partial inpatient program in a mental health or substance abuse care facility.

**Office Visits**

Office visits for services provided by your primary care physician (PCP) and other network health care professionals are covered.
**Organ, Tissue, and Bone Marrow Transplants**

All inpatient services associated with organ, tissue, and bone marrow transplants that are not considered experimental or investigational are covered only if the transplant is authorized by the Plan and performed in a designated transplant center. Travel and other expenses are covered as noted below.

<table>
<thead>
<tr>
<th>Transplant travel expenses</th>
<th>Transportation</th>
<th>Hotel expenses</th>
<th>Other expenses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recipient &amp; Companion</td>
<td>Limited to 6 trips/episode and $250/person/roundtrip</td>
<td>Limited to 1 room double occupancy/$100/day for 21 days/trip</td>
<td>Limited to $25/day/person for 21 days/trip</td>
</tr>
<tr>
<td>Donor</td>
<td>Limited to 1 trip/episode and $250/roundtrip</td>
<td>Limited to $100/day for 7 days</td>
<td>Limited to $25/day for 7 days</td>
</tr>
</tbody>
</table>

Benefits for the donor will be reduced by any benefits the donor receives from his or her own medical plan. Donor costs for a member are only covered when the recipient is also a County EPO member.

**Outpatient Hospital Services**

The Plan covers outpatient hospital facility services. Examples of outpatient hospital services include outpatient hospital, outpatient surgery, rehabilitative therapy, laboratory tests, X-rays, and radiation therapy.

**Pregnancy**

Hospital and professional services for conditions of pregnancy are covered, including prenatal and postnatal care, delivery, and newborn care. However, when the covered female is a child-dependent, the dependent’s newborn will not be covered. In cases of identified high-risk pregnancy, prenatal diagnostic procedures and genetic testing of the fetus are also covered.

The Newborns’ and Mothers’ Health Protection Act of 1996 (the Newborns’ Act), requires plans that offer maternity coverage to pay for at least a 48-hour hospital stay following childbirth and 96-hour stay in the case of a cesarean section. Therefore, under this Plan, when you give birth to a child in a hospital, you are entitled to at least 48 hours of inpatient care following a vaginal delivery and at least 96 hours of inpatient care following a cesarean section delivery. A fact sheet is available from the Claims Administrator concerning various matters such as when the 48 or 96 hours begins. Longer stays in the hospital will require concurrent review.

You may be discharged earlier only if you and your physician agree to it. If you are discharged earlier, your physician may decide that you should be seen at home or in the office, within 48 hours of the discharge, by a licensed health care provider who specializes in postpartum care and newborn care.

**Prosthetics/Corrective Appliances/Orthotics**

Internal and external prosthetic devices, including orthotics, required to replace a body part are covered. Examples are artificial legs, surgically implanted hip joints, visual aids (excluding eyewear) to assist the visually impaired with proper dosing of insulin, and internally implanted devices such as pacemakers.

Prosthetic devices designed to restore symmetry after medically necessary mastectomies are also covered, as described on page 11.

Prosthetic devices will be replaced when they are no longer functional. However, the repair or replacement of a device that has been lost or misused is not covered.
Reconstructive Surgery
Reconstructive surgery is covered if its purpose is to correct, repair, or improve function of an abnormal structure of
the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease.

Reconstructive Surgery: Mastectomy
The Plan covers reconstructive surgery to restore and achieve symmetry following a mastectomy, in accordance
with the Women’s Health and Cancer Rights Act of 1998 (WHCRA). For those individuals receiving mastectomy-
related benefits, coverage is provided for:
Ø All stages of reconstruction of the breast(s) on which the mastectomy was performed,
Ø Surgery and reconstruction of the other breast to produce a symmetrical appearance,
Ø Prostheses, and
Ø Treatment of physical complications of the mastectomy, including lymphedema.

These benefits are subject to the same copayments applicable to other medical and surgical services and supplies
provided under this Plan.

Rehabilitation Therapy
Rehabilitation therapy services (physical, speech, occupational, and respiratory therapy) are covered when
continuous functional improvement in response to the treatment plan is demonstrated. This is subject to a maximum
of 60 visits/incident per year for all therapies combined.

Second Opinion
You have the right to request a second opinion when:
Your PCP or the referred specialist gives a diagnosis or recommends a treatment plan that you are not satisfied with,
or
You are not satisfied with the result of treatment you have received, or
You are diagnosed with, or a treatment plan is recommended for, a condition that threatens loss of life, limb, or
bodily function, or a substantial impairment, including a chronic condition, or
Your PCP and the referred specialist are unable to diagnose your condition, or test results are conflicting.

To request an authorization for a second opinion, call MCS Customer Service at 1-888-587-8810.

A physician who specializes in the illness, disease, or condition must provide the second opinion associated with the
request.

Skilled Nursing Facility
Care in a semi-private room is covered. The benefit for a private room is limited to the facility’s most common
semi-private room rate, unless a private room is medically necessary. Benefits are limited to 100 days per year.

Hospitalization prior to admittance to a skilled nursing facility is not required.

Sterilization
Tubal ligation and vasectomy are covered regardless of medical necessity. Reversal of sterilization is not covered.

Surgical Services
Services by a surgeon, assistant surgeon, and anesthetist or anesthesiologist are covered for both inpatient and
outpatient surgeries.

Terminations of Pregnancy
Termination of pregnancies that are medically necessary are covered.
Vision and Hearing Examinations
Eye and ear examinations to determine the need for correction of vision and hearing are covered.

Chiropractic Coverage
The EPO Plan offers:
- Self-referral to any chiropractic provider in the MCS chiropractic network
- $10 per visit copay for up to 20 visits per year for each Plan participant.

How to Obtain Chiropractic Care
You may call an MCS chiropractic provider’s office directly to schedule an appointment. For a current list of participating chiropractic providers, contact MCS Customer Service at 1-888-587-8810 or log onto www.managedcaresystems.com.

Care that Requires Authorization
If the provider determines that your care requires more than five (5) visits, he or she will request authorization from MCS. If an MCS medical director determines that the additional visits are medically necessary, MCS will authorize the additional visits.

Filing a Claim
Typically, there are no claims to be filed for chiropractic coverage. However, if you are ever told to file a claim for benefits, you may follow the process described starting on page 20.

Prescription Drug Coverage
National Pharmaceutical Services (NPS) administers prescription drug benefits. The Plan only covers formulary prescription drugs purchased at retail pharmacies that participate in the NPS pharmacy network or through IHMO’s mail order pharmacy. For a current list of participating retail pharmacies, contact MCS Customer Service at 1-888-587-8810, log onto www.managedcaresystems.com or contact the NPS Customer Service Center at 800-546-5677 or log on to www.pti-nps.com.

Special Note to Medicare-Eligible Retirees

Medicare prescription coverage became available in 2006 to everyone with Medicare. You are entitled to elect this coverage, but the County has determined that the prescription drug coverage offered by this Plan is on average expected to pay out as much or more than what a standard Medicare Prescription Drug Plan pays. For more information, please contact the County Health Benefits office.

Where to Purchase Prescription Drugs
Participating Retail Pharmacy
You may purchase up to a 30-day supply of prescription drugs at an NPS participating retail pharmacy for one copayment. All you need to do is present your prescription and your ID card to the pharmacist and pay the appropriate copayment.

IHMO Mail Order Program
If you or a covered dependent takes long-term or ongoing medication, you can purchase up to a 90-day supply through IHMO, the EPO Plan’s mail order prescription program. To order, send in a completed mail order form (available from NPS or MCS), along with the prescription and payment, to the address on the form. For more information on the mail order pharmacy, contact MCS Customer Service at 1-888-587-8810, log onto www.managedcaresystems.com or contact NPS at 800-546-5677.
How Prescription Drug Benefits Work

Your prescription drug benefits do not have an annual deductible before coverage starts. Eligibility is from date of enrollment. In order to be covered, your prescription drug must:

- Be prescribed by a participating provider, and
- Purchased at a participating retail pharmacy or through the IHMO mail order program.

The County of Kern EPO Plan generally will not cover any prescription drugs that are prescribed by a non-participating provider or purchased at a non-participating pharmacy. The Plan covers prescriptions made by a dentist that are related to dental care. However, if you need a prescription while you are out of the network’s area, you may submit a claim form to be considered for reimbursement, as described starting on page 15.

NPS Formulary

The Plan covers prescription drugs that are included in the NPS formulary. A formulary is a Plan’s approved list of prescription drugs. The NPS formulary includes generic drugs, preferred brand name drugs, and non-preferred brand name drugs, all of which are paid at different levels (described under Three-Tier Prescription Drug Benefits, below).

The NPS formulary is created and maintained by NPS. Before deciding whether to include a drug on the formulary, NPS reviews medical literature and consults with specialists to assess the drug for its:

- Safety,
- Effectiveness,
- Cost-effectiveness (when there is a choice between two drugs having the same result, the less costly drug will be listed on the formulary),
- Side effect profile, and
- Therapeutic outcome.

NPS updates its formulary as new information becomes available and medications are approved.

Three-Tier Prescription Drug Benefits

Under the EPO Plan your copayment for a prescription is determined by which of the Plan’s three tiers applies to the drug. No matter which Tier your prescription is under, your copayment represents a significant savings to you compared to the medication’s full retail cost.

Tier 1 includes all generic medications, which are the Plan’s preferred agents or first line therapy choice. Generic drugs are chemically identical to brand name drugs but are priced at a fraction of the cost of the corresponding brand name drug. The U.S. Food and Drug Administration (FDA) requires that generic drugs provide the same effectiveness and safety as their brand name counterparts. The FDA requires drug manufacturers to show that the generic version enters the bloodstream the same way, contains the same amount of active ingredient, comes in the same dosage form and is taken the same way as the brand name drug. You pay the lowest copayment for generic medications.

Tier 2 includes preferred brand name medications that are still patent protected and do not have generic alternatives available. The NPS Pharmacy and Therapeutics (P&T) Committee has reviewed these medications and found that they are therapeutically superior, offer a better outcome, have a better safety profile, or provide the same therapeutic effect as comparable drugs in Tier 3, but Tier 2 drugs will save the Plan money. You pay the middle copayment for preferred brand name medications.

Tier 3 includes non-preferred brand name medications, drugs that either have equally effective and less costly generic equivalents or one or more alternative preferred brand name medications available in Tier 2 that provide the same therapeutic effect. You or your doctor may decide that a medication in this category is best for you. If you choose a Tier 3 drug, your contribution to the cost of the medication may be the highest copayment.

Remember: The fact that your physician prescribes a particular drug or medication does not automatically mean that it will be covered under the Plan. If the prescribed drug or medication does not have a generic form or is not on

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the NPS formulary, the network pharmacist will consult with your doctor to determine the best equivalent for you; the Plan may, on review, provide payment for non-formulary drugs if pre-authorized by your PCP, NPS or MCS.

**Drugs that Require Prior Authorization**

To promote appropriate utilization, selected high-risk or high-cost medications may require prior authorization to be eligible for coverage under the EPO Plan. Prior authorizations are only issued in cases of:

- **Medical necessity**, defined as a prescription medication which is appropriate and consistent with the diagnosis and which, in accordance with generally accepted medical standards, the current Preferred or Formulary alternatives are not acceptable to current peer-reviewed medical literature, and which meets the following conditions: a) it is recognized throughout the medical profession as safe and effective; b) it is employed appropriately in a manner and setting consistent with generally accepted United States medical standards; and c) it is not experimental in nature.

- **Off-label use of medication** - Prior authorizations for unlabeled uses of medications may be granted if: a) the medication is approved by the FDA; and b) two or more peer-reviewed professional medical journals have recognized, based on scientific medical criteria, the safety and effectiveness of the medication or combination of medications, for treatment of the indication for which the medication has been prescribed unless two articles from major peer-reviewed professional medical journals have concluded, based on scientific or medical criteria, that the drug or combination of drugs is unsafe or ineffective or the safety and ineffectiveness of the drug or combination of drugs cannot be determined for the treatment of the indication for which the drug or combination of drugs has been prescribed.

- **Over-ride an existing quantity limitation** provided a specific dosing and tapering schedule is presented.

In most cases, prior authorization requests will be approved for one year from the date the request is received in the NPS office, however certain exceptions and exclusions apply. Your health care provider should prescribe medications in which he/she feels best treats your disease state or medical condition. Prior authorization forms may be obtained from MCS or by calling NPS at 1-800-546-5677. Prior authorization request forms must be completed in full prior to evaluation of your request.

**Dispensing Limitations**

The control and utilization of medication is an important formulary measure. Quantity limits on medications that are dispensed are intended to safeguard your health, to ensure that you or a member of your family does not receive a prescription for a quantity that exceeds the recommended limits. Limits are set because some medications have the potential to be abused, misused, shared, or have a manufacturer’s limit on the maximum dose. The quantity limits are based on FDA-approved dosing schedules and medical literature related to that particular drug.

The Plan may elect its own limitations. Please review the Plan’s exclusions and limitations starting on page 18. If you are not sure a specific drug is covered, contact NPS at 1-800-546-5677 or consult the NPS Formulary at [www.pti-nps.com](http://www.pti-nps.com) or contact MCS.

Any Plan participant with a request exceeding the current quantity limits should have a letter from their health care provider. The letter should include diagnosis, reason for exceeding the quantity limit per month, and what the therapy plan will be for the participant (i.e. tapering schedule). In most cases the quantity limits selected are set at maximum dosages and should not be exceeded according to the current manufacturer’s recommendations. Prior authorizations for quantity limits exceeding the guidelines will be issued for six-month intervals and will require a new letter from your health care provider at the end of the six-month period.

**Inclusions**

Your prescription drug benefits include coverage of prescriptions for:

- State legend prescription drugs,
- Compound medications of which at least one ingredient is a prescription legend drug,
- Insulin and insulin syringes on prescription,
- Prescription drugs for the treatment of diabetes,
• Diabetic supplies, including insulin needles, syringes, blood glucose monitor strips, lancets and ketone strips,
• Contraceptive devices including oral contraceptives, contraceptive patch, injectable contraceptives and contraceptive implants,
• Dental prescriptions.

**Special Program for Over-the-counter Products**

The Plan provides benefits for certain, specific over-the-counter products, such as Prilosec and Claritin. For a complete list of products and a description of the coverage, contact NPS or MCS.

**How to Submit a Manual Claim**

If the pharmacy did not submit your request for prescription(s) payment to the NPS system at the time the prescription was filled and less than two weeks have passed, you should return to the pharmacy with your receipt and ask that they attempt to submit the prescription(s) claim to NPS for payment. Once the prescription(s) have been submitted, you should receive your refund from this pharmacy. The pharmacy may call NPS for assistance to get you set up in their computer. If your request that the pharmacy file a claim has gone longer than two weeks, you must submit the claim by following the instructions below.

As a participant with NPS, you are able to access a paperless claims network of pharmacy providers. In the rare event that you are required to file a paper claim for a covered service from a non-participating pharmacy, you may request a paper claim form which you must fill out completely, provide all listed information, then forward to NPS at:

**National Pharmaceutical Services**
PO BOX 407
Boys Town, NE 68010

Reimbursements are based on the established network agreements with our preferred providers. This agreement, in part, states that you, as a cardholder in the NPS network, will receive the lesser of usual and customary (U&C) charge of this pharmacy provider, or the contracted price of the prescription drug product. Your actual reimbursement amount may be lower than the amount submitted on your original pharmacy receipts by your pharmacy provider. NPS may process your claim for payment of reimbursement minus your copayment in cases where you paid for the prescription(s). *Requests must be submitted for review within 90 days of the date services were rendered.* This request must include the original pharmacy receipts, and the claim form must be completed in its entirety to avoid delays in processing your request. NO PHOTOCOPIES of the pharmacy receipts are accepted. Do not send cancelled checks or cash register receipts. The NPS network consists of pharmacies located in the United States; therefore no International claims will be processed. The form must be completed each time a claim is submitted to NPS.

If you are responsible for a deductible (through primary or secondary insurance coverage), the claim will count toward the date/year in which the claim was received, not the date and/or year the product was purchased. NPS network pharmacies are contracted to provide services for your employer group on a fixed reimbursement schedule and this reimbursement reflects these rates. Reimbursement may also be less than the amount submitted, if a non-participating pharmacy is used. NPS network pharmacy providers are terrific allies in building cost-containment programs for our employer groups, and we encourage you to use NPS Network Pharmacies as your preferred pharmacy provider.

If you have a question or concern regarding the dispensing of a medication, such as whether it is included in the NPS formulary, please contact NPS at 800-546-5677. Note that this does not constitute a claim or appeal on your behalf if you dispute whether a medication is or should be covered. If you have a dispute concerning the dispensing of a medication (e.g., your prescription was rejected), you must follow the claims procedures starting on page 20, under the subheading *Post-Service Claims.*

If you have a dispute concerning the prior authorization of a medication, such as described on page 14, you should follow the claims procedures starting on page 21, under the subheading *Pre-Service Claims.*

The process to appeal the denial of a claim is described starting on page 22.
EXCLUSIONS AND LIMITATIONS

Medical Exclusions and Limitations
The County of Kern EPO Plan does not cover the following medical services, treatments, and supplies:

- Acupuncture.
- Adoption expenses.
- Artificial insemination.
- Biofeedback.
- Charges for treatment of sickness or injury sustained during commission, or attempted commission, of an assault of felony, or injuries sustained while engaging in an illegal occupation.
- Conception by artificial means (IVF, GIFT, and ZIFT). Also, costs for the collection, storage, or purchase of sperm or ova are not covered.
- Contraceptive devices other than what is listed under prescription drugs on page 14.
- Cosmetic surgery, services, or supplies.
- Custodial or domiciliary care, meaning services and supplies that are provided to primarily assist with the activities of daily living.
- Dental services, except as outlined on page 8.
- Disorders of the jaw, except as outlined on page 8.
- Disposable supplies for home use.
- Durable medical equipment and supplies. The following durable medical equipment and supplies are not covered:
  - Exercise equipment.
  - Hygienic equipment and supplies.
  - Stockings, corrective shoes, and arch supports.
  - Surgical dressing.
  - Jacuzzis and whirlpools.
  - Generic orthotics (i.e., supports or braces for weak or ineffective joints or muscles) that are not custom-made to fit the person’s body.
  - Foot orthotics that are not incorporated into a cast, splint, brace, or strapping of the foot.
- Experimental or investigational procedures. (However, the Plan will cover services and supplies to treat medical complications caused by experimental or investigational services or supplies.)
- Eyeglasses and contact lenses, except after cataract surgery.
- Food supplements.
- Routine foot care, orthotics/orthotic devices, or matatarsalgia. Routine foot care includes, but is not limited to, removal or reduction of corns, clipping of toenails, flat feet, fallen arches, and chronic foot strain.
- Services or supplies for which you do not have to pay or for which no charge was made.
- Genetic testing and diagnostic procedures, except for prenatal diagnosis of fetal genetic disorders in cases of high-risk pregnancy.
- Hearing aids.
- Hypnosis.
Mental health care is covered only as outlined on page 9. The Plan does not cover care for mental retardation, mental health care as a condition or parole or probation, or court-ordered testing for mental disorders.

Missed appointments, telephone calls, preparation of medical reports, and itemized bills or the completion of forms.

Services or supplies provided by any institution that is not a legally-operated hospital, a Medicare-approved skilled nursing facility, or other properly licensed facility specified as covered in the Plan documents. Any institution that is primarily a place for the aged, a nursing home, or similar institution is not an eligible institution.

Nonprescription (over-the-counter) drugs, equipment and supplies even if the physician writes a prescription for it. (Exception: supplies and equipment for the management and treatment of diabetes.)

Physical examinations not associated with preventive care, such as physical exams for insurance, licensing, employment, school, camp, or other non-preventive care purposes.

Personal or comfort items.

Pregnancy under a surrogate arrangement.

Private rooms when hospitalized, unless medically necessary.

Private-duty nursing for hospital patients.

Any eye surgery performed to correct refractive defects of the eye, such as near-sightedness (myopia), far-sightedness (hyperopia), or astigmatism.

Rehabilitation therapy (physical, speech, occupational and respiratory therapy) when services are the result of the following conditions:
- Psychosocial speech delay (including delayed language development).
- Mental retardation, infantile autism or dyslexia.
- Syndromes associated with diagnosed disorders attributed to perceptual and conceptual dysfunctions.
- Attention deficit disorders and associated behavior problems.
- Developmental articulation and language disorders.

Reversal of surgical sterilization.

Services and supplies not authorized according to procedures the Plan and physician groups have established.

Services performed by an immediate relative.

Services received before effective date or after termination of coverage, except as specifically provided in the Extension of Benefits section of the Plan document.

Sex change procedures or treatment.

Termination of pregnancy unless determined medically necessary.

Treatment or surgery for obesity, weight reduction or weight management except for treatment of morbid obesity.

Expenses associated with a work-related illness or injury (If you suffer a work-related illness or injury, you may be eligible for medical benefits under the County’s Workers’ Compensation Insurance program).

**Chiropractic Care Exclusions and Limitations**

In addition to the medical exclusions and limitations listed above, the following list of exclusions and limitations pertains to the County of Kern EPO Plan’s chiropractic care coverage:
Any treatment or service not authorized and delivered by a MCS chiropractic provider.
Services not documented as necessary and appropriate or classified as experimental or investigational chiropractic care.
Diagnostic scanning, including MRI, CAT scan, and/or other types of diagnostic scanning.
Disk decompression therapy, Laser treatment and massage therapy
Thermography.
Treatment or services for pre-employment physicals, school physicals, sports physicals, DOT exams or vocational rehabilitation.
Any treatment or services caused by or arising out of the course of employment or covered under any public liability or auto insurance.
Hypnotherapy, behavioral training, sleep therapy and weight programs, educational programs, non-medical self-care or self-help, or any self-help physical exercise training, exercise equipment, or any related diagnostic testing.
Air conditioners, air purifiers, therapeutic beds, mattress supplies or any similar devices and appliances.
Vitamins, minerals, nutritional supplements, weight loss supplements, analgesic creams or similar products.
Anesthesia, manipulation under anesthesia, hospitalization or any related services.

Prescription Drug Exclusions and Limitations
In addition to the general exclusions and limitations listed above, the following list of exclusions and limitations pertains to the County of Kern EPO Plan prescription drug program:

- Allergy serum, products to lessen or end allergic reactions. (Serum is covered under medical benefits.)
- Appetite suppressants, diet aids, or drugs for body weight management.
- Blood and blood products, such as sera, blood derivatives, and blood plasma.
- Dietary or nutritional supplements.
- Drugs covered by another part of the Plan (i.e., prescription drugs administered while an inpatient).
- Drugs prescribed for cosmetic reasons.
- Drug supplies in excess of Food and Drug Administration’s (FDA) usage recommendations.
- Hypodermic syringes and needles (exception: insulin needles and syringes).
- All self-injectable drugs (exception: Bee Sting Kit).
- Medical devices.
- Drugs not approved by the Food and Drug Administration (FDA).
- Lost, stolen, or damaged drugs. The Plan does not cover replacement prescriptions for lost, stolen, or damaged drugs.
- Prescriptions purchased at a nonparticipating pharmacy that are not pre-authorized, unless medical necessity requires purchase while the participant is out of the network’s area.
- Nonprescription (over-the-counter) drugs or supplies (except certain diabetic supplies or when covered under the program described on page 15).
- Oxygen. (Oxygen is covered under durable medical equipment on page 8).
- Sexual dysfunction drugs.
- Smoking deterrents.
- Vaginal contraceptives.
**Additional Exclusions**

Diabetic supplies, Post coitals, Surgery supplies, Allergy and self admin syringes, Other syringes, Enteral and parenteral supplies, Durable home medical equipment, GI & GU ostomy supplies, Asthma and respiratory supplies, Surgery supplies injectables, Blood components and products, Blood components injectables, Diagnostic agents, Diagnostic agents injectables, Anesthetic agents, Anesthetic agents injectables, Fertility agents, Fertility agents injectables, Multi-vitamins, Multi-vitamins injectables, Home injectables, Other home injectables, Vaccines, sera, toxoids and allergens, Other injectables, Hematinic vitamins, Antiretrovitals injectables, Bulk chemicals, Cosmetic alteration, Accutane, Cosmetic hair products, Retin-A products, Anti-depressants injectables, Dialysis supplies, Growth hormones, Growth hormones injectables, Hypnotic/sedative agents injectables, Contraceptives other, Immunosuppressants injectables, OTC equivalents, Anti-psychotic injectables, Anti-anxiety agents injectables, Cognitive services.

Drugs which are entirely consumed at the time and place of prescribing.

Prescriptions which are covered under workers’ compensation law or which are covered without charge under any government program.

Experimental drugs or drugs labeled *Caution – limited by federal law to investigational use*.

Medication which is to be taken by or administered to a beneficiary while a patient is in a licensed hospital, nursing home, or similar institution, which operates or allows to be operated on its premises a facility for dispensing pharmaceuticals.

Refills in excess of the number specified or authorized by the prescriber or any refill dispensed after one year from the prescriber’s original order.

Mailing and delivery charges (standard delivery services are included).

Drugs which were distributed by the manufacturer as samples.

Unapproved uses of drugs, i.e., uses that are not approved by the United States Food and Drug Administration or peer-reviewed medical journals.

Prescription medications determined to be *less than effective* by the Drug Efficacy Study Implementation Program (DESI).
IMPORTANT INFORMATION ABOUT YOUR RIGHTS AND RESPONSIBILITIES UNDER THE PLAN

This section provides you with important information about the County of Kern EPO Plan. In this section, you will find information regarding the claims review process, the rights guaranteed to you under Federal law and additional administrative information. If you need more information or assistance on benefits matters, contact the County Health Benefits office or MCS at 1-888-587-8810.

Plan Document Governs

The benefit plan description contained in this document is a summary of the official Plan document. In all cases, the Plan document controls the administration and operation of the Plan. If a conflict exists between a statement in this description and the Plan document, the Plan document will govern.

Discretionary Authority of Plan Administrator and Fiduciary

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

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

Claims and Appeals Procedures for the Plan

The following claims procedures apply to claims made under this Plan. It is the intent of the Plan Sponsor, and Managed Care Systems, LLC, that the claims procedures described below comply with Department of Labor Regulations found at Section 2560.503-1. These procedures are superseded to the extent that they are inconsistent with policies, contracts or written notices to you that report on modifications mandated by law or regulation.

Filing a Claim

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

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

Post-Service Claims

When your network PCP or specialist files a claim on your behalf, such a claim is considered a Post-Service Claim. If your Post-Service Claim is denied, you will receive a written notice from MCS, the Claims Administrator, within 30 days of MCS receiving the claim. The letter or notice will explain the reason for denial and refer to the provision(s) of the Plan on which the denial is based. In addition, MCS will tell you whether the denial was based on an internal rule, guideline, protocol or similar criterion and offer to provide you with a copy of such guidelines, free of charge. If the denial was based on account of questionable medical necessity or the experimental nature of the...
requested service, MCS will offer to send you a written explanation of the scientific or clinical basis for the denial, also free of charge. You will receive a Claim Appeals form and a copy of the appeals procedures. As in all other appeals under this Plan, you have 180 days after receiving notice of denial in which to file an appeal.

Pre-Service Claims

If you are required to notify MCS or receive approval from MCS prior to obtaining a benefit under the Plan, such a request is considered a Pre-Service Claim. If your Pre-Service Claim was submitted properly with all the necessary information, you will receive a written notice of MCS’s decision within fifteen (15) days after it receives the submission. If MCS needs more time to respond, it will notify you before the 15 days have passed and tell you when it expects to respond, but this will never be more than 30 days from the time you made your first request.

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

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

Concurrent Care Claims

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

1) MCS approves an ongoing course of treatment to be provided over a certain period of time or for a specific number of treatments and MCS reduces or ends treatment before the end of the time period or number of treatments. Under this situation, the discontinuance or reduction is considered a denial of services and if you wish to appeal the denial, you must follow the procedures noted on page 22.

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

If MCS denies your request for ongoing treatment, such notice will be given to you as soon as possible but no later than 24 hours (72 hours if your request is made after the 24-hour period as described above) following your request so that you have sufficient time to appeal (see page 22) and obtain a determination before the health benefit is reduced or terminated.

You will receive a written confirmation of the determination, which will explain the reason for denial and will refer to the provision(s) of the Plan on which the denial is based. In addition, MCS will tell you whether the denial was based on an internal rule, guideline, protocol or similar criterion and offer to provide you with a copy of such guidelines, free of charge. If the denial was based on account of questionable medical necessity or the experimental nature of the requested service, MCS will offer to send you a written explanation of the scientific or clinical basis for the denial, also free of charge.

You will receive a Claim Appeals form and a copy of the appeals procedures. As with all other appeals under this Plan, you have 180 days after receiving notice of denial in which to file an appeal.
Note that if an ongoing course of treatment was previously approved for a specific period of time or number of treatments, and you request to extend treatment in a non-urgent circumstance, your request will be considered a new claim and decided according to post-service or pre-service timeframes, whichever applies.

Appealing a Denied Claim

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

The first step to resolving a dispute is to contact MCS by telephone, at 1-888-587-8810. Ask to speak to a customer service representative. Under federal law and regulations, your telephone inquiry is NOT considered a formal appeal. Rather, it is considered an informal way of attempting to resolve a dispute prior to filing a written appeal. After receiving the initial denial, you have 180 days to appeal the decision. **Contacting MCS by phone does not begin the formal appeals process.** The formal process is described below.

The Appeals Process

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

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

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

Response to your Appeal

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

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

Making A Final Appeal

If you are not satisfied with the resolution of your concern, you may request a final appeal in writing to the County Health Benefits office. The County Health Benefits office will confirm in writing that your final appeal has been received. Within 30 days of receiving your written appeal, you will be notified of the final decision.
### Summary Chart for Claims and Appeals

<table>
<thead>
<tr>
<th>Type of claim</th>
<th>Initial decision to you within</th>
<th>Appeal decision to you within</th>
</tr>
</thead>
<tbody>
<tr>
<td>Post-service</td>
<td>30 days</td>
<td>30 days</td>
</tr>
<tr>
<td>Pre-service</td>
<td>15 days</td>
<td>15 days</td>
</tr>
<tr>
<td>Concurrent care</td>
<td>As soon as possible, no later than 24 hours or 72 hours, if applicable</td>
<td>Depends on whether claim is pre-service, post-service or urgent care</td>
</tr>
</tbody>
</table>

### Privacy Rights

A federal law, the Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that health plans protect the confidentiality of your protected health information, also known by its acronym *PHI*. A complete description of your rights under HIPAA can be found in the Plan’s privacy notice, which was distributed to you upon enrollment and is available from the County Health Benefits office or MCS at 1-888-587-8810.

In the course of providing benefits to you under this Plan, the Plan Administrator, Claims Administrator, and other authorized parties may acquire PHI. Accordingly, the Plan has developed procedures to restrict access to such protected health information to persons who need to know it in order to process, complete, or administer the Plan benefits. The Plan will not use or further disclose PHI except as necessary for treatment, payment, health plan operations and plan administration or as permitted or required by law. In accordance with HIPAA rules and regulations, the Plan has required all of its business associates to also observe HIPAA’s privacy rules by certifying that they have privacy procedures in place and maintain a code of strict confidentiality in conformance with HIPAA. The Plan will not (unless you authorize it to do so) use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or benefit plan sponsored by the County.

Under HIPAA, you have certain rights with respect to your PHI, including rights to see and copy information, receive an accounting of certain disclosures of the information and, under certain circumstances, change the information. You also have the right to file a complaint with the Plan or with the Secretary of the U.S. Department of Health and Human Services if you believe your rights under HIPAA have been violated. Further information is detailed below.

Finally, you should know that this Plan maintains a detailed privacy policy, which provides a complete description of your rights under HIPAA’s privacy rules. For a copy of the policy or if you have questions about the privacy of your health information or if you wish to file a complaint under HIPAA, please contact the County Health Benefits office or MCS at 1-888-587-8810.

### Filing a Complaint

If you wish to file a privacy complaint under HIPAA, you must contact either the County Health Benefits office or MCS at 1-888-587-8810, who will direct your complaint to the Plan’s Privacy Officer. Your complaint will be recorded and reviewed by the Privacy Officer, and you will receive a written notice within 90 days of receiving your complaint of what action was taken, if any, or if any changes have been made to the Plan’s privacy policies or procedures. Any individual found to have failed to comply with the Plan’s privacy policies and procedures will be subject to disciplinary action by the Plan Sponsor, which disciplinary action may include, among other appropriate or lesser sanctions, demotion, removal to another function not involving compliance with privacy rules, and/or termination of employment as appropriate. If you wish to do so, you may file a written appeal with the Privacy Officer within 60 days after the date on which you receive a written notice regarding your complaint. The Privacy Officer will review your appeal and notify you of its decision regarding any additional action taken within 60 days of receiving your appeal.

Note that you may at any time file a privacy complaint if you believe that the Plan is not complying with HIPAA. Complaints may be filed with the Secretary of the Department of Health and Human Services, Hubert Humphrey Building, 200 Independence Avenue S.W., Washington D.C. 20201. Complaints must be filed in writing and describe the acts or omissions about which you are complaining. A complaint to the Secretary must name the entity
that is the subject of the complaint and be filed within 180 days of when you learned or should have learned about the act or omission complained of, unless this time limit is waived by the Secretary for good cause shown.

No intimidation, discrimination, or retaliation shall be permitted against you for the exercise of your rights under the Privacy Rule or our privacy policies, including the right to file a privacy complaint.

**Coordination of Benefits**

Coordination of benefits (COB) is a process regulated by law that determines financial responsibility for payment of covered expenses when an individual is covered by two or more group health plans. The objective of COB is to ensure that the group health plans—combined—will not pay more than 100% of covered expenses.

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

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

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

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

1. **Subscriber vs. Dependent.** The plan covering the person as a subscriber (for example an employee or retiree) is primary, and the plan that covers the person as a dependent is secondary.

2. **Plan Without COB Provision.** A plan that does not contain a coordination of benefits provision is always primary.

3. **Child Covered By More Than One Plan.** The order of payment when a child is covered by more than one plan is:
   a. **Birthday Rule:** The primary plan is the plan of the parent whose birthday is earlier in the year if:
      ₁ The parents are married;
      ₂ The parents are not separated (whether or not they have ever been married); or
      ₃ A court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage.
      
      If both parents have the same birthday, the plan that covered either of the parents longer is primary.
   b. **Court-Ordered Responsible Parent:** If a court decree states that one of the parents is responsible for the child’s health care expenses or health care coverage and the child is enrolled in that plan, that plan is primary. This rule applies to claim determination periods or plan years starting after the plan administrator is given notice of the court decree.
   c. **Parents Not Married, Divorced, or Separated:** If there is no court order specifying responsibility for the child’s health care coverage and the parents are not married, separated (whether or not they ever have been married), or divorced, the order of benefits is:
      ₁ The plan of the custodial parent.
      ₂ The plan of the spouse of the custodial parent.
      ₃ The plan of the noncustodial parent.
      ₄ The plan of the spouse of the noncustodial parent.
4. **Active vs. Inactive Employee.** The plan that covers a person as an active employee is primary in relation to a plan that covers the person as a laid-off or retired employee. When the person has the same status under both plans, the plan provided by active employment is first to pay.

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

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

**Effect on the Benefits of This Plan**

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

**Coverage by Two Closed Panel Plans**

The EPO Plan is considered a closed panel plan because the Plan pays benefits only when health care services are provided by a network provider. If a covered person is enrolled in two or more closed panel plans and expenses are not covered by one closed panel plan, COB rules will not apply. But if services received from a non-network provider are due to an emergency and would be covered by both plans, then both plans will provide coverage according to COB rules.

**Right to Receive and Release Information**

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under this Plan and other plans. The County may obtain the facts it needs from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under this Plan and other plans covering the person claiming benefits.

The County need not tell or obtain the consent of any person to do this. Each person claiming benefits under this Plan must give the County any facts it needs to apply those rules and determine benefits payable.

**The County’s Right to Pay Others**

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

**Recovery of Excessive Payments by the County**

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

**Facility of Payment**

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

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

Covered under Medicare, or

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

In general, Medicare is the primary payer only for retirees age 65 and older. However, if you reach age 65 and are still an active employee covered under a County health care program and are eligible for Medicare, Medicare will be considered the secondary payer of benefits while the EPO Plan will be primary. (See the section Coordination of Benefits on page 24, for details on primary and secondary plans.) Note that the EPO Plan will determine benefits payable to a Medicare-Eligible individual based on the assumption that such an individual has enrolled in Part B of Medicare. For more information, please contact the County Health Benefits office.

Medicare is also the secondary payer for an:

Active employee’s spouse who is over the age of 65,

Active employee’s covered dependent who is eligible for Medicare due to a disability (regardless of age),

or

Individual receiving treatment for end-stage renal disease (during the first 30 months of such treatment).

Right of Reimbursement

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

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

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

Promptly notify the claims administrator of any payment received from the third party, and

Reimburse the claims administrator the benefits advanced under the EPO Plan, up to the amount of any reimbursement received from the third party.

Any benefit paid will be subject to all provisions that apply under the County of Kern EPO Plan.

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

Right of Recovery

Whenever an overpayment is made, the Plan has the right to recover the excess payment from the recipient (including you, an insurance company or any other organization receiving excess payments). If necessary, the Claims Administrator may withhold payment on future benefits until the overpayment is recovered.

Further, whenever payments have been made based on fraudulent information provided by you, the Plan will exercise the right to withhold payment on future benefits until the overpayment is recovered.
**Medical Malpractice Disputes**
Any dispute alleging the medical malpractice, negligence and/or wrongful act of any health care provider shall not include the County of Kern or Claims Administrator and shall include only the provider subject to the allegation.

**No Guarantee of Employment**
By adopting and maintaining this benefit Plan, the County of Kern has not entered into an employment contract with any employee. Nothing contained in the Plan document or in the description gives any employee the right to be employed by the County or to interfere with the County’s right to discharge any employee at any time.

**Plan Future**
The County intends to continue this Plan but reserves the right through its Board of Directors (or the Board’s designees) to terminate, suspend, withdraw, amend or modify the Plan at any time.
Identification of Plan

PLAN:  County of Kern Exclusive Provider Organization (EPO) Retiree Medical Benefit Plan

PLAN SPONSOR:

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

PLAN SPONSOR TAX ID NO.:  95-6000925

PLAN NO.:  501

CLAIMS ADMINISTRATOR:

Managed Care Systems, LLC  
4550 California Ave, Suite 500  
Bakersfield, California 93309  
Customer Service Department: 1-888-587-8810

TYPE OF BENEFITS PROVIDED:  See Schedule of Benefits

TYPE OF PLAN ADMINISTRATION:  Self-Funded Third Party

PLAN ADMINISTRATOR/AGENT FOR LEGAL PROCESS/NAMED FIDUCIARY:

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

CONTRIBUTIONS TO PLAN:

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

PLAN YEAR:  Ends December 31st