

SUMMARY MATERIAL MODIFICATIONS TO
SELF FUNDED PPO (formerly Indemnity) PLAN

EFFECTIVE NOVEMBER 1, 2008

Benefit Summary

Page 29: Section V.A.1.(a)

- ii. Hospital Benefit. The Plan pays the first \$5,000 of outpatient Hospital Covered Charges in a calendar year at 100% that is, neither the deductible nor coinsurance applies) when treatment is performed at a Preferred Provider facility, and at 80% if not performed at a Preferred Provider facility.
- iii. Other Medical and Hospital Benefits. The Plan pays Covered Charges subject to the deductible at 80% if treatment is performed by a Preferred Provider or at a Preferred Provider facility. The Plan pays Covered Charges subject to the deductible at 60% after the deductible is met if treatment is not performed by a Preferred Provider or at a Preferred Provider facility.
- iv. Out-of-Pocket Maximum. Each Covered Person is subject to an out-of-pocket maximum of \$1,000 per calendar year.

Medical and Hospital Benefits for Active and Early Retiree Members and Dependents

Page 30-31: Section V.A.2.(a)

After the deductible has been satisfied, benefits will be paid at 80% of Reasonable and Customary charges incurred in a calendar year performed by a Preferred Provider or at a Preferred Provider facility, and at 60% if not performed by a Preferred Provider nor at a Preferred Provider facility. The 20% (or 40%) balance is your coinsurance, and is an out-of-pocket expense for which you are responsible. Once you or your Dependent has accumulated \$1,000 of out-of-pocket Covered Charges in a calendar year, the Plan will pay the balance of Covered Charges incurred during the remainder of the calendar year at 100%.

The Plan pays the first \$5,000 of out-patient Hospital Covered Charges in a calendar year at 100% (that is, neither the deductible nor coinsurance applies) when treatment is performed at a Preferred Provider facility, and at 80% if treatment is not performed at a Preferred Provider facility, when a member or Dependent:

- i. receives emergency outpatient treatment at a Hospital within 24 hours from the occurrence of an accident; or
- ii. receives emergency outpatient treatment for a condition characterized by acute symptoms that are of sufficient severity to cause a reasonable expectation, in the absence of immediate medical attention, that the health of the individual is in serious jeopardy; or
- iii. requires Hospital facilities as an outpatient for a surgical operation.

If emergency care is needed in a facility that is not a Preferred Provider, payment will be based on the Hospital's billed Reasonable and Customary charges at the Preferred Provider level of benefits.

Page 32: Section V.A.3(a): Benefits for Retirees and Their Dependents. [Note: All benefit changes to Section V.II.A.1, as described above *for Active and Early Retiree Members and their Dependents*, also apply to Retirees and Their Dependents.]

Page 34: Section V.A.4

- (f) Chiropractor. For up to a maximum of 30 visits per calendar year for Reasonable and Customary charges by generally accepted chiropractic standards when treated by a licensed chiropractor.
- (g) Acupuncturist. For up to a maximum of 30 visits per calendar year for Reasonable and Customary charges of a licensed acupuncturist which may be covered as a standard medical benefit, depending upon the diagnosis. You should contact the Plan Office prior to scheduling treatment to determine whether or not coverage is applicable to your specific Illness or Injury.

Page 80-83: Section XIV: Definitions

Add the following to the Definitions Section beginning on page 80.

Preferred Provider — a Physician, Hospital, Ambulatory Surgery Center, a Certified Registered Nurse Anesthetist, Participating Dialysis Center, or Home Health Care and Home Infusion Agency that has contracted with the Claims Administrator to furnish Services and to accept the Claims Administrator's payment, plus applicable deductibles and Copayments, as payment in full for covered Services. Note: This definition does not apply to Hospice Program Services. For Preferred Providers for Hospice Program Services, see the Preferred Hospice or Preferred Hospice Agency definitions.

Preferred Hospice or Preferred Hospice Agency – an entity which: 1) provides Hospice services to Terminally Ill Persons and holds a license, currently in effect, as a Hospice pursuant to Health and Safety Code Section 1747, or a home health agency licensed pursuant to Health and Safety Code Sections 1726 and 1747.1 which has Medicare certification and 2) has either contracted with the Claims Administrator or has received prior approval from the Claims Administrator to provide Hospice Service Benefits pursuant to the California Health and Safety Code Section 1368.2.

Non-Preferred Provider — Any provider that is not a Preferred Provider.