

SCHEDULE F

**Farm Credit Foundations
Blue Cross of California HMO Option
(Policy Nos. 59Q90A & L, 56AYKA & B, and 59Q90B)**



Blue Cross CaliforniaCare HMO

Policy Numbers: 59Q90A & L, 56AYKA & B and 59Q90B

Eligibility

Eligible dependents include your legally married spouse, domestic partner and unmarried child(ren) up to age 19, or up to age 25 if full-time students at an accredited institution. Child(ren) must be dependent upon the employee for financial support, unless there is a court order specifying that the employee carry health insurance, and the employee can claim the dependent for federal income tax purposes. Child(ren) are defined as: natural, stepchild(ren), adopted child(ren), and child(ren) or grandchild(ren) that the employee or the employee's spouse have been appointed legal guardian ship for by a court of law. Mentally or physically challenged child(ren) over the limiting age are covered as long as they are dependent on the employee for support, and they do not have self-sustaining employment.

Newly hired eligible employees who enroll within 45 days of eligibility for coverage will be covered on the 1st or 16th of the month following date of hire.

In the case of status changes made within 31 days of the event, the effective date of coverage will be effective the date of the status change.

Termination of Coverage

Coverage ends the 15th or end of the month following retirement or termination.

Primary Care Physician

Blue Cross HMO benefits are covered only when services are provided or coordinated by the primary care physician and authorized by the participating medical group or independent practice association (IPA), except services provided under the "Ready Access" program, OB/GYN services received within the member's medical group/IPA, and services for all mental and nervous disorders.

2008 Premium Rates

Below is the monthly premium for HMO coverage:

ACTIVE EMPLOYEES: Full-Time (32+ Hours/week)

	Employee	Employer	Total
Employee Only	\$96.00	\$508.00	\$604.00
Employee+ Spouse	\$277.00	\$930.00	\$1,207.00
Employee + Child(ren)	\$323.00	\$825.00	\$1,057.00
Family	\$458.00	\$1,354.00	\$1,812.00

ACTIVE EMPLOYEES: Part-Time (20 - 31 Hours/week)

	Employee	Employer	Total
Employee Only	\$350.00	\$254.00	\$604.00
Employee+ Spouse	\$742.00	\$465.00	\$1,207.00
Employee + Child(ren)	\$644.50	\$412.50	\$1,057.00
Family	\$1,135.00	\$677.00	\$1,812.00

Vendor Contact Information

Healthcare	Prescriptions
Blue Cross of California P.O. Box 60007 Los Angeles, CA 90060-0007 800-227-3613 – Medical	Wellpoint Pharmacy 800-700-2541 - Prescriptions www.bluecrossca.com

Summary of Benefits and Copayments for 2008

This Summary of Benefits is a brief review of benefits. Once enrolled, members will receive the Combined Evidence of Coverage and Disclosure Form, which explains the exclusions and limitations, as well as the full range of covered services of the plan, in detail.

Annual copay maximum: Individual \$500; Two-Party \$1,000; Family \$1,500

The following do not apply to the annual copay maximum: inpatient hospital services, infertility services and inpatient detoxification services

Covered Services	Per Member Copay
Inpatient Medical Services	
Semi-private room or private room if medically necessary; meals and special diets; services and supplies	\$250 per stay *
Special care units	No copay
Operating room and special treatment rooms	No copay
Nursing care	No copay
Drugs, medications & oxygen administered in the hospital	No copay
Blood & blood products	No copay
Outpatient Medical Services	
(Hospital care other than emergency room services)	No copay
Ambulatory Services	
Outpatient surgery & supplies	No copay

Covered Services	Per Member Copay
<p>Skilled Nursing Facility</p> <p>(Medical conditions & severe mental disorders limited to 100 days/calendar year)</p> <p>All necessary services & supplies (excluding take-home drugs)</p>	No copay
<p>Hospice Care</p> <p>(Inpatient or outpatient services for members with up to one year life expectancy; family bereavement services)</p>	No copay
<p>Home Health Care</p> <p>Home visits when ordered by primary care physician</p> <p>(Limited to 100 visits/calendar year; one visit by a home health aide equals four hours or less)</p>	\$15/visit

<p>Physician Medical Services</p> <p>Office & home visits</p> <p>Hospital visits</p> <p>Skilled nursing facility visits</p> <p>Specialists & consultants</p>	<p>\$15/visit</p> <p>No copay</p> <p>No copay</p> <p>\$15/visit</p>
<p>Short-Term Physical, Occupational, or Speech Therapy, or Chiropractic Care when Ordered by the Primary Care Physician</p> <p>(Limited to a 60-day period of care after an illness or injury; additional visits available when approved by the medical group)</p>	\$15/visit
<p>Acupuncture</p>	\$15/visit
<p>Surgical Services</p> <p>Surgeon & surgical assistant</p> <p>Anesthesiologist or anesthetist</p>	<p>No copay</p> <p>No copay</p>

Covered Services	Per Member Copay
<p>General Medical Services</p> <p>Diagnostic X-ray & laboratory procedures (including mammograms, pap smears, & prostate cancer screening)</p> <p>Radiation therapy, chemotherapy & hemodialysis treatment</p> <p>Prosthetic devices</p> <p>Durable medical equipment including hearing aids (limited to \$5,000/calendar year)</p>	<p>No copay</p> <p>No copay</p> <p>No copay</p> <p>No copay</p>
<p>Preventive Care</p> <p>Complete physical exams & periodic routine checkups when ordered by the primary care physician</p> <p>Well-baby & well-child care</p> <p>Well-woman exams</p> <p>Hearing exams</p>	<p>\$15/exam</p> <p>\$15/exam</p> <p>\$15/exam</p> <p>\$15/exam</p>
<p>Vision Exams</p> <p>Vision screening from primary care physician (vision screening covers evaluation only; diagnostic & treatment programs, including refractions, from an optometrist or ophthalmologist must be authorized by the primary care physician)</p>	<p>\$15/exam</p>
<p>Health Education and Wellness Programs</p> <p>Specified immunizations</p> <p>Allergy testing & treatment (including serums)</p> <p>Instruction in health maintenance & wellness</p> <p>Health education programs</p>	<p>No copay</p> <p>\$15/visit</p> <p>No copay</p> <p>Possible charge</p>
<p>Emergency Care In Area (within 20 miles of medical group) and Out of Area</p> <p>Physician & medical services</p> <p>Outpatient hospital emergency room services</p> <p>Inpatient hospital services</p>	<p>No copay</p> <p>\$100/visit (waived if admitted)</p> <p>\$250 per stay *</p>

Covered Services	Per Member Copay
Ambulance Services Ground or air ambulance transportation when medically necessary, including medical services & supplies	No copay
Pregnancy and Maternity Care Office Visits Prenatal & postnatal care Complications of pregnancy or therapeutic abortions Normal Delivery or Cesarean Section, including: Inpatient hospital & ancillary services Routine nursery care Physician services (inpatient only) Complication of Pregnancy or Therapeutic Abortion, including: Inpatient hospital & ancillary services Outpatient hospital services Physician services (inpatient only)	\$15/visit \$15/visit \$250 per stay * No copay No copay \$250 per stay * No copay No copay
Elective Abortions (including prescription drug for abortion [mifepristone])	\$150
Genetic Testing of Fetus	No copay

Covered Services	Per Member Copay
<p>Family Planning Services</p> <p>Infertility studies & tests</p> <p>Tubal ligation</p> <p>Vasectomy</p> <p>Counseling & consultation</p>	<p>50% of covered expense*</p> <p>\$150</p> <p>\$100</p> <p>\$15/visit</p>
<p>Organ and Tissue Transplant</p> <p>Inpatient Care</p> <p>Physician office visits (including primary care, specialty care & consultants)</p>	<p>\$250 per stay *</p> <p>\$15/visit</p>
<p>Mental or Nervous Disorders</p> <p>Inpatient Care</p> <p>Facility-based care (preauthorization required)</p> <p>Physician hospital visits</p> <p>Outpatient Care</p> <p>Outpatient mental health consultation</p> <p>(Limited to one visit/day & 20 visits/12-month period)</p>	<p>Not covered**</p> <p>Not covered**</p> <p>\$35/visit**</p>
<p>Acute Alcoholism or Drug Abuse</p> <p>Inpatient Care (acute phase only)</p> <p>Inpatient detoxification for alcohol or drug dependence</p>	<p>\$250 per stay *</p>

*Not applicable to the annual copay maximum.

**These limitations, copays and benefit maximums do not apply to severe mental disorders, including schizophrenia, schizoaffective disorder, bipolar disorder, major depression, panic disorder, obsessive-compulsive disorder, pervasive developmental disorder or autism, anorexia, bulimia, and serious emotional disturbances of children as defined in California state law (other than primary substance abuse or developmental disorder). Severe mental disorders are subject to the same copays and benefit maximums applicable to other medical conditions for covered services. In order to receive coverage, services must be rendered by a Blue Cross behavioral health provider. Please see the EOC for complete information.

RX 18 Three Tier Prescription Drug Benefits

Outpatient Prescriptions	Per Member Copay for Each Prescription or Refill
<p>Retail Pharmacy</p> <ul style="list-style-type: none"> • Generic drugs • Brand name formulary drugs • Brand name non-formulary drugs ¹ • Self-administered injectable drugs, except insulin 	<p>\$10</p> <p>\$20</p> <p>\$40</p> <p>20% of prescription drug covered expenses (Maximum \$100 copay)</p>
<p>Mail Service</p> <ul style="list-style-type: none"> • Generic drugs • Brand name formulary drugs • Brand name non-formulary drugs ¹ • Self-administered injectable drugs, except insulin 	<p>\$20</p> <p>\$40</p> <p>\$80</p> <p>20% of prescription drug covered expenses (Maximum \$100 copay)</p>
<p>Non-participating Pharmacies</p>	<p>Member <i>pays the above copay plus:</i></p> <p>50% of the remaining prescription drug covered expense & costs in excess of the maximum amount allowed</p>
<p>Supply Limits ²</p> <ul style="list-style-type: none"> • Retail Pharmacy (<i>participating and non-participating</i>) • Mail Service 	<p>30-day supply; 60-day supply for federally classified Schedule II attention deficit disorder drugs that require a triplicate prescription form, but require a double copay; 6 tablets or units/30-day period for impotence and/or sexual dysfunction drugs (available only at retail pharmacies)</p> <p>90-day supply</p>

¹ When the member's physician has specified "dispense as written" (DAW) for non-formulary drugs, the copay for brand name formulary drugs will apply. When the member's physician has not specified DAW for non-formulary drugs, the higher copay will apply.

² Supply limits for certain drugs may be different. Please refer to the Evidence of Coverage and Disclosure form (EOC) for complete information.

[This information is deemed to be accurate. In the event that this information is in conflict with the vendor contract or the policy, the contract or policy language will prevail. The employers intend to provide these programs on an ongoing basis; however, they reserve the right to amend or terminate any program at any time.]



ENDORSEMENT 2

to

**BLUE CROSS HMO PLAN
CALIFORNIACARE**

GROUP BENEFIT AGREEMENT SF17535-C (R-505)

for

FARM CREDIT CONSOLIDATED BENEFIT PLAN

Officers of Blue Cross of California have approved this endorsement which amends your Group Benefit Agreement to become effective January 1, 2007. Payment of subscription charges shall constitute acceptance of this endorsement.

President

Secretary

1. Pages in the NEW PAGES column are added to this *agreement* and replace corresponding pages in the REPLACED PAGES column:

NEW PAGES

Page 9, Rev. 2
Page 10, Rev. 2

REPLACED PAGES

Page 9, Rev. 1
Page 10, Rev. 1

2. Amendment RT17535-1.A2 107 is added to the Combined Evidence of Coverage (Evidence of Coverage) and Disclosure Forms RT17535-1 505.

SUBSCRIPTION CHARGE SCHEDULE

MONTHLY SUBSCRIPTION CHARGES

The Group will pay to Blue Cross the following monthly subscription charges:

Group No. 56AYKA, 59Q90A, 59Q90L:

Employee	\$ 488.00
Employee and spouse	\$ 976.00
Employee and child(ren)	\$ 855.00
Employee, spouse and child(ren)	\$1465.00

Group No. 56AYKB, 59Q90B:

Employee	\$ 534.00
Employee and spouse	\$1067.00
Employee and child(ren)	\$ 934.00
Employee, spouse and child(ren)	\$1599.00
Spouse Only	\$ 534.00

COMBINED EVIDENCE OF COVERAGE AND DISCLOSURE FORMS INCLUDED IN THIS AGREEMENT

Benefit provisions of this *agreement* appear in the Combined Evidence of Coverage and Disclosure Forms listed below. Copies of all Evidence of Coverage Forms and any applicable amendments issued to employees covered under this *agreement* are attached. These documents form an integral part of the entire *agreement*. In any interpretation of the *agreement*, all documents will be read together.

Employees are enrolled under the *plan* or *plans* indicated on their enrollment forms.

PLAN DESCRIPTION	FORM NUMBER	EFFECTIVE DATE
Blue Cross HMO Plan	RT17535-1 505	January 1, 2005
Amendment	RT17535-1.A1 206	January 1, 2006
Amendment	RT17535-1.A2 1206	January 1, 2007



Your Blue Cross HMO Plan Amendment

issued by

Blue Cross of California

to

FARM CREDIT CONSOLIDATED BENEFIT PLAN

Blue Cross of California ("Blue Cross") agrees to modify your Combined Evidence of Coverage and Disclosure (Evidence of Coverage) Form by this amendment. All other provisions of the Evidence of Coverage Form which are not inconsistent with this amendment remain in effect. Officers of Blue Cross have approved this amendment to become effective January 1, 2007.

The following provision is added to the section called "Working Together for Your Health":

RelayHealth. We have made arrangements with RelayHealth to provide an online health care information and communication program. This program will allow you to contact your *doctor* on the internet if your *doctor* is a participant in RelayHealth.

To see if your *doctor* is enrolled in the program, use the "Find Your Doctor" function on the website, www.relayhealth.com. Through this private, secure internet program, you can consult your *doctor*, request prescription refills, schedule appointments, and get lab results. You will only be required to pay a *copay* for consultations. This *copay* will be \$10 and must be paid by credit card. You will not be required to pay a *copay* when you request prescription refills, schedule appointments and get lab results.

The following change is made to the provision, **Medical Equipment** under the section called "Your Benefits at Blue Cross HMO – What We Cover":

The maximum amount of what you can rent or buy up to under **Medical Equipment** is increased to **\$5,000 worth (a calendar year)**.

The provision **When You Can Enroll Without Waiting**, under the section called **What You Should Know about Your Coverage**, is deleted and replaced by the following:

When You Can Enroll Without Waiting

You may enroll without waiting for your employer's next *open enrollment* period if all four of the following are true:

- ◆ **You were covered under another health plan** as an employee or dependent, including coverage under *COBRA* or CalCOBRA, the Healthy Families Program, or no share-of-cost Medi-Cal coverage; and
- ◆ **You chose not to enroll in writing** because you were covered under another health plan as stated above; and

- You are both members of the same sex. If you are members of opposite sexes, one or both of you must be over the age of 62 and meet the eligibility rules under Title II of the Social Security Act as defined in 42 U.S.C. Section 402(a) for old-age insurance benefits or Title XVI of the Social Security Act as defined in 42 U.S.C. Section 1381 for older people, the way these laws exist now or in the future;
- You are both able to agree to be part of a domestic partnership; and
- You must provide your employer with a signed, notarized, affidavit certifying you meet all of the rules shown above for your domestic partner to be a family member.

As used above, "have a common residence" means that both domestic partners share the same residence. It is not necessary that the legal right to possess the common residence be in both of their names. Two people have a common residence even if one or both have additional residences. Domestic partners do not cease to have a common residence if one leaves the common residence but intends to return.

The following provision is added:

Certificate of Creditable Coverage. Certificates of creditable coverage are issued automatically when your coverage under this *plan* ends. We will also provide a certificate of creditable coverage in response to your request, or to a request made on your behalf, at any time while you are covered under this *plan* and up to 24 months after your coverage under this *plan* ends. The certificate of creditable coverage documents your coverage under this *plan*. Call the *customer service number* listed on your *member ID* card to request a certificate of creditable coverage.

The provision about domestic partner who can enroll in your *plan*, under the section called **What You Should Know about Your Coverage - How Your Coverage Begins**, is deleted and replaced by the following:

- ◆ Your domestic partner, if you are in a legally registered and valid domestic partnership.

If you're not in a legally registered and valid domestic partnership, you must meet these rules:

- You have a common residence;
- Neither of you is married to someone else nor a member of another domestic partnership with someone else that has not been terminated, dissolved, or adjudged a nullity;
- You are not related by blood so closely that you cannot be legally married in California or in the state or commonwealth you live in;
- You are both 18 years of age or older;

- ◆ **You lost coverage under your other health plan** because you lost eligibility under the other plan or your employer stopped contributing toward the coverage, or the coverage under *COBRA* or *CalCOBRA* ended, you lost coverage under the Healthy Families Program because you exceeded the program's income or age limits, or you lost no share-of-cost Medi-Cal coverage; and

- ◆ **You enroll within 31 days** from the date on which you stopped being covered by giving your employer a signed Enrollment Form.

You may also enroll without waiting if you have a qualifying change in family status. Events that qualify as a change in family status include:

- ◆ a change in your marital status (marriage, divorce, legal separation, death);
- ◆ a change in the number of your eligible dependents (birth, adoption, student status);
- ◆ loss or reinstatement of a child's dependent status; or
- ◆ change of employment status for you or your spouse that affects you or your spouse's eligibility for medical coverage, including layoff, termination or beginning of employment.

If you have a change in family status, you must submit that information to your Human Resources representative/benefits coordinator within 31 days of the event to be eligible for a special enrollment. Changes to your benefit elections must relate directly to your change in family status. Failure to enroll your new dependents within 31 days results in no coverage for the new dependent until the next annual enrollment period.

You may also enroll yourself or your dependents within 31 days of one of the following "special changes."

- ◆ You did not enroll yourself or your dependents under this plan because you or your dependents were covered under another group health plan and one of the following has occurred:
 - coverage was terminated as a result of loss of eligibility for the coverage;
 - coverage was under a continuation provision which has been exhausted; or
 - the employer contributions of the other group health plan were terminated. OR
- ◆ You acquire an eligible:
 - spouse;
 - newborn child;
 - child under the age of 18 who is adopted by you; or
 - child under the age of 18 who has been placed with you for the purpose of adoption.

The new coverage will become effective on the date of your status change.

The following notice is added to the provision **CalCOBRA** under the section called **Keeping Blue Cross HMO After Your Coverage Status Changes**:

Note. Please examine your options carefully before declining this coverage. You should be aware that companies selling individual health insurance typically require a review of your medical history that could result in higher cost or you could be denied coverage entirely.

Such benefits will not apply to *medical groups* who have been terminated due to medical disciplinary cause or reason, fraud, or other criminal activity.

Please call us at the *Customer Service number* listed on your ID card to ask for continuity of care or to get a copy of the written policy. Eligibility is based on the *member's* clinical condition and is not determined by diagnostic classifications. Continuity of care does not provide coverage for services not otherwise covered under the *plan*.

We will notify you by telephone, and the *medical group* by telephone and fax, as to whether or not your request for continuity of care is approved. If approved, you will be financially responsible only for applicable deductibles, coinsurance, and copayments under the *plan*. Financial arrangements with terminated *medical groups* are negotiated on a case-by-case basis. We will ask that the terminated *medical group* agree to accept reimbursement and contractual requirements that apply to *Blue Cross HMO providers*, including payment terms, who are not capitated. If the terminated *medical group* does not agree to accept the same reimbursement and contractual requirements, we are not required to continue that *medical group's* services. If you disagree with our determination regarding continuity of care, you may file a complaint with us by following the procedures described in the section called "How to Make a Complaint".

This provision also applies if the contractual or employment relationship between your *medical group* or us and the *primary care doctor* or *specialist* from whom you are receiving care terminates. In this situation, please request continuity of care through your *Blue Cross HMO coordinator*.

The following changes are made to the section called **Other Things You Should Know**:

The provision **Continuity of Care** is deleted and replaced by **Transition Assistance for New Members and Continuity of Care after Termination of Medical Group**:

Transition Assistance for New Members: Transition Assistance is a process that allows for completion of covered services for new members receiving services from a doctor who is not a Blue Cross HMO provider. If you are a new member, you may request Transition Assistance if any one of the following conditions applies:

- ◆ An acute condition. An acute condition is a medical condition that involves a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention and that has a limited duration. Completion of covered services shall be provided for the duration of the acute condition.
- ◆ A serious chronic condition. A serious chronic condition is a medical condition caused by a disease, illness, or other medical problem or medical disorder that is serious in nature and that persists without full cure or worsens over an extended period of time or requires ongoing treatment to maintain remission or prevent deterioration. Completion of covered services shall be provided for a period of time necessary to complete a course of treatment and to arrange for a safe transfer to another provider, as determined by Blue Cross in consultation with you and the doctor who is not a Blue Cross HMO provider and consistent with good professional practice. Completion of covered services shall not exceed twelve (12) months from the time you enroll with Blue Cross.

- ◆ A serious chronic condition. A serious chronic condition is a medical condition caused by a disease, illness, or other medical problem or medical disorder that is serious in nature and that persists without full cure or worsens over an extended period of time or requires ongoing treatment to maintain remission or prevent deterioration. Completion of covered services shall be provided for a period of time necessary to complete a course of treatment and to arrange for a safe transfer to another provider, as determined by Blue Cross in consultation with you and the terminated medical group and consistent with good professional practice. Completion of covered services shall not exceed twelve (12) months from the date the medical group's contract terminates.

- ◆ A pregnancy. A pregnancy is the three trimesters of pregnancy and the immediate postpartum period. Completion of covered services shall be provided for the duration of the pregnancy.

- ◆ A terminal illness. A terminal illness is an incurable or irreversible condition that has a high probability of causing death within one (1) year or less. Completion of covered services shall be provided for the duration of the terminal illness.

- ◆ The care of a newborn child between birth and age thirty-six (36) months. Completion of covered services shall not exceed twelve (12) months from the date the medical group's contract terminates.

- ◆ Performance of a surgery or other procedure that we have authorized as part of a documented course of treatment and that has been recommended and documented by the provider to occur within 180 days of the date the medical group's contract terminates.

- ◆ A pregnancy. A pregnancy is the three trimesters of pregnancy and the immediate postpartum period. Completion of covered services shall be provided for the duration of the pregnancy.

- ◆ A terminal illness. A terminal illness is an incurable or irreversible condition that has a high probability of causing death within one (1) year or less. Completion of covered services shall be provided for the duration of the terminal illness.

- ◆ The care of a newborn *child* between birth and age thirty-six (36) months. Completion of covered services shall not exceed twelve (12) months from the time the *child* enrolls with Blue Cross.

- ◆ Performance of a surgery or other procedure that we have authorized as part of a documented course of treatment and that has been recommended and documented by the provider to occur within 180 days of the time you enroll with Blue Cross.

Call us at the *Customer Service number* listed on your ID card to ask for Transition Assistance or to get a copy of the written policy. Eligibility is based on your clinical condition and is not determined by diagnostic classifications. Transition Assistance does not provide coverage for services not otherwise covered under the *plan*.

We will notify you by telephone, and the provider by telephone and fax, as to whether or not your request for Transition Assistance is approved. If approved, you will be financially responsible only for applicable deductibles, coinsurance, and copayments under the *plan*. Financial arrangements with doctors who are not *Blue Cross HMO providers* are negotiated on a case-by-case basis. We will ask that the *doctor* agree to accept reimbursement and contractual requirements that apply to *Blue Cross HMO providers*, including payment terms, who are not capitated.

If the *doctor* does not agree to accept said reimbursement and contractual requirements, we are not required to continue that *doctor's* services. If you do not meet the criteria for Transition Assistance, you are afforded due process including having your request reviewed.

Continuity of Care after Termination of Medical Group:

Subject to the terms and conditions set forth below, Blue Cross will provide benefits at the *Blue Cross HMO provider* level for covered services (subject to applicable copayments, coinsurance, deductibles and other terms) received from a *medical group* at the time the *medical group's* contract with us terminates (unless the *medical group's* contract terminates for reasons of medical disciplinary cause or reason, fraud, or other criminal activity).

You must be under the care of the *medical group* at the time the *medical group's* contract terminates. The terminated *medical group* must agree in writing to provide services to you in accordance with the terms and conditions of the agreement with Blue Cross prior to termination. The terminated *medical group* must also agree in writing to accept the terms and reimbursement rates that apply to *Blue Cross HMO providers* who are not capitated. If the terminated *medical group* does not agree with these contractual terms and conditions, we are not required to continue the terminated *medical group's* services beyond the contract termination date.

Blue Cross will provide such benefits for the completion of covered services by a terminated *medical group* only for the following conditions:

- ◆ An acute condition. An acute condition is a medical condition that involves a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention and that has a limited duration. Completion of covered services shall be provided for the duration of the acute condition.