



***Exclusive Care Select  
Medicare Supplement Plan***

**Summary Plan Document**

**January 2010**

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Alternative formats of this publication can be made available upon request. Please contact Exclusive Care's Member Services Department at (800) 962-1133.

## **INTRODUCTION**

The Exclusive Care Select Medicare Supplement Plan is a Health Plan provided for County of Riverside employees or retirees over age 65 and their Eligible Dependent(s) who are over age 65 and Medicare-eligible, and for the employees and dependents of Qualified Public Employer Groups who are over age 65/Medicare-eligible.

This Summary Plan Document (SPD) provides a detailed description of how the Plan works and an explanation of what is and is not covered. The SPD is the primary governing document for all Plan coverage decisions and will be the basis for final determination for the provision of Benefits. It is the Plan's intent to comply with all laws and regulations that are applicable, regardless of whether they are specifically described in this SPD.

The County of Riverside is pleased to provide this Exclusive Care Select Medicare Supplement Plan for you and your Eligible Dependent(s). If you have any questions about Benefits provided by the Plan, a Representative is available to assist you at the Member Services Department phone number listed below.

<b>Exclusive Care Select Medicare Supplement</b>	
<b>Plan Sponsor</b>	The County of Riverside and any other Qualified Public Employer Group for its own Members
<b>Plan Administrator</b>	Assistant CEO, Director of Human Resources County of Riverside, Human Resources 4080 Lemon Street, 7 <sup>th</sup> Floor Riverside, CA 92502 (951) 955-3510
<b>Plan Mailing Address</b>	Exclusive Care P.O. Box 1508 Riverside, CA 92502-1508 <a href="http://www.exclusivecare.com">www.exclusivecare.com</a>
<b>Member Services</b>	(800) 962-1133 Monday through Friday 8:00 a.m. - 5:00 p.m. Pacific Coast Time

<b>Exclusive Care Select Medicare Supplement</b>	
<b>Type of Plan</b>	The Plan is a welfare benefit plan established and operated by the County of Riverside that provides health care Benefits for eligible Members of participating Qualified Public Employer Groups.
<b>Type of Funding</b>	The Plan is self-insured and unfunded. In other words, the Plan is funded through premium contributions that are made by its Members and participating Qualified Public Employer Groups, and Benefits are paid from Plan assets that are maintained by the County of Riverside. The Plan Administrator may also establish a trust for the payment of Benefits.
<b>Plan Year</b>	The Plan year begins on January 1 and ends on December 31. The Plan's financial records are based on the Plan's fiscal year.
<b>Plan Establishment</b>	The Plan was established for the exclusive benefit of its Members in 1999.
<b>SPD Effective Date</b>	The effective date of this SPD is January 1, 2010

The Plan Administrator reserves the right to change, modify or terminate, in whole or in part, this Plan at anytime.

## **SECTION 1: ELIGIBILITY AND ENROLLMENT**

### **Health Plan Eligibility**

You are eligible to enroll in this Medicare Supplement Health Plan if:

- you are an employee over age 65 or Eligible Dependent over age 65 of the County of Riverside or of a Qualified Public Employer Group, and
- you are enrolled in Part A and Part B of Medicare, and
- you reside either in Riverside County or elsewhere in the U.S. outside Riverside County.

Eligibility requirements are established by your employer group and are detailed in the Group Healthcare Services Agreement signed by your employer group. Contact your employer group for the dependent eligibility requirements including any age limits for

dependents. County of Riverside eligibility requirements are detailed in employee benefits medical plan eligibility requirements available through Human Resources.

### **Dependent Eligibility**

If your employer group provides dependent coverage and you are enrolled in the Health Plan option applicable to you, your legal spouse or Domestic Partner and Eligible Child(ren) may also enroll in the same Health Plan or the non-Medicare version of this Plan if under age 65/not Medicare-eligible, subject to the following:

- Domestic Partners must sign, agree, and meet the requirements specified in the *Employers Declaration of Domestic Partnership* and a signed *Statement of Financial Liability* to the satisfaction of the County of Riverside or the Qualified Public Employer Group;
- Your children, or those of your legal spouse or Domestic Partner, who are under the employer group's limiting age and have never been married may enroll in the same Health Plan if they meet each of the eligibility requirements as set forth below:
  - i) They must be natural born children, or children placed for the purposes of foster care or adoption or legally adopted children; or
  - ii) They must be children for whom you, or your legal spouse or Domestic Partner are appointed a legal guardian by a court; or
  - iii) They must be children for whom you or your legal spouse or Domestic Partner are required to provide health coverage pursuant to a qualified medical child support order ("QMCSO") or who reside with you (generally in the absence of the natural or adoptive parent) and who are economically dependent upon you; or
  - iv) They must be children that reside with you, generally in the absence of the natural or adoptive parent; for whom you have legal custody or guardianship. A copy of the court-ordered custody must be on file.

Dependent enrollment and eligibility shall not be denied because the dependent:

- Was born to a single person or unmarried couple; or
- Is not claimed as a dependent on your Federal income tax return.

### **Continued coverage for Disabled Dependents if your employer group provides dependent coverage**

Children who are over the employer group's limiting age, who reside with either you or your separated or divorced spouse, are incapable of self-sustaining employment by reason of mental handicap, debilitating Chronic Condition, or physical handicap that existed continuously prior to the employer group's limiting age and who are dependent upon you for support and maintenance, and who would otherwise be eligible to enroll as Eligible Children except for the fact that they are older than the limiting age, may enroll in the appropriate Exclusive Care plan (depending on Medicare eligibility status), or continue enrollment in the appropriate Exclusive Care plan beyond the limiting age,

provided proof of such incapacity is provided within sixty (60) days of the onset of the Disability, or attainment of the limiting age.

The Plan may require ongoing proof of the dependent's incapacity and dependency, but not more frequently than annually following the first two years following the attainment of the limiting age or the onset of the Disability. Such proof shall include a written statement by a licensed psychologist, psychiatrist, or other Physician to the effect that such dependent is incapable of self-sustaining employment by reason of mental handicap, debilitating Chronic Condition, or physical handicap.

### **Plan Enrollment Identification Card**

Once you are enrolled in the Plan, you and any enrolled dependent(s) will receive a new Member packet with identification cards, identifying you as a Member of the Exclusive Care Select Medicare Supplement Plan or the non-Medicare version of this Plan. Carry your identification card with you at all times. Present your identification card whenever you receive services.

### **Mid-Year Changes**

Enrollment changes that are permitted during a Calendar Year are called qualified status changes and include:

- Marriage;
- Divorce or legal separation;
- Birth or adoption of a child;
- Death of an Eligible Dependent;
- Change in an Eligible Spouse's employment that would affect medical coverage or a significant change in an Eligible Spouse's employer-offered medical coverage;
- Loss of a dependent's eligibility under another plan.

***You must notify your employer group within the timeframe established by your employer group from the date of the qualified status change; usually thirty (30) days.***

Coverage designation may be changed during the Calendar Year for any of the qualified status changes listed above. Failure to notify your employer group in a timely manner may result in the inability to correct and/or refund premium payments. Documentation that substantiates the qualified change must accompany the paperwork required by your employer group. Coverage for mid-year changes becomes effective the first day of the month following the date you notify your employer group of the status change; however, newborns or newly adopted dependents are covered as of the date of their birth or adoption contingent upon the timely completion of the enrollment paperwork.

If you wish to change your election based on a qualified status change, you must establish that the change is on account of and corresponds with the qualified status

change. The employer group shall determine whether a requested change is on account of and corresponds with a qualified status change. As a general rule, a desired election change will be found to be consistent with a qualified status change event if the event affects coverage eligibility. In addition, you must also satisfy the following specific requirements in order to alter your election based on that qualified status change:

- **Loss of Dependent Eligibility:** If your Eligible Spouse or Eligible Dependent Child(ren) lose coverage for any of the following reasons, you may only cancel coverage for the affected dependent upon:
  - i. Your divorce, annulment or legal separation from your Eligible Spouse; or
  - ii. The death of your Eligible Spouse or your Eligible Dependent; or
  - iii. Your dependent ceasing to satisfy the eligibility requirements for coverage.

For example, if your Eligible Child reaches the limiting age and no longer meets the Plan's eligibility requirements, you may cancel that child's coverage mid-year, but you may not cancel your Eligible Spouse's coverage too.

- **Gain of Coverage Eligibility Under Another Employer's Plan:** If you, your spouse, or your dependent child becomes eligible for coverage under another employer's plan (or qualified benefit plan) as a result of a change in your marital status or a change in your spouse's or your dependent child's employment status, your election to cancel or decrease coverage for that individual under the Plan would correspond with that qualified status change *only* if coverage for that individual becomes effective or is increased under the other employer's plan.

### **Termination of Benefits and Re-Enrollment**

A Member's coverage may be terminated if the Member:

- becomes deceased;
- ceases to be eligible for coverage based on the employer group's rules of eligibility;
- voluntarily cancels coverage;
- fails to pay the required premium;
- was never eligible for membership;
- engages in fraud or deception;
- permits misuse of his/her identification card;
- fails to cooperate with Exclusive Care's Third Party Lien and Non Duplication of Benefits Rights;
- exceeds his/her lifetime maximum Benefits under the Plan;
- has his/her coverage terminated at the request of the employer group;
- engages in an act of gross misconduct, which causes the interruption of the normal operations of the Plan.

Plan coverage and eligibility for Benefits stop on the date coverage ends. Any Member who is hospitalized when his/her enrollment terminates for any reason other than the voluntary termination of coverage shall be granted a continuation of Benefits with respect to medical conditions that were present or preexisting at the time of hospitalization or occurred during the hospitalization and which require continued hospitalization. This continued coverage should not extend beyond the 91st day following the termination.

If for any reason the Plan terminates your coverage, the effective date of the coverage termination will be the date determined by the Plan.

### **Reinstatement**

A Member may be reinstated at the discretion of Exclusive Care under the following circumstances:

- i. At the request of your employer group (along with payment of premiums).
- ii. Payment of premium in arrears by you.

The maximum retroactive reinstatement period is 60 days.

### **Keeping Enrollment Information Up-to-Date**

The Plan maintains enrollment information in order to communicate with you. Please help by keeping this information up-to-date. If there are any changes in your name, marital status, address, or phone number, please contact your employer group so your records may be updated and the updated information forwarded to the Plan. **Most importantly, the Plan requires up-to-date information in the event your coverage ends, in order to send COBRA continuation of coverage information as well as your “Prior Credible Coverage” certificates to the correct address, and to any dependents that may not be living at the same address.**

### **Cost of Enrollment in the Plan**

You are responsible for the payment of the entire premium for health care coverage for yourself and your enrolled dependents. It is your responsibility to stay informed about your premium deductions and your benefit elections. If you have questions about these, contact your employer’s human resources, payroll or designated department.

## **SECTION 2: HOW THE SELECT MEDICARE SUPPLEMENT PLAN WORKS**

The Plan is designed to supplement your Medicare benefits. To maximize your benefits, you should choose a provider who accepts Medicare Assignment. When you receive Covered Services, Medicare is billed first for the total cost of the services. After Medicare has made its payment, this Medicare Supplement Plan will pay the applicable amount, up to Medicare’s Approved Amount, subject to all other terms and limitations described in the Schedule of Benefits, General Provisions, or Exclusions and Limitations sections of this SPD.

## **Choice of Providers**

You may choose to go to any licensed provider, but your out-of-pocket expenses will be lower if you choose a provider who accepts Medicare Assignment. Providers who accept Medicare Assignment cannot bill you for any amounts in excess of the Medicare Approved Amount, except for any Medicare Deductibles, Coinsurance or Copays you owe.

***SHOULD YOU CHOOSE TO SEEK SERVICES FROM A PROVIDER WHO DOES NOT ACCEPT MEDICARE ASSIGNMENT, YOU MAY BE HELD FINANCIALLY RESPONSIBLE BY THE PROVIDER FOR THE DIFFERENCE BETWEEN THE MEDICARE APPROVED AMOUNT AND THE PROVIDER'S ACTUAL CHARGE FOR THE SERVICE.***

If you do not select a PCP at the time of your enrollment, one will be selected for you. Please refer to the "Changing Primary Care Provider" section of this day of Inpatient care.

## **Second Medical Opinion**

You, or your treating Physician, may request a second medical opinion by submitting a referral request in writing to the Medical Management Unit. The Medical Management Unit will provide you with a list of Specialists from which you and your Physician may choose a provider for your second medical opinion. The Plan reserves the right to submit any request to the Medical Director or Physician Review Committee for review. Non-covered treatments or conditions are subject to the "Member Grievance Procedure" (described later in this SPD) and will not be reviewed by the committee.

Second medical opinions can only be rendered by a Physician qualified to review and treat the medical condition in question. If a second medical opinion is deemed to be not Medically Necessary and the request is denied, you may appeal the denial by following the procedures outlined in the "Member Grievance Procedure" section of this SPD. For more information, please contact the Member Services Department.

## **SECTION 3: SELECT MEDICARE SUPPLEMENT PLAN BENEFITS**

The Schedule of Benefits below describes how this Plan works with your Medicare benefits to supplement certain amounts Medicare doesn't pay:



- *All services that are covered by Medicare except as noted below;*
- *Medicare coverages, exclusions and limitations apply, unless otherwise specifically noted;*
- *Exclusive Care reserves the right to modify Plan benefits in accordance with any changes in Medicare benefits;*
- Medicare Deductible, Copay and Coinsurance amounts may vary each year.

## Schedule of Benefits – Select Medicare Supplement Plan

PLAN REIMBURSEMENT METHOD	<p>Medicare is billed first and after Medicare pays, the Plan is billed for any remaining amount.</p> <p>The Plan pays your Coinsurance or Copay amount for Covered Services, which, when combined with Medicare's payment, usually equates to 100% coverage, for services received from a provider who accepts Medicare Assignment.</p> <p>You may be held financially responsible for the difference between Medicare's Approved Amount and the provider's actual charge, where the provider <u>does not</u> accept Medicare Assignment.</p>
DEDUCTIBLE - Individual	You pay the annual Medicare Part B Deductible before the Plan pays for Covered Services
DEDUCTIBLE - Family	Each Medicare-eligible Member pays the annual Medicare Part B Deductible
PRE-EXISTING CONDITION	Fully Covered
OUT-OF-POCKET MAXIMUM	Does Not Apply
LIFETIME MAXIMUM BENEFIT	\$1,000,000/Member
<b>OUTPATIENT/OFFICE VISIT</b>	<b>Coverage Level</b>
Physician Office Visit	Plan pays 20% Coinsurance (Medicare pays 80%), after Member fulfills annual Medicare Part B Deductible
Diagnostic Laboratory Test	Plan pays 20% Coinsurance (Medicare pays 80%). after Member fulfills annual Medicare Part B Deductible
Diagnostic X-ray or Other Diagnostic Test (not performed in Hospital Outpatient)	Plan pays 20% Coinsurance (Medicare pays 80%), after Member fulfills annual Medicare Part B Deductible
Immunizations	Plan pays 20% Coinsurance (Medicare pays 80%), after Member fulfills annual Medicare Part B Deductible
Periodic Health Evaluation Well Woman Care	Plan pays 100% (benefits not covered by Medicare); not to exceed 100% of Medicare Allowed Amount for specific services received.
Well Baby Care	Not Covered (not covered by Medicare)
Vision Exam (for Diabetic Patient)	Plan pays 20% Coinsurance (Medicare pays 80%), after Member fulfills annual Medicare Part B Deductible

<b>PREGNANCY &amp; MATERNITY CARE</b>	
Prenatal and Postnatal Care Normal Delivery, Cesarean Section Complications of Pregnancy and Medical Services, Hospital and Other Related Services	Not Covered (not covered by Medicare)

<b>Outpatient Prescription Drugs</b>	<b>Coverage Level</b>
<b>Prescription Drug Coverage is administered by the Plan's Pharmacy Benefit Manager (PBM)</b>	
Participating Retail Pharmacy (up to a 30-day supply)	<p style="text-align: center;">Generic Drugs: \$15 Copay Brand Name Formulary Drugs: \$25 Copay Brand Name Non-Formulary Drugs: \$40 Copay</p> <ul style="list-style-type: none"> <li>• Significant or new therapeutic class drugs: 50% Coinsurance</li> <li>• Additional Benefits for Members with Diabetes are described in the "Other Benefits" section below</li> </ul>
<b>If you use Exclusive Care's Rubidoux Pharmacy you can receive up to 3 months (90 days) of medication for only 2 Copays (saving you 1 Copay)</b>	

<b>Outpatient Prescription Drugs</b>	<b>Coverage Level</b>
Exclusive Care Rubidoux Pharmacy  (up to a 90-day supply)	<p style="text-align: center;">Generic Drugs: \$30 Copay Brand Name Formulary Drugs: \$50 Copay Brand Name Non-Formulary Drugs: \$80 Copay</p> <ul style="list-style-type: none"> <li>• Significant or new therapeutic class drugs: 50% Coinsurance</li> <li>• Additional Benefits for Members with Diabetes are described in the "Other Benefits" section below</li> </ul>
Exclusive Care Rubidoux Mail-Order Pharmacy  (up to a 90-day supply)	<p style="text-align: center;">Generic Drugs: \$30 Copay Brand Name Formulary Drugs: \$50 Copay Brand Name Non-Formulary Drugs: \$80 Copay</p> <ul style="list-style-type: none"> <li>• Significant or new therapeutic class drugs: 50% Coinsurance</li> <li>• <b><i>Mail-Order is MANDATORY for maintenance medications after the first 30-day prescription trial</i></b></li> <li>• Additional Benefits for Members with Diabetes are described in the "Other Benefits" section below</li> </ul>

<b>Hospital &amp; Emergency Room</b>	<b>Coverage Level</b>
Ambulance (as Medically Necessary)	Plan pays 20% Coinsurance (Medicare pays 80%), after Member fulfills annual Medicare Part B Deductible
Ambulatory Surgical Center	Plan pays 20% Coinsurance (Medicare pays 80%), after Member fulfills annual Medicare Part B Deductible (exception: Plan pays 25% for Sigmoidoscopy or Colonoscopy screening, where Medicare pays 75%)
Physician Hospital Visits	Plan pays 20% Coinsurance (Medicare pays 80%), after Member fulfills annual Medicare Part B Deductible
Inpatient Hospital Services	Days 1 – 60: Plan pays annual Part A Medicare Deductible Days 61 – 90: Plan pays additional Medicare daily Copay amount Days 91 and beyond: Plan pays additional Medicare daily Copay amount while Member using 60 Medicare Lifetime Reserve Days After 60 Medicare Lifetime Reserve Days exhausted: Plan pays 100%; up to 365 days/lifetime maximum; no Benefit paid after 365 days exhausted
Outpatient Hospital Services (including Diagnostic X-Ray or Other Test)	Plan pays Copay amount (Medicare requires set Copay amount based on specific test/service provided; this will not exceed Part A Deductible amount for any one item), after Member fulfills annual Medicare Part B Deductible
Hospital Emergency Room	Plan pays Copay amount (Medicare requires set Copay amount for visit) after Member fulfills annual Medicare Part B Deductible
Hospital Emergency Room – Physician Services	Plan pays 20% Coinsurance (Medicare pays 80%), after Member fulfills annual Medicare Part B Deductible
<b>Mental Health Treatment</b>	<b>Coverage Level</b>
Inpatient Care	Days 1 – 60: Plan pays annual Part A Medicare Deductible Days 61 – 90: Plan pays additional Medicare daily Copay amount Days 91 – 150: Plan pays additional Medicare daily Copay amount while Member using 60 Medicare Lifetime Reserve Days After 60 Medicare Lifetime Reserve Days exhausted: Plan pays 100% up to 190 days lifetime maximum; no Benefit paid after 190 days exhausted (combined with

	Substance Abuse lifetime maximum)
Outpatient Care (for Diagnosis or Medication Monitoring only)	Plan pays 20% Coinsurance (Medicare pays 80%), after Member fulfills annual Medicare Part B Deductible
Outpatient Care	Plan pays 45% Coinsurance (Medicare pays 55%) after Member fulfills annual Medicare Part B Deductible; maximum 30 visits/Calendar Year
<b>Substance Abuse Treatment</b>	
Inpatient Care	Days 1 – 60: Plan pays annual Part A Medicare Deductible Days 61 – 90: Plan pays additional Medicare daily Copay amount Days 91 – 150: Plan pays additional Medicare daily Copay amount while Member using 60 Medicare Lifetime Reserve Days After 60 Medicare Lifetime Reserve Days exhausted: Plan pays 100% of Medicare Approved Amount; Plan pays 100% of Medicare Approved Amount; up to 190 days lifetime maximum; no Benefit paid after 190 days exhausted (combined with Mental Health lifetime maximum)
Outpatient Care (for Diagnosis or Medication Monitoring only)	Plan pays 20% Coinsurance (Medicare pays 80%), after Member fulfills annual Medicare Part B Deductible
Outpatient Care	Plan pays 45% Coinsurance (Medicare pays 55%), after Member fulfills annual Medicare Part B Deductible

OTHER BENEFITS	Coverage Level
<b>Allergy Testing &amp; Treatment</b>	Plan pays 20% Coinsurance (Medicare pays 80%) after Member fulfills annual Medicare Part B Deductible.
<b>Blood</b>	Plan pays for the first three units of unreplaced blood after Member fulfills annual Medicare Part B Deductible (not covered by Medicare)
<b>Members Requiring Diabetes Care</b>	Pharmacy Copays are waived for all Generic and Brand Name Formulary injectible and oral Anti-Diabetic medications and Diabetic supplies (testing strips, syringes, etc.)
<b>Durable Medical Equipment</b> (As Medically Necessary)	Plan pays 20% Coinsurance (Medicare pays 80%) after Member fulfills annual Part B Deductible; up to \$1,000/Calendar Year maximum
<b>Home Health Care</b>	Plan pays 20% Coinsurance (Medicare pays 80%), after Member fulfills annual Medicare Part B Deductible  Injectible drugs to treat osteoporosis in women - up to 20% Coinsurance (Medicare pays 80%) after Member fulfills annual Part B Deductible; all other services not covered
<b>Hospice and Respite Care</b>	Plan pays 5% Coinsurance for Respite Care (Medicare pays 100% for Hospice, 95% for Respite Care)  Plan pays \$5 Copay (Medicare pays the rest) for each Medicare approved prescription drug
<b>Physical Speech &amp; Occupational Therapy (Medicare Covers)</b>	Plan pays 20% Coinsurance (Medicare pays 80%) after Member fulfills annual Medicare Part B Deductible;
<b>Chiropractic Care</b>	Not Covered
<b>Skilled Nursing Facility</b> (As Medically Necessary)	Days 1 – 20: The Plan pays initial Part A annual Medicare Deductible  Days 21 - 100: Plan pays Medicare daily Copay amount  Day 101 and beyond: Not Covered

<b>Combined Audiological Exam &amp; Hearing Aid Benefit</b>	Plan pays a <u>combined</u> Benefit based on the amounts listed below, up to \$1,000 every 60 months;
Audiological Examination	Plan pays 20% Coinsurance (Medicare pays 80%) after Member fulfills annual Medicare Part B Deductible;
Hearing Aid Instrument	Plan pays up to \$1,000

***An explanation of terms used in this Schedule of Benefits follows below, to help you get the most out of your coverage:***

**Pre-Existing Conditions**

The Plan has no pre-existing conditions limitation. Therefore, there are no limitations, waiting periods or exclusions for being treated for any diagnosis or condition currently on record for you or your enrolled dependents as long as services are Covered Services.

**Medically Necessary**

The Plan only covers Medically Necessary health care services. See Section 11 - Definition Of Terms, for a more detailed explanation.

**Copay and Coinsurance**

These are the amounts that are your share of the cost based on Medicare’s schedule of benefits. In most instances, the Plan will pay these Copay and Coinsurance amounts, in connection with Covered Services (except Outpatient prescription drug Copays and Coinsurances).

**Deductible – Individual/Family**

The Deductible is the portion of Covered Services you must pay each Calendar Year before Medicare or the Plan will pay any Benefits. In certain instances, for example, the Plan will pay your Medicare Part A Deductible for you (refer to the Schedule of Benefits)

**Medicare Assignment**

Providers who accept Medicare assignment have agreed to accept Medicare’s payment as payment in full, and will not send you a bill for the difference, if any, between what Medicare paid, based on Medicare’s Approved Amount, and the provider’s actual charge. You are still responsible for any Deductible, Coinsurance or Copay you owe.

Providers who do not accept Medicare Assignment are allowed to send you a bill for any difference between the Medicare Approved amount and the provider's actual charge, in addition to any Deductible, Coinsurance or Copay you owe.

### **Lifetime Maximum Benefit**

The Plan pays a maximum lifetime benefit of up to \$1,000,000 for each Member.

## **SECTION 4: SELECT MEDICARE SUPPLEMENT: COVERED SERVICES**

The Plan reserves the right to review all Claims submitted for payment to verify the validity of services based on Medical Necessity.

The Plan covers preventative, certain wellness services, and other Medically Necessary health care services and supplies provided to you.

### **INPATIENT SERVICES**

#### **Room and Board**

Semi-private room, Intensive Care Unit (private room), Operating, recovery and special treatment rooms;

#### **Additional Inpatient Services**

Laboratory services, X-rays, drugs, anesthesia, medications and biologicals. All other Medically Necessary Inpatient services such as Physical, Speech, Occupational and Respiratory Therapy, hemodialysis and administration of blood and blood plasma, including the collection and storage of autologous blood, nursing care and Durable Medical Equipment;

#### **Physician, Surgeon and Anesthesiologist Services**

#### **Skilled Nursing Facility or Convalescent Care**

#### **Administration of Blood and Blood Plasma**

The processing and storage of autologous blood for scheduled medical procedures;

#### **Breast Reconstructive Surgery**

Under the Women's Health And Cancer Rights Act, coverage will be provided to a Member who is receiving Benefits for a Medically Necessary mastectomy and who elects breast reconstruction after mastectomy for:

- ✓ Reconstruction of the breast on which a mastectomy has been performed;
- ✓ Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- ✓ Prostheses; and treatment of physical conditions of all stages of mastectomy, including lymphedemas;

This coverage will be provided in consultation with the attending Physician and the patient, and will be subject to the same Deductibles, Copays, and maximums, if any, that apply to the mastectomy;

### **Inpatient Dental Care**

Inpatient services associated with dental procedures under the following circumstances:

- ✓ the Member is a child, up to 6 years old, with a dental condition (such as baby bottle syndrome) that requires administration of general anesthesia in a hospital setting for dental repairs of significant complexity (e.g., multiple amalgam and/or resin-based composite restorations, pulpal therapy, extractions or any combinations of these noted or other dental procedures); or,
- ✓ the Member exhibits physical, intellectual, or medically compromising conditions, is in need of dental treatment that requires administration of general anesthesia, and for whom administration of a general anesthesia can only be safely performed in a hospital setting. Conditions include but are not limited to: mental retardation, cerebral palsy, epilepsy, cardiac problems and hyperactivity (verified by appropriate medical documentation);

Limited to Inpatient Hospital and anesthesiologist charges; charges for the actual dental procedure performed by a dentist or an oral surgeon are not covered.

## **EMERGENCY CARE SERVICES**

### **Ambulance Service**

Land or air;

### **Emergency Care Services**

Emergency Care Services are medical, emergency room or Hospital services required as the result of a medical condition, manifesting itself by the sudden onset of sufficient severity, which may include severe pain, such that a reasonable person would expect the absence of immediate medical attention to result in:

- ✓ Placing your health in serious jeopardy;
- ✓ Serious impairment to bodily functions; or
- ✓ Serious dysfunction of any bodily organ or part;

Examples of emergencies include heart attacks, strokes, poisonings, and sudden inability to breathe;

### **Follow-Up Care**

If you require additional services following Emergency Care services, you must obtain these services from your family Physician. Follow-up care provided in an emergency room is not a covered expense;

## **OUTPATIENT SERVICES**

### **Office Visits**

Periodic Health Evaluations (gender-specific, age-specific), and Well Woman Care visits;

### **Specialist and Consultant Visits**

### **Home Health Care Visits**

### **Allergy Testing and Treatment**

**Hearing Screening** when performed in a Physician's office;

### **Ambulatory Surgical Center**

### **Diagnostic X-Ray and Laboratory Services**

Procedures consistent with established medical practices;

### **Durable Medical Equipment**

- ✓ Rental (but not to exceed the purchase price) or purchase of Durable Medical Equipment used in your home;
- ✓ Corrective appliances, artificial aids, Prosthetics and Orthotics that are part of a corrective appliance; therapeutic footwear (limits may apply);
- ✓ Urinary catheters (covered for a Member who has permanent urinary incontinence or permanent urinary retention);

**Physical and Occupational Therapy** limited to treatment only where short-term therapy is expected to result in a near-term significant improvement;

### **Charges for Second Medical Opinion**

### **Immunizations**

Childhood immunizations, Hepatitis B and certain adult immunizations when Medically Necessary or when required for employee safety in the workplace;

### **Hearing Aid Benefit**

Covered Expenses include:

- ✓ An audiological evaluation to measure the extent of hearing loss;
- ✓ Hearing aid evaluation to determine the most appropriate make and model of hearing aid; Limited to maximum Benefits listed in the Schedule of Benefits for the hearing aid instrument (monaural or binaural), ear mold(s), the initial battery, cords and other ancillary equipment, or maintenance and repair of current hearing aid device. Includes visits for fitting, counseling, adjustments, and repairs.

You may be asked to pay the full cost of the hearing aid at the time of purchase. Should this occur, you may receive prompt reimbursement (up to any benefit limitations that apply) by submitting a copy of the provider's bill and your receipt to the Plan's Claims Department;

### **Well Woman Care**

- ✓ Annual pelvic examination and PAP smear based on current recommendations from the US Preventive Services Task Force and your Physician's assessment of need (subject to medical review);
- ✓ Periodic clinical breast examination and annual clinical breast examination for women age 40 and above.

### **OTHER SERVICES**

#### **Hospice Care**

Hospice Care services are covered up to the benefit level described in the Schedule of Benefits if the Member:

- Has been certified by the attending Physician to have 180 days of life expectancy or less;
- Decided to no longer pursue aggressive medical treatment; and,
- The goal of treatment is to provide supportive nursing care and counseling to the Member during the terminal phase of illness, social services evaluation, and Home Health aid services;

#### **Respite care**

Continuous care of the patient in the most appropriate setting for the primary purpose of providing temporary relief to the family from the duties of caring for the patient. Care must be pre authorized by the Plan and must be provided in the most appropriate setting;

**Organ Transplants** The Plan will pay for Covered Services described in the Inpatient Services section above, in connection with a Medicare-approved organ transplant, subject to all other terms and limitations described in the Schedule of Benefits, General Provisions, or Exclusions and Limitations sections of this SPD for Medical and Hospital services and other costs of a donor or prospective donor when the recipient is a Member:

Travel expenses - limited to a maximum lifetime benefit of \$7,000 for organ transplants performed at a special transplant facility, or \$3,000 for organ transplants performed at other facilities. Travel expenses associated with an organ transplant are covered if the facility at which the transplant is performed is more than 100 ground miles from the organ recipient's home address. Child care or charges for house-sitting are not covered by the Plan. Benefits paid will be based on actual incurred costs. Covered travel expenses include:

- Coach airfare on a public airline for the organ recipient and one companion (two companions if the organ recipient is a minor child) to travel to and from the site of the transplant. A “companion” includes the organ recipient’s legal spouse, legal parent(s) or legal guardian(s);
- Reimbursement for mileage at the Federal maximum rate for use of a personal car or rental car used to travel to and from the site of the transplant;
- Up to \$200/day for reasonable and necessary lodging and meals for the organ recipient (while not confined) and companion(s). The \$200/day maximum applies to the organ recipient and companion(s) collectively, not individually.

## **SECTION 5: PLAN EXCLUSIONS AND LIMITATIONS**

### **GENERAL EXCLUSIONS**

All services not specifically included in the preceding “Schedule of Benefits” and “Covered Services” sections of this SPD;

Services requiring approval and authorization by the Plan where pre authorization was not obtained (except for Emergency Care );

Services rendered prior to your Plan effective date or after Plan termination date;

Services received that, based on Medical Management review, are not Medically Necessary, in accordance with professionally recognized standards of proven and effective medical practice recognized within the organized medical community;

Services that are part of a plan of treatment for a non-Covered Service. This may include services and supplies to treat medical conditions which are recognized by the organized medical community in the State of California, in conformance with professionally recognized standards of practice, to be direct and predictable consequences of such non-Covered Services; Medically Necessary services required to treat medical conditions that may arise but are not predictable in advance, such as unexpected complications of surgery are not subject to this exclusion;

Charges incurred while on active duty with the Army, Navy or Air Force of any country or international organization;

Services rendered in excess of the benefit levels provided by the Plan;

Charges in excess of the Plan’s Allowed Charges;

Charges submitted for which you are not obligated to pay, or for which you would not have been billed had insurance coverage not existed.

### **SPECIFIC EXCLUSIONS**

- **Acupuncture, Acupressure, Biofeedback**
- **Ambulance Service** (except when Medically Necessary or necessitated by a life-

threatening emergency);

- **Bariatric, Gastric By-Pass Surgery And Other Weight Reduction Surgeries -**  
For further details, refer to Weight Control Programs section;
- **Bone Marrow Transplants** (when Experimental or Investigational);
- **Chiropractic Care**
- **Cosmetic Surgery**
  - ✓ Services or supplies related to cosmetic surgery, unless required as a result of an illness or injury sustained while covered under the Plan, or to correct a functional defect resulting from a congenital abnormality or developmental anomaly;
  - ✓ Complications of cosmetic surgery or drugs prescribed for cosmetic purposes;
  - ✓ Surgery to alter and improve your physical appearance or to improve your self-esteem, which provides no improvement to a functional impairment;
- **Custodial Or Domiciliary Care**  
Homemaker services, , convalescent care or extended care not requiring skilled nursing;
- **Dental Appliances**
- **Dental Care Services -**  
Required for prevention and treatment of diseases and disorders of the teeth, including, but not limited to:
  - ✓ Oral exams, X-rays, routine fluoride treatment, plaque removal, tooth decay, dental embryonal tissue disorders, periodontal disease;
  - ✓ Anesthesia, repair and restoration, tooth extraction, replacement of missing teeth, dental implants, dentures and other oral prosthetic devices;
  - ✓ Dental services rendered more than six months after an accidental injury to sound natural teeth;
  - ✓ Treatment, prevention or relief of pain in connection with dysfunction of the Temporomandibular Joint or the muscles of mastication;
- **Developmental Disorders**  
Services which are primarily oriented towards treating a social, developmental or learning problem rather than a medical diagnosis, including treatment for dyslexia, and behavioral modification therapy;
- **Disabilities Connected To Military Services**

Treatment for disabilities connected to military service for which you are legally entitled through a Federal government agency, and to which you have reasonable access;

- **DNA Testing**

If not related to a specific medical diagnosis for a covered Member (i.e. paternity, family history of potential illness or disease);

- **Drug Testing** - for a non-medical diagnosis;

- **Replacement of Durable Medical Equipment, corrective appliances, or Prosthetics -**

Additional optional accessories to Durable Medical Equipment, corrective appliances, or prosthetics, which are primarily for your comfort or convenience;

Personal comfort items such as electric heating or cooling units, orthopedic mattresses or support chairs, blood pressure instruments, scales, elastic bandages or support stockings, waterbeds, exercise equipment and swimming pools, motorized scooters and/or wheelchairs, home or automobile remodeling/modification. This includes Prosthetics that require surgical connection to nerves, muscles or other tissues (bionic) and Prosthetics that have electric motors to enhance motion (myoelectronic);

- **Experimental Or Investigational Treatment**

Unless otherwise dictated by Federal or state law, decisions as to whether a particular treatment is Experimental or Investigational, and therefore not a covered Benefit, are determined by the Plan's Medical Director or his/her designee, based upon criteria established pursuant to the following guidelines:

- Any drug, device, treatment, or procedure shall be deemed as Experimental or Investigational treatment if, as determined solely by the Plan, any one or more of the following criteria are met:
  - ✓ It cannot be lawfully marketed without the approval of the United States Food and Drug Administration ("FDA") and such approval has not been granted at the time of its use or proposed use;
  - ✓ It is the subject of a current investigational new-drug or new-device application on file with the FDA;
  - ✓ It is being provided pursuant to a Phase I or Phase II clinical trial or as the experimental or research arm of a Phase III clinical trial, as these Phases are defined in regulations and other official actions and publications issued by the FDA and the Department of Health and Human Services ("HHS");
  - ✓ It is being provided pursuant to a written protocol that describes among its objectives determinations of safety and/or efficacy as compared with the standard means of treatment;

- ✓ It is being delivered or should be delivered subject to the approval and supervision of an institutional review board as required and defined by Federal regulations and other official actions and publications issued by the FDA and the HHS;
  - ✓ The predominant opinion among experts as expressed in the published authoritative literature is that usage should be substantially confined to research settings;
  - ✓ The predominant opinion among experts as expressed in the published authoritative literature is that further research is necessary in order to define safety, toxicity, effectiveness or effectiveness compared with conventional alternatives;
  - ✓ It is not investigational or experimental in itself pursuant to the above, and would not be Medically Necessary, but for the provision of a drug, device, treatment, or procedure which is Investigational or Experimental.
- The exclusive sources of information to be relied upon by the Plan in determining whether a particular treatment is Experimental or Investigational, and therefore not a Covered Service under the Plan, are limited to the following:
- ✓ The Member's medical records;
  - ✓ The protocol(s) pursuant to which the drug, device, treatment, or procedure is to be delivered;
  - ✓ Any consent document the Member, or his/her representative, has executed or will be asked to execute, in order to receive the drug, device, treatment, or procedure;
  - ✓ The published authoritative medical or scientific literature regarding the drug, device, treatment, or procedure at issue as applied to the medical condition at issue;
  - ✓ Opinions of other agency/review organizations, e.g. ECRU Health Technology Assessment Information Service, HAYES New Technology Summaries, or AHCPR (Agency for Health Care Policy and Research);
  - ✓ Expert medical opinion; and
  - ✓ Regulations and other official actions and publications issued by the FDA and HHS.

A terminally ill Member may be entitled to an expedited hearing in cases in which a proposed treatment is denied as Experimental or Investigational (refer to the "Member Grievance Procedure" section of this SPD for more information);

- **Eye Surgery**

Surgery to correct refractive error, such as, but not limited to radial keratotomy, refractive keratoplasty;

- **Foot Care**

Routine foot care, such as removal or reduction of corns and calluses, clipping of toenails, treatment for flat feet, fallen arches, and chronic foot strain, except as determined to be Medically Necessary, such as for diabetic care;

- **Gender Reassignment** - consultation and/or surgery;
- **Hypnotherapy** - including behavior training, sleep therapy, education programs;
- **Infertility Services** -, including diagnostic testing, treatment, and surgery;
- **Institutional Services And Supplies - Non-Eligible**  
Any services or supplies furnished by a non-eligible institution, which is defined as other than a legally operated Hospital, Ambulatory Surgical Center, or Medicare-approved Skilled Nursing Facility, or which is primarily a place of rest, a place for the aged, a nursing home, or any similar institution, regardless of how denominated;
- **Non-Licensed Professionals**  
Treatment for any illness or injury when not attended by a licensed Physician or other licensed Health Care Professional;
- **Nursing - Private Duty**  
Unless determined to be Medically Necessary and approved by the Plan's Medical Director;
- **Nutritional Supplement Formulas**  
Phenylketonuria (PKU) formula is limited to under age thirteen (13), or as Medically Necessary;
- **Organ Donor Services**  
Medical and Hospital services and other costs of a donor or prospective donor when the recipient is not a Member of the Plan;
- **Organ Transplants**  
Organ transplants that are not Medically Necessary and organ transplants considered Experimental or Investigational as defined herein;
- **Orthodontia and/or Orthodontic Injury Treatment;**
- **Orthotic Supplies** (except for diabetics);
- **Physical Examinations**  
Routine physical examinations for insurance, licensing, employment, school, camp, recreational or organizational, including appearances at hearings or court proceedings, examinations precedent to engaging in travel, or other non-preventative purposes, pre-employment physicals or vocational Rehabilitation, or for pre-marital and pre-adoption purposes;
- **Pregnancy Of Covered Dependent**  
Charges for all services related to the prenatal care/birth/delivery of the dependent's newborn are excluded, including pediatric services;
- **Private Rooms and Personal/Comfort Items –**

Private rooms during Inpatient hospitalization unless Medically Necessary, includes (but not limited to) cable television, telephones, communication devices, exercise equipment, air purifiers, humidifiers, saunas, hot tubs, therapeutic mattress, and supplies or any other similar devices or appliances;

- **Prosthetic for Sexual Dysfunction**

- **Public Facility Care**

Care of conditions for which state or local law requires treatment in a public facility. However, the Plan will reimburse you for out-of-pocket expenses incurred by you for any Covered Services delivered at such public facility;

- Injuries or illnesses sustained while incarcerated in a municipal, state or Federal prison;

Emergency Care Services required after participating in a criminal act are covered only until the member is stabilized and placed on a police hold. Notwithstanding the foregoing, in compliance with California Health & Safety Code section 1374.12, nothing in this provision shall be deemed to restrict the liability of the Plan with respect to Covered Services solely because such services were provided while the Member was in a state hospital;

- **Random Drug Testing**

All drug testing for a non-medical diagnosis regardless if court ordered;

- **Recreational or Educational Therapy**

All treatment and related diagnostic testing, except as provided as part of an otherwise covered Inpatient hospitalization);

- **Rehabilitation**

Long term, maintenance, or chronic- level Rehabilitation services such as Physical, Occupational and Speech Therapy provided on an Inpatient or Outpatient basis;

- **Reversal of Voluntary Sterilization**

- **Self Inflicted Injuries/Suicide Attempts -**

Medical expenses arising from treatment of physical/medical needs related to any suicide attempt or from any intentionally self-inflicted injury;

- **Sex Transformations**

- **Sexual Dysfunction**

Treatment for sexual dysfunctions or inadequacies unless pre authorized by the Plan; Sexual dysfunctions as a side effect to a disease state such as prostatic hyperplasia, diabetes, kidney disease, endometriosis, fibroid tumors, ovarian cysts, and/or atherosclerosis are covered;

- **Skilled Nursing Care/Transitional Care**

Skilled Nursing Facility room and board charges incurred beyond the limits outlined in the "Schedule of Benefits" section for each qualifying condition. A qualifying condition is a medical condition which requires skilled nursing services, which as a

practical matter, determined by the Plan and the Member's Physician, cannot be delivered in a setting other than a Hospital or a Skilled Nursing Facility. A medical condition will not be considered a qualifying condition if during the 60 days preceding the medical condition, the Member has received skilled nursing services;

- **Snoring Corrective Treatments**
- **Surrogate Pregnancy**
- **Temporomandibular Joint (TMJ) Disorder**
- **Third-Party Liability Services -**

Please refer to the "Payment by Third Parties" section of this document;

- **Unlicensed Services** - not supervised by a licensed professional;
- **Vision Care** - eye refractive examinations, corrective lenses and frames, contact lenses, contact lens fitting and measurements (except post cataract extraction, keratoconus, aphakic or corneal bandages), vision correction surgery, including but not limited to, radial keratotomy and refractive keratoplasty;
- **Vitamins** - including minerals, nutritional supplements, or similar products;
- **Weight Control Programs (Inpatient Or Outpatient)**  
Eating disorder programs for dietary control, surgery or other treatment of obesity such as food and food supplements, laboratory tests in association with weight reduction programs, vitamins, gastric by-pass and bubble, Roux-en-Y gastric bypass, Laparoscopic Gastric Banding, Biliopancreatic diversion with duodenal switch or other similar procedures, or bariatric surgery related surgeries;
- **Work-Related Illnesses/Injuries**  
Injury, sickness or disease which arises out of or in the course of any employment, or which is covered under any workers' compensation law or similar law.

## **LIMITATIONS**

### **Circumstances Beyond Control**

If, due to circumstances not reasonably within the control of the Plan, such as complete or partial destruction of facilities, war, riot, civil insurrection, or similar causes, the provision of Covered Services is delayed or rendered impractical, neither the Plan nor its Participating Providers have any liability or obligation for such delay or failure to provide services;

### **Follow-up care**

Follow up care after a surgery is handled by the surgeon performing the surgery as part of the surgical procedure;

### **Major Disaster Or Epidemic**

In the event of any major disaster or epidemic, Participating Providers shall provide or attempt to arrange for the provision of Covered Services insofar as is practical,

according to their best judgment, within the limitations of such facilities and personnel as are then available, but neither the Plan, nor its Participating Providers have any liability or obligations for delay or failure to provide any such services or personnel if such lack is the result of such disaster or epidemic.

## **SECTION 6: OUTPATIENT PRESCRIPTION DRUG PROGRAM**

Refer to this section of this Summary Plan Document for details of how all Outpatient prescribed and non-prescribed medications are covered.

The Plan provides Benefits for Outpatient prescription drugs on the Navitus (The Plan's Pharmacy Benefit Manager) Formulary ("Drug Formulary" or "Formulary"), when prescribed by a licensed Physician or licensed dentist. .

### **How The Program Works**

- Present your prescription and Navitus identification card at any Participating Pharmacy;
- Pay your Copay for each 30-day supply of prescription drugs you have filled, or the retail cost of the prescription, whichever is less;
- Receive your medications.

### **The Drug Formulary**

The Drug Formulary is a list of Outpatient prescription drugs that will be covered by the Plan without preauthorization when a prescription is filled at a Participating Pharmacy. The Formulary is created and regularly updated by a Pharmacy and Therapeutic Committee that consists of practicing Physicians and pharmacists. The Formulary is revised periodically to incorporate new developments in pharmaceutical care.

The evaluation of the products included in the Formulary is a continuous process resulting in the review of new and existing medications to ensure the Formulary is up-to-date and meets the needs of Members and their providers.

The Formulary is extensive and covers all therapeutic classes of drugs, including medications that treat both Acute and Chronic Conditions. Acute Conditions include, but are not limited to, the flu, colds, and other short-term illnesses. Chronic Conditions include, but are not limited to, glaucoma, diabetes, high blood pressure, heart disease, and asthma. The Formulary includes:

- Federal Legend Drugs: Any medicinal substance which bears the legend: "Caution: Federal law prohibits dispensing without a prescription";
- State Restricted Drugs: Any medicinal substance that may be dispensed by prescription only according to state law;
- Compounded Medication: Any medicinal substance that has at least one ingredient that is Federal Legend or State Restricted in a therapeutic amount;

- Generic Drugs: Generic Drugs will be automatically substituted for Brand-Name Drugs if available, unless the Physician has indicated “Dispense as Written” on the prescription;
- Insulin, insulin syringes, blood glucose test strips, lancets, inhaler extender devices, epipens and anakits;
- Federal Legend oral contraceptives, prescription diaphragms.

If you would like additional information about the Formulary, contact Navitus Customer Care at (866) 333-2757.

### **Pre Authorization of Non-Formulary Drugs**

If a non-Formulary drug is prescribed, it will not be covered unless the non-Formulary drug is pre authorized. All pre authorization requests for non-Formulary drug treatments may be initiated by your Physician. Non-Formulary drugs that are not otherwise excluded from coverage will be authorized in the following instances:

- No Formulary alternative is appropriate and the Plan determines the drug is Medically Necessary for your individual needs;
- The Formulary alternative has failed after therapeutic trial. Your prescribing Physician will be asked to provide a copy of your medical chart notes that specifically state treatment failure with the Formulary drug;
- You have been under treatment and remain stable on a non-Formulary prescription drug and conversion to a Formulary drug would be medically inappropriate;
- You have experienced a typical allergic reaction or medically established adverse reaction which are effects related to the chemical properties of the Formulary drug. These allergies and/or adverse effects are attributed to formulations or differences in absorption, distribution or elimination; and,
- Your Physician provides evidence in the form of documents, records or clinical tests, which demonstrate that use of the requested non-Formulary drug over the Formulary drug is Medically Necessary, as determined by the Plan.

Authorizations for non-Formulary medications will be given for a time period varying from six months to indefinitely, upon request for the prescribed medication.

Note: The Plan reserves the right to expand the pre authorization requirement for any drug product to assure adherence to FDA-approved indications and national practice standards. The Formulary has medications added and deleted throughout the year based on the recommendations of the Pharmacy and Therapeutic Committee’s quarterly review.

## **Maintenance Drug Dispensing**

Maintenance drugs will be dispensed for up to a 30-day supply through Navitus Participating Pharmacies, or for up to a 90-day supply through the mail order service. These products include, but are not limited to:

- Antiarthritics
- Antiasthmatics
- Anti-clotting drugs
- Antiepileptic drugs
- Antihypertensives
- Anti-Parkinson drugs
- Birth control pills
- Cardiac drugs
- Cholesterol and lipid lowering agents
- Diuretics
- Gastrointestinals
- Glucose test strips
- Hormones
- Insulin and Insulin syringes
- Oral contraceptives
- Oral hypoglycemics
- Prenatal vitamins
- Psychotropics
- Thyroid suppressants or replacements

An initial 30-day supply of these medications can be received for one Copay at a Participating Pharmacy, or a 90-day supply of these medications through the mail order service for two Copays (saving you one Copay by using the mail order service). It is your responsibility to pay the Copay amount required each time a prescription is filled.

***The Plan requires all maintenance medications to be ordered through the mail order service after the first 30-day prescription trial.***

## **Mandatory Generic Substitution**

All prescriptions will automatically be filled with a Generic Drug where one is available, unless your Physician indicates the Brand-Name Drug must be dispensed (by writing "Dispense as Written" or "DAW" on your prescription). If your Physician does not indicate "Dispense as Written" on the prescription for the Brand-Name Drug, and you

specifically request the Brand-Name Drug, you'll be responsible for paying any difference in cost between the Brand-Name Drug and the Generic Drug, as well as the Brand-Name Drug Copay.

### **Mail Order Service**

Having your prescriptions filled by mail is easy - Just follow these steps:

- ✓ STEP 1: Obtain a written prescription from your Physician for each prescription you would like to have filled using the mail order service. A new prescription must be provided in order to fill any mail order request. Please ask your Physician to indicate on your prescription if you can obtain a 90-day supply with additional refills;
- ✓ STEP 2: Fill out the prescription mail order envelope. A new mail order envelope will be mailed back to you along with your prescription for your next order;
- ✓ STEP 3: Mail the envelope with your written prescriptions and your payment method information enclosed;
- ✓ STEP 4: Your medication will arrive within 10-14 days upon receipt of your order.

For the nearest Participating Pharmacy in your area, or additional information regarding the mail order service, please contact Navitus Customer Care at (866) 333-2757 or the Plan's Member Services Department at 800-962-1133 ext. 1.

### **Exclusions and Limitations**

The Outpatient prescription drug program excludes drugs, medicines and/or related items that are not covered by the Plan. These items are your financial responsibility. The following are excluded:

- Drugs or medicines not on the Formulary, unless pre authorized. Pre authorization must be obtained prior to a prescription being filled -- no retro authorizations will be allowed;
- Drugs or medicines purchased and received prior to your effective date or subsequent to your coverage termination date;
- Therapeutic devices or appliances including hypodermic needles, syringes (except insulin syringes, other diabetic supplies and syringes for self-injected drugs), support garments and other non-medicinal substances;
- Non-prescription (over-the-counter) contraceptive jellies, ointments, foams and devices;
- Drugs or medicines to be taken or administered to you while you are a patient in a Hospital, rest home, nursing home or sanitarium;
- Drugs or medicines delivered or administered to you by a prescriber or the prescriber's staff;

- Dietary supplements including vitamins fluoride supplements, health or beauty aids and anorexiant (i.e. diet pills);
- Drugs or medicines for which the cost is recoverable under any workers' compensation or occupational disease law, any state or government agency, or furnished by any other drug or medical service for which no charge is made to you;
- Immunizations, Vaccinations -- for the purpose of travel/vacation;
- Drugs or medicines limited to investigational use or prescribed for experimental or non-FDA approved indications, unless prescribed in a manner consistent with:
  - i. A specific indication in "Drug Information Specifications for the Health Care Professional", published by the United States Pharmacopoeia Convention;
  - ii. The American Hospital Formulary Services edition of Drug Information;
  - iii. Any other source which reflects community practice standards;
- Drugs or medicines available without a prescription (over-the-counter) or for which there is a non-prescription equivalent available, even if ordered by a Physician;
- Drugs, medicines or cosmetic aids prescribed to primarily improve or otherwise modify your external appearance;
- Smoking cessation products are limited to one treatment course each Calendar Year when enrolled in a smoking cessation program;
- Injectable drugs (except as listed) or;
- Durable Medical Equipment that can be obtained without a prescription.

### **Dispensing Quantity Limitations**

The amount of drug that may be dispensed with each prescription or refill will be in quantities normally prescribed for up to and including a 30-day supply. Prescriptions requiring greater amounts will be completed on a refill basis, except as explained under the "Maintenance Drug Dispensing" section above.

If you wish to obtain Generic maintenance medications at retail pharmacies which offer Copays lower than Exclusive Care's plan, please contact Exclusive Care Member Services at (800) 962-1133 or Navitus Customer Care at (866) 333-2757 to arrange authorization for this service. Using this option may result in considerable cost savings for you and provide added convenience. If you choose this option, you will not be required to use mail-order for qualifying generic maintenance medications. The medications covered under the lower retail Copay pricing may vary by pharmacy, so please call Exclusive Care for assistance. All other medications (Brand Name, Non-Formulary or significant/new therapeutic class drugs) must still be purchased through

Exclusive Care's mail-order program or in person at Exclusive Care's Rubidoux pharmacy.

## **SECTION 7: MENTAL HEALTH/SUBSTANCE ABUSE SERVICES**

The Plan provides Benefits for Mental Health, Severe Mental Illness and Substance Abuse treatment and services, when approved by Medicare, or for an Emergency Mental Health Condition when pre authorized by the Plan. Non-Emergency Treatment or services that are not authorized by Medicare may be your financial responsibility. The Plan will pay the amounts described in the Schedule of Benefits for the following Covered Services:

### **Covered Services**

- The Plan will provide Benefits for the following services furnished in connection with the treatment of a Mental Health/Substance Abuse Disorder as outlined in the "Schedule of Benefits" as long as the services are incurred while you are a Member. Behavioral Health Services provided for Inpatient treatment, treatment at a Residential Treatment Center or Residential Treatment Facility, and treatment at a Day Treatment Center;
- Outpatient services provided by a certified or licensed mental health professional and/or Partial Day Program;
- Inpatient Detoxification - - limited to hospitalization to remove toxic substances from the system;
- Nursing by a Registered Nurse, a Licensed Practical Nurse, or a Licensed Vocational Nurse when Medically Necessary to accompany services provided by the attending Physician; Local ambulance service to and from a facility in the event of an Emergency Mental Health Condition;
- Laboratory services authorized by an attending Physician which are related to approved Behavioral Health Services
- Psychological testing provided by a licensed psychologist when determined to be Clinically Necessary;
- Emergency Treatment and services;

### **What To Do In Emergencies**

Whenever possible, you should contact the Plan before obtaining Emergency Treatment and services in order to ensure any charges for treatment will be covered. In some critical emergencies, such as a serious suicide risk, it may not be possible to call the Plan before going for treatment. In the event of such an emergency, you, a family member, or the provider must contact the Plan immediately upon admission, or as soon as reasonably possible (within 24 hours).

If you are admitted to any facility without pre authorization from the Plan, upon notification, the Plan will review the situation by telephone and conduct an assessment as appropriate.

### **Exclusions And Limitations**

The following services are excluded:

- Injury, sickness or disease which arises out of or in the course of any employment, or which is covered under any workers' compensation law or similar law;
- Behavioral Health Services that are payable under any state or governmental agency;
- Charges incurred while on active duty with the Army, Navy or Air Force of any country or international organization;
- Experimental or Investigational Behavioral Health Services and treatment;
- Services performed in connection with conditions not classified in the DSM-IV;
- Treatment for any reading or learning disorder, mental retardation, autism, or other developmental Disability, as defined by the DSM-IV;
- Counseling for adoption, custody, family planning or pregnancy in the absence of a psychiatric diagnosis generally recognized and accepted by the medical community and limited to a DSM-IV psychiatric diagnosis;
- Counseling in preparation for or associated with a sex change operation;
- Sex therapy, including without limitation, therapy for sexual addiction, in the absence of a psychiatric diagnosis generally recognized and accepted by the medical community and limited to a DSM-IV psychiatric diagnosis;
- Pastoral or spiritual counseling;
- Dance, poetry, music or art therapy;
- Non-organic therapies including, but not limited to the following: bio-energetic therapy, confrontation therapy, crystal healing therapy, educational remediation, Eye Movement Desensitization and Reprocessing (EMDR), guided imagery, marathon therapy, primal therapy, Rolfing, sensitivity training, transcendental meditation, Z therapy;
- Organic therapies including, but not limited to the following: aversion therapy, carbon dioxide therapy, environmental ecological treatment or remedies, herbal therapies, massage therapy, hemodialysis for schizophrenia, vitamin or orthomolecular therapy, narcotherapy with LSD, sedative action electrostimulation therapy;
- Private rooms and private duty nursing unless Clinically Necessary as determined by the Plan;
- Custodial Care;

- Treatment for caffeine intoxication or dependency on any food substance, in the absence of a psychiatric diagnosis generally recognized and accepted by the medical community and limited to a DSM-IV psychiatric diagnosis;
- Medical expenses arising from treatment of physical/medical needs related to any suicide attempt or from any intentionally self-inflicted injury;
- Services which are required or referred by court order or as a condition of parole or probation;
- Services which are not Clinically Necessary for the treatment of Mental Health or Substance Abuse Disorders;
- Treatments designed to regress the Member emotionally or behaviorally;
- Personal enhancement or self-actualization and other non-Clinically Necessary treatment programs;
- Evaluation or treatment for educational or professional training, investigational purposes related to employment, fitness for duty evaluations, career/personal counseling;
- Services which are provided by a non-licensed and/or non-qualified practitioner and/or non-licensed facility;
- Neurological services and tests, including but not limited to EEG's, brain scans, MRI's, skull X-rays and lumbar punctures for non-diagnosed medical conditions;
- Academic or tutorial programs during treatment at a Residential Treatment Center or Residential Treatment Facility;
- Treatment of organic mental disorders associated with permanent brain dysfunction;
- Treatment of insomnia and other sleep disorders, dementia, neurological disorders and other disorders with a known physical basis;
- Marriage and family counseling.

## **SECTION 8: PLAN GENERAL PROVISIONS**

### **CLAIM PAYMENT PROCEDURES**

The Plan is designed to eliminate as much paperwork as possible and limit your out-of-pocket expenses other than Coinsurance, Copays and Deductibles required by Medicare and/or the Plan. In some circumstances, you may incur expenses for Covered Services. If this happens, submit a copy of the bill and your receipt to the Claims Department, and the Plan will reimburse you for those expenses according to the Plan's Benefits, minus any applicable Copay amounts that are your responsibility.

If you receive a bill for Covered Services, that you believe should have been paid by the Plan, please submit a copy of the bill within 90 days of the date the service was rendered to:

**Exclusive Care  
Claims Department  
P.O. Box 1508  
Riverside CA 92502**

In the event such a Claim is denied, you may resubmit within 180 days of the initial denial, explaining in writing why you believe your Claim should be approved. Your request will be considered a formal grievance and handled under the “Member Grievance Procedure” section described below.

**MEMBER GRIEVANCE PROCEDURE**

If a pre authorization request or a Claim for Benefits is denied in whole or in part, you may appeal the decision by contacting Exclusive Care at the above address. The following chart outlines the responsibilities of the Plan and of the Member, during the appeal process, and the steps taken to ensure the appeal is administered according to the Plan’s Member Grievance Procedure:

<b>Service Authorization, Claims Review and Appeal Chart</b>	
<b>Type of Transaction</b>	<b>Steps to Take</b>
<b>PRE AUTHORIZATION FOR HEALTH CARE SERVICES</b>	
<i>Pre authorization requests for Benefits under this Plan where treatment must be authorized before it is performed.</i>	<b>Step 1:</b> The Plan has <b>15 days</b> after receiving your initial pre authorization request to notify you if your request is approved or denied.
	<b>Step 2:</b> You have <b>180 days</b> after receiving the pre authorization denial to appeal the Plan’s decision.
	<b>Step 3:</b> The Plan has <b>30 days</b> after receiving your appeal to notify you of its decision.
<b>IF YOUR PRE AUTHORIZATION REQUEST IS IMPROPERLY FILED OR INCOMPLETE</b>	
<i>Pre authorization requests for Benefits under this Plan where treatment must be authorized before it is performed.</i>	<b>Step 1:</b> As long as your pre authorization request is received by a person or organizational unit customarily responsible for handling pre authorizations, and it names a specific Member, a specific medical condition or symptom, and a specific treatment, service, or product for which approval is requested, the Plan has <b>5 days</b> after receiving your initial pre authorization request to notify you that your request is improper or incomplete.

## Service Authorization, Claims Review and Appeal Chart

Type of Transaction	Steps to Take	
	<b>Step 2:</b>	The Plan has <b>15 days</b> after receiving your pre authorization request to notify you of its decision to approve or deny the pre authorization request. If the Plan needs more information and provides an extension notice during the initial 15-day period, it has <b>30 days</b> after receiving the pre authorization request to notify you of its decision (the time the Plan waits for requested additional information is not counted in totals).
	<b>Step 3:</b>	You have <b>45 days</b> after receiving the extension notice to provide additional information or complete the pre authorization request.
	<b>Step 4:</b>	If your pre authorization is denied, you have <b>180 days</b> after receiving the pre authorization denial to appeal the Plan's decision.
	<b>Step 5:</b>	The Plan has <b>30 days</b> after receiving your appeal to notify you of its decision.
<b>POST-SERVICE HEALTH CARE CLAIMS</b>		
<i>Claims for Benefits where health care services have already been received by the Member.</i>	<b>Step 1:</b>	The Plan has <b>30 days</b> after receiving your initial Claim to notify you if your Claim is denied.
	<b>Step 2:</b>	If your Claim is denied, you have <b>180 days</b> after receiving the Claim denial to appeal the Plan's decision.
	<b>Step 3:</b>	The Plan has <b>60 days</b> after receiving your appeal to notify you of its decision.
	<b>IF THE PLAN NEEDS FURTHER INFORMATION OR AN EXTENSION</b>	
	<b>Step 1:</b>	The Plan has <b>30 days</b> after receiving the initial Claim to notify you if your claim is denied. If the Plan needs more information and provides an extension notice during the initial 30-day period, it has <b>45 days</b> after receiving the Claim to notify you if your Claim is denied (the time the Plan waits for requested additional information is not counted in totals).
	<b>Step 2:</b>	You have <b>45 days</b> after receiving the extension notice to provide the requested additional information or complete your Claim.
<b>Step 3:</b>	If your Claim is denied, you have <b>180 days</b> after receiving the Claim denial to appeal the Plan's decision.	

## Service Authorization, Claims Review and Appeal Chart

Type of Transaction	Steps to Take	
	<b>Step 4:</b>	The Plan has <b>60 days</b> after receiving your appeal to notify you of its decision.

### Pre Authorization Denials / Claim Denials - Appeal Procedure

In most cases, Medicare determines Covered Services, Approved Amounts and amounts you owe, except as noted in this SPD. If your pre authorization request or Claim for Benefits is wholly or partially denied by the Plan, any pre authorization denial/Claim denial notice you receive will:

- State the specific reasons for the decision;
- Reference specific Plan provisions on which the decision is based;
- Describe additional material or information necessary to complete the pre authorization request or Claim request, and why such information is necessary; and,
- Describe Plan procedures and time limits for appealing the decision, and your right to obtain information about those procedures.

The pre authorization denial/Claim denial notice will also:

- Disclose any internal rule, guidelines, protocol or similar criterion relied on in making the decision (or state that such information will be provided free of charge upon request);
- Provide an explanation of the scientific or clinical judgment for the decision, applying layperson terms to your medical condition, if the denial is based on Medical Necessity or Experimental or Investigational treatment (or state that such information will be provided free of charge upon request); and,

If you believe your pre authorization request or Claim was denied in error, you may appeal this decision. You have 180 days after receiving the denial to appeal the Plan's decision. You may submit written comments, documents, or other information to the Plan in support of your appeal and have access, upon request, to all relevant documents free of charge. The review by the Plan of the initial denial will take into account all new information, whether or not presented or available at the initial pre authorization/Claim review, and will not be influenced by the initial decision.

A different person than the person who made the initial pre authorization or Claim denial will conduct the appeal review and will not work under the original decision maker's authority. If your Claim was denied on the grounds of Medical Necessity, the Plan will consult with a Health Care Professional with appropriate training and experience. This Health Care Professional will not be the individual who was consulted during the initial decision and will not work under his/her authority.

## **Outcome of Appeal Procedure**

If your appeal is denied, the appeal denial notice will contain the following information:

- The specific reasons for the appeal denial;
- A reference to the specific Plan provisions on which the denial was based;
- A statement that you are entitled to receive upon request, and without charge, reasonable access to or copies of all documents records, or other information relevant to the appeal denial;
- A statement describing any additional voluntary appeal procedures offered by the Plan and your right to obtain information about these procedures.

The appeal denial notice will also include:

- A statement disclosing any internal rule, guidelines, protocol or similar criterion relied on in making the decision (or a statement that such information will be provided free of charge upon request);
- An explanation of the scientific or clinical judgment for the decision, if the denial is based on Medical Necessity or Experimental or Investigational treatment, applying layperson terms to your medical condition (or state that such information will be provided free of charge upon request);
- A statement that “You or your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact the California Department of Managed Health Care.” The appeal denial notice may be provided in written or electronic form. Electronic notices will be provided in a form that complies with any applicable legal requirements.

## **Member Services Responsibilities**

Member services representatives answer all incoming Member calls and explain the Plan Benefits and applicable policies and procedures. Upon receiving a Member’s complaint, a member services representative will gather as many facts as possible and attempt to reach a resolution with the Member. If the complaint is something that can not be resolved through the clarification of Benefits or further education about the Plan, the member services representative will inform the Member of his/her right to submit a Member grievance form for further consideration. The grievance form must contain the facts surrounding the circumstances and must be submitted by the Member to the Member Services Department listed on the form.

## **Administrative Review Committee Responsibilities**

The Administrative Review Committee will respond to all written grievances related to operational and non-clinical issues within 30 days of receipt of the written grievance.

## **Physician Review Committee Responsibilities**

The Physician Review Committee will respond to all written grievances related to clinical issues within the specified timeframes outlined in the “Service Authorization, Claims Review and Appeal Chart” in this section.

## **Experimental or Investigational Treatment Of Terminal Illness**

If the Plan’s Medical Director denies a treatment as Experimental or Investigational (refer to the Plan’s “Specific Exclusions” section) for a Member who has a terminal illness, the Plan, at the Member’s request, will hold a Physician Review Committee within thirty (30) days of the receipt of the request to review the denial and the basis for determining that the proposed treatment or services are Experimental or Investigational. The review will be held within five (5) days if the treating Physician determines, in consultation with the Medical Director, based on standard medical practice, that the effectiveness of either the proposed treatment or services would be materially reduced if not provided at the earliest possible date.

If the denial is appealed, the Medical Director or another appropriately licensed health care provider will only review the appeal if he/she determines that he/she is competent to evaluate the specific clinical issues presented in the appeal. If the Medical Director or health care provider determines that he/she is not competent to evaluate the specific clinical issues of the appeal, a review/consultation will be obtained from an appropriately licensed health care provider or Specialist who has the education, training, and relevant expertise that is pertinent to evaluating the clinical issues underlying the appeal. Appeals include Claims that are denied: (1) on the basis of a clinical issue; (2) on the basis of the necessity for treatment, or (3) on the basis of the type of treatment proposed or utilized.

## **ALTERNATIVE DISPUTE RESOLUTION**

If no resolution to your complaint is achieved by the Plan’s internal Member Grievance Procedure, you have several options depending on the nature of your complaint:

### **Eligibility Issues**

This matter must be referred directly to your employer group.

### **Malpractice**

You must proceed directly to court regarding issues of malpractice.

### **Bad Faith**

You must proceed directly to court regarding issues of bad faith.

### **Neutral Binding Arbitration**

Arbitration is an alternative method of resolving disputes in which two parties present their individual sides of a complaint to an objective arbitrator or panel of arbitrators, who will weigh the facts and arguments of both parties and resolve the dispute.

→ ***Exclusive Care uses neutral binding arbitration to resolve disputes. By enrolling in the Plan, you are waiving your rights to a jury or court trial for disputes. These disputes will be settled by neutral binding arbitration.***

### **State of California Laws Regarding Arbitration**

Arbitration is a vehicle for the resolution of any disputes concerning health care services, Benefits, or contract interpretation pertaining to any personal liability, tort claims, or contract disputes originating from Exclusive Care's employer group agreement. Personal liability, tort claims, or contract disputes related to eligibility for enrollment, effective date of coverage, and malpractice or bad faith are EXCLUDED from binding arbitration. For allegations of bad faith or malpractice, proceed directly to the appropriate court. Arbitration will be held in the County of Riverside.

Costs associated with the services of the named Arbitrator will be shared by the parties involved. Costs for individual preparation and/or attendance (complaining parties, witnesses, travel expenses, etc.) at the arbitration will be the sole responsibility of the party incurring the expense.

Pursuant to California law, any claim of up to \$200,000 must be decided by a single neutral arbitrator who shall be chosen by the parties and who shall have no jurisdiction to award more than \$200,000.

However, Exclusive Care and the Member may agree in writing to waive the requirement to use a single arbitrator and instead opt to use a tripartite arbitration panel that includes the two-party appointed arbitrators or a panel of three neutral arbitrators, or another multiple arbitrator system mutually agreeable to the parties. You have three (3) business days to rescind the waiver agreement unless the agreement has also been signed by your attorney, in which case the waiver cannot be rescinded.

In cases of extreme hardship, Exclusive Care may assume all or part of your share of the fees and expenses of the neutral arbitrator provided you submitted a hardship application to the American Arbitration Association. The approval or denial of a hardship application shall be determined by the American Arbitration Association. You may obtain a hardship application by contacting the American Arbitration Association at (800) 778-7879.

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at **1-800-962-1133** and use your health plan's grievance process before contacting the department. Utilizing this grievance process does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the Medical Necessity of a proposed service or treatment, coverage decisions for treatments that are Experimental or Investigational in nature and payment disputes

for emergency or urgent medical services. The department also has a toll-free telephone number **(1-888-HMO-2219)** and a TDD line **(1-877-688-9891)** for the hearing and speech impaired. The department's Internet Web site <http://www.hmohelp.ca.gov> has complaint forms, IMR application forms and instructions online.

## **COBRA CONTINUATION OF COVERAGE**

Under the terms of the Consolidated Omnibus Budget Reconciliation Act (COBRA), continued coverage is available to a qualified Beneficiary should he/she lose coverage under the circumstances described below. Each COBRA-eligible person has a right to make a separate election—choosing or declining COBRA coverage—when there is a qualifying event that causes loss of coverage under the Plan.

### **Qualified Beneficiaries**

A qualified Beneficiary generally is an individual covered by a group health plan on the day before a qualifying event occurs who is an employee, the employee's spouse, or an employee's dependent child. In certain cases, a retired employee, the retired employee's spouse, and the retired employee's dependent children may be qualified Beneficiaries. In addition, any child born to or placed for adoption with a covered employee during the period of COBRA coverage is considered a qualified Beneficiary. Agents, independent contractors, and directors who participate in the group health plan may also be qualified Beneficiaries.

### **Qualifying Events**

Qualifying events are certain events that would cause an individual to lose health coverage. The type of qualifying event will determine who the qualified Beneficiaries are and the amount of time that a plan must offer the health coverage to them under COBRA. A plan, at its discretion, may provide longer periods of continuation coverage:

#### **Qualifying Events for Employees:**

- ✓ Voluntary or involuntary termination of employment for any reason other than gross misconduct;
- ✓ Reduction in the number of hours worked.

#### **Qualifying Events for Spouses:**

- ✓ Voluntary or involuntary termination of the covered employee's employment for any reason other than gross misconduct;
- ✓ Reduction in the number of hours worked by the covered employee;
- ✓ Divorce or legal separation of the covered employee;
- ✓ Death of the covered employee.

#### **Qualifying Events for Dependent Children:**

- ✓ Loss of dependent child status under the Plan rules;
- ✓ Voluntary or involuntary termination of the covered employee's employment for any reason other than gross misconduct;

- ✓ Reduction in the number of hours worked by the covered employee;
- ✓ Divorce or legal separation of the covered employee;
- ✓ Death of the covered employee.

If a qualified Beneficiary chooses COBRA continuation coverage, his/her Benefits will be the same as the coverage he/she had under the Plan prior to coverage termination. The qualified Beneficiary pays the full premium cost of continuation coverage, plus any additional amounts permitted by law. If benefit levels and/or rates change for Plan Members, the qualified Beneficiary will be subject to those same changes. COBRA coverage for each of the above qualifying events will continue for up to 36 months from the date of the qualifying event unless COBRA is canceled for any one of the reasons specified below under "Canceling COBRA Coverage."

### **COBRA Notice Requirement**

A qualified Beneficiary must notify his/her employer group or its designee prior to the qualifying event, or as soon as possible thereafter, and not more than 30 days after the qualifying event. When the employer group or its designee receives notice, it must in turn notify you, any spouse and/or children (individually or jointly) of your and their right to elect COBRA coverage by sending COBRA continuation information and a COBRA election form, within thirty (30) days of the qualifying event.

You may enroll newly acquired, adopted or newborn children into your COBRA coverage if you notify the employer group or its designee within 30 days of the birth or placement for adoption.

### **COBRA Election Deadline**

To elect COBRA coverage, you must submit a completed COBRA election form to your employer group or its designee **within 60 days** after receiving the election form or, if later, 60 days after coverage under the Plan would otherwise end if COBRA coverage was not elected. Your spouse or children cannot elect COBRA coverage after the expiration of this 60-day deadline.

The Benefits under COBRA are identical to the Plan Benefits offered at the time of the qualifying event and the Cost Of Coverage, under the initial COBRA term, may not exceed 102% of the current group premium.

### **Canceling COBRA Coverage**

If you choose COBRA, your coverage will be canceled in less than 36 months if:

- ✓ Payments for the COBRA coverage are not paid on a timely basis. To be timely, a payment must be paid within 30 days of its due date (or 45 days of the due date for the initial payment);
- ✓ You become covered under another group health plan. However you may continue COBRA coverage if the other group health plan limits coverage for pre-existing medical conditions that you, your spouse or children may have;

- ✓ The Plan terminates.

### **COBRA Coverage - Bankruptcy Provision**

Under COBRA, continued coverage is available in the event that a County bankruptcy proceeding causes a loss of coverage (including a substantial elimination of coverage within one year before or after the bankruptcy proceeding commences). As a Plan Member, you are eligible for this continuation coverage if you enrolled in the Plan before the substantial elimination of coverage occurred. As a dependent participating in the Plan, you are eligible for this continuation coverage if, on the day before the bankruptcy, you were covered under the Plan as a spouse, dependent child, or surviving spouse.

COBRA coverage also continues under these circumstances, as follows:

- ✓ Affected retirees and surviving spouses of deceased retirees may elect lifetime COBRA coverage;
- ✓ Spouses and dependent children may continue COBRA coverage until the retiree dies;
- ✓ When the retiree dies, his/her surviving spouse and dependent children may elect an additional 36 months of COBRA coverage commencing with the date of the retiree's death. Coverage could end sooner if COBRA coverage otherwise ends (e.g., due to nonpayment of premiums or discontinuation of all group health coverage by the County).

If you have any questions about these laws, please contact the County of Riverside Benefits Division or your employer group or its designee.

### **HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)**

The following is Exclusive Care's "Notice of Privacy Practices" statement governing Exclusive Care's use of Members' health information which Exclusive Care is required by Federal law to provide to its Members:

#### **Exclusive Care – Notice of Privacy Practices**

Exclusive Care creates records of health care to provide quality care and comply with legal requirements. Exclusive Care understands your health information is personal and private, and commits to safeguarding it to the extent reasonably possible. The law requires Exclusive Care to keep your health information private and to provide you this notice of the Plan's legal duties and privacy practices. The law also requires Exclusive Care to follow the terms of this notice.

This notice outlines the limits on how Exclusive Care will handle your health information. Under federal law, Exclusive Care must provide a copy of this notice when you receive health care and related services from Exclusive Care, or participate in certain health plans administered or operated by Exclusive Care. Exclusive Care reserves the right to change practices and make new provisions effective for all health information it maintains. Exclusive Care retains all final authority and responsibility for the Plan and its operations, including Plan privacy policies, practices and procedures.

Exclusive Care will interpret and construe the benefits of the Plan in accordance with current laws and regulations as identified in this notice and as amended from time to time. You may request an updated copy of this notice at any time.

### **A. Use and Disclosure – General**

Generally, except as otherwise specified below, Exclusive Care may use and disclose the following health information, as allowed by state and Federal law:

1. **For treatment.** Exclusive Care uses and discloses health information to provide you health care and related services. For instance:
  - Nurses, doctors, or other Exclusive Care employees may record your health information, and they may share such information with other Exclusive Care employees.
  - Exclusive Care may disclose health information to people outside Exclusive Care involved in your care who provide treatment and related services.
  - Exclusive Care may use and disclose health information to contact you to remind you about appointments for treatment or health care-related services.
  - In emergencies, Exclusive Care may use or disclose health information to provide you treatment. Exclusive Care will make its best effort to obtain your permission to use or disclose your health information as soon as reasonably practical.
2. **For payment.** Exclusive Care may bill you, insurance companies, or third parties. Information on or accompanying these bills may identify you, as well as diagnoses, assessments, procedures performed, and medical supplies used.
3. **For health care operations.** Exclusive Care may use information in your health record to assess the care and outcomes in your case to improve our services, and in administrative processes such as purchasing medical devices, or for auditing financial data.
4. **For health plan administration.** As administrator of certain health plans, such as Medicare, Medi-Cal, and Exclusive Care, Exclusive Care may disclose limited health information to plan sponsors. The law only allows using such information for purposes such as plan eligibility and enrollment, benefits administration, and payment of health care expenses. The law specifically prohibits use for employment-related actions or decisions.

### **B. Use and Disclosure Requiring Your Authorization**

On a limited basis, Exclusive Care may use and disclose health information only with your permission, as required by state and Federal law:

1. From mental health records.
2. From Substance Abuse treatment records.

### **C. Use and Disclosure Requiring an Opportunity for You to Agree or Object**

In certain cases, Exclusive Care may use and disclose health information only if it informs you in advance and provides an opportunity for you to agree or object, as required by state and Federal law:

1. Exclusive Care may include your name, location in a facility, general condition, and religious affiliation in a facility directory while you are a patient so your family, friends and clergy can visit you and know how you are doing.
2. To individuals assisting with your treatment or payment.
3. To assist with disaster relief and to notify your family about you.

### **D. Use and Disclosure NOT Requiring Permission or an Opportunity for You to Agree or Object**

In specific cases, Exclusive Care may use and disclose the following health information without your permission and without providing you the opportunity to agree or object:

1. As required by law.
2. For public health activities, which may include the following:
  - Preventing or controlling disease, injury or disability;
  - Reporting births and deaths;
  - Reporting abuse or neglect of children, elders and dependent adults;
  - Reporting reactions to medications or problems with products;
  - Notifying people of recalls of products they may use; or,
  - Notifying a person exposed to or at risk to contract or spread a disease or condition.
3. For mandated reporting of abuse, neglect or domestic violence.
4. For health oversight activities necessary for the government to monitor the health care system government programs and compliance with civil rights laws.
5. To the minimum extent necessary to comply with judicial and administrative proceedings when compelled by court order, or in response to a subpoena, discovery request or other lawful process as allowed by law.
6. To law enforcement:
  - To identify or locate a suspect, fugitive, material witness, or missing person;
  - About the victim of a crime if, under certain limited circumstances, Exclusive Care is unable to obtain the person's agreement;
  - About a death we believe may be the result of criminal conduct;
  - About criminal conduct at the Hospital; or,
  - In emergency circumstances to report a crime, the location of a crime or

crime victims, or the identity, description or location of a person who may have committed a crime.

7. To coroners, medical examiners and funeral directors as necessary for them to carry out their duties.
8. For organ donation once you are deceased.
9. For public health research in compliance with strict conditions approved and monitored by an Institutional Review Board.
10. To avert serious threats to the health and safety of you or others.
11. Regarding military personnel for activities deemed necessary by appropriate military command authorities to assure proper execution of a military mission.
12. To determine your eligibility for or entitlement to veterans' benefits.
13. To authorized Federal officials for the conduct of lawful intelligence, counter-intelligence, and other national security activities.
14. To correctional institutions and other law enforcement custodial situations, inmates of correctional institutions or in custody of a law enforcement official.
15. To determine your eligibility for or enroll you in government health programs.
16. For Workers Compensation or similar programs, to the minimum extent necessary.

Exclusive Care will not disclose your health information for marketing, fundraising, or other reasons not listed above without your prior written permission, and you may withdraw that permission in writing at any time. If you do, Exclusive Care will no longer use or disclose health information about you for the reasons you permitted. Exclusive Care is unable to retract disclosures already made with your permission, and must retain records of care already provided.

### **E. Rights and Responsibilities**

With regard to health information, Exclusive Care recognizes and commits to safeguard your:

1. **Right to request restrictions on certain use and disclosure.** You have the right to request restriction or limitation on the health information Exclusive Care uses or discloses for treatment, payment or health care operations, though the law does not require Exclusive Care to agree to your request. If Exclusive Care agrees, it will comply, except to provide Emergency Treatment. Requests must be in writing and state: the information you want to limit; whether to limit use, disclosure, or both; and to whom limits apply. For instance, you may ask not to disclose to your spouse.
2. **Right to confidential communications.** You have the right to ask Exclusive Care to communicate with you in a certain way, or at a certain location.
3. **Right to request to inspect and copy records.** You have the right to request to inspect and obtain copies of your health information. Requests may be required

in writing, and Exclusive Care may charge you a fee for the costs of fulfilling your request. Exclusive Care may deny requests to inspect or copy psychotherapy notes, mental health records, or materials for legal proceedings. You may ask for review of a denial by another Health Care Professional chosen by Exclusive Care. Exclusive Care will comply with the results of that review.

4. **Right to amend health records.** If information Exclusive Care has about you is incorrect or incomplete, you may ask to amend it. Requests must be in writing, and provide a reason supporting your request. Exclusive Care may deny your request if it is not in writing, or does not include a reason supporting it. Exclusive Care may deny requests if the information:
  - Was not created by Exclusive Care;
  - Is not health information kept by or for Exclusive Care;
  - Is not information you are permitted to inspect and copy; or,
  - Is accurate and complete.
  
5. **Right to an accounting of certain disclosures.** You have the right to ask for a listing of the last six years of disclosures of your health information since April 14, 2003, not pertaining to treatment, payment or health care operations. Requests must be in writing. The first list you request in a twelve-month period is free. Exclusive Care may charge you the cost of providing or reproducing additional lists. When told the cost, you may withdraw or modify your request.
  
6. **Right to obtain a paper copy of the notice of privacy practices upon request.**
  
7. **Right to file complaints without fear of retaliation.** Under law, you cannot be penalized for filing a complaint. If you believe Exclusive Care violated your privacy rights, you may file a complaint with Exclusive Care, the County of Riverside Privacy Office, or with the U.S. Secretary of Health and Human Services.

**Privacy Complaint Contacts**

<p><b>Exclusive Care Plan</b>          P.O. Box 1508          Riverside, CA 92502          (800) 962-1133</p>	<p><b>County of Riverside          Privacy Office</b>          P.O. Box 1569          Riverside, CA 92502          (951) 955-1000</p>	<p><b>U.S Department of Health          &amp; Human Services</b>  <b>Region IX Office of Civil          Rights</b>          50 United Nations Plaza          Room 322          San Francisco, CA 94102          TEL: (415) 437-8310          TDD: (415) 437-8311          FAX: (415) 437-8329</p>
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## **Release Of Health Information**

The Health Insurance Portability and Accountability Act (HIPAA) includes a provision that grants individuals certain rights regarding their Protected Health Information (PHI) maintained by their health plan. HIPAA also defines the obligation that the Health Plan has in protecting each Member's PHI. Each Member's PHI will be used and disclosed only in accordance with the Plan's privacy policy outlined above and applicable law.

At the time of enrollment, each Member agrees to authorize the Plan, or its designee, to have access to and use of his/her medical records (including mental health medical records and medical records for drug and alcohol abuse treatment or prevention) for purposes of utilization review, quality assurance, surveys, processing of claims, financial audits, ratings, insurance underwriting, or purposes related to the performance of providing medical care or applying policies outlined in this Summary Plan Document.

The Plan continually safeguards PHI. If it is the desire of a Member that the Plan share PHI with an unknown party or entity not directly involved with a Member's care, or the administration of care, please contact the Member Services Department to request a "release of information" form.

## **Certificate Of Coverage**

Upon termination of Plan coverage, a "Certificate of Group Health Plan Coverage" is provided to you and any affected dependents, which identifies your coverage period with the Plan. The Plan mails this certificate to your last known address noted in the Plan's records.

For additional information regarding the Plan's Privacy Policy Statement and additional copies of the Plan's Privacy Policy with respect to medical coverage, contact the Member Services Department at (800) 962-1133.

## **SECTION 9: PAYMENT BY THIRD PARTIES**

### **Third Party Recovery Process and Your Responsibilities**

If you are ever injured through the actions of another (a third party) and receive compensation for your medical care, you will be required to reimburse the Plan, or its designee, for the reasonable value of medical services and benefits provided. The amount of reimbursement shall not exceed the amount of compensation you receive from the third party.

You must obtain the Plan's written consent prior to settling any claim or releasing any third party from liability, if such a release would limit the Plan's right to reimbursement.

- Should you settle your claim against a third party and compromise the Plan's reimbursement rights, the Plan reserves the right to initiate legal action. Attorney fees will be awarded to the prevailing party.

You are required to cooperate in protecting the interest of the Plan by providing the Plan with all liens, assignments and/or other documents. Failure to cooperate with the Plan in this regard could result in termination of coverage.

### **Non-Duplication of Benefits with Automobile, Accident or Liability Coverage**

If you are receiving benefits as a result of other automobile, accident or liability coverage, the Plan will not duplicate those benefits. It is your responsibility to take whatever actions are necessary to receive payment under the other coverage.

### **Non-Duplication of Benefits with other Group Health Coverage**

- If you have other group health coverage(s), this "Non-Duplication of Benefits" provision may result in reduced Benefits by the Plan. For example, you may be covered as a dependent under your spouse's medical plan. Exclusive Care may not pay any Benefits if the primary plan's benefits are equal to or greater than Exclusive Care's Benefits. The goal of the "Non-Duplication of Benefits" rule is to maximize coverage for expenses, and to prevent any payment duplication.
- The Plan determines Benefits in accordance with the National Association of Insurance Commissioners' guidelines, and California law.
- In order to ensure proper coordination with other health coverage(s) you may have, you must inform the Plan of any other health coverage for which you or your enrolled dependents may be eligible.
- If the Plan pays more Benefits than are appropriate, the Plan may recover excess payments from you, the plan with primary responsibility, or any other person or entity that benefited from the overpayment.

### **Order of Benefit Determination**

The rules establishing the order of benefit determination are:

- The benefits of a plan which covers the Member as an active employee will be determined before the benefits of a plan which covers the Member as a non-active employee (i.e. a retired or laid off employee, a COBRA participant, etc.), or as a dependent. If the other plan does not have this rule, and if as a result the plans do not agree on the order of benefit determination, the rule of the other plan will prevail;
- When the Member is a dependent child and such child's parents are not separated or divorced, the benefits of the plan of the parent whose birthday falls earlier in the year are determined before those of the plan of the parent whose birthday falls later in the year, however;:

- ✓ If both parents have the same birthday, the benefits of the plan which covered the parent longer are determined before those of the plan which covered the other parent for a shorter period of time; or
  - ✓ If the other plan does not have this rule, and if as a result the plans do not agree on the order of benefit determination, the rule of the other plan will prevail.
- When the Member is a dependent child whose father and mother are legally separated or divorced:
    - ✓ The benefits of the plan which covers the Member as a dependent child of the parent with custody will be determined first, except that if a court decree assigns financial responsibility for the health care coverage of a dependent child to one of the parents, the benefits of the assigned parent's plan will be determined first and the other parent's plan will be determined second;
    - ✓ The plan of the spouse of the parent with custody will be determined next;
    - ✓ The plan of the parent not having custody of the child will be determined last.
  - If none of the above rules establish an order of benefits determination, the benefits of the plan that has covered the Member for the longer period of time are determined before those of the plan that has covered the Member for the shorter period of time.

When this provision operates to reduce the total benefit otherwise payable to a person covered under the Plan during any Claim determination period, each Benefit will be reduced proportionately, and such reduced amount will be charged against any applicable Benefit limit of the Plan.

### **Workers' Compensation**

If you are receiving benefits as a result of a work-related injury or illness the Plan will not duplicate those benefits.

It is your responsibility to take whatever action is necessary to receive payment under workers' compensation laws, when such payments can reasonably be expected.

If for whatever reason, the Plan duplicates benefits to which you are entitled under workers' compensation law, you are required to reimburse the Plan at prevailing rates, immediately after receiving the monetary award, whether by settlement or judgment.

In the event of a dispute arising between you and the workers' compensation administrator, the Plan will provide the Benefits described in this SPD until the dispute is resolved.

If you receive a workers' compensation benefit that includes payment of future medical costs, you may be liable for reimbursing the Plan.

## **SECTION 10: HEALTH PLAN ADMINISTRATION & INTERPRETATION**

### **Funding of Benefits and administration**

The Plan is self-insured and unfunded. In other words, the Plan is funded through premium contributions made by Members and participating employer groups, and all Benefits are paid from Plan assets that are maintained by the County of Riverside. The Plan Administrator may also establish a trust for the payment of Benefits.

Your rights to Benefits under the Plan shall be determined in accordance with the terms of the Plan as provided in this Summary Plan Document. Furthermore, the County has complete and discretionary authority to determine all questions relating to the interpretation of ambiguous, unclear or implied terms in this Summary Plan Document, to make any findings of fact or law needed to determine eligibility to participate in the Plan, and to receive Benefits. The County also has the full responsibility and authority to take any and all actions not specifically described in this Summary Plan Document that may be necessary or appropriate for the effective administration of the Plan. The decisions of the Plan Administrator and its representatives shall be given the maximum deference permitted by law.

**All changes to Benefits, Providers, and health care services provided under the Plan will be ultimately determined by the County of Riverside's Board of Supervisors, in conjunction with the County of Riverside Human Resources Department.**

### **Member Rights**

You and your enrolled dependents:

- Will be treated with respect and dignity by everyone that works for the Plan.
- Can obtain information about the Plan.
- Will receive Medically Necessary Covered Services without regard to race, religion, age, gender, national origin, disability, sexual identity or orientation, family composition or size, or medical condition, or state of illness.
- Can receive help making decisions about your health care.
- Can refuse medical treatment.
- Will have the privacy of your medical records and personal health information protected.
- Can address any concerns to the Plan.
- Can file a grievance with the Plan Administrative Review Committee.
- Can ask for a second opinion about your health by writing to the Plan's Medical Management Unit.

- Can disenroll from the Plan.
- Can receive Emergency Care services.

### **Member Responsibilities**

You and your enrolled dependents are expected to:

- Ask questions and learn about your health benefits. If you have questions about your benefits, contact the Member Services Department at (800) 962-1133.
- Give necessary information to your Physician or to the Plan so appropriate care can be provided to you..
- Be proactive in making decisions about your health care.
- Be on time for your appointments. If you are unable to keep your appointment or you are going to be late, call your Physician's office as soon as possible.
- Show your Member identification card wherever you seek medical care.
- Call your physician or pharmacy at least three days in advance before running out of medicine.
- Cooperate with your physician and his/her staff and treat them with respect.
- Work with your Physician to make plans about your health care.
- Follow through with the plans and instructions you and your Physician have agreed upon.

## **SECTION 11: DEFINITION OF TERMS**

**Acute Condition** - Care provided in the course of treating an illness, injury or condition marked by a sudden onset or change of status requiring prompt attention, which may include hospitalization, but which is of limited duration and not expected to last indefinitely.

**Administrative Review Committee** - As part of the Member Grievance Procedure, the committee of individuals selected to provide a secondary review of a Member's appeal upon receipt of an initial pre authorization/Claim denial notice.

**Allowed Charge(s)** - An amount on which the Plan's payment/reimbursement for a Covered Service is based; an amount which is consistent with the going rate or charge, in a certain geographical area, for identical or similar services, as determined by the Plan.

**Ambulatory Surgical Center** - A facility that performs surgery on a non-hospitalized patient. The patient returns home the same day the surgery is performed.

**Autologous Blood** - A process allowing an individual to receive a transfusion of his/her own blood, which is removed at scheduled intervals prior to a planned surgery. The individual's body will make more blood to replace what has been donated. The advantage of autologous blood donations is that the blood received is a perfect match for that individual.

**Behavioral Health/Behavioral Health Service(s)** - Services rendered or made available to a Member for treatment of Mental Health and Substance Abuse Disorders.

**Beneficiary** - A person eligible to receive Benefits.

**Benefits** - Covered Services paid by the Plan subject to all other terms and conditions of the Summary Plan Document.

**Brand-Name Drug** - A Brand-Name Drug is a drug marketed under a proprietary trademark protected name.

**Calendar Year** - The period of time commencing at 12:01 a.m. on January 1 and ending at 12:01 a.m. on the next January 1. Each succeeding like period will be considered a new Calendar Year. A Calendar Year is necessary for purposes of determining the number of treatment days for the maximum benefit specified for each benefit under the Plan.

**Chronic Condition** - Treatment for an illness, injury or condition which does not require hospitalization (although confinement in a lesser facility may be appropriate), which may be expected to be of long duration, has no reasonably predictable date of termination, and may be marked by recurrence requiring continuous or periodic care as necessary.

**Claim** - A bill issued by a provider for services provided to a Member.

**Clinically Necessary** - Behavioral Health Services or supplies for treatment of an active Mental Health or Substance Abuse Disorder which have been established in

accordance with generally accepted professional standards and the Plan's Utilization Review Committee to be:

- Rendered for the treatment and diagnosis of a Mental Health or Substance Abuse Disorder as defined by the DSM-IV and limited to impairment of a Member's mental, emotional or behavioral functioning;
- Appropriate for the severity of symptoms, consistent with diagnosis, and otherwise in accordance with generally accepted mental health practice and professionally recognized standards;
- Not furnished primarily for the convenience of the Member, the attending Participating Practitioner, or other provider of service;
- Furnished at the most appropriate level which may be provided safely and effectively to the Member.

**Clinician** - A person licensed as a psychiatrist, psychologist, clinical social worker, marriage/family/child counselor, nurse, or other licensed Health Care Professional with appropriate training and experience in Mental Health or Substance Abuse Services, who is employed or under contract with the EAS or the Plan, to perform case management services which include assessing psychiatric disorders, referring to appropriate participating facilities and/or Participating Mental Health and Substance Abuse Providers, recommending payment, monitoring and reviewing care, participating in provider relations, and coordinating health care Benefits for Members and their Eligible Dependents.

**Coinsurance** - The Member's share of the cost of Covered Services.

**Copay** - The Member's share of the cost to be paid at the time Covered Services are received.

**Covered Expense(s)** - Any Medically Necessary expense incurred by a Member subject to all other terms and conditions of the Summary Plan Document.

**Covered Service(s)** - Any Medically Necessary service received by a Member subject to all other terms and conditions of the Summary Plan Document.

**Cost of Coverage** - You are responsible for the payment of the entire premium for coverage for yourself and your covered Eligible Dependents.

**Custodial Care** - Care provided primarily for the maintenance of the patient or which is designed to provide room and board or meet the activities of daily living (which may include nursing care, training in personal hygiene and other forms of self care); or care furnished to a Member who is mentally or physically disabled, and who is not under specific medical, surgical or psychiatric treatment to reduce the Disability to the extent necessary to enable the patient to live outside an institution providing such care or when, despite such treatment, there is no reasonable likelihood that the Disability will be so reduced.

**Day Treatment Center** - A facility which provides Mental Health and/or Substance Abuse Services on a full or part-day basis and which facility is also licensed, certified or approved as such by the appropriate state agency.

**Deductible** - The Deductible is the portion of medical expenses you must pay each Calendar Year before the Plan will pay Benefits.

**Dental Care** - Services or treatment on or to the teeth or gums whether or not caused by accidental injury, including any appliance or device applied to the teeth or gums.

**Disability** - An injury, an illness (including any Mental Health or Substance Abuse Disorders), or a condition; however,

- All injuries sustained in any one accident will be considered one Disability;
- All illnesses existing simultaneously which are due to the same or related causes will be considered one Disability;
- If any illness is due to causes that are the same as, or related to, the causes of any prior illness, the succeeding illness will be considered a continuation of the previous Disability and not a separate Disability.

**Domestic Partner** - An individual, with whom the Member has registered as a domestic partnership with the State of California, as evidenced by a signed *California Declaration of Domestic Partnership*. Such individual must live in a mutually exclusive relationship with the Member, both must be jointly responsible for each other's welfare and financial obligations, and live in the same principal residence and intend to do so indefinitely. In addition, a domestic partnership must consist of two individuals who are at least 18 years of age and are of either the same sex, or of the opposite sex as long as one individual is over the age of 62. Individuals in a domestic partnership also must be unmarried and not be blood relatives close enough to bar marriage in the State of California.

**Drug Formulary/Formulary** - A listing of drugs in major therapeutic categories, selected by an independent committee of medical and pharmacy professionals who are either Physicians or clinical pharmacists with a doctorate in pharmacology (Pharm D), and which are considered to be preferred over other drug alternatives. Formulary drugs are evaluated for: (1) indications; (2) side effects; (3) interaction with other drugs; (4) dosage form availability; (5) pharmacokinetics (how a drug is absorbed, distributed, metabolized and excreted); and (6) Physician preference. The objective of the Formulary is to improve the quality of patient care by promoting high quality, cost-effective prescribing and dispensing of prescription drugs to meet Members' prescription drug needs.

**DSM-IV** - *The Diagnostic and Statistical Manual of Mental Disorders (most current edition)* which lists diagnostic criteria for Mental Health Disorders as defined by the American Psychiatric Association.

**Durable Medical Equipment** - Equipment intended for repeated use, which is primarily and customarily used to serve a medical purpose, and generally is not useful to a person in the absence of an illness or injury.

**Eligible Child(ren)** - Dependent natural children, adopted children, foster children, grandchildren, and stepchildren under the employer group's limiting age and who have never been married; any child, who is under the employer group's limiting age, and has never been married, for whom you have legal custody, have been required to cover under your medical plan as part of a QMCSO or who resides with you (generally in the absence of the natural or adoptive parent) and who is economically dependent upon you; or an otherwise Eligible Child past the employer group's limiting age who has never been married if the child is incapable of self-support because of a mental or physical handicap and you continue to claim the child as a dependent on your Federal income tax return.

**Eligible Dependent(s)** - A legal spouse or Domestic Partner, and all Eligible Child(ren).

**Eligible Spouse** - A legal spouse or Domestic Partner as defined by California Law.

**Emergency Care** - Care rendered in response to the sudden and unexpected onset of acute illness or accidental injury requiring alleviation of severe pain; or immediate medical or surgical care which you secure immediately after the onset, or as soon thereafter as practicable, but in no event later than 24 hours after onset. The absence of immediate medical attention could reasonably be expected to result in any of the following:

- Placing the Member's health in serious jeopardy;
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part.

**Emergency Mental Health Condition** - A Mental Health/Substance Abuse Disorder which manifests itself by acute symptoms of sufficient severity such that the absence of immediate Behavioral Health Services could reasonably be expected to result in the following:

- Immediate harm to self or others;
- Placing the Member's health in serious jeopardy;
- Serious impairment of the Member's functioning; or
- Serious and permanent dysfunction of the Member.

**Emergency Treatment** - The immediate and unscheduled screening, examination, and evaluation of a Member by a medical or psychiatric practitioner to determine if an emergency condition exists. If an emergency condition is found to exist, Emergency Treatment will include the care and treatment necessary to relieve or eliminate the emergency condition or stabilize the Member before transfer to a facility capable of handling higher levels of emergency care..

**Exclusive Care** - The County of Riverside Exclusive Provider Organization (EPO) Health Plan.

**Experimental or Investigational** - Any treatment, therapy, procedure, drug or drug usage, facility or facility usage, equipment or equipment usage, device or device usage,

or supplies which are not recognized as being in accordance with generally accepted professional medical standards, or if safety and efficacy have not been determined for use in the treatment of a particular illness, injury or medical condition for which it is recommended or prescribed.

**FDA** - Food and Drug Administration.

**Generic Drugs** - A Generic Drug available in the marketplace after the Brand Name Drug loses patent protection; contains a medication's basic chemical components and usually has a Brand Name Drug equivalent. The FDA requires that Generic Drugs have the same form as their Brand Name Drug equivalents. Generic Drugs must meet the same FDA standards as Brand Name Drugs and are tested and certified by the FDA to be as effective as their Brand Name Drug equivalents.

**Health Plan** - The plan(s) as described in this Summary Plan Document, as applicable.

**Health Care Professional** - Dentist, optometrist; podiatrist or chiropractor; clinical psychologist; chiropractor; licensed clinical social worker; marriage, family and child counselor; physical therapist; speech pathologist; audiologist; radiologist; licensed occupational therapist; physician assistant; registered nurse; registered dietitian for the provision of diabetic medical nutrition therapy only; a nurse practitioner and/or nurse midwife providing services within the scope of practice as defined by the appropriate clinical license and/or regulatory board.

**Home Health** - Home Health care providers who are licensed according to state and local laws to provide skilled nursing and other services on a visiting basis in your home and recognized as Home Health providers under Medicare.

**Hospice** - A program designed to care for the terminally ill individual with a life expectancy of six (6) months or less. Hospice programs include the following components for individuals who have decided to no longer pursue curative medical treatment:

- Control of pain and other symptoms through medication, environmental adjustment, and education;
- Psychosocial support for both the patient and family, including all phases from diagnosis through bereavement;
- Medical services equal with the needs of the patient;
- Interdisciplinary "team" approach to patient care, patient and family support, and education under physician leadership; and
- Specially trained personnel with expertise in care of the dying and their families.

**Hospital** - An institution which is licensed under all applicable state and local laws and regulations to provide, under supervision of Physicians, diagnostic and therapeutic services for the medical diagnosis, treatment and care of the injured, disabled or sick persons in need of acute Inpatient medical and psychiatric or psychological care, and which is registered as a general Hospital with the American Hospital Association and

accredited by the Joint Commission on Accreditation of Healthcare Organizations. Hospital also includes:

- A psychiatric Hospital licensed as a health facility accredited by the Joint Commission on Accreditation of Health Care Organizations; or
- A licensed health facility operated primarily for the treatment of alcoholism and/or substance abuse accredited by the Joint Commission on Accreditation of Health Care Organizations; or
- A “psychiatric health facility” as defined in Section 1250.2 of the Health and Safety code.

**Inpatient** - An individual confined as a bed patient in a Hospital or Skilled Nursing Facility who requires routine or specialized Hospital services. Also refers to services rendered in Hospital or Skilled Nursing Facility while confined as a bed patient.

**Medical Director** - A Physician, designated by the Plan, who is responsible for the medical/clinical administration of the Plan.

**Medical Management Unit** - The Plan’s Medical Director and qualified clinical/case management staff under his/her direction, who provide pre authorization review, Medical Necessity review, and other medical review/case management activities, to assist in the administration and determination of Covered Services and Benefits.

**Medically Necessary/Medical Necessity** - Care that is required and determined to be appropriate and necessary for the treatment of illness or injury according to accepted standards of medical practice and includes those services which have been established as safe and effective and are furnished in accordance with generally accepted professional standards to treat an illness or injury, and which, as determined by Exclusive Care are:

- Consistent with Exclusive Care’s medical/case management policy; and
- Consistent with the symptoms or diagnosis; and
- Not furnished primarily for the convenience of the patient, the attending Physician or another provider; and
- Furnished at the most appropriate level that can be provided safely and effectively to the patient.

**Medicare** - The programs of medical care coverage set forth in Title XVIII of the Social Security Act, as amended by Public Law 89-97, or as thereafter amended.

**Medicare Approved Amount** – the amount upon which Medicare bases its reimbursement amount that it pays to a provider, which may be the same or less than the provider’s actual charge.

**Medicare Assignment** – a provider accepts Medicare Assignment by signing a contract with Medicare to accept all payments from Medicare based on Medicare’s Approved Amount, even if the Medicare payment is less than the provider’s actual charge.

**Member** - An employee, retiree, Eligible Spouse, Eligible Child(ren) or Eligible Dependent enrolled in the Plan. Also referred to as “you” or “your”.

**Mental Health Disorder(s)** - A mental disorder diagnosed by a licensed qualified Participating Practitioner according to the criteria in the DSM-IV and limited to impairment of a Member’s mental, emotional or behavioral functioning on a daily basis.

**Mental Health Services** - Psychoanalysis, psychotherapy, counseling, medical management or other services most commonly provided by a psychiatrist, psychologist, licensed clinical social worker, or marriage/family/child counselor, for diagnosis or treatment of mental or emotional disorders or the mental or emotional problems associated with illness, injury, or any other condition.

**Occupational Therapy** - Treatment under the direction of a Physician and provided by a certified occupational therapist, utilizing specific training in daily living skills, to improve and maintain a patient’s ability to function.

**Orthotics** - An orthopedic appliance or apparatus used to support, align, prevent or correct deformities or to improve the function of movable body parts.

**Outpatient** - An individual receiving services under the direction of a Health Plan provider, but not as an Inpatient.

**Partial Day Program** – a short-term treatment program that provides daily group or individual therapy, or crisis intervention, utilizing short term treatment methods and intensive medication management.

**Participating Pharmacy** - A pharmacy contracted by Exclusive Care’s Pharmacy Benefits Manager to provide Members with outpatient prescription drug services.

**Pharmacy and Therapeutic Committee** - A committee of practicing Physicians and pharmacists who are responsible for creating and updating the Drug Formulary.

**Pharmacy Benefit Manager** - The provider organization that has contracted with Exclusive Care to provide access to a network of retail pharmacies and pharmacy benefit management services including Formulary maintenance.

**Physical Therapy** - Treatment under the direction of a Physician and provided by a registered physical therapist, certified occupational therapist or licensed doctor of podiatric medicine, utilizing physical agents, such as ultrasound, heat and massage, to improve a patient’s musculoskeletal, neuromuscular and respiratory systems.

**Physician** - An individual licensed and authorized to engage in the practice of medicine (M.D.) or osteopathy (D.O.).

**Physician Review Committee** - A committee appointed by Exclusive Care to review a Member’s appeal of a pre authorization or Claim denial, upon the request of the Member.

**Plan** - Exclusive Care Exclusive Provider Organization (EPO) providing Benefits for Covered Services subject to all terms and provisions of the Summary Plan Document.

**Prosthetics** - An artificial part, appliance or device(s) used to replace a missing part of the body.

**Psychiatric Admission** - The scheduled and unscheduled admission of a Member for care and treatment Clinically Necessary to relieve or eliminate the Emergency Mental Health Condition due to a Mental Health/Substance Abuse Disorder which manifests itself by acute symptoms of sufficient severity such that the absence of immediate Behavioral Health Services could reasonably be expected to result in the following: (i) immediate harm to self or others; (ii) placing the Member's health in serious jeopardy; (iii) serious impairment of the Member's functioning; or (iv) serious and permanent dysfunction of the Member.

**Qualified Public Employer Group**

The employees, retirees, and the dependents of those employees and retirees, of any city, county, city and county, public entity, or political subdivision that has signed a participating health care service agreement with Exclusive Care. Exclusive Care is not available to the general public pursuant to Section 1349.2 of the California Health and Safety Code.

**QMCSO** - A Qualified Medical Child Support Order, as defined in Section 609 of the Employment Retirement Income Security Act of 1974, as amended.

**Rehabilitation** - Care furnished primarily to restore an individual's ability to function as normal as possible after a disabling illness or injury. Rehabilitation services may consist of the combined use of medical, social, educational, occupational, or vocational treatment modalities and are provided with the expectation that the patient has restoration potential and will realize significant improvement in a reasonable length of time.

**Residential Treatment Center** - An acute care facility which provides Mental Health and Substance Abuse services in an acute, Inpatient setting, pursuant to a written Treatment Plan approved and monitored by a Physician and which facility also:

- Provides 24-hour nursing and medical supervision; and
- Is licensed, certified or approved as such by the appropriate state agency.

**Residential Treatment Facility** - A facility which provides Substance Abuse services in a residential setting on a full- or part-day basis, pursuant to a written Treatment Plan approved and monitored by the Plan, and which is licensed, certified or approved as such by the appropriate state agency.

**Respiratory Therapy** - Treatment under the direction of a Physician and provided by a trained and certified respiratory therapist, to preserve or improve a patient's pulmonary function.

**Respite Care** - Continuous care of the patient in the most appropriate setting for the primary purpose of providing temporary relief to the family from the duties of caring for

the patient.

**Severe Mental Illness** - A Severe Mental Illness is defined as one or more of the following conditions: schizophrenia, schizoaffective disorder, bipolar disorder (manic depressive illness), major depressive disorders, panic disorder, obsessive-compulsive disorder, pervasive developmental disorder or autism, anorexia nervosa, and bulimia nervosa.

**Skilled Nursing Facility** - A facility licensed by the California State Department of Health as a “skilled nursing facility” or any similar institution licensed under the laws of any other state, territory, or foreign country.

**Specialist** - Any duly licensed Physician, osteopath, psychologist or other Practitioner (as defined by Medicare) who provides health care services for a specific disease or body part and to whom your Primary Care Provider may refer you. Also, any duly licensed emergency room Physician who provides Emergency Care services to you.

**Speech Therapy** - Treatment under the direction of a Physician and provided by a licensed speech pathologist or speech therapist, to improve or retrain a patient’s vocal skills.

**Substance Abuse/Substance Abuse Disorder** - An addictive relationship between a Member or his/her Eligible Dependent, and any drug, alcohol, or chemical substance that can be documented according to the criteria in the DSM-IV. Substance Abuse does not include addiction to or dependency on:

- Tobacco in any form; or
- Food substances in any form.

**Summary Plan Document (SPD)** - The written evidence of coverage furnished to Members of the Health Plan, providing details of Benefits, Covered Services and Exclusions under the Health Plan.

**Temporomandibular Joint Disorder (TMJ)** – A group of problems related to pain and difficulty in function associated with the temporomandibular joint. The temporomandibular joint is a complex joint that moves in four degrees of freedom around all three axes in the jaw.

**Utilization Review Committee** - The Medical Management Utilization Review Committee that meets periodically and that consists of the Medical Director, licensed Physicians and other case management staff.

**HEALTH PLAN ADDRESSES  
&  
IMPORTANT TELEPHONE NUMBERS**

**Member Services Department**

EXCLUSIVE CARE Member Services  
P.O. Box 1508  
Riverside, CA 92502-1508  
(800) 962-1133, option 1  
8:00 a.m. - 5:00 p.m. Monday - Friday

**Claims Department**

EXCLUSIVE CARE Claims  
P.O. Box 1508  
Riverside, CA 92502-1508  
(800) 962-1133, option 2  
8:00 a.m. - 5:00 p.m. Monday - Friday

**Mental Health/Substance Abuse Services**

COUNTY OF RIVERSIDE  
Employee Assistance Service (EAS)  
3600 Lime Street, Riverside, CA 92506  
(951) 778-3970 — Western County  
(760) 328-6863 — Desert Area

**Department of Managed Health Care**

California HMO Help Center  
980 Ninth Street, Suite 500  
Sacramento, CA 95814-2725  
Voice: (888) 466-2219 Fax: (916) 229-0465 TDD: (877) 688-9891

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