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Exclusive Care Select Plan
Non-Medicare Eligible Retirees

Exclusive
Care

Summary Plan Document
for
COUNTY OF RIVERSIDE

January, 2010

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

INTRODUCTION

The Exclusive Care Select Plan (the Plan) for Non-Medicare-Eligible Retirees has been created as a health care alternative for non-Medicare eligible retirees. The Plan offers coverage for non-Medicare eligible retirees of qualified public Employer Groups that elect to join the Plan and their qualifying dependents.

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.

Exclusive Care Select Plan	
Plan Sponsor	Each Employer Group for its own Members
Plan Administrator	Assistant CEO, Director of Human Resources County of Riverside, Human Resources 4080 Lemon Street, 7 th Floor Riverside, CA 92502 (951) 955-3510
Plan Mailing Address	Exclusive Care P.O. Box 1508 Riverside, CA 92502-1508 www.exclusivecare.com
Member Services	(800) 962-1133 Monday through Friday 8:00 a.m. - 5:00 p.m. Pacific Coast Time
Type of Plan	The Plan is a welfare benefit plan established and operated by the County of Riverside that provides health care benefits for eligible retirees of participating Employer Groups.
Type of Funding	The Plan is self-insured and unfunded. In other words, the Plan is funded through contributions that are made by its Members and participating Employer Groups, and benefits are paid from Plan assets which are maintained by the County of Riverside. The Plan Administrator may also establish a trust for the payment of benefits.

Exclusive Care Select Plan	
Plan Year	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.
Plan Establishment	The Plan was established for the exclusive benefit of its Members on January 1, 2008.
SPD Effective Date	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: EXCLUSIVE CARE SELECT PLAN INFORMATION

The Plan provides benefits for medically necessary, comprehensive health care services with three tiers of coverage. The Plan is a Point of Service (POS) plan that lets you receive care from any provider of your choice.

- **Tier 1: The Exclusive Care network** is made up of physicians, medical groups, and hospitals that have contracted with Exclusive Care to provide covered services to Plan members. This tier offers the highest benefits with the lowest out-of-pocket costs.
- **Tier 2: A National Provider network** is under contract with Exclusive Care to provide covered services nationwide. While this tier provides comprehensive, affordable benefits, the out-of-pocket costs are higher than in Tier 1.
- **Tier 3: Out-Of-Network providers** are providers who are not contracted with the Tier 1 or Tier 2 provider networks. The out-of-pocket costs are highest with this tier. Any licensed provider can deliver covered services; however, they will be reimbursed based on the allowable charges determined by Exclusive Care.

Centers of Excellence

Members must obtain prior authorization for services in cardiac care, complex and rare cancer treatments, transplant services, joint replacement surgery, mental health care and other highly specialized complex care programs. Exclusive Care's Medical Director has designated and approved access to medical facilities across the nation that have demonstrated expertise in delivering quality healthcare for these treatments. The Center's of Excellence designation is based on rigorous, evidence-based, objective selection criteria established in collaboration with expert physicians' and medical organizations' recommendations. The Exclusive Care Select plan will provide benefits at the Tier 1 level for all allowable charges approved under this program. Allowable charges obtained at non designated Centers will be reimbursed as an out of network provider. Exclusive Care members with these special treatment needs will be

evaluated through prior authorization and other medical management programs to improve the overall quality and delivery of healthcare and to support better overall health outcomes for members.

HOW THIS PLAN WORKS

This Point of Service (POS) Plan is designed to allow those enrolled in the Plan the flexibility to access medical care at three distinct benefit levels. Members choose the level of benefits according to the healthcare providers they use. Members may access physicians and specialists at any level at any time. However, there are some services that require prior authorization. You can go to any doctor you like within the Exclusive Care or national provider networks, including specialists. If you prefer to go to a doctor or health care facility that does not belong to one of these provider networks, you are free to do so — but your out-of-pocket costs will be higher and the provider will be reimbursed by the Plan only up to the allowable charges determined by Exclusive Care. Both Tier 1 and Tier 2 are Preferred Provider Organization (PPO) networks, although use of Tier 1 (the Exclusive Care network) results in a higher level of benefits for you.

The Exclusive Care Select Plan: Benefits at a Glance			
	Tier 1 Exclusive Care Network	Tier 2 National Provider Network	Tier 3 Out of Network
Lifetime Maximum	\$1,000,000		
Deductible	\$250/person \$750/family	\$500/person \$1,500/family	\$1,000/person \$3,000/family
Out-of-Pocket Maximum	\$1,500/person \$4,500/family	\$2,500/person \$7,500/family	\$5,000/person \$15,000/family
Coinsurance	90%	80%	60% of Allowable Charges
Office Visit Copayment	\$10 – primary care \$20 – specialists	\$25 – primary care \$50 – specialists	None; deductible and coinsurance apply

All covered services are based upon medical necessity.

For additional information regarding the network providers, please call Member Services at (800) 962-1133 or visit the Exclusive Care websites at: www.exclusivecare.com.

The following are terms you will need to understand to utilize your Benefits effectively:

Cost of Coverage

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

Deductible – Per Person

The deductible is the portion of medical expenses you must pay each calendar year before the Plan will pay benefits. This deductible applies across all three tiers of coverage.

There is a separate deductible for each tier of coverage. The amount applied toward your deductible in one Tier will count toward your Deductible in another Tier. For example, if you meet your \$250 deductible in the Exclusive Care network (Tier 1) and then decide to see a provider in the National Provider Network (Tier 2), you will only have to spend another \$250 to reach the Tier 2 Deductible of \$500 — you will get credit for the \$250 you already spent.

Deductible - Family

If you have more than one covered Member in your family, each member has to meet an individual deductible. The maximum family deductible is equal to no more than three times the per person deductible. The family deductible will be met by any combination of claims that are applied to each person's individual deductible.

Coinsurance

After the deductible is paid, you will also pay a percentage of the cost for most healthcare services you receive; this amount is called your coinsurance.

Copayments

These are flat dollar amounts you pay for certain covered services within the PPO network, such as office visits, preventive care and prescription drugs. After you pay the required Copayment, the Plan will pay the remainder of the covered costs. Except as noted, deductible and coinsurance amounts do not apply to services for which only a Copayment is required.

Copayments do not apply toward deductibles or toward the out-of-pocket maximums.

Out-of-Pocket Maximum

The Plan helps protect you from costly medical expenses by limiting the out-of-pocket amount you pay for certain services in any one calendar year. When the coinsurance you pay reaches a level called the out-of-pocket maximum, you will not have to pay any more coinsurance for the rest of the calendar year. If the coinsurance paid by three or more of your covered family Members reaches the family out-of-pocket maximum, the Plan will pay 100% of Covered Services for you and your enrolled family Members for the rest of the calendar year except for the expenses described below. There is a separate out-of-pocket maximum for each tier of coverage. However, the amount applied toward your out-of-pocket maximum in one tier will count toward your out-of-pocket maximum in another Tier.

The following expenses do not count toward your out-of-pocket maximum:

- Deductible
- Copayments

- Charges above the Allowable Charges covered by the Plan
- Charges for services that are not Covered Services under the Plan such as a charge for a service listed as an exclusion
- Charges for services for which no Benefit is payable because the dollar or usage limit on that Benefit has been exceeded
- Prescription Drug benefits

Lifetime Maximum Benefit

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

Medical Necessity

The Plan only covers medically necessary healthcare services. See Section 10, Glossary of Terms for the definition of medically necessary.

Network Providers

When you go to a Tier 1 or Tier 2 network provider, the Plan pays benefits based on allowable charges that have been negotiated between the Plan and the provider. Network providers have agreed to accept the Plan's allowable charges as payment in full, which means they cannot "balance bill" you for amounts above this negotiated charge. You still must pay your portion of the allowable charges resulting from required copayments, deductibles, and coinsurance.

→ ***Please note that some services—such as preventive care, hearing tests, and allergy testing and treatment—are only covered if you go to a Tier 1 or Tier 2 network provider.***

Go to www.exclusivecare.com for information on network providers.

Out-of-Network Providers

These providers have not been contracted by Exclusive Care to accept the Plan's allowable charges as payment in full. If you seek care from an out-of-network provider, your Benefits will be based on what the Plan has determined is the allowable charge for your provider. You are responsible for paying the difference between the allowable charges covered by the Plan and the out-of-network provider's charges in addition to your portion of the allowable charges resulting from required copayments, deductibles and coinsurance.

→ ***Refers to Tier 3 services received by a Member from a provider who is not a participating provider in the Tier 1 or Tier 2 networks.***

YOUR PLAN MEMBERSHIP CARD

Once you are enrolled in the Plan, you will receive a membership card in the County of Riverside's Exclusive Care Health Plan. Please carry your membership card with you at all times. If your membership card is ever damaged, lost, or stolen, call Member Services immediately at (800) 962-1133 and a new card will be sent to you.

Keeping Your Membership Information Current

Exclusive Care 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, address, or phone number, please contact your employer group so your record may be updated.

SECTION 2: ELIGIBILITY

HEALTH PLAN ELIGIBILITY

You are eligible to enroll in the Plan if:

- You are a retiree or eligible dependent of a qualified public employer group that offers the Exclusive Care Select Plan; and
- You are not eligible for Medicare.

Eligibility requirements are established by your employer group and are detailed in the Group Retiree Healthcare Services Agreement signed by your Employer Group. Contact your employer group for the retiree and dependent eligibility requirements. Eligibility requirements for Riverside County Members are detailed in the County of Riverside Eligibility Document.

ELIGIBILITY AND ENTITLEMENT TO MEDICARE

If you are enrolled in the Exclusive Care Select Plan as a non-Medicare-eligible retiree and you later enroll in Medicare A or B, your coverage under the Plan will end at that time. Contact your employer group for benefit options.

Retirees and Dependents Who Do Not Qualify for Medicare

If you reach age 65 but are not entitled to Medicare coverage, you may continue your coverage under the Exclusive Care Select Plan for Non-Medicare-Eligible Retirees. Your benefits under the Plan will not change, but the premium you pay for coverage will increase. This rule applies to your covered dependents as well.

If you do not elect to continue your enrollment in the Plan at the post-age-65 premium, your coverage will end on the last day of the month in which you turn 65. Your dependents' coverage under the Plan will also end, and your dependents would be eligible to continue their coverage under COBRA.

TERMINATION OF BENEFITS AND RE-ENROLLMENT

A Member's coverage may be terminated if any of the following events occur:

- The Member becomes deceased;
- The Member ceases to be eligible for coverage based on the Plan Sponsor's rules of eligibility;
- The Member voluntarily cancels coverage;
- The Member fails to pay the required premium;

- The Member was never eligible for membership;
- The Member engages in fraud or deception;
- The Member permits misuse of identification card;
- The Member fails to cooperate with Exclusive Care's Third Party Lien and Non Duplication of Benefits Rights;
- The Member exceeds his/her life-time maximum benefits under the Plan.
- The Member may be terminated at the request of the employer group
- Gross misconduct by the member which causes 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 their 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 shall 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.

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 spouse's employment that would affect medical coverage or a significant change in spouse's employer-offered medical coverage;
- Loss of a dependent's eligibility under another plan; or
- Entitlement to Medicare.

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 the employer group of the status change; however, newborns or newly adopted dependents are covered as of the date of their birth or adoption contingent on 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 spouse or dependent child loses coverage for any of the following reasons, you may only cancel coverage for the affected spouse or dependent:
 - i) Your divorce, annulment or legal separation from your spouse; or
 - ii) The death of your spouse or your 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 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.

REINSTATEMENT

A Member may be reinstated under the following circumstances:

1. At the request of the employer group (along with payment of premiums)
2. Payment of premium in arrears by the member

The maximum reinstatement period is 60 days.

SECTION 3: BENEFITS

Exclusive Care Select Plan

Schedule of Benefits

As a Member of the Plan, you have the freedom to choose a provider from any tier of coverage. You make that choice at the time you need services. Each time you need services, you may obtain those services from a different tier of coverage. The choice is yours.



The Plan has no preexisting condition limitations. Therefore, there are no limitations, waiting periods or exclusions based upon a diagnosis or condition currently on record for you or your family Members as long as services are covered services.

CENTERS OF EXCELLENCE

Exclusive Care has partnered with Blue Shield of California to provide access to medical facilities that have demonstrated expertise in delivering quality healthcare. The Blue Distinction Centers for Specialty Care® use over 800 centers across the nation with expertise in cardiac care, complex and rare cancer treatments, transplant services and other highly specialized complex care programs. The designation is based on rigorous, evidence-based, objective selection criteria established in collaboration with expert physicians' and medical organizations' recommendations. Exclusive Care members with these special treatment needs will be evaluated through the prior authorization and other medical management programs by Exclusive Care and Blue Shield to improve the overall quality and delivery of healthcare, resulting in better overall health outcomes for members.

Call Exclusive Care Medical Management at (800) 962-1133 to receive information regarding Centers of Excellence.

Summary Table of Benefits	Tier 1	Tier 2	Tier 3
	Exclusive Care Provider Network	National Provider Network	Out-of-Network Providers
Calendar Year Deductible	\$250/person \$750/family	\$500/person \$1,500/family	\$1,000/person \$3,000/family
Calendar Year Out-of-Pocket Maximum	\$1,500/person \$4,500/family	\$2,500/person \$7,500/family	\$5,000/person \$15,000/family
Maximum Lifetime Benefit	\$1,000,000 per person		
Prescription Drug Benefits			
Prescription Drug Coverage is provided through The Plan's Pharmacy Benefit Manager (PBM).			
Participating Retail pharmacy (up to a 30-day supply)	Generic drugs: \$15 copayment Brand name drugs (Preferred): \$25 copayment Brand name drugs (Non-Preferred): \$40 copayment <ul style="list-style-type: none">• Significant or new therapeutic class drugs: 50% copayment• Additional Benefits for members with diabetes are described in the section below		
If you use Exclusive Care's Rubidoux Pharmacy you can receive up to 3 months (90 days) of medication for 2 copayments			

Summary Table of Benefits	Tier 1	Tier 2	Tier 3
	Exclusive Care Provider Network	National Provider Network	Out-of-Network Providers
Exclusive Care's Rubidoux pharmacy (up to a 90-day supply) 	Generic drugs: \$30 copayment Brand name drugs (Preferred): \$50 copayment Brand name drugs (Non-Preferred): \$80 copayment <ul style="list-style-type: none"> Significant or new therapeutic class drugs: 50% copayment Additional Benefits for members with diabetes are described in the section below 		
Exclusive Care Rubidoux Mail-Order pharmacy (up to a 90-day supply) 	Generic drugs: \$30 copayment Brand name drugs (Preferred): \$50 copayment Brand name drugs (Non-Preferred): \$80 copayment <ul style="list-style-type: none"> Significant or new therapeutic class drugs: 50% copayment Mail-order is MANDATORY for maintenance medications after the first 30-day prescription trial. Additional Benefits for members with diabetes are described in the section below 		
Members with Diabetes	Pharmacy copays are waived for all Generic and Brand Name Preferred injectible and oral anti-diabetic medications and diabetic supplies (testing strips, syringes, etc)		
Hospital/Facility Benefits			
Inpatient Medical/ Maternity/Surgical Intensive Care (semi-private room)	Subject to prior authorization.		
	90% of network contracted rate	80% of network contracted rate	60% of Allowable Charges
Inpatient Medical/ Maternity/Surgical Intensive Care (ancillary)	Subject to prior authorization.		
	90% of network contracted rate	80% of network contracted rate	60% of Allowable Charges
Transplants / Orthopedic / Cardio Vascular / Oncology	Subject to prior authorization. See Centers of Excellence section for details.		
	90% of network contracted rate	80% of network contracted rate	60% of Allowable Charges
Skilled Nursing Facility ➤ Maximum of 100 days per year	Subject to prior authorization.		
	90% of network contracted rate	80% of network contracted rate	60% of Allowable Charges
Outpatient Medical/Surgical	Subject to prior authorization.		

Summary Table of Benefits	Tier 1	Tier 2	Tier 3
	Exclusive Care Provider Network	National Provider Network	Out-of-Network Providers
Care	90% of network contracted rate	80% of network contracted rate	60% of Allowable Charges
Physician & Professional Services			
Physician Office Visits (Primary Care)	\$10 copayment; Deductible does not apply	\$25 copayment; Deductible does not apply	60% of Allowable Charges
Physician Office Visits (After Hours)	\$20 copayment; Deductible does not apply	\$50 copayment; Deductible does not apply	60% of Allowable Charges
Physician Office Visits (Specialty Care)	\$20 copayment; Deductible does not apply	\$50 copayment; Deductible does not apply	60% of Allowable Charges
Inpatient Physician Visits	\$10 copayment; Deductible does not apply	\$25 copayment; Deductible does not apply	60% of Allowable Charges
Outpatient Physician Visits (including emergency room)	\$10 copayment; Deductible does not apply	\$25 copayment; Deductible does not apply	60% of Allowable Charges
Maternity Care	90% of network contracted rate	80% of network contracted rate	60% of Allowable Charges
Anesthesiology – inpatient and outpatient	90% of network contracted rate	80% of network contracted rate	60% of Allowable Charges
Immunizations and Injections – Office	\$10 copayment; Deductible does not apply	\$25 copayment; Deductible does not apply	60% of Allowable Charges
Allergy Testing	90% of network contracted rate	80% of network contracted rate	Not covered
Allergy Treatment/Serum	90% of network contracted rate	80% of network contracted rate	Not covered
Family Planning – tubal ligation, elective abortion, vasectomy	90% of network contracted rate	80% of network contracted rate	Not covered
Infertility Treatment	Not covered		
Surgical Procedures	Subject to prior authorization.		
Office	90% of network contracted rate	80% of network contracted rate	60% of Allowable Charges
Inpatient	90% of network contracted rate	80% of network contracted rate	60% of Allowable Charges

Summary Table of Benefits	Tier 1	Tier 2	Tier 3
	Exclusive Care Provider Network	National Provider Network	Out-of-Network Providers
Outpatient (including ER)	90% of network contracted rate	80% of network contracted rate	60% of Allowable Charges
Bariatric Surgery	Not covered	Not covered	Not covered
Other Medical Services			
Home Health Care (instead of inpatient hospital care) ➤ Maximum of 26 days per year	Subject to prior authorization.		
	90% of network contracted rate	80% of network contracted rate	60% of Allowable Charges
Hospice Care	Subject to prior authorization.		
	90% of network contracted rate	80% of network contracted rate	60% of Allowable Charges
Preventive Care Services			
Annual Physical Exams	\$10 copayment; Deductible does not apply	\$25 copayment; Deductible does not apply	Not covered
Well Baby	\$10 copayment; Deductible does not apply	\$25 copayment; Deductible does not apply	Not covered
Annual Well Woman Exams	\$10 copayment; Deductible does not apply	\$25 copayment; Deductible does not apply	Not covered
Annual Vision Exams	\$10 copayment; Deductible does not apply	\$25 copayment; Deductible does not apply	Not covered
Hearing Care Benefits			
Routine Hearing Exams	\$10 copayment; Deductible does not apply	\$25 copayment; Deductible does not apply	Not covered
Hearing Tests ➤ Benefit up to \$1,000 every five (5) years	90% of network contracted rate	80% of network contracted rate	Not covered
Hearing Aids ➤ Benefit up to \$1,000 every five (5) years	90% of network contracted rate	80% of network contracted rate	Not covered

Summary Table of Benefits	Tier 1	Tier 2	Tier 3
	Exclusive Care Provider Network	National Provider Network	Out-of-Network Providers
Accident & Emergency Benefits	Benefit payment for emergency admission subject to notification for authorization within 48 hours, next business day, or when medically possible, whichever is earliest.		
Emergency Room & Care ² See definition in Section 10 Glossary of Terms	\$50 copayment, then 90% of network contracted rate; Deductible does not apply.	\$100 copayment, then 80% of network contracted rate; Deductible does not apply.	\$100 copayment, then 80% of Allowable Charges; Deductible does not apply.
Urgent Care Clinic	\$20 copayment; Deductible does not apply.	\$50 copayment; Deductible does not apply.	60% of Allowable Charges; Deductible does not apply.
Ambulance – Land/Air (as medically necessary)	90% of network contracted rate	\$80% of network contracted rate	80% of Allowable Charges.
Dental Injury Treatment	Not covered	Not covered	Not covered
Orthodontic Injury Treatment	Not covered	Not covered	Not covered
Diagnostic Testing Benefits			
Major Diagnostic Testing, CT Scan, MRI, NMR	Subject to prior authorization.		
	90% of network contracted rate	80% of network contracted rate	60% of Allowable Charges
Minor Diagnostic Test, X-Ray or Lab Test	90% of network contracted rate	80% of network contracted rate	60% of Allowable Charges
Radiology/Pathology – inpatient, outpatient or ER	90% of network contracted rate	80% of network contracted rate	60% of Allowable Charges
Rehabilitation Therapy Benefits			
Physical, Speech, Occupational Therapy – Inpatient or Outpatient (Maximum calendar year benefit of 20 visits per year)	Subject to prior authorization.		
	90% of network contracted rate	80% of network contracted rate	60% of Allowable Charges
Cardiac, or Pulmonary Therapy – Inpatient or Outpatient	Subject to prior authorization.		
	90% of network contracted rate	80% of network contracted rate	60% of Allowable Charges
Chiropractic Therapy	Not covered	Not covered	Not covered
Medical Supplies & Equipment			

Medical Supplies (physician's office)	90% of network contracted rate	80% of network contracted rate	60% of Allowable Charges
Other Medical Supplies	90% of network contracted rate	80% of network contracted rate	60% of Allowable Charges
Durable Medical Equipment ➤ Maximum calendar year benefit of \$1,000 per person	90% of network contracted rate	80% of network contracted rate	60% of Allowable Charges
Orthotic Supplies	Not covered	Not covered	Not covered
Mental Health	Subject to prior authorization.		
Inpatient Facility Care (semi-private room)	90% of network contracted rate	80% of network contracted rate	60% of Allowable Charges
Inpatient Facility Care (ancillary)	90% of network contracted rate	80% of network contracted rate	60% of Allowable Charges
Inpatient Facility Physician Visits	90% of network contracted rate	80% of network contracted rate	60% of Allowable Charges
Outpatient Office Visits (psychologist, psychiatrist, MSCW, and APRN)	\$20 copayment		60% of Allowable Charges
Substance Abuse	Subject to prior authorization.		
Inpatient Program	90% of network contracted rate	80% of network contracted rate	60% of Allowable Charges
Inpatient Detoxification	90% of network contracted rate	80% of network contracted rate	60% of Allowable Charges
Outpatient Hospital Services	\$20 copayment; limited to 30 visits per calendar year		60% of Allowable Charges
Outpatient Office Visits (psychologist, psychiatrist, MSCW, and APRN)	\$20 copayment		60% of Allowable Charges

Women's Health And Cancer Rights

Federal law requires the Plan to provide coverage for the following services to an individual receiving Plan benefits in connection with a mastectomy:

- Reconstruction of the breast on which the mastectomy has been performed
- Surgical reconstruction of the other breast to produce a symmetrical appearance
- Prosthesis and treatment of physical complications for all stages of mastectomy, including lymphedemas (swelling associated with the removal of lymph nodes)

The Plan must determine the manner of coverage in consultation with the attending physician and patient. Coverage for breast reconstruction and related services is subject to Deductibles, Copayments, and Coinsurance amounts that are consistent with those that apply to other Benefits under the Plan.

Prior Authorization

Centers of Excellence - Exclusive Care has partnered with Blue Shield of California to provide access to medical facilities that have demonstrated expertise in delivering quality healthcare. The Blue Distinction Centers for Specialty Care® use over 800 centers across the nation with expertise in cardiac care, complex and rare cancer treatments, transplant services and other highly specialized complex care programs. The designation is based on rigorous, evidence-based, objective selection criteria established in collaboration with expert physicians' and medical organizations' recommendations. Exclusive Care members with these special treatment needs will be evaluated through the prior authorization and other medical management programs by Exclusive Care and Blue Shield to improve the overall quality and delivery of healthcare, resulting in better overall health outcomes for members. The Exclusive Care Select plan will provide benefits at the Tier 1 level for all allowable charges approved under this program. Allowable charges obtained at non designated Centers will be reimbursed as an out of network provider. Call Exclusive Care Medical Management at (800) 962-1133 for information.

❖ **Major Diagnostic Testing** – Members must obtain prior authorization from Exclusive Care for Major diagnostic testing. Coverage amounts will be reduced by 50% for unauthorized medically necessary tests. Major diagnostic tests are all diagnostic tests including but not limited to: Magnetic Resonance Imaging (MRIs) (other than of the extremities), Positron Emission Tomography (PET) scans, and Nuclear Magnetic Resonance Spectroscopies (NMRs). The following diagnostic tests do NOT require prior authorization:

- Computed Tomography (CT) Scans
- Magnetic Resonance Imaging (MRIs) of the extremities
- Routine X-rays
- Ultrasounds
- Electrocardiograms (EKGs)
- Electroencephalography (EEGs)
- Intravenous Pyelograms (IVPs)
- Kidney-Ureter-Bladder studies (KUBs)
- Pulmonary function studies
- Upper Gastro Intestinal (GI) studies
- Barium enemas
- Diabetic annual eye exams
- Cardiac stress tests

- *Colonoscopies for Members age 50 years and older*
- *Annual mammograms for women age 40 and over, or mammograms as follow-up after abnormal results.*
- ❖ **Other Services Requiring Prior Authorization Include but are not limited to:**
 - Hospital Inpatient Services
 - Skilled Nursing Facility Services
 - Outpatient Surgical Care
 - Surgical Procedures
 - Home Health Care
 - Hospice Care
 - Physical, Speech, or Occupational Therapy
 - Cardiac or Pulmonary Therapy
 - Mental Health and Substance Abuse services (non-Emergency)

FOR SERVICES REQUIRING PRIOR AUTHORIZATION, THE PLAN WILL NOT PROVIDE ANY BENEFITS IF SUCH SERVICES ARE OBTAINED WITHOUT THE REQUIRED AUTHORIZATION.

MATERNITY CARE

Under Federal law, the Plan may not restrict Benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than forty-eight (48) hours following a normal vaginal delivery, or less than ninety-six (96) hours following a cesarean section, nor may the Plan require that a provider obtain authorization from the Plan for ordering a length of stay not in excess of the above time periods. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or newborn earlier than 48 hours or 96 hours as applicable.

THIRD-PARTY RECOVERY PROCESS AND MEMBER RESPONSIBILITIES

If you are injured through the actions of another and receive compensation for medical care from this party, you are required to reimburse the Plan for the reasonable value of medical services provided under the Plan. The amount of reimbursement shall not exceed the amount of compensation received from the third party.

- The Plan must provide written consent prior to the settlement of any claim or release of a third party from liability, if such a release would limit the Plan's right to reimbursement.
- The Plan reserves the right to initiate legal action against a Member who has settled a third-party claim that compromises the Plan's reimbursement rights.
- Members are required to cooperate in protecting the interest of the Plan by providing copies of all liens, assignments, or other documents. Failure to cooperate with the Plan in this regard could result in Membership termination.

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

If you receive benefits as a result of an automobile, accident or other liability coverage, you should not look to Exclusive Care to provide the same coverage. It is your responsibility to take appropriate action in order to receive benefits under liability forms of coverage.

Non-Duplication of Benefits (with other Group Health Coverage)

- Benefits for Non-Medicare eligible members. The Plan medical benefits are intended to provide benefits up to the plan reimbursement level when combined with benefit payments you receive from other group health coverages you or your eligible dependents may have. This is known as non-duplication of benefits. If you have other group health coverages for your eligible dependents, the non-duplication of benefits provision may result in reduced benefits payable under the Plan. If the Plan is the secondary plan and another plan covering you or a eligible dependent is the primary plan, it is possible that the Plan will not pay any benefits if the primary plan's benefits are equal to or better than the Plan's. The goal of non-duplication of benefits 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 coverages you may have, you must inform the Plan of any other health coverage for which you or your eligible dependents may be eligible.
- If the Plan pays more benefits than appropriate, the Plan may recover excess benefit 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 claimant as an active employee will be determined before the benefits of a plan which covers the claimant as a non-active enrollee (i.e., a retired or laid off employee, a COBRA enrollee, 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 claimant 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 a year are determined before those of the plan of the parent whose birthday falls later in the year, but:
- 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.

- However, when the claimant is a dependent child whose father and mother are legally separated or divorced:
- The benefits of the plan which covers the claimant 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 expenses 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; and
- 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 which has covered the claimant for the longer period of time are determined before those of the plan which has covered that person for the shorter period of time.
- When this provision operates to reduce the total benefit otherwise payable to a person covered under this Health 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 Health Plan.

Qualified Medical Child Support Orders

A Qualified Medical Child Support Order (QMCSO) is a state court or administrative agency order that requires an employer's medical plan to provide benefits to the child of an employee who is covered, or eligible for coverage, under an employer's plan.

QMCSOs should be sent to the employer group. When the employer group receives a QMCSO, it must promptly notify you and the child that the order has been received and what procedures it will use to determine if the order is "qualified." To be considered qualified, a medical child support order must include the following:

- Name and last known address of the parent who is covered under the Plan;
- Name and last known address of each child to be covered under the Plan;
- Type of coverage to be provided to each child; and
- Period of time the coverage is to be provided.

If the employer group determines the order is qualified, you may be required to provide coverage for your child pursuant to the QMCSO. The Employer Group will notify you once it determines whether or not the order is qualified. As a beneficiary covered under the Plan, your child will be entitled to information that the Plan provides to other beneficiaries under ERISA's reporting and disclosure rules.

Workers' Compensation

The Plan will not duplicate benefits that you are entitled to receive under the Workers' Compensation program.

- You are expected to pursue reimbursement for medical expenses under Workers' Compensation Laws, when reimbursement can be reasonably expected under this program.
- If the Plan pays for services reimbursable under Workers' Compensation, you are required to reimburse the Plan, at prevailing rates, immediately after receiving the monetary award, whether by settlement or judgment.
- When there is a dispute or a question of coverage between you and Workers' Compensation, the Plan will provide coverage for medical care until the dispute is resolved.
- When you receive a Workers' Compensation settlement that includes reimbursement for future medical costs, you may be liable for reimbursement to the Plan for any services paid on your behalf.

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 service, are determined by Exclusive Care's Medical Director or his or her designee based upon criteria established pursuant to the following guidelines.

Any drug, device, treatment, or procedure shall be deemed an experimental or investigational treatment if, as determined solely by Exclusive Care, any one or more of the following criteria are met:

- The drug, device, treatment, or procedure 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;
- The drug, device, treatment, or procedure is the subject of a current investigational new-drug or new-device application on file with the FDA;
- The drug, device, treatment, or procedure 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 (DHHS);
- The drug, device, treatment, or procedure 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;
- The drug, device, treatment, or procedure 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 DHHS;
- The predominant opinion among experts as expressed in the published authoritative literature is that usage of the drug, device, treatment, or procedure 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, or

effectiveness compared with conventional alternatives of the drug, device, treatment, or procedure; or

- The drug, device, treatment, or procedure 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 Exclusive Care in determining whether a particular treatment is experimental or Investigational 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 or 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, such as ECRU Health Technology Assessment Information Service, HAYES New Technology Summaries, or Agency for Health Care Policy and Research (AHCPR);
- Expert medical opinion; and
- Regulations and other official actions and publications issued by the FDA and DHHS.

A terminally ill Member may be entitled to an expedited hearing in cases in which a proposed treatment is denied as Experimental or Investigational. See the "Member Grievance Procedure" section for more information.

SECTION 4: MEDICAL EXCLUSIONS AND LIMITATIONS

GENERAL EXCLUSIONS

General exclusions are services NOT covered by the Plan. They apply to medical, outpatient prescription drug, and behavioral health benefits. The Plan will not authorize nor cover the following:

- Services not included in this Summary Plan Document.
- Services provided in a hospital emergency department that are not urgent care or emergency care as determined by the Plan.
- Services rendered prior to your Plan effective date or after Plan termination date.
- Services received that in the judgment of the Health Plan are not medically necessary or not required in accordance with professionally recognized standards of proven and effective medical practice recognized within the organized medical community..
- Services that are part of a treatment plan for non-covered services.

- Charges incurred while on active duty with military, naval or air force of any country or international organization.
- Services rendered in excess of benefit levels.
- Services not otherwise indicated as covered.
- Charges in excess of the Exclusive Care Allowable Charges.
- Services requiring prior authorization when not authorized by the Plan.
- Changes made that the member is not obligated to pay or for which the member would not have been billed had insurance coverage not existed

MEDICAL EXCLUSIONS

Medical exclusions are non-covered services that are your financial responsibility. Authorization requests for medical exclusions are not issued by the Plan, and claims for payment of medical exclusions rendered will be denied for payment. The Plan's medical exclusions are:

- Acupuncture, acupressure, or biofeedback
- Ambulance service (except when medically necessary or necessitated by a life threatening emergency)
- Alternative treatments such as aromatherapy, hypnotism, rolfing, massage therapy
- Chiropractic therapy
- Bariatric and gastric bypass surgery
- Bone marrow transplants when experimental or investigational
- Charges for all services related to the newborn of a non-spouse or non-domestic-partner dependent
- Services or supplies related to cosmetic surgery, (unless it is required as a result of an illness or injury sustained while covered under the Health Plans or to correct a functional defect resulting from a congenital abnormality or developmental anomaly), complications of cosmetic surgery or drugs prescribed for cosmetic purposes. Cosmetic or reconstructive surgery used 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. Includes all homemaker services, respite care, convalescent care or extended care not requiring skilled nursing.
- Dental appliances
- Dental services such as implants, braces, dental x-rays, jaw bone surgery or orthodontic treatment 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; and treatment, prevention or relief of pain for dysfunction of the temporomandibular joint or the muscles of mastication.

- Developmental disorders. Services that are primarily oriented towards treating a social, developmental or learning problem rather than a medical problem, including dyslexia, and behavioral modification therapy.
- Disabilities related to military services for which you are legally entitled to and have reasonable access to medical services.
- DNA Testing if not related to a specific medical diagnosis
- Drug testing for a non-medical diagnosis
- Replacement of lost 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 stockings, waterbeds, exercise equipment and swimming pools including home and car remodeling or 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).
- Eye Surgery to correct refractive error (such as, but not limited to radial keratotomy, refractive keratoplasty).
- Routine foot care, including, but not limited to, removal or reduction of corns and calluses, clipping of toenails, treatment for flat feet, fallen arches, and chronic foot strain, except as EXCLUSIVE CARE determines is medically necessary
- Gender reassignment consultation and/or surgery
- Home birth services
- Hypnotherapy, behavior training, sleep therapy, education programs
- Infertility diagnostic testing and treatment (including surgery)
- Any services or supplies furnished by a non-eligible institution, which is defined as other than a legally operated hospital, outpatient 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.
- Liposuction
- Non-medical self-care or self-help treatment for any illness or injury when not attended by a licensed physician, surgeon or health care professional.
- Nursing-Private Duty unless determined to be medically necessary and ordered by your Primary Care Provider and approved by the EXCLUSIVE CARE Medical Director.
- Nutritional Supplement Formulas such as Phenylketonuria (PKU) formula is limited to under age thirteen (13), or as medically necessary.
- Organ Donor Services such as Medical and hospital services and other costs of a donor or prospective donor when the recipient is not a covered member.
- Organ transplants that are not medically necessary and organ transplants considered experimental or investigational as defined herein.
- Orthodontic injury treatment

- Orthotic supplies (except for diabetics)
- 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-preventive purposes or for pre-marital and pre-adoption purposes.
- All treatment and service for pre-employment physicals or vocational rehabilitation.
- Services related to a non-spousal dependent's pregnancy are limited to prenatal care of the dependent. Charges for all services related to the birth/delivery of the dependent's newborn are excluded, including pediatric services.
- Private duty nursing
- Private rooms and personal/comfort items and 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
- 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. Also excluded are injuries or illnesses sustained while incarcerated in a municipal, state or Federal prison. Emergency care and urgently needed 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 EXCLUSIVE CARE with respect to covered services solely because such services were provided while the member was in a state hospital.
- Recreational, educational, or hypnotic therapy, and any related diagnostic testing except as provided as part of an otherwise covered Inpatient hospitalization
- Long term, maintenance, or chronic level rehabilitation services including physical, occupational and speech therapy provided on an inpatient or outpatient basis.
- Reversal of voluntary sterilization
- All medical expenses arising from treatment of physical/medical needs related to any suicide attempt or from any intentionally self-inflicted injury
- Procedures, services, medications and supplies related to sex transformations.
- Sexual dysfunctions or inadequacies unless pre-authorized by EXCLUSIVE CARE. Services and supplies furnished at facilities designated as a place for the aged, nursing home, or other non-covered facility
- Services deemed experimental or investigational and not documented as medically necessary
- Snoring corrective treatments
- Surrogate pregnancy
- Temporomandibular joint (TMJ) disorder

- Unlicensed services not supervised by a licensed professional
- Vision care: corrective lenses, frames, fittings, and measurements
- Vision correction surgery (including but not limited to radial keratotomy and refractive keratoplasty)
- Vitamins, minerals, nutritional supplements, or similar products
- Weight loss programs
- 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;

MEDICAL LIMITATIONS

Medical limitations provide partial benefits coverage in the event certain circumstances exist. Supplemental justification for care should be requested by a provider of service when requesting prior authorization or when a member is submitting a claim for reimbursement consideration.

Ambulance transportation via ground or air is a covered service when determined to be Medically Necessary as in the case of a life-threatening medical or psychiatric emergency.

Autologous blood processing, storage, and administration is covered for scheduled procedures where autologous blood donation is medically necessary.

Bone marrow transplantation is used to treat several medical conditions; some conditions have extensive statistical results outlining the effectiveness, while other conditions are in the experimental or investigational stages of determining effectiveness. Bone marrow transplants that are considered to be experimental or investigational are not a covered service.

Breast reconstructive surgery is covered for a member who has undergone a medically necessary mastectomy and who elects breast reconstruction after the mastectomy. Reconstructive surgery for the remaining breast in order to produce a symmetrical appearance is also covered, as are breast prostheses and treatment of physical conditions related to the mastectomy (including but not limited to lymphedema).

Circumstances beyond the Plan's control, such as the complete or partial destruction of a facility, extreme weather, disaster, epidemic, war, riot, civil insurrection, or similar causes that delay or make the rendering of care impractical, shall not be litigiously held against the Plan or its contracted providers.

Corrective appliances, durable medical equipment, and/or prosthetics that are used primarily for personal comfort and convenience are not covered and include but are not limited to:

- Electrical or cooling units
- Orthopedic mattresses
- Support chairs
- Blood pressure instruments

- Scales
- Elastic bandages
- Support stockings
- Waterbeds
- Exercise equipment
- Swimming pools
- Motorized scooters and/or wheelchairs
- Optional accessories
- Home or automobile remodeling/modification
- Bionics or myoelectronic prosthetics that are directly connected to nerves, muscles, or other tissue

Medically necessary and approved corrective appliances, durable medical equipment, and/or prosthetics are limited to what is deemed appropriate based on the Plan's policies and procedures.

Cosmetic surgery to correct a functional defect resulting from a congenital abnormality or development anomaly is covered, while cosmetic surgery desired to improve one's physical appearance or improve one's self-esteem without improving a functional impairment is not covered.

Diabetic foot care requiring the medically necessary removal or reduction of corns and calluses, clipping of toenails, and specialized footwear is a covered service. Routine foot care for non-diabetic members is not a covered benefit, nor is custom made footwear permanently attached to an orthopedic brace.

DNA testing related to a covered and specific medical diagnosis is a benefit, while DNA testing to determine paternity or the potential of illness or disease based on familial genetics is not a benefit.

Family planning services such as vasectomies, tubal ligations, contraceptive devices, oral contraceptives, implantable contraceptives, and the voluntary termination of pregnancy (up to 20 weeks gestation) are covered services only if provided by Tier 1 or Tier 2 network providers.

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

Immunizations or vaccinations given for the purpose of travel or vacation are not a covered benefit. Childhood immunizations are covered, as are adult immunizations, including Hepatitis B as required for a public employee's safety.

Nutritional supplements such as vitamins and minerals are not covered; however, prenatal vitamins are covered for pregnant women, as is medically necessary Phenylketonuria (PKU) formula for children up to age 13.

Organ transplantation considered to be experimental or investigational is not a covered service, nor is the required medical care of a living organ donor that is not a Plan member.

Physical examinations performed for preventive health maintenance purposes are covered, while physical examinations needed for the issuance of insurance, licensing, employment, school registration, summer camp, legal proceedings, travel, pre-marital, or pre-adoptive purposes are not covered.

Prenatal and Maternity care coverage includes physician care and hospital services from the determination of pregnancy through the birthing process. Normal vaginal and cesarean section delivery and any complications related to pregnancy or delivery are also covered services. The hospital length of stay will be no shorter than the legal minimums of 48 hours for normal vaginal deliveries and 96 hours for cesarean sections unless the mother, the Plan, and physician agree to an earlier discharge.

Reconstructive surgery related to an illness or injury sustained while covered by the Plan is a covered service.

Respite care is a rest period provided to a caregiver of a terminally ill (hospice) member. Care must be prior authorized by the Plan and must be provided in the most appropriate setting.

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. Implants are not covered.

Well-woman care includes annual pelvic examinations, Pap smears, and clinical breast examinations. Baseline mammograms are taken for women of average risk starting at age 40 and annually thereafter. Mammograms may be done earlier if clinically indicated.

SECTION 5: OUTPATIENT PRESCRIPTION DRUG PROGRAM

This portion of the SPD applies to all prescribed medications used on an outpatient basis. The Plan covers generic, preferred brand-name, and some non-preferred brand-name outpatient prescription drugs when ordered by a physician or licensed dentist. The Plan's prescription drug program is administered by Exclusive Care. The drug formulary is approved by Exclusive Care and may be modified at any time at Exclusive Care's sole discretion as long as drugs are available in all therapeutic classes. Exclusive Care covers Outpatient prescription drugs on the Navitus Formulary ("Drug Formulary" or "Formulary"), when ordered by a Participating Physician or licensed dentist.

The difference between copayment levels is based on whether a medication is generic or brand-name, preferred or non-preferred, and purchased at retail pharmacies or via mail-order. Copayments are the Member's financial responsibility and a copayment is charged each time a prescription is filled.

How to Use the Retail Pharmacy Prescription Drug Program

1. Call Exclusive Care Member Services at (800) 962-1133 to find the participating retail pharmacy nearest you, visit the Exclusive Care Web site at www.exclusivecare.com

for links to the online interactive pharmacy locator, or ask your local pharmacy if they belong to the Exclusive Care Pharmacy Benefit Manager network.

2. Give the written prescription to the pharmacy technician at a participating retail pharmacy, or let the pharmacy technician know that a prescription has been called in for you.
3. Show the pharmacy technician your drug benefit identification card.
4. Pay the lesser of your copayment or the retail cost of each prescription written for up to a 30-day supply. **If you utilize Exclusive Care's Rubidoux pharmacy, you can purchase a 3 month (90 day) supply of medications for only two (2) copayments.**
5. If you wish to obtain Generic maintenance medications at retail pharmacies which offer copayments 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 copayment 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) still must be purchased through Exclusive Care's mail order program below or in person at Exclusive Care's Rubidoux pharmacy.

How to Use the Mail Order Pharmacy Prescription Drug Program

Have your physician write you two prescriptions:

1. One 30-day prescription that can be filled at a retail pharmacy so you can begin taking the medication right away; and
2. One 90-day prescription for the mail-order service (two (2) copayments instead of three (3))
3. You will need a written prescription from your physician for *each* prescription you need filled using the mail-order service, even if a previous prescription is on file with one of the retail pharmacies. Ask the physician to indicate if you're allowed to have a **90-day** supply of the maintenance medication plus additional refills.
4. Complete a prescription mail-order envelope (found in your prescription drug packet).
5. Mail the order envelope containing the written prescription(s) and payment information (i.e., check, money order, credit/debit card number). Your medication will arrive at the address provided within 10-14 days of receipt of your order.

For additional information regarding the mail-order service, please contact Exclusive Care Member Services at (800) 962-1133.

Formulary Drugs

The Drug Formulary is a list of outpatient prescription drugs that will be covered by EXCLUSIVE CARE without pre-authorization when prescribed by an EXCLUSIVE CARE

Participating Physician or licensed dentist and 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 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 glaucoma, diabetes, high blood pressure, heart disease, and asthma.

- 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: Comparable generic drugs will be substituted for brand name drugs if available.
- Insulin, insulin syringes, blood glucose test strips, lancets, inhaler extender devices, epipens and anakits.
- Federal Legend oral contraceptives, prescription diaphragms.

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. 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 pre-authorized in the following instances:

- No Formulary alternative is appropriate and EXCLUSIVE CARE 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 to EXCLUSIVE CARE in the form of documents, records or clinical tests, which demonstrates that use of the requested non-Formulary drug over the Formulary drug is medically necessary, as determined by EXCLUSIVE CARE.

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: EXCLUSIVE CARE reserves the right to expand the prior 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.

Mandatory Generic Substitution

Because many brand-name drugs have lower-cost generic equivalents, all prescriptions are automatically filled with a generic drug when a generic equivalent is available unless the prescribing physician specifically orders otherwise. If a non-generic drug is purchased for any reason and there is a generic equivalent available, the Plan will only pay the cost of the generic drug and the member will be responsible for the non-generic copayment plus any additional difference in drug cost.

Maintenance Drug Dispensing

Maintenance drugs may be dispensed for up to a 30-day supply through EXCLUSIVE CARE'S Pharmacy Benefit Manager Participating Pharmacies, or for up to a 90-day supply through the Pharmacy Benefit Manager EXCLUSIVE CARE's 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 member copayment at an EXCLUSIVE CARE Participating Pharmacy, or a 90-day for the price of 60-day supply of these medications through the mail order service for two member copayments (saving you one copayment by using the mail order service).

Mail-order is MANDATORY for maintenance medications after the first 30-day prescription trial

copayment amount: It is your responsibility to pay the current copayment each time a prescription is filled.

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. 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 any difference in cost between the brand name drug and generic drug, plus your brand name drug copay.

OUTPATIENT PRESCRIPTION DRUG BENEFIT EXCLUSIONS AND LIMITATIONS

The outpatient prescription drug benefit exclusions and limitations are drugs, medications and/or related items which are not covered by the Plan or are limited in benefit. Those items which are exclusions are your financial responsibility:

- Drugs or medicines not on the Formulary, unless pre-authorized by EXCLUSIVE CARE. Pre-authorization must be obtained prior to medication being filled, no retro-authorizations;
- 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;
- All non-prescription (over-the-counter) contraceptive jellies, ointments, foams and devices;
- Medications 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 (except prenatal vitamins), fluoride supplements, health or beauty aids and anorexiant (i.e. diet pills), However, prescribed prenatal vitamins for pregnant women are covered, as are other prescribed vitamins for various medical conditions.;

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- Medication for which the cost is recoverable under any worker's compensation or occupational disease law, any state or government agency, or medication furnished by any other drug or medical service for which no charge is made to you;
- Immunizations - Vaccinations – for the purpose of travel/vacation.
- Medications limited to investigational use or medications prescribed for experimental or non-FDA approved indications, unless prescribed in a manner consistent with:
 1. A specific indication in Drug Information Specifications for the Health Care Professional, published by the United States Pharmacopoeia Convention;
 2. The American Hospital Formulary Services edition of Drug Information;
 3. Any other source which reflects community practice standards.
- Medications 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;
- Medications prescribed by non-participating physicians (except for prescriptions required as a result of an urgently needed service for an acute condition or prescribed by a licensed dentist);
- Smoking cessation products are limited to one (1) treatment course each calendar year when enrolled in a smoking cessation program;
- Injectable drugs (except as listed under covered benefits) or;
- All durable medical equipment that can be obtained without a prescription.

Some medications are covered by the Plan only for certain uses or only in certain quantities.

If you take a maintenance drug, you must obtain your drugs through Exclusive Care's mail-order service after your first 30-day trial. Many local retail pharmacies offer generic maintenance drugs at copayments lower than Exclusive Care's plan. If you choose to purchase at a local retail pharmacy please review Section 5 ordering information above.

Outpatient Prescription Drug Dispensing Limitations

Non-maintenance drugs are dispensed for up to a 30-day supply; prescriptions requiring greater quantities will be supplemented on a refill basis.

Prescriptions for maintenance drugs (up to 90 day supply) must be filled through Exclusive Care pharmacy's mail-order service. Exceptions may be made for generic maintenance drugs filled at some retail pharmacies. All other long-term brand name, non-Formulary or significant/new therapeutic class maintenance drugs must be refilled via Exclusive Care mail order or in person at Exclusive Care's Rubidoux pharmacy after the first 30-day prescription trial period.

SECTION 6: MENTAL HEALTH AND SUBSTANCE ABUSE

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MENTAL HEALTH & SUBSTANCE ABUSE SERVICES

Unless it is an emergency mental health condition, members must obtain authorization from Exclusive Care's Employee Assistance Service (EAS) prior to receiving clinically necessary mental health and substance abuse services. Non-emergency treatment or services that are not prior authorized by Exclusive Care will not be covered by this Plan.

The following clinically necessary mental health services are covered when authorized prior to service:

- Inpatient behavioral health services;
- Outpatient behavioral health services including partial day programs;
- Professional behavioral health services rendered by certified or licensed mental health professionals;
- Ambulance services related to emergency mental health needs; and
- Clinically necessary psychological testing

MENTAL HEALTH & SUBSTANCE ABUSE EXCLUSIONS

The Plan's behavioral health benefit is administered by Exclusive Care. Behavioral health exclusions are considered your financial responsibility and include the following:

- Academic or tutorial programs
- Behavioral health services that are payable under any state or governmental agency
- Behavioral health service rendered without prior approval and/or the determination of Clinical Necessity
- Behavioral health services provided at a non-licensed or non-certified facility
- Behavioral health services provided by an unlicensed and/or uncertified practitioner
- Behavioral health services rendered while on active military duty
- Treatment for food dependency or sexual addiction in the absence of a recognized psychiatric diagnosis as defined by the current DSM (Diagnostic and Statistical Manual of the American Psychiatric Association)
- Counseling for adoption, custody, family planning, or pregnancy in the absence of a psychiatric diagnosis as defined by the current DSM
- Counseling in preparation for or associated with a sex change operation
- Court-ordered services or services required as a condition of parole or probation
- Custodial or domiciliary care
- Dance, poetry, music or art therapy
- Evaluation or treatment for educational or professional training
- Evaluation or treatment for investigational purposes related to employment

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- Experimental or investigational behavioral health treatment
- Marriage and Family counseling
- Pastoral or spiritual counseling
- Services performed in connection with conditions not classified in the current DSM
- Services or supplies for the diagnosis or treatment of mental illness that, in the reasonable judgment of Exclusive Care, are not consistent with prevailing national standards of clinical practice for the treatment of such conditions
- Treatment designed to emotionally or behaviorally regress a patient
- Treatment of insomnia and other sleep disorders, dementia, neurological disorders and other disorders with a known physical basis
- Treatment of organic mental disorders associated with permanent brain dysfunction

MENTAL HEALTH & SUBSTANCE ABUSE LIMITATIONS

Private rooms and/or private duty nursing are not Covered Services unless determined as clinically necessary by Exclusive Care.

SECTION 7: PRIVACY

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

The following is the Exclusive Care “Notice of Privacy Practices” statement governing Exclusive Care’s use of members’ health information:.

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 our 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. 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:

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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 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 to agree or object, as required by state and federal law:

1. Exclusive Care may include your name, location in the 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.

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2. To individuals assisting with your treatment or payment.
3. To assist with disaster relief 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, we are 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.

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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. You understand 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

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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

Exclusive Care Plan P.O. Box 1508 Riverside, CA 92502 (800) 962-1133	★ County of Riverside Privacy Office ★ P.O. Box 1569 Riverside, CA 92502 (951) 955-1000	U.S Department of Health & Human Services Region IX Office of Civil Rights 50 United Nations Plaza, Room 322 San Francisco, CA 94102 TEL: (415) 437-8310 TDD: (415) 437-8311 FAX: (415) 437-8329
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Upon termination of Plan coverage, a “Certificate of Group Health Plan Coverage” is provided that shows a Member’s specific eligibility period. The Plan mails this certificate to the 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 Member Services at (800) 962-1133.

Release of Information

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The Health Insurance Portability and Accountability Act (HIPAA) includes a provision that grants individuals certain rights regarding the 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 and applicable law.

At the time of enrollment, each member agrees to authorize the Plan, or a designee, to have access to and use of his or 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 the 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 Member Services to request a release of information form.

SECTION 8: HEALTH PLAN INTERPRETATION AND ADMINISTRATION

The right of any member to receive benefits under the Plan shall be determined in accordance with the terms of the Plan as provided for in this SPD. The Plan Administrator has the complete and discretionary authority to determine all questions relating to the interpretation of ambiguous, unclear, or implied terms in this SPD, and to make any findings of fact or law needed to determine eligibility to participate in the Plan. The Plan Administrator also has the full responsibility and authority to take any and all actions not specifically described in this SPD that may be necessary or appropriate for the effective administration of the Plan.

All changes to benefits, participating providers, and services provided under the Plan will be ultimately determined by the County of Riverside's Board of Supervisors in conjunction with the Plan Administrator.

SECTION 9: MEMBER RIGHTS AND RESPONSIBILITIES

MEMBER RIGHTS

You and your 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 their health care.

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- Can refuse medical treatment.
- Will have the privacy of their 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 department.
- Can disenroll from the Plan.
- Can receive emergency care services.

MEMBER RESPONSIBILITIES

- Learn and ask questions about your health benefits. If you have questions about your benefits, call Member Services at (800) 962-1133.
- Give necessary information to your doctor or to the Plan so they are able to properly care for you.
- Be proactive in making decisions about your health care.
- Be on time and keep appointments. If you are unable to keep your appointment or running late, call your doctor's office as soon as possible.
- Show your Member ID card when getting medical care. Call Member Services if you need a new card.
- Call your doctor or pharmacy at least three days in advance before running out of medicine.
- Cooperate with your doctor and their staff and treat them with respect.
- Work with your doctor to make plans about your health care.
- Follow through with the plans and instructions you and your doctor have agreed upon.
- Call your doctor for routine or urgent health care.
- Understand the limitations and exclusions of the Plan.
- Make a good faith effort to pay any health care out-of-pocket expenses you may incur.

COBRA CONTINUATION RIGHTS

Under the terms of the Consolidated Omnibus Budget Reconciliation Act (COBRA), continued coverage is available to you, your covered spouse and your dependents should they 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.

Continued Coverage for Your Spouse. Your covered spouse has the right to continue medical coverage under this Plan for a limited period of time, if that coverage is otherwise lost (including if there is an increase in costs or reduction in coverage) under the Plan due to your divorce or legal separation.

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Continued Coverage for Your Dependent Child. If your dependent child is covered by the Plan, he or she has the right to continue coverage, for a limited period of time, if coverage under the Plan is otherwise lost (including if there is an increase in costs or reduction in coverage) under the Plan:

- Because of your divorce or legal separation, or
- Because he or she no longer qualifies as a dependent child under the Plan.

If your spouse or dependent children choose COBRA coverage, their benefits will be the same as the group coverage they had under the Plan prior to coverage termination. The COBRA participant pays the full cost of continuation coverage, plus any additional amounts permitted by law. If benefit levels and/or rates change for Plan members, COBRA participants will be subject to those same changes. COBRA coverage for each of the above qualifying events will continue for 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.”

Notice Requirement

If your spouse or children qualify for COBRA coverage, your covered spouse or children must notify the employer group or its designee. You should give this notice prior to the qualifying event, or as soon as possible thereafter (but not more than 30 days after the qualifying event). When the employer group or its designee receives notice, it must in turn notify your spouse and children (individually or jointly) of their right to elect COBRA coverage.

While on COBRA coverage, you may enroll newly acquired, adopted or newborn children into 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, your covered spouse or children must submit a completed COBRA election form to the 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 is 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.

COBRA coverage may be extended for up to an additional eleven (11) months if the covered individual is recognized by the Social Security Administration as disabled, but not yet Medicare eligible. This extension of COBRA coverage is available at a cost not to exceed 150% of the current group premium and may become effective after the initial 36 months of eligibility is exhausted.

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Canceling COBRA Coverage

If you, your spouse or your dependents choose COBRA, your coverage will be canceled in less than 36 months if the following situation occurs:

- 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, your spouse or children become covered under another group health plan. However you, your spouse or children may continue COBRA coverage if the other group health plan limits coverage for preexisting medical conditions that your spouse or children may have.
- You, your spouse or children become enrolled in Medicare.
- If the Plan terminates.

COBRA Coverage for You, Your Spouse, and Your Dependents: 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 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); however, the maximum COBRA coverage period will not expire due to Medicare entitlement.

If you have any questions about these laws, please contact your employer group or its designee. Also, if you have a change in marital status or address, please notify your employer group or its designee.

The employer group or its designee will provide the affected eligible person with COBRA information within thirty (30) days of the qualifying event.

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SECTION 10: APPEALS AND GRIEVANCE RESOLUTION POLICY AND PROCEDURES

Service Authorization and Claims Review Chart		
Type of Transaction	Steps to Take	
PRIOR AUTHORIZATION FOR URGENT HEALTH CARE SERVICES		
<p><i>Prior authorizations for conditions that could jeopardize life, health, or ability to regain maximum function, or would subject you to severe pain.</i></p>	Step 1:	The Plan has 72 hours after receiving your initial prior authorization request to notify you if your request is approved or denied.
	Step 2:	If denied, you have 180 days after receiving the authorization denial to appeal the Plan's decision.
	Step 3:	The Plan has 72 hours after receiving your appeal to notify you of its appeal decision.
<p><i>The reasonable layperson standard is used for these claims, except that if a physician determines the condition is urgent, the Plan must accept the physician's determination.</i></p>	IF YOUR PRIOR AUTHORIZATION REQUEST IS IMPROPERLY FILED OR INCOMPLETE	
	Step 1:	The Plan has 24 hours after receiving your initial prior authorization request to notify you that your prior authorization request is improper or incomplete.
	Step 2:	You have 48 hours after receiving notice from the Plan to correct or complete your prior authorization request.
	Step 3:	The Plan has 48 hours to notify you if your prior authorization request is approved or denied. The Plan must do so within the earlier of 48 hours of: Receiving your completed prior authorization request, or your deadline to complete the prior authorization request.
	Step 4:	If denied, you have 180 days after receiving the authorization denial to appeal the Plan's decision.
	Step 5:	The Plan has 72 hours after receiving your appeal to notify you of its appeal decision.
PRIOR AUTHORIZATION FOR HEALTH CARE SERVICES		
<p><i>Prior authorization requests for Benefits under this Plan where treatment must be authorized before it is</i></p>	Step 1:	The Plan has 15 days after receiving your initial prior authorization request to notify you if your request is approved or denied.
	Step 2:	You have 180 days after receiving the authorization denial to appeal the Plan's decision.

Service Authorization and Claims Review Chart		
Type of Transaction	Steps to Take	
<i>performed.</i>	Step 3:	The Plan has 30 days after receiving your appeal to notify you of the appeal decision.
	IF YOUR PRIOR AUTHORIZATION REQUEST IS IMPROPERLY FILED OR INCOMPLETE	
	Step 1:	As long as your prior authorization request is received by a person or organizational unit customarily responsible for handling prior authorizations, and that 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 5 days after receiving your initial prior authorization request to notify you that your request is improper or incomplete.
	Step 2:	The Plan has 15 days after receiving your prior authorization request to notify you of its decision to approve or deny the authorization. If the Plan needs more information and provides an extension notice during the initial 15-day period, it has 30 days after receiving the prior authorization request to notify you of its decision. (The time the Plan waits for requested additional information is not counted in totals.)
	Step 3:	You have 45 days after receiving the extension notice to provide additional information or complete the prior authorization request.
	Step 4:	If your authorization is denied, you have 180 days after receiving the authorization denial to appeal the Plan's decision.
	Step 5:	The Plan has 30 days after receiving your appeal to notify you of the appeal decision.
POST-SERVICE HEALTH CARE CLAIMS		
<i>Claims for Benefits where healthcare services have already been received by the Member.</i>	Step 1:	The Plan has 30 days after receiving your initial claim to notify you if your claim is denied.
	Step 2:	If your claim is denied, you have 180 days after receiving the claim denial to appeal the Plan's decision.

Service Authorization and Claims Review Chart	
Type of Transaction	Steps to Take
	Step 3: The Plan has 60 days after receiving your appeal to notify you of the appeal decision.
	IF THE PLAN NEEDS FURTHER INFORMATION OR AN EXTENSION
	Step 1: The Plan has 30 days 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 45 days 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.)
	Step 2: You have 45 days after receiving the extension notice to provide the requested additional information or complete your claim.
	Step 3: If your claim is denied, you have 180 days after receiving the claim denial to appeal the Plan's decision.
	Step 4: The Plan has 60 days after receiving your appeal to notify you of the appeal decision.

Authorization / Claim Denials. If your authorization request or claim for Benefits is wholly or partially denied, any notice of adverse benefit determination under the Plan will:

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

The authorization / claim denial notice will also:

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

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- For urgent care prior authorizations, the denial notice will include a description of the expedited review process applicable to such authorizations. This denial may be given orally, provided that a written or electronic notification is furnished to you no later than 3 days after the oral notification.

If you believe your authorization request or claim was denied in error, you may appeal this decision to the Plan. You have 180 days after receiving the claim 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 authorization or claim denial will take into account all new information, whether or not presented or available at the initial authorization or claim review, and will not be influenced by the initial decision.

A different person than the one who made the initial authorization or claim determination will conduct the appeal review and such person will not work under the original decision maker's authority. If your claim was denied on the grounds of medical judgment, the Plan will consult with a health professional with appropriate training and experience. This health care professional will not be the individual who was consulted during the initial determination or work under their authority.

If your claim involves urgent care, a request for an expedited appeal may be submitted orally or in writing and all necessary information shall be transmitted between the Plan and you by telephone, fax, or other similar method.

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

- The specific reasons for the appeal determination;
- A reference to the specific Plan provisions on which the determination was based;
- A statement that you are entitled to receive upon request, and without charge, reasonable access to or copies of all document, records, or other information relevant to the determination;
- A statement describing any 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 adverse determination (or a statement that such information will be provided free of charge upon request);
- If the denial is based on Medical Necessity or experimental treatment, an explanation of the scientific or clinical judgment for the determination, applying plain 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."

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The appeal determination notice may be provided in written or electronic form. Electronic notices will be provided in a form that complies with any applicable legal requirements.

In the event a claim for payment is denied, the appeal may be submitted within 90 days, along with written justification as to why you believe your claim should be approved for payment. The resubmission of a denied claim will be considered a formal grievance and handled as described below.

MEMBER SERVICES

Member Services Representatives shall answer all incoming Member calls and explain the Plan Benefits and applicable policies and procedures. Upon receiving a Member's complaint, the Member Services Representative will gather as many facts as possible and attempt to reach a resolution to the issue with the Member. If the complaint is something that can't be resolved through the clarification of Benefits or further education about the Plan, the Member Services Representative will inform the Member of their right to submit a Member Grievance Form for further consideration. The grievance must contain the facts surrounding the circumstances and must be submitted by the Member in written form to the Member Services Department listed on the Member Grievance Form.

ADMINISTRATIVE REVIEW COMMITTEE

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

The Physician Review Committee will respond to all written grievances related to clinical issues within the specified timeframes.

TIMELY DECISION ON EXPERIMENTAL OR INVESTIGATIONAL TREATMENT OF TERMINAL ILLNESS

When services requested for a terminally ill Member are denied as experimental or investigational, the Member may request further consideration by the Physician Review Committee. Exclusive Care 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. If the treating physician feels that waiting up to thirty (30) days for the next scheduled Physician Review Committee meeting would materially reduce the proposed effectiveness of the treatment or service in question, a Physician Review Committee meeting will be held within five (5) working days.

If the Exclusive Care Medical Director needs additional information to evaluate specific clinical issues related to treatment that may be considered experimental or investigational, a consultation will be obtained from an appropriately licensed health care provider that has the education, training, and relevant expertise pertinent in evaluating the clinical issues of a specific case.

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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 decide 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 this 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.

The Member shall have three (3) business days to rescind the waiver agreement unless the agreement has also been signed by the Member's attorney, in which case the waiver cannot be rescinded.

In cases of extreme hardship, Exclusive Care may assume all or part of a Member's share of the fees and expenses of the neutral arbitrator provided the Member has submitted a hardship application with the American Arbitration Association. The approval or denial of a hardship application shall be determined by the American Arbitration Association. Members 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 procedure 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

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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.

SECTION 11: GLOSSARY OF TERMS

When capitalized within this Summary Plan Document, the following terms will have the meanings shown below:

Access – The patient's ability to obtain appropriate, necessary medical care.

Activities of Daily Living – Grooming, dressing, eating, ambulating, and toileting.

Acute – A condition marked by a sudden onset or change of health status requiring prompt attention, which may include hospitalization, but which is of limited duration and not expected to last indefinitely.

Administrative Review Committee – An Exclusive Care committee that provides secondary review of a Member's denied claims for Benefits in accordance with the Member grievance process.

Allowable Charges – Reasonable and customary charges for expenses that are medically necessary and subject to all other terms of this Summary Plan Document. The allowed amount determined by the Plan to be payable for services rendered by out-of-network (Tier 3) providers is based on a fee schedule established by Exclusive Care which may be modified by Exclusive Care at any time at its sole discretion.

Ambulatory Surgery – Surgery performed on a non-hospitalized patient. The patient goes home the same day as the surgery.

Anesthesia – Substances used to remove the effects of pain. There are generally four (4) types of anesthesia: topical, local, general, and neuroleptic.

Ancillary Providers – Providers that provide skilled nursing home care, outpatient rehabilitation, and transportation, plus facility-based services such as ambulatory surgery, dialysis, laboratory, and diagnostic imaging.

Anniversary Date – The beginning of a member's coverage year.

Authorized Services – Treatment or procedures that will be covered by the Plan because the service has been approved by the Exclusive Care Medical Management Department.

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Autologous Blood Transfusion – A process allowing individuals to receive a transfusion of their 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.

Balance Billing – The process whereby a provider of service requests reimbursement from a Plan member in addition to copayments, deductibles, coinsurance and the amount that the Plan has paid.

Behavioral Health Services - Services rendered to Plan members for treatment of mental health and/or substance abuse disorders.

Beneficiary – A person eligible to receive benefits.

Benefit Package – The list of covered services provided by a health care coverage program.

Benefits – Covered services which a member is entitled to receive pursuant to the terms of this Summary Plan Document.

Biological – A biological product is any virus, therapeutic serum, toxin, antitoxin, vaccine, blood, blood component or derivative, allergenic product, or analogous product applicable to the prevention, treatment, or cure of diseases or injuries to humans. Biological products include bacterial and viral vaccines, human blood and plasma and their derivatives, and certain products produced by biotechnology, such as interferon and erythropoietin.

Brand Name Drug – 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 12:00 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.

Case Management – The process and technique to manage the care of specific health care needs in a way that is designed to achieve the optimum patient outcome in the most cost-effective manner.

Case Manager – A nurse, doctor, or professional who works with patients, providers, and insurers to arrange and coordinate all services to provide the patient with medically necessary, appropriate health care.

Catastrophic Case – Any medical condition for which the total cost of treatment exceeds levels expected by the health plan.

Centers of Excellence – Designated facilities providing service for certain specialty procedures and care. These facilities are characterized by exemplary outcome results in areas of specialty.

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Chronic Condition – An illness, injury, or condition of long duration with no predictable date of termination. The condition 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 that 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 current *Diagnostic and Statistical Manual of Mental Disorders (DSM)*, 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 practitioner, or other provider of service; and
- 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 therapist, nurse, or other licensed/certified health care professional with appropriate training and experience in mental health services or substance abuse services, who is under contract with the Plan to perform counseling or case management services, which include assessing psychological 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 – A percentage of the cost for most covered services that the member is required to pay under the provisions of this Plan.

Cosmetic – Any surgical procedure, service, drug, or supply designed to improve the appearance of an individual by alteration of a physical characteristic which is within the broad range of normal but which is considered unpleasing or unsightly.

Continuity of Care – The degree to which the care of a patient over time is provided and/or managed by the same provider.

Copayment – A cost-sharing arrangement in which a member pays a fixed amount to the provider as part of the payment for specific covered service under this Plan.

Covered Services – Benefits that a member is entitled to receive pursuant to the terms of this Summary Plan Document (SPD).

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Custodial Care – Care provided primarily for the maintenance of the patient or designed to provide room and board or meet the activities of daily living (which may include non-skilled levels of nursing care, and 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.

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

Deductible – The amount of eligible expense you must pay each year before the health plan will make payment for covered services.

Disability – A permanent or temporary condition, injury, or illness that renders an individual unable to perform fully as a consequence of physical or mental limitations.

- All injuries sustained in any one accident are considered one disability;
- All illnesses existing simultaneously that are due to the same or related causes will be considered one disability; and
- 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.

Day Treatment Center – A licensed, certified, and state-approved facility that provides behavioral health services on a full- or part-day basis pursuant to a written treatment plan authorized by the Exclusive Care's Medical Management Team.

Detoxification – A process whereby individuals are systematically withdrawn from addictive drugs, under the care of a physician, in an inpatient or outpatient setting. Detoxification is sometimes called a distinct treatment modality but is more appropriately considered a precursor of treatment, because it is designed to treat the acute physiological effects related to the discontinuation of drug use.

Detoxification is not designed to address the psychological, social, or behavioral problems associated with addiction and therefore does not typically produce lasting behavioral changes necessary for recovery.

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 of 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.

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DSM – 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 (DME) – 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.

EAS - The County of Riverside Employee Assistance Service.

Eligible Child – Dependent natural children, adopted children, foster children, grandchildren, and stepchildren under age 23 and who have never been married; any child, who is under age 23, 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 age 23 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 – Determined by each employer group and the signed group services agreement.

Eligible Retiree – A retiree of an employer group who is not eligible for the federally sponsored Medicare program.

Eligible Spouse – A legal spouse or domestic partner as defined by California law.

EOB (Explanation of Benefits) – A statement explaining how or why a claim was paid or denied.

Emergency Care – Care given for a medical condition that is manifested by acute symptoms of sufficient severity (including severe pain) such that a prudent lay person, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in one or more of the following conditions: placing the health of the individual or unborn child in serious jeopardy; serious impairment to bodily function; or serious dysfunction of any bodily organ or part.

Emergency Medical Condition – A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected by the member to result in: 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 disorder that manifests itself by acute symptoms of sufficient severity such that the absence of immediate mental health services could reasonably be expected to result in: 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.

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Emergent/Urgent 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 to relieve or eliminate the emergency condition or stabilize the member before transfer to a facility capable of handling higher levels of emergent care.

Employer Group – a qualified public employer group in the State of California participating in the Exclusive Care Select Plans for Retirees and has a valid, current Group Retiree Healthcare Services Agreement appropriately signed by both parties. A Group Retiree Healthcare Services Agreement is not required by the County of Riverside for its retirees as it operates the Exclusive Care Health Plan.

Enrollee – A person enrolled in a health plan.

Enrollment – The process of applying for and enrolling in a health plan.

Exclusion – A specific condition or circumstance for which benefits are not provided.

Exclusive Care Select Plan – The medical plan created by the County of Riverside as a health care alternative for retirees.

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 that 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.

Extended Care Facility – A health care facility offering skilled nursing care, rehabilitation, and convalescent services for patients who no longer need hospital care.

FDA – The Food and Drug Administration that is an agency of the federal government.

Generic Drugs – A generic drug contains a medication's basic chemical name and usually has a brand name drug equivalent. The FDA requires that generic drugs be available in 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 Care Professional – An individual who renders health care services to others within the scope of practice as defined by the regulatory body that oversees the clinical license they hold.

HIPAA (Health Insurance Portability and Accountability Act) of 1996 – Federal legislation that improves access to health insurance when changing jobs by restricting certain preexisting condition limitations and guaranteeing availability and reviewability of health insurance coverage for all employees regardless of claims experience or business size.

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Home Health Agencies – A Medicare-certified and state-licensed in-home provider of health related services, including but not limited to social services, skilled nursing and physical, occupational, and speech therapies.

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 that is registered with the American Hospital Association, accredited by the Joint Commission on Accreditation of Healthcare Organizations, and 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/or psychiatric or psychological care (as defined by Section 1250.2 of the Health and Safety Code).

Infertility – The presence of a demonstrated bodily malfunction recognized by a licensed medical doctor as a cause of infertility or because of a demonstrated bodily malfunction, e.g. the inability to conceive a pregnancy or to carry a pregnancy to a live birth after a year or more of regular sexual relations without contraception.

Inpatient – An individual confined to a bed in a hospital or skilled nursing facility who requires routine skilled or specialized hospital services.

Intensive Care Unit – A unit of a hospital especially designed and staffed to meet the specific needs of critically or seriously ill patients.

Limitation – A specific condition or circumstance for which partial coverage is provided.

Licensed Provider – An individual who is licensed to perform certain healthcare services and who is acting within the scope of his or her license; or, in the absence of licensing requirements, is certified by the appropriate regulatory agency or professional association.

Major Diagnostic Tests – Any diagnostic test except the following:

- *Computed Tomography (CT) Scans*
- *Magnetic Resonance Imaging (MRIs) of the extremities*
- *Routine X-rays*
- *Ultrasounds*

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- *Electrocardiograms (EKGs)*
- *Electroencephalography (EEGs)*
- *Intravenous Pyelograms (IVPs)*
- *Kidney-Ureter-Bladder studies (KUBs)*
- *Pulmonary function studies*
- *Upper Gastro Intestinal (GI) studies*
- *Barium enemas*
- *Diabetic annual eye exams*
- *Cardiac stress tests*
- *Colonoscopies for Members age 50 years and older*
- *Annual mammograms for women age 40 and over, or mammograms as follow-up after abnormal results.*

Major Diagnostic Tests include but are not limited to: *Magnetic Resonance Imaging (MRIs) (other than of the extremities); Positron Emission Tomography (PET) scans; and Nuclear Magnetic Resonance Spectroscopies (NMRs).*

Medical Director – An Exclusive Care designated physician responsible for the medical/clinical administration of the Plan.

Medical Group – A group of physicians, practicing together under a professional corporation, limited partnership, or association who have entered into a written agreement to provide Covered Services to plan Members at contracted fees.

Medically Necessary – Care that is required to be appropriate, necessary, safe, and effective for the treatment of illness or injury in accordance with accepted standards of professional medical practice. Medically Necessary care, as determined by the Plan, is:

- Consistent with the Plan's medical policy;
- Consistent with illness and injury symptoms or diagnosis;
- Not furnished primarily for the convenience of the patient, attending physician, or other health care provider; and
- Furnished at the most appropriate level that can be provided safely and effectively to the patient.

Medicare – The federal health program for people 65 years of age or older, some people under age 65 with disabilities, and people with End Stage Renal Disease (generally those with permanent kidney failure who need dialysis or a kidney transplant).

Medicare Assignment – The process where providers have entered into an agreement with Medicare to accept the Medicare Allowable Charges as payment in full for the services provided to persons enrolled in Medicare.

Medication – A medicinal substance.

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Member – A retiree of an employer group or his/her eligible dependent who has enrolled in the health plan.

Mental Health Disorder – A mental disorder diagnosed by a licensed and/or qualified clinician according to the criteria in the current DSM and limited to impairment of a member's mental, emotional, or behavioral functioning on a daily basis.

Mental Health Provider – A psychiatrist, licensed psychologist, licensed clinical social worker, licensed marriage, family therapist, or hospital or other facility duly licensed and qualified to provide mental health services under the law or jurisdiction in which treatment is received.

Mental Health Services – Psychotherapy, assessment, case management, or other services most commonly provided by a psychiatrist, psychologist, licensed clinical social worker, or marriage/family/child therapist, for diagnosis or treatment of mental, behavioral, or emotional disorders.

National Provider Network - A nationwide provider network that has contracted with Exclusive Care to provide covered services to Members across the country.

Newborn Care - Newborns who are born while the mother is covered under the Plan are also covered by the Plan for up to 30 days after birth. These newborns will be identified using the mother's member ID. Newborn dependent coverage will only be extended beyond the first 30 days after birth if the child is enrolled in the plan as a dependent within the first 30 days after birth.

Non Duplication of Benefits – A group health insurance policy provision designed to eliminate duplicate payments and provide the sequence in which coverage will apply (primary and secondary) when a person is insured under two health plans.

Non-Preferred (or Non-Formulary) Drugs – Outpatient generic and brand name prescription drugs that are not included on the pharmacy vendor's Preferred Drug List. These drugs are covered under the Plan but require a higher member copayment. Most non-preferred drugs have a more cost effective alternative on the Preferred Drug List.

Occupational Therapy – Treatment by a licensed health professional who is trained to evaluate patients with joint conditions or injuries to determine the impact on their activities of daily living. Under the direction of a physician, a certified occupational therapist teaches patients adaptive daily living skills that maintain and/or improve a patient's ability to function.

Out-of-Network – Refers to Tier 3 services received by a Member from a provider who is not a participating provider in the Tier 1 or Tier 2 networks.

Outpatient – Services rendered on a non-inpatient basis at a doctor's office, clinic, home, day surgery center or other healthcare facility.

Partial Day for Mental Health – A short term treatment program that provides daily group, individual therapy and crisis intervention utilizing short term treatment methods and intensive medication management.

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Participating Pharmacy – A local retail pharmacy that has an agreement with Exclusive Care’s Pharmacy Benefit Manager to dispense drugs to persons covered under the Plan while the agreement remains in effect.

Participating Providers – Any provider that has an agreement with Exclusive Care (Tier 1) or the National Provider Network, (Tier 2) to provide covered services to Members. These providers may include but are not limited to hospitals, physicians, pharmacies, residential treatment facilities, day treatment facilities, and ancillary providers.

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 rendered under the direction of a physician and provided by a registered physical therapist, certified occupational therapist, or licensed physician of podiatric medicine. Physical therapy utilizes 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 prior authorization or claim denial based on a medical determination in accordance with the member grievance procedure process.

Plan – The benefit plan described in this Summary Plan Document.

Preferred Drug List (also known as a Formulary)– The outpatient prescription drug listing, designed to meet members’ prescription drug needs, which includes generic and brand name drugs approved for coverage by the Plan. The objective of the list of preferred drugs is to improve the quality of patient care by promoting high quality, cost effective prescribing and dispensing of prescription drugs.

Preexisting Condition – A physical and/or mental condition of an insured person that existed prior to the issuance of his or her policy.

Premium – A predetermined monthly fee that is paid to the Plan for health care benefits.

Prescription Drugs – A prescription drug is a drug, biological, or compounded prescription which, by federal law, may be dispensed only by a prescription and is required to be labeled “Caution: Federal Law prohibits dispensing without prescription.”

Preventive Care – Comprehensive care emphasizing priorities for prevention, early detection, and early treatment of conditions, generally including routine physical examinations, immunizations and well person care.

Prior Authorization – The process of obtaining approval for a service before the service is provided.

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Psychiatric Admission – The scheduled and unscheduled admission of a Member to a contracted facility for care and treatment determined to be clinically necessary to relieve or eliminate a condition due to a mental health disorder that manifests itself by acute symptoms.

Public Facility Care – Care for conditions for which state or local law requires care to be rendered.

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

Reasonable and Customary Charges – For Exclusive Care (Tier 1) or the National Provider Network, (Tier 2) services, the amount a Health Plan provider agrees to accept as payment from EXCLUSIVE CARE. For services by a non-network (Tier 3) provider, an allowed charge which is consistent with the going rate or charge in a certain geographical area for identical or similar services as determined by EXCLUSIVE CARE.

Reconstructive Surgery – Surgery that is medically necessary to restore an individual to normalcy by correcting deformities resulting from injury or disease.

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

Residential Treatment Center – A care facility that provides mental health services and also:

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

Residential Treatment Facility – An appropriately licensed, certified and/or state approved facility that provides substance abuse services in a residential setting on a full-time or partial day basis, pursuant to a written treatment plan approved by the Plan.

Respiratory Therapy – Treatment rendered 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 home-based caregiver.

Skilled Nursing Facility (SNF) – 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.

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Specialist – A duly licensed physician, osteopath, psychologist, or other practitioner (as defined by Medicare) who provides health care services for a specific disease or body part. Also, any duly licensed emergency room physician who provides emergency care services.

Speech Therapy – Treatment under the direction of a physician provided by a licensed speech pathologist or speech therapist, to improve or retrain a patient's vocal skills.

Standard Wheelchair – A fixed-arm wheelchair, with swing-away foot rests, that does not include any additional attachments and is not motorized, customized, or considered lightweight.

Substance Abuse Disorder – An addictive dependency or abuse of any drug (including alcohol) or chemical substance that can be documented according to the criteria contained in the DSM. Substance abuse does not include addiction to or dependency on tobacco or any food substance.

Summary Plan Document (SPD) – The written evidence of coverage furnished to Members of the Plan that provides details of benefits and covered services under the 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.

Tier 1 Network Providers – The hospitals, facilities, individual providers, and ancillary providers that have contracted with Exclusive Care to provide covered services to Plan members.

Tier 2 Network Providers – The hospitals, facilities, individual providers, and ancillary providers that have contracted with the National Provider Network to provide covered services to Plan members.

Tier 3 Providers – All other hospitals, facilities, individual providers, and ancillary providers that have not contracted with Exclusive Care, or the National Provider Networks to provide covered services to Plan members.

Treatment Plan – A plan of care established for a member and authorized by the Plan. Continuous covered care under a treatment plan is based on Plan eligibility and valid authorization.

Urgent Care – Medical care needed as the result of an unforeseen illness or injury whereby not receiving medical care could result in the serious deterioration of an individual's health.

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