

**SUBMITTAL TO THE BOARD OF SUPERVISORS
COUNTY OF RIVERSIDE, STATE OF CALIFORNIA**

482



FROM: Human Resources Department

SUBMITTAL DATE:
September 12, 2006

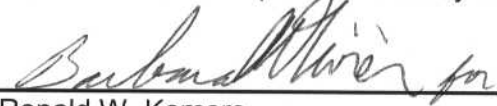
SUBJECT: Approval of the Summary Plan Document and Rates for the Exclusive Care Medicare Supplement Plan for Retirees

RECOMMENDED MOTION: That the Board of Supervisors:

1. Approve the Summary Plan Document for a revised Exclusive Care (EPO) Medicare Supplement Plan (Attachment A) to be offered to eligible County retirees effective January 1, 2007; and,
2. Approve the monthly rates as stated in Attachment B for calendar year 2007; and,
3. Authorize the Asst. County Executive Officer/Human Resources Director to modify the Summary Plan Document approved in #1 above to conform with periodic modifications approved by the federal government for the Medicare program.

Departmental Concurrence

Background: Riverside County provides a monthly contribution to Medicare eligible retirees to help offset the cost of health insurance. To receive this contribution, which ranges from \$25 to \$256 per month, the retired employees must enroll in one of the health benefit plans offered by the County.



 Ronald W. Komers
 Asst. County Executive Officer/Human Resources Dir.

FINANCIAL DATA	Current F.Y. Total Cost:	n/a	In Current Year Budget:	n/a
	Current F.Y. Net County Cost:	n/a	Budget Adjustment:	No
	Annual Net County Cost:	n/a	For Fiscal Year:	2006/07

SOURCE OF FUNDS: Payments of Medicare approved premiums to Medco for enrollment in Medco's Medicare Part D program will be made from premiums collected from individuals enrolled in the Exclusive Care Medicare Supplement Plan.	Positions To Be Deleted Per A-30	<input type="checkbox"/>
	Requires 4/5 Vote	<input type="checkbox"/>

C.E.O. RECOMMENDATION:

APPROVE

County Executive Office Signature



- Policy
- Consent
- Policy
- Consent

Dep't Recomm.:
Per Exec. Ofc.:

Prev. Agn. Ref.: _____ | District: _____ | Agenda Number: **3.34**

Background (continued):

For 2006 the health plans available to Medicare eligible retirees were: two Medicare "Risk" Plans, which replace Medicare with HMO type coverage: Kaiser Permanente Senior Advantage Plan and PacifiCare Secure Horizons Plan; and the Blue Shield PPO Plan which is a Medicare supplement plan. The Exclusive Care Medicare Supplement Plan will give Medicare retirees an additional health plan option for 2007.

In 1999, the Board of Supervisors established the County's self-funded Exclusive Provider Option (EPO) health plan, Exclusive Care, to provide a value health plan option to the employees of Riverside County and their families. In January 2004 Exclusive Care coverage was expanded to include retirees on Medicare covered under a Medicare Supplement Plan that provided coverage primarily for the Medicare copayments and deductibles as well as for prescription drugs. This plan was discontinued as of January 2006 due to the uncertainties surrounding the implementation of the Medicare Prescription Drug program (Medicare Part D).

With the Medicare Part D program now clarified, Exclusive Care would like to again offer a Medicare supplement plan. Medco, the prescription drug provider for all Exclusive Care participants, has agreed to include their Medicare approved prescription drug plan, YOURx Plan, as the prescription drug coverage for the Medicare Supplement Plan. Eligible persons who enroll in the Exclusive Care Medicare Supplement Plan will be automatically enrolled by Exclusive Care into Medco's Medicare Part D plan. If persons are already enrolled in a different Medicare Part D plan, their enrollment in Exclusive Care will change their Part D plan coverage.

Benefits of the Exclusive Care Medicare Supplement Plan are:

- Retirees will have an additional health plan option that will be particularly attractive to retirees out of state, as this plan is available nationally.
- Premium cost will be 18% less than the current Blue Shield PPO plan; premiums will be higher than the HMO Medicare Risk Plans which do not permit care outside the HMO network.
- Retirees do NOT assign their Medicare benefits which eliminates the need to stay within a network of HMO providers. Retirees may choose ANY provider.
- The Plan will pay eligible Medicare expenses. Retirees who choose Medicare providers will have little out of pocket expenses; retirees who choose non-Medicare providers will pay for all charges in excess of Medicare permitted charges.
- Similar to current medical plans, retirees will have their Medicare Part D benefits included in the health plan, eliminating the need to purchase a separate pharmacy plan.

A recent Employee Benefit Research Institute (EBRI), Issue Brief examined the cost of health insurance for current and future retirees. The EBRI study estimates that for retirees with access to employment-based retiree health benefits, to pay the full cost of premiums and out-of-pocket expenses for the rest of their lives, a couple aged 65 today will need \$295,000. The development and offering of the Exclusive Care Medicare Supplement Plan reflects the ongoing commitment of the Riverside County Human Resources Department to find approaches to providing County employees and retirees with comprehensive, cost-effective health care coverage that meets their needs.

By offering the Exclusive Care Medicare Supplement Plan to retirees, Riverside County will help to mitigate the increasing health care cost pressures faced by current and future retirees while continuing to provide comprehensive health benefits. Experience with the active employee population indicates that Exclusive Care provides the best value to employees in both rates and benefit coverage.

The 2007 premium rates for the Exclusive Care Medicare Supplement Plan as shown in Attachment A are submitted for approval by the Board as part of this action approving the Summary Plan Document. These rates were developed by underwriters at Aon, the County's employee benefits consultants.

If the Exclusive Care Medicare Supplement Plan is approved by the Board, information regarding the Plan will be provided to eligible retirees through the County's 2007 open enrollment process for Retirees. Eligible retirees will be allowed to enroll in the Plan at that time and in the event of qualifying circumstances as established by the County.

If approved, the Assistant CEO/Human Resource Director will periodically amend the Exclusive Care Supplement Plan Summary Plan Document as required to conform with rules and regulations promulgated by the federal government for the Medicare program. The Summary Plan Document will need to be amended at least annually to reflect new Medicare reimbursement rates and changes in coverage. Approval of this measure will allow for timely and expeditious updates. Information regarding the amended plan will be provided to eligible retirees through the subsequent open enrollment process for Retirees.

Exclusive
Care

**MEDICARE SUPPLEMENT
SUMMARY PLAN DOCUMENT**

for

**County of Riverside Medicare Eligible Retirees
(In-Area & Out-of-Area)**

January 2007

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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 Medicare Supplement Plan For Retirees ("Medicare Supplement Plan") is EXCLUSIVE CARE's health plan designed specifically by the County of Riverside ("County") for retired employees of Riverside County, and other public employer groups who want to provide coverage for their Medicare eligible retired employees and their eligible dependents.

This Summary Plan Document provides a detailed description of how the Health Plan works and the coverage provided. Detailed Benefit explanations are included along with an explanation of Member responsibilities.

The County of Riverside is pleased to provide this Health Plan for Eligible Employees and their Eligible Dependents. Should you have any questions about Benefits under this Health Plan, an EXCLUSIVE CARE Representative is available to assist you at:

EXCLUSIVE CARE Member Services Department
(800) 962-1133
8:00 a.m. - 5:00 p.m.
Monday through Friday

Our Plan Administrator is:
Ronald W. Komers
Assistant Chief Executive Officer, Human Resources Director
County of Riverside, Human Resources
4080 Lemon Street, 7th Floor
Riverside, CA 92502
(951) 955-3510

This Summary Plan Document will be the primary governing document for all Health Plan coverage decisions and will be the basis for final determination for the provision of benefits. It is the Health Plan's intent to comply with all laws and regulations that are applicable, whether or not specifically described in this Summary Plan Document.

Established in 1999, Exclusive Care is a self-funded County of Riverside Health Plan that operates under Section 1349.2 of the Knox Keene Act and is regulated by:

DEPARTMENT OF MANAGED HEALTH CARE
STATE OF CALIFORNIA
980 Ninth Street, Suite 500
Sacramento, CA 95814-2725
(888) 466-2219 Voice
(916) 229-0465 Facsimile
(877) 688-9891 TDD

The mailing address for all Exclusive Care departments is:

EXCLUSIVE CARE
P.O. Box 1508
Riverside, CA 92502-1508

PLAN INFORMATION
HOW TO USE THE MEDICARE SUPPLEMENT PLAN

Medicare Eligible Retirees and their Eligible Dependents living within or outside of the County of Riverside are eligible for the Medicare Supplement Plan. Under the Medicare Supplement Plan, you may receive Covered Services from any licensed provider; however, a **provider who accepts Medicare assignment will reduce Member out of pocket expenses.** Under this supplemental plan, Medicare is billed first for the total cost of the services. After Medicare pays, the Medicare Supplement Plan will pay the applicable amount of allowable charges for Covered Services, subject to any limitations, Co-pays or deductibles, as indicated in the "Summary of Covered Services". **If you are treated by a provider that does not accept Medicare assignment, you will be responsible for the difference between the Medicare approved amount and the billed charges.**

Members will receive an *Identification Card* that should be shown to the provider when health care services are rendered.

Who is eligible to enroll?

Retired County of Riverside employees **who are Medicare eligible and have enrolled in Medicare Part A and B.** The Eligible Dependents of Medicare Eligible County of Riverside Retirees are also eligible for this plan.

Choice of Physicians and Providers

This Plan is designed to supplement Medicare benefits. To ensure full coordination of benefits between Medicare and this Health Plan, it is best to select a provider who accepts Medicare assignment. ***SHOULD YOU CHOOSE TO SEEK SERVICES FROM A PROVIDER WHO DOES NOT ACCEPT MEDICARE ASSIGNMENT, YOU MAY BE HELD FINANCIALLY RESPONSIBLE BY THE PROVIDER FOR THE DIFFERENCE BETWEEN THE MEDICARE ALLOWABLE FEES AND THE PROVIDER'S USUAL AND CUSTOMARY CHARGES.***

Scheduling Appointments

Call any provider to schedule an appointment and remember that in order to receive the maximum benefit allowed by Medicare and this supplemental Health Plan you should select a provider who accepts Medicare assignment.

Scheduling Appointments

- For routine office visit appointments, call for an appointment at least 48 hours in advance.
- For health evaluation appointments, such as annual check-ups, call at least four weeks in advance. These appointments are scheduled based on availability.

- If more immediate attention is needed, call your selected provider and request the next available appointment or visit an urgent care clinic

Please be considerate of others by canceling appointments no longer desired so your time slot can be offered to someone else.

Second Medical Opinion

A Member or treating physician, may desire a second medical opinion. Second medical opinions can only be rendered by a physician qualified to review and treat the medical condition in question. If a second medical opinion is deemed to be not Medically Necessary or rendered by an unqualified physician, the claim for payment might be denied. An appeal can be filed by adhering to the procedures outlined in the "Member Grievance Procedure" section below.

For more information or assistance, please contact EXCLUSIVE CARE's Member Services Department.

Liability

Members may be liable for any sums owed to a provider who does not accept Medicare, for non-covered services, and/or for claims not submitted within 12 months from the date of service.

**MEDICARE SUPPLEMENTAL HEALTH PLAN INFORMATION
GENERAL PROVISIONS**

ELIGIBILITY

Exclusive Care Medicare Supplemental Health Plan Eligibility

If you eligible for and enrolled in Part A and Part B of Medicare and are a retired employee of the County of Riverside or a contracted employer group, you may enroll in the Medicare Supplemental Plan (if you reside inside of or outside of Riverside County).

Eligible Dependents

A legal spouse, domestic partner or qualifying child of a subscriber are considered Eligible Dependents subject to the following conditions:

- A Domestic Partner must sign, agree, and meet the requirements specified in the *Employers Declaration of Domestic Partnership* and a signed *Statement of Financial Liability* to the satisfaction of the County or contracted employer group must also be submitted.
- A child or children of a lawful spouse or Domestic Partner who are under the age of 23 ("limiting age") and have never been married may enroll in the Health Plan if they meet one of the eligibility requirements as set forth below:
 - i) They must be natural born, legally adopted (i.e. stepchildren), or placed in the home for purposes of foster care or adoption; or
 - ii) They must be children for whom you, or your lawful spouse or Domestic Partner are appointed a legal guardian by a court; or
 - iii) They must be children for whom you or your lawful spouse or Domestic Partner are required to provide health coverage pursuant to a qualified medical child support order ("QMCSO") or who resides with you (generally in the absence of the natural or adoptive parent) and who is economically dependent upon you; or
 - iv) They must be grandchildren who reside with you, generally in the absence of the natural or adoptive parent; and who are economically dependent upon you. A copy of the court-ordered custody must be on file.

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

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

Disabled Dependent Coverage

A child who is older than 23 years of age, who resides with either the Member or the Member's separated or divorced spouse, is incapable of self-sustaining employment by reason of mental handicap, debilitating chronic condition, or physical handicap that existed continuously prior to age 23 and who is dependent upon the Member for support

and maintenance, and who would otherwise be eligible to enroll as eligible child, except for the fact that they are older than the limiting age, may enroll or continue enrollment in Exclusive Care beyond the limiting age.

Proof of such incapacity needs to be provided to Exclusive Care within sixty (60) days of the onset of the disability, attainment of the limiting age, or during Open Enrollment Period.

Exclusive Care may require periodic proof of the dependent's incapacity and dependency after the initial notification. Such proof shall include a written statement by a licensed psychologist, psychiatrist, or other physician to the effect that such dependent is incapable of self-sustaining employment by reason of physical handicap, mental handicap or chronic condition.

It is the Member's responsibility to stay informed about eligibility, benefit elections and premium payments. Contact the subscriber's Employer for answer's to any questions that may arise.

Covered benefits for dependents who are not eligible for Medicare

Eligible Dependents enrolled in the Health Plan who are not eligible for Medicare will receive benefits as described in the EXCLUSIVE CARE EPO Plan Document or the EXCLUSIVE CARE Out of Area Plan Document as applicable. Copies of the appropriate Summary Plan Documents are available upon request by contacting EXCLUSIVE CARE Member Services.

REIMBURSEMENT PROVISIONS

In some circumstances Members may have to pay out-of-pocket for Covered Services. If a non-contracted provider requires up-front payment for authorized care, Exclusive Care will reimburse Member for Covered Service.

Bills for Covered Services must be submitted within 90 days from the date of service. Please submit the bill to:

**EXCLUSIVE CARE
ATTN: Claims Department
P.O. Box 1508
Riverside, CA 92502**

In the event a claim for payment is denied, the denial may be submitted within 90 days along with written justification as to why you feel your claim should be approved for payment. The resubmission of a denied claim will be considered a formal grievance and handled under the "Member Grievance Procedure" section described below.

MEMBER GRIEVANCE RESOLUTION POLICY & PROCEDURE

Exclusive Care has been especially designed to handle the health care needs of our Members by providing high quality, affordable health care coverage. If you have a question or concern, we'd like to know about it. We'll listen to your concern and make every effort to assist you. Simply contact the Member Services Department at (800) 962-1133, between 8:00 a.m. and 5:00 p.m. Monday through Friday, excluding county holidays.

If you have an issue that is not resolved to your satisfaction, you may initiate a formal grievance by following the outlined policy & procedure below:

Exclusive Care Grievance Policy

Member questions or concerns should be first voiced to the EXCLUSIVE CARE Member Services Department at (800) 962-1133. If the Member Services Department is unable to resolve the member's grievance, the member will be sent a Member Grievance Form and instructed to submit a written grievance.

Members are to submit all written grievances within thirty (30) days of the incident or unfavorable determination, after discussing their issue with a Member Services Representative.

Once the written grievance is received by Exclusive Care, an Acknowledgement Letter will be sent to the Member and Exclusive Care will have thirty (30) days from the receipt of the grievance to research the issue, meet to discuss the grievance and issue a determination to the Member.

If the Member is dissatisfied with the initial determination, the Member may request a secondary and final review by submitting an appeal within 30 days of receipt of the initial determination.

Exclusive Care Member Grievance Resolution Procedure

MEMBER SERVICES

Member Services Representatives shall answer all incoming Member calls and explain Exclusive Care benefits and applicable policies and procedures. Should the Member Services Representative receive a Member 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 should 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 or other non-clinical issues within the timeframes specified in the policy above.

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 doesn't feel qualified 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.

NEUTRAL BINDING ARBITRATION

Arbitration is an alternative method of resolving disputes in which two parties present their individual sides of a complaint to an arbitrator or panel of arbitrators. The arbitrator or panel of arbitrators, who has no bias to either side, then weighs the facts and arguments of both parties and decides the dispute.

BY ENROLLING IN EXCLUSIVE CARE, THE MEMBERS HAVE AGREED TO HAVE CERTAIN DISPUTES DECIDED BY NEUTRAL BINDING ARBITRATION. BOTH EXCLUSIVE CARE AND MEMBERS WAIVE THEIR RIGHT TO A JURY OR COURT TRIAL FOR THESE DISPUTES.

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.

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. Please refer to the "Important Phone Numbers" section of this document.

The California Department of Managed Health Care is responsible for regulating public agency self-funded health care service plans. If you have a grievance against Exclusive Care, you should contact Exclusive Care and use the Exclusive Care grievance process.

If you need the Department of Managed Health Care's help with a complaint involving an emergency grievance or with a grievance that has not been satisfactorily resolved by Exclusive Care, you may call the Department of Managed Health, toll free, at (888) 466-2219.

TERMINATION / CONTINUATION OF COVERAGE

Termination of Benefits and Re-Enrollment

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

- The member dies;
- A member ceases to be eligible for coverage based on the rules of eligibility; or
- The member voluntarily cancels coverage.

Plan coverage and eligibility for care 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 Health Plan terminates your coverage, the effective date of the coverage termination will be the date determined by the Health Plan.

If you are an Exclusive Care Member and your enrolled Eligible Dependent is moving to a geographical area outside the County for 90 consecutive days, you must contact Exclusive Care's Member Services Department at least 30 days prior to their move to change coverage to the Out-of-area Indemnity Plan. If you have questions regarding specific benefits provided under this Health Plan, please contact EXCLUSIVE CARE Member Services at (800) 962-1133.

MID-YEAR CHANGES

Health Plan coverage is effective for one full calendar year as long as the Member continues to satisfy the employer's eligibility requirements. 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 eligibility due to a dependent child reaching the age of 23 or the marriage of a dependent child;
- Eligible Dependent's entitlement to Medicare; or
- Relocation into or outside the Health Plan's service area

Coverage designation may be changed during the calendar year for any of the qualified status changes listed above. Employers must be notified in writing, usually within 60 days, of the qualified status change. Failure to notify your Employer in a timely manner may result in the inability to correct and/or refund premium deductions. Documentation substantiating the qualified change must accompany the paperwork required by your employer. Coverage for mid-year changes become effective the first day of the month following the status change; however, newborns are covered as of the date of their birth contingent on the completion of the enrollment paperwork.

During the Open Enrollment period, individuals have the option of changing Health Plan coverage for reasons not limited to those that are listed as qualified status changes.

EXTENSION OF BENEFITS

In the event that Exclusive Care ceases to operate, any Member confined to a Hospital or Nursing Home will continue to be covered through discharge. Upon discharge the member may be covered under the new Health Plan selected through his/her employer.

Continuation of Coverage

In order to comply with the Consolidated Omnibus Reconciliation Act of 1985 (COBRA), Exclusive Care includes continuation of coverage, which is available to certain covered persons whose health care coverage under Exclusive Care would terminate. This provision is intended to comply with that law, and if it is found to be incomplete or in conflict in any way with the law or changes to the law, the law will prevail.

COBRA the Consolidated Omnibus Reconciliation Act of 1985, as amended, allows employees and/or their dependents to continue group health benefits when there is a qualifying event that causes loss of coverage. Each COBRA-eligible employee and/or dependent has a right to choose or decline COBRA coverage.

An enrolled employee or eligible dependent may qualify for continuation of coverage for up to thirty-six (36) months from the date of the qualifying event if coverage is lost for one of the qualifying events listed in the table below:

Qualifying Event	Person Covered	Maximum Length of Coverage
<ul style="list-style-type: none"> • Employment ends or hours are reduced to a level below benefit eligibility 	Employee and/or eligible dependent	18 months*
<ul style="list-style-type: none"> • Employee becomes Medicare eligible • Divorce or legal separation • Death of covered employee 	Spouse and/or eligible dependent	36 months
<ul style="list-style-type: none"> • Loss of Dependent Child Status 	Dependent child	36 months

* An additional 18 months is available under Cal COBRA for employees and their dependent spouses and/or child(ren) whose coverage is lost due to the discontinuation of employment or the reduction of hours to such a degree that makes them ineligible for benefits.

The benefits under COBRA are identical to the Health Plan benefits offered at the time of the qualifying event and the cost of coverage, under the initial COBRA term, may not exceed the amount established by law.

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.

An Eligible Dependent is entitled to elect COBRA coverage provided an election is made within sixty (60) days of notification of eligibility and the premium is paid.

COBRA continuation of coverage will remain in effect for the time period specified above, or until one of the following events terminates the coverage:

- The premium is not paid on a timely basis;
- The enrollee becomes covered by another health plan; or
- The Employer no longer offers health plan coverage to its employees.

The affected Member is responsible for requesting information about COBRA continuation coverage within thirty (30) days of the qualifying event. It is the Member's obligation under the law to monitor when COBRA benefits expire.

Health Insurance Portability and Accountability Act (HIPAA)

All EXCLUSIVE CARE members are provided a "Notice of Privacy Practices" statement in their *New Member Packet* at the establishment of his or her eligibility and annually at the beginning of each year thereafter.

Upon termination of EXCLUSIVE CARE coverage, a "Certificate of Group Health Plan Coverage" is provided that shows a member's specific eligibility period. EXCLUSIVE CARE mails this certificate to the last known address noted in our Health Information System.

Additional information regarding the County of Riverside's Privacy Policy Statement is available through the County of Riverside Human Resources Department (Policy number B-23) and additional copies of Riverside County's Privacy Policy with respect to medical coverage may be obtained by contacting the Member Services Department at (800) 962-1133.

Release of Information

The Health Insurance Portability and Accountability Act (HIPAA) includes provisions 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 Protected Health Information. Each member's PHI will be used and disclosed only in accordance with the Employer's privacy policy and applicable law.

At the time of enrollment each Member agrees to authorize EXCLUSIVE CARE, 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.

Exclusive Care continually safeguards PHI. If it is the desire of a Member that Exclusive Care 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.

Special Extension Period for Senior COBRA

In the past, under California state law, if you are age 60 or over at the time of your termination of employment and you have worked for your Employer for at least the past five years, then the normal continuation period for you and your lawful spouse can be extended for an additional period of time. However, effective January 1, 2005, this extension is no longer available unless you have already begun senior COBRA or are currently on regular COBRA but would meet the criteria for senior COBRA before January 1, 2005.

The extension lasts until the earliest of (a) the date you attain age 65, (b) the date the Employer ceases to offer any group health plan, (c) the date you become covered under another group health plan, regardless of whether the coverage is less valuable than the extended coverage, (d) the date you become entitled to Medicare, or (e) for a spouse, five years from the date your employment ended. Of course, the extension is also contingent upon the timely submission of premium payments. Coverage of Eligible Children is not allowed.

To qualify for this extension, you and your spouse must both be covered at the end of the normal 36-month continuation coverage period. However, there is no requirement that you take the extension for your spouse to continue coverage.

In general, the premium charge for this special extension period is 213% of the current premium rate.

FUNDING OF BENEFITS

The Medicare Supplement Plan is self-insured and funded through contributions made by both Members and the County of Riverside. Benefits are paid from these contributions. The County of Riverside also has the option of establishing a trust to provide for the payment of employee benefits.

PAYMENT BY THIRD PARTIES

Third Party Recovery Process and Member Responsibilities

In the event a Member is injured through the actions of another (a third-party) and receives compensation for medical care, the Member is required to reimburse EXCLUSIVE CARE, or its nominee, for the reasonable value of medical services provided. The amount of reimbursement shall not exceed the amount of compensation received from the third party.

- EXCLUSIVE CARE 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 EXCLUSIVE CARE's right to reimbursement.
- EXCLUSIVE CARE reserves the right to initiate legal action against a Member who has settled a third party claim that compromises EXCLUSIVE CARE's reimbursement rights.

- Members are required to cooperate in protecting the interest of EXCLUSIVE CARE by providing EXCLUSIVE CARE with copies of all liens, assignments or other documents. Failure to cooperate with EXCLUSIVE CARE in this regard could result in membership termination.

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

Members receiving benefits as a result of an automobile accident or other liability coverage should not look to Exclusive Care to provide the same coverage. It is the Member's responsibility to take appropriate action in order to receive benefits under liability forms of coverage.

Coordination of Benefits

The goal of coordination of benefits is to maximize coverage for allowable expenses, minimize out-of-pocket costs, and to prevent payment duplication.

- EXCLUSIVE CARE coordinates benefits in accordance with the National Association of Insurance Commissioners' guidelines and California law.
- In order to ensure proper coordination of benefits, Members need to inform EXCLUSIVE CARE of all other health coverage for which they and/or their qualified dependents are eligible for.
- If EXCLUSIVE CARE makes an overpayment, EXCLUSIVE CARE may request a refund of that over payment from the Member, another Health Plan, or the entity that benefited from the overpayment.

Order of Benefit Determination

The benefit determination rules:

- The benefits of a Plan that covers a claimant directly as a Subscriber will be determined as primary before the benefits of a Plan which covers the claimant indirectly as a dependent.
- The benefits of a Plan that covers a claimant directly as an active employee will be determined as primary before the benefits of a Plan which covers the claimant as in-active employee (i.e. Retiree, laid off employee, COBRA payee etc.).
- A dependent child, whose parents are not legally separated or divorced, shall have his/her claims adjudicated first by the coverage of the parent whose birthday falls earliest in the year. If both parents have the same birthday, the benefits of the plan which has covered one of the parents the longest shall be determined primary.
- A dependent child, whose parents are legally separated or divorced, shall have his/her claims adjudicated by the plan of the parent that the court decree assigns financial responsibility for the health care expenses to. If healthcare expenses are not part of a court decree the Plan of the spouse of the parent with custody will be determined primary and the Plan of the parent not having custody of the child will be determined secondary.

If none of the above rules establish an order of benefits determination, the benefits of the Plan which has covered the claimant for the longest period of time will be deemed primary.

If the other Plan that provides coverage for a shared member does not agree on the order of benefit determination, the rule(s) of the other Plan will prevail.

When this provision is used 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 the reduced amount will be charged against any applicable Health Plan benefit limits.

Workers' Compensation

EXCLUSIVE CARE will not duplicate benefits that a Member is entitled to receive under the Workers' Compensation program.

- Members are expected to pursue reimbursement for medical expenses under Workers Compensation Laws, when reimbursement can be reasonably expected under that program.
- In the event EXCLUSIVE CARE pays for services reimbursable under Workers Compensation, the Member is required to reimburse EXCLUSIVE CARE, 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 a Member and Workers Compensation, EXCLUSIVE CARE will provide coverage for medical care until the dispute is resolved.
- When a Member receives a workers compensation settlement that includes reimbursement for future medical costs, the Member may be liable for reimbursement to EXCLUSIVE CARE for any services paid on the member's behalf.

HEALTH PLAN INTERPRETATION AND ADMINISTRATION

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

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

SCHEDULE OF COVERED SERVICES
Medicare Eligible Retirees and their Eligible Dependents

ALL SERVICES COVERED BY MEDICARE EXCEPT AS NOTED BELOW. MEDICARE COVERAGES, EXCLUSIONS, AND LIMITATIONS APPLY UNLESS OTHERWISE SPECIFICALLY NOTED.

<i>Benefit Provisions</i>	
COORDINATION WITH MEDICARE	Medicare is billed first and after Medicare pays Exclusive Care is billed for the difference. Exclusive Care will pay up to 20% of the Medicare Allowable rate for Covered Services, which should equate to 100% coverage when services are rendered by a Provider who accepts Medicare assignment.
DEDUCTIBLE - individual	Through the supplemental payments of claims Exclusive Care covers Members for the Medicare Part A and B deductibles and co-payments.
DEDUCTIBLE - family	None
PRE-EXISTING CONDITION LIMITATION	None
OUT-OF-POCKET MAXIMUM	None
LIFETIME MAXIMUM BENEFIT	\$1,000,000/Member
OFFICE VISIT BENEFITS	
Diagnostic X-ray and Lab Hospital visits Immunizations Physician Office Visits Maternity Care	Supplemental coverage after Medicare reimbursement up to 20% of Medicare Allowable.
Periodic Physical Evaluations Well Woman Care	Covered 100% by Exclusive Care (benefits are not covered under Medicare) not to exceed 100% of Medicare fee schedule.
Well Baby Care Vision Examinations	Not covered by the Exclusive Care. Not covered by the Exclusive Care.
PREGNANCY AND MATERNITY CARE	
Prenatal and Postnatal Care Normal Delivery, Cesarean Section Complications of Pregnancy and Medical Services Hospital and Other Related Services	Covered 100% by Exclusive Care (benefits are not covered under Medicare).

<i>Benefit Provisions</i>	
PRESCRIPTION DRUGS	
	Prescription Drug Coverage is provided through Medco's Medicare Part D approved Prescription Drug Plan offered under the name YOURx Plan. See the description of the YOURx Plan in the information provided by Medco for specific details of coverage.
HOSPITAL AND EMERGENCY ROOM BENEFITS	
Ambulance Service (As Medically Necessary)	Supplemental coverage after Medicare reimbursement up to 20% of Medicare Allowable.
Ambulatory Surgical Center	Supplemental coverage after Medicare reimbursement up to 20% of Medicare Allowable.
Inpatient Hospital	<p><u>Days 1 – 60:</u> Exclusive Care pays initial Part A annual Medicare deductible.</p> <p><u>Days 61 - 90:</u> Exclusive Care pays Medicare additional day deductible.</p> <p><u>Day 91 and after:</u></p> <ul style="list-style-type: none"> ▪ While using 60 lifetime reserve days: Exclusive Care pays additional day deductible. ▪ After 60 lifetime reserve days are used: <ul style="list-style-type: none"> □ 365 lifetime additional days: Plans pay 100% of Medicare eligible expenses. □ Beyond 365 lifetime additional days: No Plan Benefit. <p>Up to 365 days/ lifetime maximum</p>
Outpatient Hospital	Supplemental coverage after Medicare reimbursement up to 20% of Medicare Allowable.
Hospital Emergency Room	Supplemental coverage after Medicare reimbursement up to 20% of Medicare Allowable.
Urgent Care	Supplemental coverage after Medicare reimbursement up to 20% of Medicare Allowable.

<i>Benefit Provisions</i>	
MENTAL HEALTH	
Inpatient Benefits	<p><u>Days 1 – 60</u>: Exclusive Care pays initial Part A annual Medicare deductible.</p> <p><u>Days 61 - 90</u>: Exclusive Care pays Medicare additional day deductible.</p> <p><u>Days 91-150</u>: Exclusive Care pays Medicare additional day deductible.</p> <p><u>Days 151 – 190</u>: Exclusive Care pays 100% of Medicare eligible expenses.</p> <p>Up to 190 days/ lifetime max. (combined with Inpatient Substance Abuse Benefits.)</p>
Outpatient Benefits	<p>Up to 50% of Medicare approved amount.</p> <p>Maximum 30 visits/ calendar year.</p>
SUBSTANCE ABUSE	
Inpatient Benefits	<p><u>Day 1 – 60</u>: Exclusive Care pays initial Part A annual Medicare deductible.</p> <p><u>Day 61 - 90</u>: Exclusive Care pays Medicare additional day deductible</p> <p><u>Day 91-150</u>: Exclusive Care pays Medicare additional day deductible</p> <p><u>Day 151 – 190</u>: Exclusive Care pays 100% of Medicare eligible expenses.</p> <p>Up to 190 days/ lifetime max. (combined with Inpatient Mental Health Benefits.)</p>
Outpatient Benefits	<p>Up to 50% of Medicare approved amount.</p> <p>Maximum 30 visits/ calendar year.</p>
OTHER BENEFITS	
Allergy Testing & Treatment	Supplemental coverage after Medicare reimbursement up to 20% of Medicare Allowable.
Chiropractic	<p>Supplemental coverage after Medicare reimbursement up to 20% of Medicare Allowable.</p> <p>Maximum 20 visits/ calendar year.</p>
Durable Medical Equipment (As Medically Necessary)	Supplemental coverage after Medicare reimbursement up to 50% of Medicare Allowable.
Family Planning Voluntary Interruption of Pregnancy	<p>1st trimester - \$50 Member Co-payment / 2nd trimester - \$100 Member Co-payment.</p>

Benefit Provisions	
Tubal Ligation Vasectomy	Covered 100% by Exclusive Care (benefits are not covered under Medicare) not to exceed 100% of Medicare fee schedule.
Infertility Services, Testing, Drugs and Treatment	50% member Co-payment of \$10,000 lifetime maximum charges.
Home Health Care	Supplemental coverage after Medicare reimbursement up to 20% of Medicare Allowable Up to 20% of Medicare Allowable for injectable drugs to treat osteoporosis in women; all other services not covered.
Hospice and Respite Care	Up to 5% of Medicare approved amount for Inpatient care. Exclusive Care reimburses members for \$5 Medicare Co-payment for each Medicare approved drug.
Physical Therapy	Supplemental coverage after Medicare reimbursement up to 20% of Medicare Allowable
Skilled Nursing Facility (As Medically Necessary)	<u>Days 1 – 20:</u> Exclusive Care pays initial Part A annual Medicare deductible <u>Days 21 - 100:</u> Exclusive Care pays Medicare additional day deductible <u>Day 101 and beyond:</u> Not covered by Exclusive Care.
Hearing Aid Benefit Audiological Examination Hearing Aid Instrument	Covered 100% by Exclusive Care not to exceed 100% of Medicare fee schedule Up to \$1,000 per Member every 36 months.

OUTLINE OF COVERED BENEFITS

INPATIENT

Room & Board

- Acute
- Sub-acute
- Transitional Care
- Step-down
- Skilled
- Operating, recovery & special treatment rooms/units
- Residential Treatment Facility

Professional & Para-professional Services

- Physicians
- Physician Assistants
- Nurses
- Physical, Occupational & Speech Therapists
- Technicians
- Aides
- Medical & Licensed Clinical Social Workers
- Marriage Family & Child Counselors/Marriage & Family Therapist
- Psychologist
- Phlebotomist
- Other approved

Ancillary

- Laboratory
- Radiology
- Durable Medical Equipment
- Orthotics
- Prosthetics
- Implants
- Pharmacy (medication, anesthesia, drugs & biologicals)
- Pathology
- Blood Bank
- Hemodialysis
- Family Planning

OUTPATIENT

Primary Care Physician Office Visits

Consulting Specialist Office Visits

Clinic Visits

Home Health Visits

Testing, treatments, procedures, screenings, examinations, evaluations and/or periodic preventative care

Operating, recovery & special treatment rooms

Professional & Para-professional Services

- Physicians
- Physician Assistants
- Nurses
- Therapists
- Technicians
- Aides
- Chiropractors
- Audiologist
- Licensed Clinical Social Worker
- Marriage & Family Therapist
- Psychologist
- Medical Assistants
- Phlebotomist
- Other approved

Ancillary

- Laboratory
- Radiology
- Durable Medical Equipment
- Orthotics
- Prosthetics
- Hemodialysis
- Family Planning
- Hearing Aid
- Home Health Care
- Hospice Respite Care
- Ambulance Transportation
- Pathology
- Blood Bank

GENERAL EXCLUSIONS

General exclusions are applicable to medical, chiropractic, outpatient prescription drug and behavioral health benefits. Authorization requests for general exclusions are not issued by Exclusive Care and claims for payment of general exclusions rendered will be denied for payment. Exclusive Care's general exclusions are as follows:

- Services not included in this Summary Plan Document
- Services not covered by Medicare unless coverage is specifically stated in this SPD
- Services rendered prior to member's Plan effective date or after Plan termination date
- Services deemed, by the Health Plan, as not medically necessary based on professionally recognized standards of medical practice
- Services that are part of a treatment plan for non-covered services
- Services rendered while on active military duty
- Services rendered in excess of benefit level

Limitations

Circumstances beyond the control of Exclusive Care 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 Exclusive Care or their contracted providers.

GENERAL LIMITATIONS

General limitations outline partial insurance coverage in the event that certain circumstances exist and are applicable to medical, chiropractic, outpatient prescription drug and behavioral health benefits.

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 ("HHS");
- 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 the HHS;
- 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, effectiveness 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 e.g., ECRU Health Technology Assessment Information Service, HAYES New Technology Summaries or AHCPR (Agency for Health Care Policy and Research);
- Expert medical opinion; and
- Regulations and other official actions and publications issued by the FDA and HHS.

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

MEDICAL LIMITATIONS

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

Ambulance transportation via ground or air, is a covered benefit when deemed 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 in the experimental or investigational are not a covered benefit.

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 is breast prostheses and treatment of physical conditions related to the mastectomy including but not limited to lymphedema.

Circumstances beyond the control of Exclusive Care 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 Exclusive Care or their 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 Exclusive Care'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 benefit. Routine foot care for non-diabetic members is not a covered benefit, nor is custom made footwear permanently attached to an orthopedic brace.

Dental Care related to an accidental injury to the teeth is covered within six (6) months of the injury.

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.

An **emergent 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 a) placing the Member's health in serious jeopardy, b) serious impairment to bodily functions and/or c) serious dysfunction of any bodily organ or part.

Family Planning Services in addition to infertility and prenatal coverage, additional 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 also covered benefits.

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.

Infertility diagnostic testing and medically necessary procedures (including surgery) that are consistent with established medical practices in the treatment of infertility when authorized through a Member's PCP is covered up to the Plan limits.

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

Organ Transplantation considered to be experimental or investigational is not a covered benefit nor is the required medical care of a living organ donor that is not an Exclusive Care member.

Emergent or urgent care needed due to **participation in a criminal act** is covered until the member is stabilized and placed in police custody.

Physical Examinations performed for health maintenance preventative 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 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 benefits. 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, Health Plan and physician agree to an earlier discharge.

Reconstructive Surgery related to an illness or injury sustained while covered by Exclusive Care is a covered benefit.

Respite Care is a rest period provided to a caregiver of a terminally ill (Hospice) Member. Exclusive Care will authorize approved care 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.

Urgent 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 is a covered benefit.

Well-woman Care includes annual pelvic examinations, PAP smears and clinical breast examinations. Baseline mammograms are taken for women between the ages of 35 to 39 and annually after the age of 40 unless more frequent testing is recommended by the woman's physician.

MEDICAL EXCLUSIONS

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

- Acupuncture, Acupressure, Biofeedback
- Bariatric & Gastric Bypass Surgery
- Charges for all services related to the newborn of a non-spouse dependent
- Custodial or Domiciliary Care
- Chiropractic Care
- Dental Appliances
- Developmental Disorders
- Disabilities Connected to Military Services for which the member is legally entitled to and has reasonable access to
- Drug Testing for a non-medical diagnosis
- Private duty nursing
- Private rooms and personal/comfort items
- Public Facility treatment required by state or local law and rendered to an incarcerated individual
- Recreational, Educational or Hypnotic Therapy
- Reversal of voluntary sterilization
- Services & supplies furnished at facilities designated as a place for the aged, nursing home or other non-covered facility
- Sex Change Consultation and/or Surgery
- Surrogate Pregnancy
- Temporomandibular Joint (TMJ) Disorder
- Unlicensed services not supervised by a licensed professional
- Vision care - eye refraction examinations, corrective lenses, frames, fittings and measurements
- Vision Correction Surgery (including but not limited to radial keratotomy, refractive keratoplasty)
- Weight control programs

PRESCRIPTION DRUG COVERAGE

When signing up for the Exclusive Care Medicare Supplement Plan, Medicare Eligible Retirees are automatically enrolled in Medco's Medicare Part D approved Prescription Drug Plan offered nationally in 34 Medicare regions under the name YOURx Plan. Medco will provide enrollees with specific information describing the coverage and the procedures for obtaining services under the YOURx Plan. Information may also be obtained from the following sources:

Visiting the Medco website at: <http://yourxplan.com>

or

Calling Medco at: 1-800-758-3605

TTY/TDD users call: 1-800-716-3231

Customer Service Hours are:

8:00 a.m. to 8:00 p.m., EST, Monday through Friday; and

8:00 a.m. to 6:00 p.m., EST, Saturday

Except Thanksgiving and Christmas

or

Writing Medco at: YOURx Plan

Medco Health Solutions, Inc.

Atten: Service Grievance Resolution Team

P.O. Box 639405

Irving, TX 75063

Additional information may also be obtained from Medicare by:

Visiting the Medicare website at: www.medicare.gov

or

Calling Medicare at: 1-800-Medicare (1-800-633-4227)

TTY/TDD users call: 1-877-486-2048

The premiums for the YOURx Plan are included in the premiums paid for coverage under the Exclusive Care Medicare Supplement Plan. Exclusive Care will pay Medco for coverage under the YOURx Plan. **THE EXCLUSIVE CARE MEDICARE SUPPLEMENT PLAN DOES NOT COVER THE DEDUCTIBLES AND COPAYMENTS THAT ARE PART OF THE MEDCO YOURx PLAN. SEE THE YOURx PLAN INFORMATION FOR ADDITIONAL RESTRICTIONS, LIMITATIONS, AND EXCLUSIONS.**

MENTAL HEALTH & SUBSTANCE ABUSE COVERED SERVICES

Exclusive Care's mental health & substance abuse provides coverage to Exclusive Care members needing confidential & professional assistance in areas such as marital/family difficulties, interpersonal relationship conflicts, emotional/psychological problems and alcohol/drug abuse.

The following Behavioral Health services are covered when clinically necessary and rendered to an eligible Exclusive Care member:

- 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;
- Clinically necessary psychological testing; and
- Emergency Treatment;

MENTAL HEALTH & SUBSTANCE ABUSE LIMITATIONS

Private rooms and/or private duty nursing are not covered benefits unless determined as clinically necessary by EAP.

Medical expenses related to suicide attempts or other self inflicted injuries are covered under the medical benefit.

MENTAL HEALTH & SUBSTANCE ABUSE EXCLUSIONS

Behavioral Health exclusions are considered the member's 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 by a non-contracted or contracted provider 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 unqualified 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;
- 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;
- Experimental or Investigational Behavioral Health Treatment;
- Pastoral or spiritual counseling;
- Treatment designed to emotionally or behaviorally regress a patient; and
- Treatment of organic mental disorders associated with permanent brain dysfunction;

DEFINITIONS

Active Labor – A stage of childbirth when there isn't adequate time to safely transfer the Member and/or unborn child to another hospital prior to delivery.

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 denied Member's health claims, in accordance with the member grievance process.

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

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.

Behavioral Health Services - Services rendered to Exclusive Care Members for treatment of Mental Health and/or Substance Abuse Disorders.

Balance Billing – The process whereby a provider of service requests reimbursement from an Exclusive Care Member in addition to what Exclusive Care has already paid.

Behavioral Health Services - Services rendered to Exclusive Care Members for treatment of Mental Health and Substance Abuse Disorders.

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

Billed Charges – The amount the provider usually charges for services rendered to patients without healthcare coverage.

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 interferons and erythropoietins.

Brand-name Drug - A drug marketed under a proprietary, trademark-protected name.

Board – The Board of Supervisors for the County of Riverside.

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 Health Plans.

Chiropractic Care– Chiropractic services billed by any contracted licensed provider which will apply toward the chiropractic benefit calendar year maximum.

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.

Clinically Necessary - Behavioral Health Services or supplies for treatment of an active Mental Health or Substance Abuse Disorder which have been established in accordance with generally accepted professional standards and EXCLUSIVE CARE'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 Participating Practitioner, or other provider of service;
- Furnished at the most appropriate level which may be provided safely and effectively to the Member.

Clinician - A person licensed as a psychiatrist, psychologist, clinical social worker, marriage/family/child therapist, nurse, or other licensed/certified health care professional with appropriate training and experience in Mental Health Services or Substance Abuse services, who is employed by the County of Riverside or under contract with EXCLUSIVE CARE, 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.

Co-payment - The Member's share of the costs to be paid at the time services are received.

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.

Covered Services - Benefits which a Member is entitled to receive pursuant to the terms of this Summary Plan Document.

Custodial Care - Care designed to assist individuals with grooming, dressing, eating, ambulating and toileting and may include room and board; care may be furnished to individuals who are physically and/or mentally unable to live independently.

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.

1. All injuries sustained in any one accident are considered one disability;
2. All illnesses existing simultaneously which are due to the same or related causes will be considered one disability;
3. If any illness is due to causes which 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 approved and monitored by the EXCLUSIVE CARE.

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

Detoxification - is 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, and behavioral problems associated with addiction and therefore does not typically produce lasting behavioral changes necessary for recovery.

Domestic Partner – An individual, with whom an Exclusive Care 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 Exclusive Care 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. Individuals in a domestic partnership must be unmarried and not be blood relatives close enough to bar marriage in the State of California.

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 - 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.

EAP - The County of Riverside's Employee Assistance Program.

Eligible Child - Any child (including natural, adopted, foster, grand or step child), who is under age 23, and has never been married, for whom a member has legal custody of or who a Member has been required to cover their medical plan as part of a Qualified Medical Child Support Order (QMCSO) or who resides with a Member and who is economically dependent upon that Member. Any otherwise eligible child older than 23 years of age, who has never been married if he/she is incapable of self-support because of a mental or physical handicap and the Member continues to claim the child as a dependent on their federal income tax return.

Eligible Dependent – A legal spouse, domestic partner or eligible child.

Eligible Retiree – A County of Riverside retired employee who is not eligible for the federally sponsored Medicare program.

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

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 which 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

Employer - The County of Riverside or contracted public entity employer group.

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

Exclusive Care - The County of Riverside's self-funded Exclusive Provider Organization (EPO) Health Plan.

Experimental or Investigational - Any treatment, therapy, procedure, drug or drug usage, facility or facility usage, equipment or equipment usage, device or device usage, or supplies which are not recognized as being in accordance with generally accepted professional medical standards, or if safety and efficacy have not been determined for use in the treatment of a particular illness, injury or medical condition for which it is recommended or prescribed.

FDA – Food and Drug Administration.

Generic Drugs – A Generic Drug 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 Plan - The benefit plan(s) described in this Summary Plan Document.

Healthcare Professional – An individual who renders healthcare services to others within the scope of practice as defined by the regulatory body that oversees the clinical license they hold.

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 & 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:

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

Hospital – A American Hospital Association registered institution that is accredited by the Joint Commission on Accreditation of Healthcare Organizations, which is licensed under all applicable state and local laws and regulations to provide, under supervision of physicians, diagnostic and therapeutic services for the medical diagnosis, treatment and care of the injured, disabled or sick persons in need of acute inpatient medical and/or psychiatric or psychological care (as defined by Section 1250.2 of the Health and Safety Code).

Infertility – Is the presence of a demonstrated bodily malfunction recognized by a licensed Doctor of Medicine as a cause of infertility or because of a demonstrated bodily malfunction, 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.

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

Medical Director – An Exclusive care designated physician responsible for the medical/clinical administration of the health plan.

Medical Group - A group of physicians, practicing together under a professional corporation, limited partnership or association who have entered into a written agreement with EXCLUSIVE CARE to provide Covered Services to plan members.

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 Exclusive Care is:

- Consistent with EXCLUSIVE CARE's medical policy;
- Consistent with illness and injury symptoms or diagnosis;
- Not furnished primarily for the convenience of the patient, Attending Physician or other healthcare provider; and
- Furnished at the most appropriate level which can be provided safely and effectively to the patient.

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

Medication - A medicinal substance.

Member – Is a County of Riverside retiree who is Medicare Eligible and enrolled in Part A & Part B or eligible family member 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 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.

Network - The Hospitals, Medical Groups, individual providers and ancillary providers which are contracted to provide care and services to EXCLUSIVE CARE members.

Non-Preferred Drugs: The outpatient prescription drug listing of prescription drugs, which includes, generic and brand-name drugs that are covered but require a higher Member co-payment. Most drugs represented on the Non-Preferred Drug list 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.

Open Enrollment - A period of time established by contracting employers during which Eligible Employees, Retirees and Dependents may enroll in employer sponsored medical plans.

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

Outpatient - services rendered in a non-hospitalized patient at a doctor's office, clinic, home or day surgery center.

Participating Pharmacy – A local retail pharmacy, which is party to an agreement with Medco to dispense drugs to persons covered under Exclusive Care while the agreement remains in effect.

Participating Providers – Any provider that has an agreement with EXCLUSIVE CARE to provide covered services to Members. These providers include but are not limited to hospitals, physicians, chiropractors, pharmacies, residential treatment facilities, day treatment facilities, and ancillary providers.

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 – An EXCLUSIVE CARE established committee that reviews denied claims, in accordance with the Member grievance procedure, upon the request of the Member.

Plan Service Area - The geographic area that includes all of Riverside County as well as that area immediately adjacent to Riverside County whose zip codes are partially or wholly within thirty (30) miles of the Riverside County border line.

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

Primary Care Provider - A general practitioner, board-certified or eligible family practitioner, internist, or pediatrician who has contracted with Exclusive Care to provide primary care services to Members and to refer, authorize, supervise and coordinate the provision of all benefits to Members in accordance with the Health Plan's provisions.

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 which 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 – The amount a healthcare provider agrees to accept as payment from Exclusive Care; or, the allowed amount determined to be payable by Exclusive Care for non-Network providers.

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, occupational/vocational treatment modalities and are provided with the expectation that the patient has restorative potential and will realize significant improvement in a reasonable length of time.

Residential Treatment Center - An acute care facility which provides mental health and substance abuse services on an inpatient basis, pursuant to a written treatment plan approved and monitored by a doctor. The facility 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 which provides Substance Abuse services in a residential setting on a full time or partial day basis, pursuant to a written treatment plan approved and monitored by EXCLUSIVE CARE.

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.

Severe Mental Illness - Includes schizophrenia, schizoaffective disorder, bipolar disorder (manic-depressive illness), major depressive disorders, panic disorder, obsessive-compulsive disorder, pervasive developmental disorder or autism, anorexia nervosa and bulimia nervosa.

Skilled Nursing Facility - A facility licensed by the State government to provide skilled nursing care under the laws of that state, territory, or foreign country.

Specialist - A duly licensed physician, osteopath, psychologist or other Medicare defined practitioner who provides specialized health care services related to specific diseases or body functions.

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.

Subscriber – The person who enrolls in a Health Plan and meets all the employer's eligibility requirements, including employment status and for whom premiums have been received by the Health Plan. Family dependency is not considered an employment status.

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 Diagnostic and Statistical Manual of Mental Disorders. Substance Abuse does not include addiction to or dependency on tobacco or any food substance.

Summary Plan Document - The written evidence of coverage furnished to Members of the Health Plans, providing details of Benefits and Covered Services under the Health Plans.

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

Treatment Plan – A Plan of Care established for an eligible member and preauthorized by Exclusive Care. Continuous covered care under a treatment plan is based on Health 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.

Usual and Customary Charges - The amount a provider of healthcare services usually charges for services rendered to patients without healthcare coverage.

Utilization Review Committee – An Exclusive Care appointed committee that meets periodically to review and discuss utilization patterns.

**HEALTH PLAN ADDRESSES
AND
IMPORTANT TELEPHONE NUMBERS**

Human Resources Department:

Riverside County Human Resources
P.O. Box 1569
Riverside, CA 92502
(951) 955-4981
8:00 a.m. – 5:00 p.m. Monday – Friday
www.workforceexchange.net

Department of Managed Healthcare:

980 Ninth Street, Suite 500
Sacramento, CA 95814-2725
(888) 466-2219 Voice
(916) 229-0465 Facsimile
(877) 688-9891 TDD

EXCLUSIVE CARE

P.O. Box 1508
Riverside, CA 92502-1508
(800) 962-1133
8:00 a.m. - 5:00 p.m. Monday - Friday
exclusivecare.com

EXCLUSIVE CARE MEDICARE SUPPLEMENT PLAN
MONTHLY RATES FOR PLAN YEAR 2007
Effective January 1, 2007

<u>Contract Type</u>	<u>Monthly Rate</u>
Retiree Only	\$ 564.00
Retiree plus One Dependent	\$1,121.00
Retiree plus Two or more Dependents	\$1,476.00