

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

667



FROM: Human Resources Department and SUPERVISOR BOB BUSTER

SUBMITTAL DATE:
September 22, 2008

SUBJECT: 2009 Medicare Plans, Rates, and Plan Changes for County Retirees

RECOMMENDED MOTION: That the Board of Supervisors 1) approve the 2009 plan rates for retired employees and their dependents (Attachment "A" through "E"); 2) approve the addition of the SCAN Health Plan (Attachment "F" & "G") and the Exclusive Care Select Medicare Supplement Plan Document (Attachment "H") as options for County of Riverside retirees and their dependents that are Medicare eligible; 3) approve the replacement of Vision coverage provided to retirees and their dependents through the County's contract with Spectera Vision plan with a similar plan underwritten by Medical Eye Services (MES) (Attachment "I").

Departmental Concurrence

Bob Buster

Bob Buster
Supervisor, 1st District

Ronald W. Komers

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

FINANCIAL DATA	Current F.Y. Total Cost:	\$ 0	In Current Year Budget:	N/A
	Current F.Y. Net County Cost:	\$ 0	Budget Adjustment:	N/A
	Annual Net County Cost:	\$ 0	For Fiscal Year:	2008/09

SOURCE OF FUNDS: Premiums from retirees	Positions To Be Deleted Per A-30	<input type="checkbox"/>
	Requires 4/5 Vote	<input type="checkbox"/>

C.E.O. RECOMMENDATION:

APPROVE

BY: *Elizabeth J. Olson*
Elizabeth J. Olson

County Executive Office Signature

- Consent
- Policy
- Consent
- Policy

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

Prev. Agn. Ref.:

District:

Agenda Number:

3.50

BACKGROUND:

The County contracts directly with health plan insurance carriers for the majority of County employees and retirees. The Law Enforcement Management Unit (LEMU), RSA Public Safety Unit, and the Prosecution Unit (DDAA) remain in the health plans offered through CalPERS, and the Riverside Sheriff's Association (RSA) continues coverage of its members and early retirees through a Medical Trust.

The Human Resources Department worked with Aon, our benefits consultant, to request renewal quotations from the health plan carriers for 2009. The Joint Health Care Labor Management Committee (the "Committee") comprised of Service Employees International Union (SEIU), the Laborers International Union of North America (LIUNA), County management, and retirees' representatives reviewed proposed 2009 rates, as well as pricing alternative benefit options. The Committee recommended no change in current plan benefits. Rate renewals are based on the County's group-specific claims experience and anticipated market trend for medical costs in 2009.

Non-Medicare-Eligible Retirees: On September 12, 2006, the Board adopted a policy to establish separate medical rates starting January 1, 2009 for non-Medicare-eligible retirees rather than blending their rates with active employee rates. The action eliminates the "implicit subsidy" that must otherwise be reported under Government Accounting Standards Board (GASB) Policy #45 on the County's notes to financial statements. The cost savings of this decision on the GASB 45 present value of benefits for County employees is \$143.6 million dollars. Additional savings will accrue to each Special District within the County, as they determine their liability for retiree health benefits for reporting on their financial statements.

In accordance with this policy, employees who retire before January 1, 2009 will pay a "blended" rate (same rate as active employees) until January 1, 2011 or they become Medicare eligible, whichever comes first. Employees retiring on or after January 1, 2009 will pay an "unblended" higher rate beginning January 1, 2009.

On July 29, 2008 the Board approved 2009 medical, dental and vision rates for active employees which will be the "blended" rates (subsidized by active employees) paid by non-Medicare-eligible retirees, whose retirement predates January 1, 2009 (Attachment "A").

The "unblended" medical premiums (Attachment "B") for non-Medicare-eligible retirees (who retire on or after January 1, 2009) are, as predicted, on average 76% higher than "blended" rates. The "unblended" rates are substantially higher because retirees overall utilize medical benefits to a greater extent than active employees.

Aon has actuarially calculated the Exclusive Care plan 2009 premium rates based on the prior claims experience and anticipated healthcare cost trends for 2009. Their calculations show that for non-Medicare-eligible retirees who retire on or after January 1, 2009, the 2009 "unblended" premium for the Exclusive Care EPO plan (plan in which active employees participate) will be higher by approximately 33% than the premium for the Exclusive Care Select Plan (plan designed for retirees), see Attachment C for these non-Medicare-eligible retirees. Because of the premium differential, the Human Resources Department recommends limiting the choice of Exclusive Care plans to the Exclusive Care Select Plan.

Non-Medicare-eligible retirees eligible for CalPERS health plans will pay rates outlined in Attachment "D".

Medicare-Eligible Retirees: When the Board approved the 2009 active medical rates, the Centers for Medicare and Medicaid Services (CMS) had not yet released Medicare reimbursement rates for 2009, that carriers use to determine plan rates for Medicare coverage. Medicare reimbursement rates have since been received and the County has completed the medical plan renewal with these carriers for 2009. New rates are outlined in Attachment "E".

The Human Resources Department recommends offering two additional plan options for Medicare eligible retirees and their dependents who are Medicare eligible. The proposed plans are offered in addition to the existing health plan selection, and are in response to retiree requests for comprehensive medical coverage at a lower cost. The Joint Health Care Labor-Management Committee supports this recommendation:

The Scan Health Plan: The Scan Health Plan is a fully insured Medicare Advantage plan. Medicare Advantage plans require the participant to assign their Medicare A and B coverage to Scan Health Plan in exchange for coverage under the plan. Dependents must be eligible for Medicare parts A and B to enroll in the Scan Health Plan. A summary of covered services outlining this new benefit is provided (Attachment "F"). The Service Agreement and Evidence of Coverage (EOC) will be submitted to the Board prior to January 1, 2009 after Scan receives CMS approval of this plan design.

Coverage for most services is provided with a small co-pay. The Scan Health Plan also provides unique in-home services called Independent Living Power that can help members during recovery from a hospital stay or provide support during an episode of long-term illness. The plan provides up to \$500 per month for these additional services (Attachment "G") The service includes home delivered meals, a personal care assistant, the installation of an emergency response system, a transportation escort, and homemaker service to assist with light cleaning, grocery shopping, laundry and meal preparation.

The Exclusive Care Select Medicare Supplement Plan: This new Exclusive Care plan is a Medicare Supplement Plan that provides additional coverage and pays more than Medicare part A and B. The plan also includes a prescription drug benefit that is better than the standard Medicare Part D coverage. With this plan design Medicare is billed by the provider as the primary payer and this plan is billed for supplemental payment. The result is generally 100% coverage for Medicare eligible services, with little out-of-pocket expense, up to the Medicare-approved amount. The official governing document, the Summary Plan Document (Attachment "H"), for the administration and detailed plan benefits, including Limitations and Exclusions is presented for Board approval. This plan requires the retiree to be enrolled in Medicare parts A and B. Enrolled dependents who are not Medicare eligible will enroll in the existing Exclusive Care Select Retiree Health Plan.

The Human Resources Department also recommends replacing retiree vision coverage providers from Spectera to MES. MES has a broader network of providers that will be more convenient to retirees. The County has contracted with MES since January 1, 2004 to provide voluntary vision coverage for County employees represented by SEIU, LIUNA and RSA Public Safety. The proposed MES contract before the Board (Attachment "I") reflects negotiated rates and coverage that match Spectera. Additionally, MES has guaranteed the rates and benefits for the next two years. The Human Resources Department is working with MES to draft a contract amendment to cover retirees beginning January 1, 2009 and will present this contract to the Board prior to January 1, 2009. The plan is underwritten by AIG, but vision plans have very low risk, since the benefits are limited to eye exams and eye wear.

There is no direct cost to the County as a result of the recommended action, as retirees pay their own medical premiums, with County contributions toward retiree premiums ranging from \$25 to \$256 monthly.

County of Riverside

2009 County Medical Plan Renewal Rates

Blended Rates for Non-Medicare Retirees who Retire before January 1, 2009*

	2008 Current	2009 Renewal	Monthly Dollar Increase	Percent Increase
Exclusive Care (EPO)				
Single	\$313.38	\$338.14	\$24.76	7.9%
Two-Party	\$639.62	\$690.15	\$50.53	7.9%
Family	\$804.90	\$868.19	\$63.29	7.9%
Kaiser Permanente (HMO)				
Single	\$428.00	\$454.00	\$26.00	6.1%
Two-Party	\$854.00	\$906.00	\$52.00	6.1%
Family	\$1,109.00	\$1,177.00	\$68.00	6.1%
Blue Shield (HMO)				
Single	\$414.60	\$461.70	\$47.10	11.4%
Two-Party	\$827.18	\$921.30	\$94.12	11.4%
Family	\$1,073.32	\$1,195.60	\$122.28	11.4%
Blue Shield (PPO)				
Single	\$743.58	\$887.80	\$144.22	19.4%
Two-Party	\$1,486.32	\$1,775.10	\$288.78	19.4%
Family	\$1,931.74	\$2,307.10	\$375.36	19.4%

*Enrollment consists of retirees under age 65 who are not Medicare eligible ("Early Retirees").

County of Riverside
2009 County Medical Plan Renewal Rates
Unblended Rates for Non-Medicare Retirees who Retire on or after January 1, 2009*

	2008 Current Blended	2009 Rate if Blended	% Increase	2009 Renewal Unblended	% Increase from 2008
Exclusive Care (EPO)					
Single	\$313.38	\$338.14	7.9%	Not Available	N/A
Two-Party	\$639.62	\$690.15	7.9%	Not Available	N/A
Family	\$804.90	\$868.19	7.9%	Not Available	N/A
Kaiser Permanente (HMO)					
Single	\$428.00	\$454.00	6.1%	\$712.00	66.4%
Two-Party	\$854.00	\$906.00	6.1%	\$1,420.00	66.3%
Family	\$1,109.00	\$1,177.00	6.1%	\$1,848.00	66.6%
Blue Shield (HMO)					
Single	\$414.60	\$461.70	11.4%	\$730.20	76.1%
Two-Party	\$827.18	\$921.30	11.4%	\$1,458.20	76.3%
Family	\$1,073.32	\$1,195.60	11.4%	\$1,892.70	76.3%
Blue Shield (PPO)					
Single	\$743.58	\$887.80	19.4%	\$1,369.70	84.2%
Two-Party	\$1,486.32	\$1,775.10	19.4%	\$2,739.70	84.3%
Family	\$1,931.74	\$2,307.10	19.4%	\$3,561.10	84.3%

*Enrollment consists of retirees under age 65 who are not Medicare eligible ("Early Retirees").

County of Riverside
2009 County Medical Plan Renewal Rates
Exclusive Care Select Non-Medicare Eligible Retiree Health Plans

	2008 Current Rates	2009 Renewal Rates	Monthly Dollar Increase	Percent Increase
Exclusive Care Select: Non-Medicare Retiree Plan				
Retiree Only (< 65, no Medicare)	\$529.75	\$582.52	\$52.76	9.96%
Retiree + 1 (all < 65, no Medicare)	\$962.46	\$1,058.32	\$95.86	9.96%
Retiree + 2 (all < 65, no Medicare)	\$1,385.27	\$1,523.24	\$137.97	9.96%
Retiree Only (> 65, no Medicare)	\$807.76	\$888.22	\$80.46	9.96%
Retiree + 1 (all > 65, no Medicare)	\$1,469.47	\$1,615.83	\$146.36	9.96%
Retiree + 2 (> 65, no Medicare)	\$2,130.39	\$2,342.58	\$212.19	9.96%
Exclusive Care Select Post 65 Retiree Plan				
Retiree Only (> 65, no MC)	\$807.76	\$888.22	\$80.45	9.96%
Retiree + 1 (all > 65, no MC)	\$1,469.47	\$1,615.83	\$146.36	9.96%
Retiree + 2 (> 65, no MC)	\$2,130.39	\$2,342.58	\$212.19	9.96%

INFORMATIONAL PURPOSES ONLY

Exclusive Care (EPO) Unblended Rates				
Single	\$313.38	\$771.54	\$458.16	146.2%
Two-Party	\$639.62	\$1,574.74	\$935.12	146.2%
Family	\$804.90	\$1,981.66	\$1,176.76	146.2%

County of Riverside
2009 CalPERS Medical Plan Renewal Rates
Non-Medicare Retirees under age 65

	Other Southern California Counties Region*			Los Angeles Region			Out-of-State Region		
	2008	2009	% Difference	2008	2009	% Difference	2008	2009	% Difference
2009 Plan Rates									
Blue Shield HMO Access +									
Employee Only	\$ 447.97	\$ 471.18	5.18%	\$ 392.01	\$ 412.35	5.19%	Plan Not Available	Plan Not Available	
Two-Party	\$ 895.94	\$ 942.36	5.18%	\$ 784.02	\$ 824.70	5.19%	Plan Not Available	Plan Not Available	
Family	\$ 1,164.72	\$ 1,225.07	5.18%	\$ 1,019.23	\$ 1,072.11	5.19%	Plan Not Available	Plan Not Available	
Kaiser Permanente									
Employee Only	\$ 393.63	\$ 425.11	8.00%	\$ 359.30	\$ 388.02	7.99%	\$ 625.52	\$ 660.32	5.56%
Two-Party	\$ 787.26	\$ 850.22	8.00%	\$ 718.60	\$ 776.04	7.99%	\$ 1,251.04	\$ 1,320.64	5.56%
Family	\$ 1,023.44	\$ 1,105.29	8.00%	\$ 934.18	\$ 1,008.85	7.99%	\$ 1,626.35	\$ 1,716.83	5.56%
PERSCare PPO									
Employee Only	\$ 712.71	\$ 712.71	0.00%	\$ 697.87	\$ 697.87	0.00%	\$ 816.65	\$ 816.65	0.00%
Two-Party	\$ 1,425.42	\$ 1,425.42	0.00%	\$ 1,395.74	\$ 1,395.74	0.00%	\$ 1,633.30	\$ 1,633.30	0.00%
Family	\$ 1,853.05	\$ 1,853.05	0.00%	\$ 1,814.46	\$ 1,814.46	0.00%	\$ 2,123.29	\$ 2,123.29	0.00%
PERS Choice PPO									
Employee Only	\$ 458.59	\$ 458.59	0.00%	\$ 449.04	\$ 449.04	0.00%	\$ 525.47	\$ 525.47	0.00%
Two-Party	\$ 917.18	\$ 917.18	0.00%	\$ 898.08	\$ 898.08	0.00%	\$ 1,050.94	\$ 1,050.94	0.00%
Family	\$ 1,192.33	\$ 1,192.33	0.00%	\$ 1,167.50	\$ 1,167.50	0.00%	\$ 1,366.22	\$ 1,366.22	0.00%
PORAC									
Employee Only	\$ 452.00	\$ 484.00	7.08%	\$ 452.00	\$ 484.00	7.08%	\$ 452.00	\$ 484.00	7.08%
Two-Party	\$ 847.00	\$ 906.00	6.97%	\$ 847.00	\$ 906.00	6.97%	\$ 847.00	\$ 906.00	6.97%
Family	\$ 1,076.00	\$ 1,151.00	6.97%	\$ 1,076.00	\$ 1,151.00	6.97%	\$ 1,076.00	\$ 1,151.00	6.97%

*Includes Riverside, Orange, San Diego and Imperial counties

County of Riverside
2009 Medical Renewal Rates
Medicare Eligible Retirees

	2008 Current Rates	2009 Renewal Rates	Dollar Increase	Percent Increase
Kaiser Senior Advantage				
Retiree Only with Medicare Parts A & B	\$240.00	\$240.00	\$0.00	0.0%
Retiree Only, with Medicare Part B only	\$545.00	\$548.00	\$3.00	0.6%
Retiree Only, with Medicare Part B only, unassigned to Kaiser	\$1,043.00	\$1,110.10	\$67.10	6.4%
Retiree Only, with Medicare Part A only, unassigned to Kaiser	\$740.00	\$797.09	\$57.09	7.7%
Retiree Only, with Medicare Part A & B only, unassigned to Kaiser	\$740.00	\$797.09	\$57.09	7.7%
Retiree Only, with Medicare Part A & B only, assigned to another carrier	\$1,043.00	\$1,110.10	\$67.10	6.4%
Retiree & Spouse, one with Medicare Parts A & B	\$656.00	\$692.00	\$36.00	5.5%
Retiree & Spouse, one Medicare Parts A & B, one over 65 not eligible for Medicare	\$1,281.00	\$1,348.10	\$67.10	5.2%
Retiree & Spouse, one Medicare Part B only, one over 65 not eligible for Medicare	\$1,586.00	\$1,656.10	\$70.10	4.4%
Retiree & Spouse, two with Medicare Parts A & B	\$478.00	\$478.00	\$0.00	0.0%
Retiree, Spouse & Dependent(s), one with Medicare Parts A & B	\$905.00	\$963.00	\$58.00	6.4%
Retiree, Spouse & Dependent(s), two with Medicare Parts A & B	\$802.00	\$749.00	-\$53.00	-6.6%
Secure Horizons				
Retiree Only	\$199.21	\$213.22	\$14.01	7.0%
Retiree & Spouse, One Medicare	\$740.89	\$864.79	\$123.90	16.7%
Retiree & Spouse, Two Medicare	\$396.42	\$426.44	\$30.02	7.6%
Retiree & Spouse, One Medicare, Deps.	\$1,060.72	\$1,249.51	\$188.79	17.8%
Retiree & Spouse, Two Medicare, Deps.	\$716.25	\$811.16	\$94.91	13.3%
Blue Shield Access+ HMO				
Retiree Only	\$538.94	\$755.50	\$216.56	40.2%
Retiree & Spouse, One Medicare	\$1,081.32	\$1,516.70	\$435.38	40.3%
Retiree & Spouse, Two Medicare	\$1,075.88	\$1,509.10	\$433.22	40.3%
Retiree & Spouse, One Medicare, Deps.	\$1,404.88	\$1,970.80	\$565.92	40.3%
Retiree & Spouse, Two Medicare, Deps.	\$1,399.42	\$1,963.10	\$563.68	40.3%
Retiree & Spouse, Three Medicare, Deps.	\$1,612.82	\$2,262.60	\$649.78	40.3%

COUNTY OF RIVERSIDE
Year 2009 Benefits



Calendar Year Deductibles and Out of Pocket Maximum	Not Applicable
Lifetime Maximum	Unlimited
Doctor Office Visits	
PCP visit	\$15 copay
Specialist Visit	\$15 copay
Inpatient Hospital Services	\$100 copay/admission
Semi-private room (unlimited days)	
Intensive care/cardiac care unit	
Nursing care, private duty nursing (as medically necessary)	
Laboratory, X-rays, anesthesia, medications, biologicals and hemodialysis	
Physical, speech, occupational and respiratory therapy	
Skilled Nursing	
Worldwide Emergency Care (waived if admitted into a hospital)	\$50 copay each visit
Outpatient Surgery To an ambulatory surgical center or outpatient hospital facility	\$0 copay
Ambulance	\$0 copay
Transportation Unlimited rides in a passenger vehicle, taxi or wheelchair to contracted medical providers	\$0 copay
Vision	\$15 copay for exam
Hearing Services	\$15 copay
Hearing exam	
Coverage up to \$300 per hearing aid, or \$600 for two hearing aids, every two calendar years	
Diagnostic Tests, X-Rays and Lab Services For specialized scans such as CT, SPECT, MRI, MRA, Myelogram, Cystogram, Angiogram, and other invasive procedures	\$0 copay
Prescription Drug Benefit	1-Month/31 Day Supply
Generic Drugs	\$10
Brand Drugs	\$20
Additional Brand Drugs	\$20
Specialty Drugs	\$40
Mail Order Service	3-Month/90 Day Supply
Generic Drugs	\$20
Brand Drugs	\$40
Additional Brand Drugs	\$40
Chiropractic Care Maximum of 20 self-referred visits per year	\$15 copay
Medical Supplies and Equipment DME	\$0 copay

COUNTY OF RIVERSIDE

Year 2009 Independent Living Power



SCAN offers unique in-home services, known as Independent Living Power, to keep people on Medicare healthy and independent. These services can help you during recovery from a hospital stay or provide support during an acute episode of long-term illness. Many seniors find that these services provide the extra assistance necessary to stay out of a nursing home. Members who qualify for Independent Living Power are eligible for up to \$500 per month for these additional services.

Independent Living Power is only available to approved zip codes in Los Angeles, Orange, Riverside and San Bernardino counties.

Independent Living Power services include:

Personal Care Coordinator SCAN staff will provide personal assistance to coordinate your Independent Living Power services.	\$0 copay
Home Delivered Meals SCAN members are covered for home delivery of frozen meals to meet caloric or dietary needs based on a medical condition or to provide nutrition if you are injured or disabled (example – recovery from a stroke).	\$0 copay
Personal Care You are covered for in-home assistance during your recovery for tasks such as bathing, dressing, toileting, meal preparation, and bed linen changes to protect skin integrity.	\$15 copay
Emergency Response System SCAN members are covered for the installation of a personal emergency response device that alerts emergency medical personnel to provide immediate help. (There is no cost for installation.)	\$15/month
Transportation Escort As a SCAN member you are eligible to receive an escort to assist you during transportation to and from post-discharge medical appointments.	\$15 copay
Homemaker Service SCAN members are eligible to receive assistance with light cleaning, grocery shopping, laundry, and meal preparation.	\$15 copay
Inpatient Custodial Level Care You are covered for up to 14 days for post acute support while staying in an in-patient facility such as a skilled nursing facility. You may use this service following a hospital discharge, ER visit, or for respite care purposes.	\$0 copay
In-Home Caregiver Relief SCAN provides alternative caregiver services in your home when a regular caregiver cannot be there.	\$15 copay
Adult Day Care SCAN covers adult day care services to provide relief for your regular caregiver while addressing the individual needs of the member for physical, social, or intellectual exercises and stimulation.	\$15 copay

**Exclusive Care Select
Medicare Supplement Plan**

*Exclusive
Care*

SUMMARY PLAN DOCUMENT

January 2009

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INTRODUCTION

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

This Summary Plan Document (SPD) provides a detailed description of how the Health Plan works and an explanation of what is and is not covered. This SPD 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 SPD.

Medicare Supplement Plan	
Plan sponsor	Each Employer Group for their 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 Medicare Supplement Plan 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 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.

Medicare Supplement 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, 2009.
SPD Effective Date	The effective date of this SPD is January 1, 2009.

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

SECTION 1: EXCLUSIVE CARE MEDICARE SUPPLEMENT PLAN INFORMATION

HOW THIS PLAN WORKS WITH MEDICARE

Medicare Eligible Retirees and their Medicare-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 your out-of-pocket expenses.** Under this supplemental plan, Medicare is billed first for the total cost of the services. After Medicare pays, This 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.**

As a Member, you will receive an *Identification Card* that should be shown to the provider when health care services are rendered.

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.***

The following are some terms you will need to be familiar with to understand the Benefits you are eligible to receive:

Cost of Coverage

You are responsible for the payment of the entire premium for coverage for yourself and your covered Medicare eligible dependents.

Deductible – Per Person

The Deductible is the portion of most medical expenses you must pay each calendar year before the Plan will pay benefits.

Coinsurance

After the Medicare Part B 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 such as prescription drugs. After you pay the required Copayment, the Plan will pay the remainder of the cost except for Emergency Room care which is also subject to Coinsurance. Except as noted, Deductibles and Coinsurance amounts do not apply to services for which only a Copayment is required.

Copayments do not apply toward Deductibles.

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.

Providers who accept Medicare Assignment

Providers who accept Medicare Assignment have agreed to accept the Medicare reimbursement level as payment in full. They will receive a combination of Medicare payment and Plan payment. This means they cannot bill you for amounts above the Medicare reimbursement level. You are still responsible for payment of the required Copayments, Deductibles and Coinsurance.

Providers who do not accept Medicare Assignment

If you receive care from a provider who does not accept Medicare Assignment, you will be responsible for any charges above the amounts payable by Medicare and the Plan in addition to Plan Copayments, Deductibles, and Coinsurance.

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 Medicare Supplement 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 right away at (800) 962-1133 and a new card will be sent to you.

Keeping Your Membership Information Current

The Plan maintains enrollment information in order to communicate with you. Please help by keeping this information up to date. If there are any changes in your name, address, or phone number, please contact your Employer Group so your record may be updated.

SECTION 2: ELIGIBILITY

EXCLUSIVE CARE MEDICARE SUPPLEMENTAL HEALTH PLAN ELIGIBILITY

If you are 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 out or outside of Riverside County).

DEPENDENT ELIGIBILITY

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. (see Appendix A)

TERMINATION OF BENEFITS AND RE-ENROLLMENT

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

- The Member dies;
- The Member ceases to be eligible for coverage based on the 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 Coordination of Benefits Rights;

- The Member exceeds his/her life-time maximum benefits under 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
- Eligible dependent's entitlement to Medicare is rescinded.

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 substantiating 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 are covered as of the date of their birth contingent on the 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.

SECTION 3: BENEFITS

Health Plan Interpretation And Administration

The right of any Member to benefits under The Plan shall be determined in accordance with the terms of The Plan 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.

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.

Schedule Of Covered Services

Medicare Eligible Retirees and their Medicare Eligible Dependents

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

EXCLUSIVE CARE RESERVES THE RIGHT TO MODIFY PLAN BENEFITS SUBJECT TO CHANGES IN MEDICARE BENEFITS

EXCLUSIVE CARE IS REFERRED TO AS "THE PLAN" WITHIN THE SCHEDULE OF COVERED SERVICES BELOW.

Note: The Medicare deductible and coinsurance amounts may vary each year


<i>Benefit Provisions</i>	
COORDINATION WITH MEDICARE	Medicare is billed first and after Medicare pays The Plan is billed for the difference. The Plan 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 The Plan covers Members for the Medicare Part A annual deductibles and co-payments and Part B coinsurance. The member must pay for Part B annual deductible.
DEDUCTIBLE - family	Each Medicare eligible member must pay for Part B annual deductible
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	The Plan pays 20% coinsurance (Medicare pays 80%) after member fulfills annual Part B deductible.
Annual Physical Evaluations Annual Well Woman Care	Covered 100% by The Plan (benefits are not covered under Medicare) not to exceed 100% of Medicare fee schedule.
Well Baby Care Vision Examinations	Not covered by The Plan (benefits not covered under Medicare). Not covered by The Plan (benefits not covered under Medicare).


PREGNANCY AND MATERNITY CARE

Prenatal and Postnatal Care Normal Delivery, Cesarean Section Complications of Pregnancy and Medical Services Hospital and Other Related Services	Not covered by The Plan (benefits not covered under Medicare).
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PRESCRIPTION DRUGS

Prescription Drug Coverage is provided through The Plan's Pharmacy Benefit Manager (PBM).

Participating Retail pharmacy including Exclusive Care's Rubidoux pharmacy (up to a 30-day supply) 	Generic drugs: \$15 copayment Brand-name formulary drugs: \$25 copayment Non-formulary drugs: \$40 copayment Significant or new therapeutic class drugs: 50% copayment
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Exclusive Care Rubidoux Mail-Order pharmacy (up to a 90-day supply) 	Generic drugs: \$30 copayment Brand-name formulary drugs: \$50 copayment Non-formulary drugs: \$80 copayment <i>Mail-order is MANDATORY for maintenance medications after the first 30-day prescription trial.</i>
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HOSPITAL AND EMERGENCY ROOM BENEFITS

Ambulance Service (As Medically Necessary)	The Plan pays 20% coinsurance (Medicare pays 80%) after member fulfills annual Part B deductible.
Ambulatory Surgical Center	The Plan pays 20% coinsurance (Medicare pays 80%) after member fulfills annual Part B deductible.
Inpatient Hospital	<p><u>Days 1 – 60:</u> The Plan pays initial Part A annual Medicare deductible.</p> <p><u>Days 61 - 90:</u> The Plan 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: The Plan 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.

Benefit Provisions	
	Up to 365 days/ lifetime maximum
Outpatient Hospital	The Plan pays 20% coinsurance (Medicare pays 80%) after member fulfills annual Part B deductible.
Hospital Emergency Room	The Plan pays 20% coinsurance (Medicare pays 80%) after member fulfills annual Part B deductible.
Urgent Care	The Plan pays 20% coinsurance (Medicare pays 80%) after member fulfills annual Part B deductible.
MENTAL HEALTH	
Inpatient Benefits	<p><u>Days 1 – 60:</u> The Plan pays initial Part A annual Medicare deductible.</p> <p><u>Days 61 - 90:</u> The Plan pays Medicare additional day deductible.</p> <p><u>Days 91-150:</u> The Plan pays Medicare additional day deductible.</p> <p><u>Days 151 – 190:</u> The Plan 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 (Medicare pays 50%) after member fulfills annual Part B deductible.</p> <p>Maximum 30 visits/ calendar year.</p>
SUBSTANCE ABUSE	
Inpatient Benefits	<p><u>Day 1 – 60:</u> The Plan pays initial Part A annual Medicare deductible.</p> <p><u>Day 61 - 90:</u> The Plan pays Medicare additional day deductible</p> <p><u>Day 91-150:</u> The Plan pays Medicare additional day deductible</p> <p><u>Day 151 – 190:</u> The Plan 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 (Medicare pays 50%) after member fulfills annual Part B deductible.</p> <p>Maximum 30 visits/ calendar year.</p>
OTHER BENEFITS	

<i>Benefit Provisions</i>	
Allergy Testing & Treatment	The Plan pays 20% coinsurance (Medicare pays 80%) after member fulfills annual Part B deductible.
Blood	The Plan pays for the first three units of unreplaced blood after member fulfills annual Part B deductible (not covered by Medicare).
Chiropractic	Not covered
Durable Medical Equipment (As Medically Necessary)	The Plan will pay 20% of Medicare approved amount (Medicare pays 80% of approved amount) up to \$1,000 after member fulfills annual Part B deductible.
Family Planning Voluntary Interruption of Pregnancy Tubal Ligation/Vasectomy Infertility Services, Testing, Drugs and Treatment	Not covered Not covered Not covered
Home Health Care	The Plan pays 20% coinsurance (Medicare pays 80%) after member fulfills annual Part B deductible. Up to 20% of Medicare Allowable for injectable drugs to treat osteoporosis in women (Medicare pays 80%) after member fulfills annual Part B deductible; all other services not covered.
Hospice and Respite Care	Up to 5% of Medicare approved amount for Inpatient care. The Plan reimburses members for \$5 Medicare Co-payment for each Medicare approved drug.
Physical Therapy	The Plan pays 20% coinsurance (Medicare pays 80%) after member fulfills annual Part B deductible.
Skilled Nursing Facility (As Medically Necessary)	<u>Days 1 – 20:</u> The Plan pays initial Part A annual Medicare deductible <u>Days 21 - 100:</u> The Plan pays Medicare additional day deductible <u>Day 101 and beyond:</u> Not covered by The Plan.
Hearing Aid Benefit Combined Audiological Examination and Hearing Aid Benefit	The Plan will pay the combined amounts listed below up to \$1,000 every 60 months

<i>Benefit Provisions</i>	
Audiological Examination	The Plan will pay 20% of Medicare approved amount (Medicare pays 80% for approved services) subject to the limitations of the combined benefit
Hearing Aid Instrument	The Plan will cover up to \$1,000 subject to the limitations of the combined benefit.

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.

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

❖ MENTAL HEALTH & SUBSTANCE ABUSE SERVICES

Services are covered only if it is an emergency mental health condition or is covered by Medicare Mental Health. Non-emergency treatment or services that are not authorized by Medicare may be determined to be your financial responsibility. If services are authorized by Medicare, the following services are covered:

Covered Services

The following Clinical Necessary mental health services are covered when prior authorized when approved by Medicare:

- 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 Limitations

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

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;
- Or any other service not covered by Medicare

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.

OUTPATIENT PRESCRIPTION DRUG BENEFIT

This portion of the Summary Plan Document 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 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 co-payment is charged each time a prescription is filled.

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.

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 difference.

Mandatory Mail Order for Maintenance Drugs

A maintenance drug is one that requires a physician's prescription by law and is prescribed to treat a medical condition for an indefinite period of time. Maintenance drugs 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

If you take a maintenance drug, you must obtain your drugs through Exclusive Care's mail-order service after your first 30-day trial. You do not have the option of purchasing long-term maintenance drugs via your local retail pharmacy except for the first 30-day prescription trial period.

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.

How to Use the Mail Order Pharmacy Prescription Drug Program

Have your physician write you two prescriptions:

- One 30-day prescription that can be filled at a retail pharmacy so you can begin taking the medication right away; and
- One 90-day prescription for the mail-order service.

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.

1. Complete a prescription mail-order envelope (found in your prescription drug packet).
2. 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.

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.

COORDINATION OF BENEFITS (OTHER THAN MEDICARE)

If you have other health care coverage, this section is for you. For example, you may be covered as a dependent under your spouse's medical plan. This "coordination of benefits" provision prevents duplicating benefit payments when you or your dependents also have coverage through another group plan. Coordination of benefits also determines which plan pays first. The goal of coordination of benefits is to maximize coverage for allowable expenses, minimize out-of-pocket costs, and to prevent payment duplication.

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

Order of Benefit Determination

The first step is to determine which plan is "primary" and which is "secondary." The primary plan is the one that pays benefits first, without taking the existence of another plan into consideration. The secondary plan may reduce its benefits after taking into consideration the benefits paid by the primary plan. A secondary plan may also recover from the primary plan the reasonable cash value of any services it provided to you.

Note: Coverage under this Plan plus another plan does not guarantee 100% coverage.

- The benefits of a plan that covers a Member directly as a subscriber will be determined as primary before the benefits of a Plan which covers the Member indirectly as a dependent.
- The benefits of a plan that covers a Member directly as an active employee will be determined as primary before the benefits of a plan that covers the Member as an inactive employee (such as a retiree, laid-off employee, COBRA beneficiary, etc.).
- For a dependent child whose parents are not legally separated or divorced, the primary plan will be the one that covers the parent whose birthday falls first in the calendar year. If both parents have the same birthday, the benefits of the plan that has covered one of the parents the longest shall be determined primary.
- For the dependent child of legally separated or divorced parents, the primary plan will be the plan of the parent to whom a court decree assigns financial responsibility for health care expenses. If health care expenses are not part of a court decree, the plan 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 that has covered the Member 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 the 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.

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: EXCLUSIONS

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 not Medically Necessary.
- 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.
- 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.
- Services not covered by Medicare (unless otherwise stated in the Summary Plan Document)

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
- Alternative treatments such as aromatherapy, hypnotism, rolfing, massage therapy
- Chiropractic therapy
- Bariatric and gastric bypass surgery
- Charges for all services related to the newborn of a non-spouse or non-domestic-partner dependent
- Cosmetic procedures; any procedure performed mainly to modify a person's appearance
- Custodial or domiciliary care

- Dental appliances
- Dental injury treatment
- Dental services such as implants, braces, dental x-rays, jaw bone surgery or orthodontic treatment
- Developmental disorders
- Disabilities related to military services for which you are legally entitled to and have reasonable access to medical services.
- Drug testing for a non-medical diagnosis
- Gender reassignment consultation and/or surgery
- Home birth services
- Hypnotherapy, behavior training, sleep therapy, education programs
- Infertility diagnostic testing and treatment (including surgery)
- Liposuction
- Non-medical self-care or self-help
- Orthodontic injury treatment
- Orthotic supplies
- Private duty nursing
- Private rooms and personal/comfort items
- Prosthetic for sexual dysfunction
- 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 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

OUTPATIENT PRESCRIPTION DRUG BENEFIT EXCLUSIONS

The outpatient prescription drug benefit exclusions are non-covered drugs, medications, and/or related items that are your financial responsibility. The Plan's outpatient prescription drug benefit excludes:

- All durable medical equipment that can be obtained without a prescription
- Drugs, medicines, or cosmetic aids prescribed primarily to improve or otherwise modify one's external appearance
- Drugs or medicines delivered or administered by a prescriber or the prescriber's staff
- Medication for which cost is recoverable under any Workers' Compensation or occupational disease law
- Medications to be taken or administered while an inpatient in a hospital, rest home, nursing home, or sanitarium
- Medications available without a prescription (over the counter) or for which there is a non-prescription equivalent available, even if ordered by a physician
- Medication for which cost is recoverable under state or governmental agencies
- Injectable drugs administered in a home setting by a non-contracted provider or self-administered
- Support garments and other non-medicinal substances

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
- 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

SECTION 5: LIMITATIONS

GENERAL LIMITATIONS

General limitations provide for Benefits coverage only in the event that certain circumstances exist and are applicable to medical, outpatient prescription drug, and behavioral health services.

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 are 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.

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.

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 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.

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.

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

OUTPATIENT PRESCRIPTION DRUG BENEFIT LIMITATIONS

Dietary supplements, including vitamins, fluoride supplements, diet pills, and health or beauty aides, are not covered. However, prescribed prenatal vitamins for pregnant women are covered, as are other prescribed vitamins for various medical conditions.

Medications furnished by any other drug or medical service for which there is no charge made to the person being prescribed to are not covered.

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

Smoking cessation products are limited to one (1) treatment course each calendar year when the Member is enrolled in a smoking-cessation program.

Syringes and hypodermic needles for approved self-injectable drugs such as insulin are covered; however, hypodermic needles and syringes for non-approved self-injectable drugs are not covered. Therapeutic devices or appliances are not covered.

Over-the-counter contraceptive jellies, ointments, foams, and devices are not covered; however, injectable contraceptives are covered.

Medications limited to investigational use or medications prescribed for experimental or non-FDA approved indications, unless prescribed in a manner consistent with the guidelines below, are not covered.

1. A specific indication in *Drug Information Specifications for the Health Care Professional*, published by the United States Pharmacopoeial Convention;

2. The American Hospital Formulary Services edition of *Drug Information*; or
3. Any other source that reflects community practice standards.

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 a ninety day supply of maintenance drugs must be filled through Exclusive Care Pharmacy's mail-order service. You do not have the option of purchasing long-term maintenance drugs via your local retail pharmacy except for the first 30-day prescription trial period.

MENTAL HEALTH & SUBSTANCE ABUSE LIMITATIONS

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

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

SECTION 6: 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:

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.
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.
 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 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

The Health Insurance Portability and Accountability Act (HIPAA) include 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 7: 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 8: MEMBER RIGHTS AND RESPONSIBILITIES

MEMBER RIGHTS

- Be treated with respect and dignity by everyone that works for the Plan.
- Get information about the Plan.
- 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.
- Receive help making decisions about your health care.
- Refuse medical treatment.
- Have the privacy of your medical records and personal health information protected.
- Address concerns to the Plan.
- File a grievance with the Plan Administrative Review Committee.
- Ask for a second opinion about your health by writing to the Plan's Medical Management Department.
- Disenroll from the Plan.
- 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 information to your doctor or the Plan that is needed to care for you.
- Be active in 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 the plans and instructions you and your doctor have agreed on.
- 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.
- Maintain your enrollment in Medicare Parts A and/or B as applicable.

COBRA CONTINUATION RIGHTS

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

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 in 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, 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.

Canceling COBRA Coverage

COBRA 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 by your spouse or children, as the case may be. 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).
- If after your spouse or children have elected COBRA coverage under the Plan, your spouse or children become covered under another group health plan. However, 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.
- If after your spouse or children have elected COBRA coverage under the Plan, 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 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.

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; or,
- The enrollee becomes covered by another health plan; or,
- The Employer Group no longer offers health plan coverage to its employees.

The Plan will provide the affected eligible person with COBRA information within thirty (30) days of the qualifying event.

SECTION 9: APPEALS AND GRIEVANCE RESOLUTION POLICY AND PROCEDURES

Service Authorization and Claims Review Chart		
Type of Transaction	Steps to Take	
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.
	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.

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

- Medicare determines covered services and allowable fees except as noted on Summary Plan Document.
- 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.

If you believe your 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 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 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 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);
- A statement that "You or your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact the California Department of Managed Health Care."

The appeal 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.

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 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 10: 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 – The allowed amount determined by the Plan to be payable for services rendered by providers. The Exclusive Care allowed amount is based on a fee schedule established by Exclusive Care which may be modified by Exclusive Care at any time at its sole discretion. The Medicare allowed amount is based on Medicare's reimbursement levels which may be modified annually at the discretion of the Center for Medicare and Medicaid Services (CMS).

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.

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 and their use requires prior authorization by the Plan.

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.

Coordination 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.

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

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

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.

Deductible – The amount of eligible expense a covered person must pay each year from his/her own pocket 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 do not typically produce lasting behavioral changes necessary for recovery.

Domestic Partner – Two adults who have chosen to share each other's lives in an intimate and committed relationship of mutual caring. A domestic partnership shall be

established in California when both persons file a Declaration of Domestic Partnership with the Secretary of State.

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.

established in California when both persons file a Declaration of Domestic Partnership with the Secretary of State.

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.

Eligible Child – Determined by each Employer Group and the signed group service agreement.

Eligible Dependent – Determined by each Employer Group and the signed group services agreement.

Eligible Retiree – A retiree of an Employer Group who is eligible for and enrolled in the federally sponsored Medicare program, Parts A and/or B as applicable.

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.

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.

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.

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.

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 that 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*
- *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.

Member – A retiree of an Employer Group or his/her Eligible Dependent who has enrolled in this 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.

Non-Preferred 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.

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.

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

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.

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.

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.

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 California State Department of Health as a "skilled nursing facility" or any similar institution licensed under the laws of any other state, territory, or foreign country.

Specialist – 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 – 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.

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.

APPENDIX A – County of Riverside Retirees

You may enroll your Medicare eligible dependents. Dependents must have Medicare Parts A and B to qualify for the Medicare Supplement Plan (those dependents that do not have Medicare may be eligible to enroll in Exclusive Care's Select plan for non-Medicare retirees). Eligible dependents include:

Your legal spouse/registered domestic partner

You and/or your spouse/domestic partner's dependent natural children adopted child, foster children, and stepchildren who are under age 23 and have never been married.

- Any child, who is under age 23 and has never been married, whom you have legal custody, whom you are required to cover under your medical plan as part of a qualified medical child support order, or who lives with you (generally in the absence of the natural or adoptive parent) and is economically dependent upon you

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, is Medicare eligible and who resides with either the you or your 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 you 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.



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

Exclusive
 *Care*



Vision Benefit Proposal
for

County of Riverside - Retirees

Group Size:..... 480
Proposed Effective Date:..... 1/1/2009
Requested by:.....AON Consulting & Insurance
Insurance Company:..... AIG Life
State of Issue:.....CA
Date Quoted:.....4/10/2008
Valid Until:.....7/10/2008

Administrated By:



PO Box 25209
Santa Ana, CA 92799

Underwritten By:



80 Pine Street, 13th Floor
New York, NY 10005

MESVISION COMPANY PROFILE

Since 1976, MESVision has provided outstanding vision care services to large and small employer groups through well-known insurance companies, health plans, preferred provider organizations and self-funded (administrative services only) plans.

MESVision is a third party administrator focused on efficiently and effectively administering vision benefit programs. MESVision performs claims administration, eligibility verification, billing and collections, as well as customer service regarding all member and provider inquiries.

MESVision offers the largest and most comprehensive network in California with over 16,000 providers nationally. MESVision members have full access to the MESVision national network, with their choice of Ophthalmologists (MDs), Optometrists (ODs) or Opticians. The MESVision network also includes many popular retail outlets that offer the flexibility of later weekday and weekend hours (often without an appointment).

MESVision is a Preferred Provider Organization committed to developing and maintaining a strong vision provider network. MESVision's participating providers are required to meet stringent quality of care and credentialing standards. Historically, members utilize participating providers 97% of the time.

Not only do members have the freedom to choose from a variety of eye care providers, but they also have the choice to receive an exam from one provider and eye wear from another provider (many feel they can extend their benefit dollar by going to an optical store for materials after they visit an MD or OD for their exam).

While vision benefits are relatively simple to understand, there are many options available to maximize employee satisfaction while making the best use of scarce budget dollars. MESVision prides itself on the human experience. Customers calling MESVision are not greeted by a maze of electronic messages or voice mail obstacles. Rather, members are quickly routed to a knowledgeable MESVision representative for assistance.

THE NEED FOR VISION CARE

Vision care is always rated at or near the top of the list of benefits most desired by employees. "69% of employees would be willing to trade a vacation day for annual eye exams and eyeglasses, and 60% would trade two vacation days."¹ Vision benefits are a growing addition to employee benefit packages as compensation for changes in medical plans, such as higher deductibles, co-pays, increased employee contributions, and other cost containment changes.

There are many health benefits to receiving proper eye care treatment. Routine eye exams can detect problems that, if untreated, could cause vision damage or blindness, and can also detect such conditions as glaucoma, cancer, high blood pressure, diabetes, and cataracts. In addition, vision care may help eliminate loss in productivity and absenteeism due to headaches, eyestrain, and fatigue associated with heavy computer usage.

UNDERWRITTEN BY

National Union Fire Insurance Company of Pittsburgh, Pa.

AIG Life Insurance Company, with its principal place of business in Wilmington, DE.

American International Life Assurance Company, with its principal place of business in New York, NY.

This proposal provides a summary description of the coverage. Certain limitations, exclusions, and conditions apply. For complete details, please refer to policy form no. series 22438. In the event of a conflict between the proposal and the policy, the policy will govern in all cases. The coverage may not be available in all states. The rates may change at any time without notice.

¹ Best's Review, 2001.

AMERICAN INTERNATIONAL COMPANIES

Throughout the years, National Union Fire Insurance Company of Pittsburgh, Pa., AIG Life Insurance Company, and American International Life Assurance Company of New York, underwriters of AIG Vision Care and members of American International Companies, have earned a reputation for service efficiency and reliability. Between our underwriting companies, they are licensed in all 50 states and the District of Columbia.

AIG is proud to have a division dedicated to the domestic accident and health market. This expertise has helped develop the Domestic A&H Division into a premier marketer of corporate and occupational accident programs, a leader in accident programs for recreational and sporting activities, as well as one of the few insurers providing around-the-clock insurance protection for student and intercultural exchanges, missionary groups, and domestic and international companies.

FINANCIAL STRENGTH

The AIG Companies underwriting the products of the Domestic Accident & Health Division have strong financial ratings, helping assure businesses we'll be there when they need us. These companies include National Union Fire Insurance Company of Pittsburgh, Pa., American International Life Assurance Company of New York, and AIG Life Insurance Company. American International Group, Inc. (AIG), our parent company is the leading U.S.-based international insurance and financial services organization and the largest underwriter of commercial and industrial insurance in the United States.

COVERED BENEFITS

Vision Examination

A comprehensive exam is covered which includes but is not limited to, case history, examination for pathology or anomalies, job visual analysis, refraction, visual field testing, and tonometry, if indicated. The exam will be consistent with the community standards, rules, and regulations of the jurisdiction in which the provider practice is located.

Standard Lenses

Any size lenses manufactured from glass or plastic, which are optically clear; standard multifocal lenses include segments through flat top 35 for plastic bifocal and lenticular lenses, glass trifocals through flat top 28 and plastic trifocals through flat top 35.

Frames

Frames are covered up to the stated retail value shown in this proposal. Any amount in excess of quoted frame allowance is at the Insured's expense. Since our frame allowance is based on a retail value, frame choices are not limited.

Contact Lenses

Contact lenses are available in lieu of all other materials benefits (unless otherwise specified in the policy) up to the stated allowance shown in this proposal. The contact lens benefit includes conventional and disposable lenses.

Medically necessary contact lenses is also covered, but pre-authorization from MES is required. This means vision is not correctable to better than 20/40 in the better eye by the use of conventional lenses.

MESVISION MEMBER DISCOUNTS

A 20% discount is available for cosmetic extras, such as tints, coatings and other add-on charges to standard lenses, after covered benefits are rendered. The discount may be applied to charges for the frame or contact lenses (except disposable or replacement contact lenses) over the stated allowances. The 20% discount also applies to additional pairs of glasses and/or pairs of standard contact lenses. To determine whether a provider offers the 20% discount, an insured individual can review their Participating Provider Directory, visit www.MESVision.com or call MES at (800) 877-6372. Discounts are available through TLCVision for conventional and custom LASIK procedures with the TruVision Advantage Program.

Eye Sight Loss Benefit: Pays lump sum benefits to an insured person who suffers Loss of Eye Sight due to an accident within 90 days from the date of the injury*.

* Injury" means bodily injury: (1) which is sustained as a direct result of an unintended, unanticipated accident that is external to the body and that occurs while the injured person's coverage under the Policy is in force, and (2) which directly (independent of sickness, disease, mental incapacity, bodily infirmity or any other cause) causes a Loss of Sight. "Loss of Sight" means total and irrecoverable loss of the entire sight in that eye due to an Injury.

[Rates quoted for all plans include a total benefit amount for Lost of Sight in both eyes of \$25,000 or one eye of \$12,500. For additional benefit amount please contact your Sales Representative for premium rates.]