8b5A

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

FROM: Human Resource Department

SUBMITTAL DATE:
January 28, 2010

SUBJECT: Approval of the Exclusive Care Select Point of Service Summary Plan Description

RECOMMENDED MOTION: That the Board of Supervisors approves the attached Exclusive Care Select Point of Service Summary Plan Description.

BACKGROUND: On September 15, 2009, Item 3.31, the Board approved the 2010 Medical, Dental, and Vision rates and updated County health care insurance plan designs. There are currently 219 active and retired employees enrolled in this plan, which was specifically designed to replace the Blue Shield Preferred provider Option (PPO). Summary Plan Descriptions (SPD) are provided to eligible members of the plan to describe the benefits and plan provisions. Human Resources developed a SPD to describe the 2010 Point of Service Plan Design that was approved by the Board on September 15, 2009. This SPD contains all approved plan provisions and descriptions of coverage. It has been reviewed and approved by County Counsel.

Ronald W. Komers
Asst. County Executive Officer/Human Resource Director

FORM APPROVED COUNTY COUNSEL
BY: BEAUFORD T. MILLER, JR. DATE
Departmental Concurrence

FINANCIAL DATA				
	Current F.Y. Total Cost:	$ 0	In Current Year Budget:	No
	Current F.Y. Net County Cost:	$ 0	Budget Adjustment:	No
	Annual Net County Cost:	$ 0	For Fiscal Year:	2009/10

SOURCE OF FUNDS: N/A

Positions To Be Deleted Per A-30 ☐

Requires 4/5 Vote ☐

C.E.O. RECOMMENDATION:

APPROVE

BY: Karen L. Johnson

County Executive Office Signature

☐ Consent ☒ Policy

☐ Consent ☒ Policy

Dep't Recomm.:

Per Exec. Ofc.:

Prev. Agn. Ref.: 9/15/09, Item 3.31 | **District:** | **Agenda Number:** 3.36

ATTACHMENTS FILED
WITH THE CLERK OF THE BOARD

Exclusive Care

Exclusive Care Select Point of Service (POS)

Summary Plan Document

January 2010

INTRODUCTION 6

SECTION 1: ELIGIBILITY 8

Health Plan Eligibility 8

Dependent Eligibility 8

Coverage for Disabled Dependents 9

Plan Enrollment Identification Card 9

Mid-Year Changes 9

Termination of Benefits and Re-Enrollment 11

Reinstatement 11

Keeping Enrollment Information Up-to-Date 12

Cost of Enrollment in the Plan 12

SECTION 2: HOW THE SELECT POS PLAN WORKS 12

Choice of Providers 12

Centers of Excellence 13

SECTION 3: SELECT POS PLAN BENEFITS 13

Pre-Authorization Process 22

SECTION 4: SELECT POS - EXPLANATION OF COVERED SERVICES 23

INPATIENT SERVICES 23

OUTPATIENT SERVICES 25

OTHER SERVICES 27

SECTION 5: PLAN EXCLUSIONS AND LIMITATIONS 28

GENERAL EXCLUSIONS 28

SPECIFIC EXCLUSIONS 29

LIMITATIONS 34

SECTION 6: OUTPATIENT PRESCRIPTION DRUG PROGRAM 35

How The Program Works 35

The Drug Formulary 36

Pre Authorization of Non-Formulary Drugs 36

Maintenance Drug Dispensing 37

Mandatory Generic Substitution 38

Mail Order Service 38

Exclusions and Limitations 38

Dispensing Quantity Limitations 40

SECTION 7: MENTAL HEALTH/ SUBSTANCE ABUSE SERVICES 40

Covered Services 40

What To Do In Emergencies 41

Exclusions And Limitations 42

SECTION 8: PLAN GENERAL PROVISIONS 43

CLAIM PAYMENT PROCEDURES 43

MEMBER GRIEVANCE PROCEDURE 44

COBRA CONTINUATION OF COVERAGE 50

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) 53

Exclusive Care – Notice of Privacy Practices 53

Release Of Health Information 58

SECTION 9: PAYMENT BY THIRD PARTIES 58

SECTION 10: HEALTH PLAN ADMINISTRATION AND INTERPRETATION 61

SECTION 11: DEFINITION OF TERMS 62

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

INTRODUCTION

The Exclusive Care Select Point-of-Service (POS) Plan is a Health Plan option provided for employees and under age 65 retirees of the County of Riverside and their Eligible Dependent(s), and for the employees and dependents of other Qualified Public Employer Groups.

The Select POS Plan provides you with a choice when you obtain health care services. You may choose health care providers contracted with the POS Plan or to go to any provider. This gives you more flexibility to choose where you wish to go for care. If you prefer, you can make a different choice each time you need to seek care. Where you receive services will affect how your Benefits are paid, and how much your out-of-pocket cost will be. The choice is yours. You may choose from three types of providers:

- **The Exclusive Care Network** – this is a regional Network, located primarily in Riverside and San Bernadino counties, consisting of Physicians, Medical Groups and Hospitals that have contracted with Exclusive Care to provide Covered Services to Plan Members. By using this Network you receive the highest level of benefits the POS Plan offers, which results in the lowest out-of-pocket costs for you.
- **The National Provider Network** – this is a large national Network of providers under contract with Exclusive Care to provide Covered Services to Plan Members. While you still receive comprehensive affordable Benefits, your out-of-pocket costs will be higher than if you use providers in the Exclusive Care Network. Exclusive Care has contracted with Blue Shield of California as of January 1, 2010 to provide access to the Blue Shield national provider network.
- **Non-Network Providers** – these are providers who are not contracted with Exclusive Care or the National Provider Network. Benefits are paid at the lowest level of the three options, and your out-of-pocket costs are the highest.

Select POS Benefits include preventative care and services to improve your overall health, including specialty services, hospitalization and prescription drugs. Your services will be covered and paid according to where you receive your treatment and based on the coverage amounts outlined in the Schedule of Benefits

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

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

Exclusive Care Select POS Plan	
Plan Sponsor	The County of Riverside and any other Qualified Public Employer Group for its own Members
Plan Administrator	Assistant CEO, Director of Human Resources County of Riverside, Human Resources 4080 Lemon Street, 7th Floor Riverside, CA 92502 (951) 955-3510
Plan Mailing Address	Exclusive Care P.O. Box 1508 Riverside, CA 92502-1508 www.exclusivecare.com
Member Services	(800) 962-1133 Monday through Friday 8:00 a.m. - 5:00 p.m. Pacific Coast Time
Type of Plan	The Plan is a welfare benefit plan established and operated by the County of Riverside that provides health care Benefits for eligible employees of participating Qualified Public Employer Groups.
Type of Funding	The Plan is self-insured and unfunded. In other words, the Plan is funded through premium contributions that are made by its Members and participating Qualified Public Employer Groups, and Benefits are paid from Plan assets, which are maintained by the County of Riverside. The Plan Administrator may also establish a trust for the payment of Benefits.
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, 2010.
SPD Effective Date	The effective date of this SPD is January 1, 2010

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

SECTION 1: ELIGIBILITY

Health Plan Eligibility

You are eligible to enroll in the Select POS Plan if:

- You are an employee or Eligible Dependent of the County of Riverside or of a Qualified Public Employer Group that offers the Exclusive Care Select POS Plan;
- You are a County of Riverside retiree under age 65.

Eligibility requirements are established by your employer group and are detailed in the Group Healthcare Services Agreement signed by your employer group. Contact your employer group for the dependent eligibility requirements including any age limits for dependents. County of Riverside eligibility requirements are detailed in employee benefits medical plan eligibility requirements available through Human Resources.

Dependent Eligibility

If your employer group provides dependent coverage and you are enrolled in the Health Plan option applicable to you, your legal spouse or Domestic Partner and Eligible Child (ren) may also enroll in the same Health Plan, subject to the following:

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

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

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

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

Children who are over your employer group's limiting age, who reside with either you or your separated or divorced spouse, are incapable of self-sustaining employment by reason of mental handicap, debilitating Chronic Condition, or physical handicap that existed continuously prior to your employer group's limiting age and who are dependent upon you for support and maintenance, and who would otherwise be eligible to enroll as Eligible Children except for the fact that they are older than the limiting age, may enroll or continue enrollment beyond the limiting age, provided proof of such incapacity is provided within sixty (60) days of the onset of the Disability, or attainment of the limiting age.

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

Plan Enrollment Identification Card

Once you are enrolled in the Plan, you and any enrolled dependent(s) will receive a new Member packet with identification cards, identifying you as a Member of the Select POS Plan. You will also receive an identification card from the National Provider Network to use for services you receive from Tier 2 providers. Carry your identification cards with you at all times. Present the correct identification card to the provider whenever you receive services. If an identification card is ever damaged, lost, or stolen, contact the Member Services Department at (800) 962-1133 and a new card will be sent to you.

Mid-Year Changes

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

- Marriage;
- Divorce or legal separation;
- Birth or adoption of a child;
- Death of an Eligible Dependent;

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

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

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

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

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

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

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

Termination of Benefits and Re-Enrollment

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

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

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

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

Reinstatement

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

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

The maximum retroactive reinstatement period is 60 days.

Keeping Enrollment Information Up-to-Date

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

Cost of Enrollment in the Plan

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

SECTION 2: HOW THE SELECT POS PLAN WORKS

The Plan provides benefits for Covered Services based on three levels of coverage, and these coverage levels are determined by the type of provider you use.

Choice of Providers

PLEASE READ THE FOLLOWING INFORMATION SO THAT YOU WILL KNOW WHICH PROVIDERS ARE AVAILABLE TO YOU AND WHAT TO EXPECT IN BENEFIT PAYMENTS AND OUT-OF-POCKET COSTS:

- **Tier 1: Exclusive Care Network:** By obtaining your care from Tier 1 Network providers, you receive the highest benefits available with the lowest out-of-pocket costs. For preventative care and certain basic services you will simply pay a low Copay.
- **Tier 2: National Provider Network:** Contracted with Exclusive Care to provide Covered Services nationwide, the Tier 2 Network provides comprehensive, affordable benefits but your out-of-pocket costs will be higher than in Tier 1. Exclusive Care has contracted with Blue Shield of California as of January 1, 2010 to provide access to the Blue Shield national provider network.
- **Tier 3**: **Non-Network Providers:** These are providers who are not contracted with the Plan. Your out-of-pocket costs are the highest with Tier 3. Any licensed Health Care Professional or facility can deliver care to you; however, reimbursement will be based on an Allowed Charge determined by the Plan (refer to "Definition of Terms" in this SPD for more details). The Health Care Professional or facility may or may not choose to accept this amount and may "Balance Bill" you for the difference between what was charged and what the Plan paid (in addition to any Coinsurance, Copay, and Deductible amounts due from you).

For additional information about the Networks, contact the Member Services Department at (800) 962-1133 or visit the Exclusive Care website at: www.exclusivecare.com

Centers of Excellence

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

You must obtain pre authorization for services in cardiac care, complex and rare cancer treatments, transplant services, joint replacement surgery, mental health care and other highly specialized complex care. The POS Plan will pay Benefits at the Tier 1 level for all Allowed Charges approved through this Centers of Excellence program. Services in any of these categories obtained at facilities not designated as Centers of Excellence will be reimbursed at the Tier 3 level, as Non-Network Providers.

For more information about Centers of Excellence, contact Exclusive Care's Medical Management Unit at (800) 962-1133.

SECTION 3: SELECT POS PLAN BENEFITS

When you need to access your benefits, where you receive services will affect how your Benefits are paid, and how much your out-of-pocket costs will be. The choice is yours. You may choose from three options; benefits are determined based on which Tier of coverage you choose as outlined below:

The Exclusive Care Select POS – Benefits At A Glance			
	Tier 1 **Exclusive Care Network**	**Tier 2** **National Provider Network**	**Tier 3** **Non-Network Provider**
Deductible	$250/person $750/family	$500/person $1,500/family	$1,000/person $3,000/family
Coinsurance	90%	80%	60% of Allowed Charges

Office Visit Copay	$10 – primary care $20 –Specialists	$25 – primary care $50 –Specialists	Deductible and Coinsurance both apply
Out-of-Pocket Maximum	$1,500/person $4,500/family	$2,500/person $7,500/family	$5,000/person $15,000/family
Lifetime Maximum	$1,000,000/Member		
Pre-existing Conditions	Fully Covered		

An explanation of the terms used in the preceding table follows below, to help you get the most out of your coverage:

Deductible – Each Person

The Deductible is the portion of Covered Services you must pay each Calendar Year before the Plan will pay any benefits. The Deductible applies across all three tiers of coverage.

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

Deductible - Family

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

Coinsurance

After the Deductible is paid, you will also be required to pay a percentage of the cost for most health care services you receive; this is called the Coinsurance amount.

Copays

These are flat dollar amounts you pay for certain Covered Services when using the Exclusive Care and National Provider Networks, such as office visits, preventative care and outpatient prescription drugs. After you pay the required Copay, the Plan will pay the remainder of the covered costs. Except as noted in the Schedule of Benefits below, Deductible and Coinsurance amounts do not apply to any services where only a Copay

is required. Copays do not count toward Deductibles or toward the out-of-pocket maximums.

Out-of-Pocket Maximum

The Plan helps protect you from costly medical expenses by limiting the out-of-pocket amount you pay for certain services in any one Calendar Year. When the Coinsurance amount that you or any enrolled dependent has paid for these services reaches the designated level (the Out-of-Pocket Maximum), you will pay nothing further for Covered Services for the rest of the Calendar Year (up to any benefit maximums that may apply). If the Coinsurance paid by three or more of your covered family Members reaches the family out-of-pocket maximum, the Plan will pay 100% of Covered Services for you and your enrolled family Members for the rest of the Calendar Year. There is a separate out-of-pocket maximum for each tier of coverage. However, the amount applied toward your out-of-pocket maximum in one tier will also count toward your out-of-pocket maximum in any other Tier.

Out-of-Pocket amounts you pay which do not count towards each Member's Out-of-Pocket Maximum include:

- Deductibles;
- Copays;
- Charges in excess of the Allowed Charges covered by the Plan;
- Charges for services that are not Covered Services under the Plan such as a charge for a service listed as an exclusion;
- Charges for services for which no Benefit is payable because the dollar or benefit limit has been exceeded;
- Prescription drug flat dollar amount Copays.

Allowed Charges

For services provided by a Non-Network Provider (Tier 3), the Plan's reimbursement to the provider is based on an Allowed Charge, which is consistent with the current rate or charge for the service being rendered, in a certain geographic area, for identical or similar services as determined by the Plan and subject to all other terms of this Summary Plan Document.

Lifetime Maximum Benefit

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

Pre-Existing Conditions

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

Network Providers

When you use Tier 1 or Tier 2 Network providers, the Plan pays Benefits based on Allowed Charges that have been negotiated between the Plan and the provider. Network providers have agreed to accept the Plan's Allowed Charges as payment in full, which means they cannot "Balance Bill" you for amounts above this negotiated amount. You are still responsible for your portion of the Allowed Charges (any required Copays, Deductible, and Coinsurance).

✓ ***Note that some services—such as preventative care, hearing tests, and allergy testing and treatment—are only covered if you go to a Tier 1 or Tier 2 Network provider.***

Non-Network Providers

Tier 3 Non-Network Providers have not been contracted by Exclusive Care or Blue Shield of California to accept the Plan's Allowed Charges as payment in full. If you seek care from a Non-Network Provider, your Benefits will be paid based on the Plan's Allowed Charges. You are responsible for paying any amount in excess of the Allowed Charge, in addition to any Deductible, Coinsurance or Copay amounts required from you.

Schedule of Benefits – Select POS Plan			
Type of Service	Tier 1 Exclusive Care Provider Network	Tier 2 National Provider Network	Tier 3 Non Network Provider
Preventative Care Services			
Periodic Health Evaluation	$10 Copay; Deductible does not apply	$25 Copay; Deductible does not apply	Not covered
Well Baby Care	$10 Copay; Deductible does not apply	$25 Copay; Deductible does not apply	Not covered
Well Woman Care	$10 Copay; Deductible does not apply	$25 Copay; Deductible does not apply	Not covered
Vision Exam	$10 Copay; Deductible does not apply	$25 Copay; Deductible does not apply	Not covered
Outpatient Prescription Drugs (Deductible Does Not Apply)			

Schedule of Benefits – Select POS Plan			
Type of Service	Tier 1 **Exclusive Care Provider Network**	Tier 2 **National Provider Network**	Tier 3 **Non Network Provider**
Prescription Drug Coverage is administered by the Plan's Pharmacy Benefit Manager (PBM)			
Participating Retail Pharmacy (up to a 30-day supply)	Generic Drugs: $15 Copay Brand Name Formulary Drugs: $25 Copay Brand Name Non-Formulary Drugs: $40 Copay • Significant or new therapeutic class drugs: 50% Coinsurance • Additional Benefits for Members with Diabetes are described in the section below		
If you use Exclusive Care's Rubidoux Pharmacy you can receive up to 3 months (90 days) of medication for only 2 Copays (saving you 1 Copay)			
Exclusive Care Rubidoux Pharmacy (up to a 90-day supply)	Generic Drugs: $30 Copay Brand Name Formulary Drugs: $50 Copay Brand Name Non-Formulary Drugs : $80 Copay • Significant or new therapeutic class drugs: 50% Coinsurance • Additional Benefits for Members with Diabetes are described in the section below		
Exclusive Care Rubidoux Mail-Order Pharmacy (up to a 90-day supply)	Generic Drugs: $30 Copay Brand Name Formulary Drugs: $50 Copay Brand Name Non-Formulary Drugs: $80 Copay • ***Mail-Order is MANDATORY for maintenance medications after the first 30-day prescription trial.*** • Significant or new therapeutic class drugs: 50% Coinsurance • Additional Benefits for Members with Diabetes are described in the section below		
Members Requiring Diabetes Care	Pharmacy Copays are waived for all Generic and Brand Name Formulary injectible and oral anti-diabetic medications and diabetic supplies (testing strips, syringes, etc)		
Hospital/Facility Services			
Inpatient Medical/ Maternity/Surgical/Intensive Care (semi-private room)	**Pre-Authorization Required**		
	90% of Network contracted rate	80% of Network contracted rate	60% of Allowed Charges

Schedule of Benefits – Select POS Plan			
Type of Service	Tier 1 **Exclusive Care Provider Network**	Tier 2 **National Provider Network**	Tier 3 **Non Network Provider**
Inpatient Medical/ Maternity/Surgical/Intensive Care (ancillary)	**Pre-Authorization Required**		
	90% of Network contracted rate	80% of Network contracted rate	60% of Allowed Charges
Transplants / Orthopedic / Cardio Vascular / Oncology	**Pre–Authorization Required**		
	90% of Network contracted rate	80% of Network contracted rate	60% of Allowed Charges
Skilled Nursing Facility ➢ Maximum 100 days/Calendar Year (combined across all Tiers)	**Pre-Authorization Required**		
	90% of Network contracted rate	80% of Network contracted rate	60% of Allowed Charges
Outpatient Medical/Surgical Care	**Pre Authorization Required**		
	90% of Network contracted rate	80% of Network contracted rate	60% of Allowed Charges
Physician & Professional Services			
Physician Office Visit (Primary Care)	$10 Copay; Deductible does not apply	$25 Copay; Deductible does not apply	60% of Allowed Charges
Physician Office Visit (After Hours)	$20 Copay; Deductible does not apply	$50 Copay; Deductible does not apply	60% of Allowed Charges
Physician Office Visit (Specialty Care)	$20 Copay; Deductible does not apply	$50 Copay; Deductible does not apply	60% of Allowed Charges
Inpatient Physician Visit	$10 Copay; Deductible does not apply	$25 Copay; Deductible does not apply	60% of Allowed Charges
Outpatient Physician Visit (including Emergency Room)	$10 Copay; Deductible does not apply	$25 Copay; Deductible does not apply	60% of Allowed Charges
Maternity Care	90% of Network contracted rate	80% of Network contracted rate	60% of Allowed Charges
Anesthesiology – Inpatient and Outpatient	90% of Network contracted rate	80% of Network contracted rate	60% of Allowed Charges
Immunizations and Injections – Office	$10 Copay; Deductible does not apply	$25 Copay; Deductible does not apply	Not Covered

Schedule of Benefits – Select POS Plan			
Type of Service	Tier 1 Exclusive Care Provider Network	Tier 2 National Provider Network	Tier 3 Non Network Provider
Allergy Testing	90% of Network contracted rate	80% of Network contracted rate	Not covered
Allergy Treatment/Serum	90% of Network contracted rate	80% of Network contracted rate	Not covered
Family Planning – Tubal Ligation, Elective Abortion, Vasectomy	90% of Network contracted rate	80% of Network contracted rate	Not covered
Surgical Services	**Pre-Authorization Required**		
Physician's Office	90% of Network contracted rate	80% of Network contracted rate	60% of Allowed Charges
Inpatient	90% of Network contracted rate	80% of Network contracted rate	60% of Allowed Charges
Outpatient (including Emergency Room)	90% of Network contracted rate	80% of Network contracted rate	60% of Allowed Charges
Other Medical Services			
Home Health Care (instead of Inpatient Hospital Care) ➢ Maximum 26 days/Calendar Year(combined across all Tiers)	**Pre-Authorization Required**		
	90% of Network contracted rate	80% of Network contracted rate	60% of Allowed Charges
Hospice Care	**Pre-Authorization Required**		
	90% of Network contracted rate	80% of Network contracted rate	60% of Allowed Charges
Hearing Care			
Routine Hearing Exam	$10 Copay; Deductible does not apply	$25 Copay; Deductible does not apply	Not covered
Hearing Test ➢ Limited to $1,000 maximum Benefits every five (5) years	90% of Network contracted rate	80% of Network contracted rate	Not covered

Schedule of Benefits – Select POS Plan			
Type of Service	Tier 1 **Exclusive Care Provider Network**	Tier 2 **National Provider Network**	Tier 3 **Non Network Provider**
Hearing Aid ➢ Limited to $1,000 maximum Benefits every five (5) years	90% of Network contracted rate	80% of Network contracted rate	Not covered
Accident & Emergency Care Services			
Emergency Room & Care*	$50 Copay, then 90% of Network contracted rate; Deductible does not apply	$100 Copay, then 80% of Network contracted rate; Deductible does not apply	$100 Copay, then 80% of Allowed Charges; Deductible does not apply
Urgent Care Clinic	$20 Copay; Deductible does not apply	$50 Copay; Deductible does not apply	60% of Allowed Charges;
Ambulance – Land/Air (as Medically Necessary)	90% of Network contracted rate	80% of Network contracted rate	80% of Allowed Charges

* **Benefits will only be paid for emergency admissions when the Plan receives notification within 48 hours, the next business day, or when medically reasonable, whichever is earliest, and the admission is authorized by the Plan.**

Diagnostic Testing			
Minor Diagnostic Testing, X-Ray or Lab	90% of Network contracted rate	80% of Network contracted rate	60% of Allowed Charges
Radiology/Pathology – Inpatient, Outpatient, or Emergency Room	90% of Network contracted rate	80% of Network contracted rate	60% of Allowed Charges
Major Diagnostic Testing, CT Scan, MRI, NMR	**Pre-Authorization Required**		
	90% of Network contracted rate	80% of Network contracted rate	60% of Allowed Charges
Rehabilitation Therapy			
Physical, Speech, Occupational Therapy – Inpatient or Outpatient (maximum 20 visits/ Calendar Year)	**Pre–Authorization Required**		
	90% of Network contracted rate	80% of Network contracted rate	60% of Allowed Charges
Cardiac or Pulmonary Therapy –	**Pre Authorization Required**		

Inpatient or Outpatient	90% of Network contracted rate	80% of Network contracted rate	60% of Allowed Charges
Medical Supplies & Equipment			
Medical Supplies (Physician's Office)	90% of Network contracted rate	80% of Network contracted rate	60% of Allowed Charges
Other Medical Supplies	90% of Network contracted rate	80% of Network contracted rate	60% of Allowed Charges
Durable Medical Equipment ➢ Maximum Calendar Year Benefit: $1,000/person/ Calendar Year	90% of Network contracted rate	80% of Network contracted rate	60% of Allowed Charges
Severe and Non-Severe Mental Health Treatment	**Pre-Authorization Required**		
Inpatient Facility Care (semi-private room)	90% of Network contracted rate	80% of Network contracted rate	60% of Allowed Charges
Inpatient Facility Care (ancillary)	90% of Network contracted rate	80% of Network contracted rate	60% of Allowed Charges
Inpatient Facility Physician Visit	90% of Network contracted rate	80% of Network contracted rate	60% of Allowed Charges
Outpatient Hospital Services	$20 Copay; Deductible does not apply		60% of Allowed Charges
Outpatient Office Visit (psychologist, psychiatrist, MSCW, APRN) [1]	$20 Copay; Deductible does not apply		60% of Allowed Charges
Substance Abuse Treatment	**Pre-Authorization Required**		
Inpatient Care	90% of Network contracted rate	80% of Network contracted rate	60% of Allowed Charges
Inpatient Detoxification	90% of Network contracted rate	80% of Network contracted rate	60% of Allowed Charges
Outpatient Hospital Services	$20 Copay; Deductible does not apply		60% of Allowed Charges
Outpatient Office Visit (Psychologist, Psychiatrist, MSCW, and APRN)	$20 Copay; Deductible does not apply		60% of Allowed Charges

Note that a Tier 3 non-Network provider may or may not accept the "Allowed Charge" paid by the Plan and may "Balance Bill" you for the difference between what was actually charged and what the Plan paid, <u>in addition</u> to any Deductible, 20%, 40%, or 50% Coinsurance, or Copay that you owe.

Pre-Authorization Process

Centers of Excellence – Complex Care Management

Exclusive Care has partnered with Blue Shield of California to provide access to medical facilities that have demonstrated expertise in delivering quality healthcare. The Blue Distinction Centers for Specialty Care® use over 800 centers across the nation with expertise in cardiac care, complex and rare cancer treatments, transplant services and other highly specialized complex care programs. The designation is based on rigorous, evidence-based, objective selection criteria established in collaboration with expert physicians' and medical organizations' recommendations. Plan Members with any of these special treatment needs will be evaluated through the pre-authorization process and other medical management programs to improve the overall quality and delivery of healthcare, resulting in better overall health outcomes. You must obtain pre authorization for services in cardiac care, complex and rare cancer treatments, transplant services, joint replacement surgery, mental health care and other highly specialized complex care. When pre authorization is obtained for these services, the Plan will pay Benefits at the Tier 1 level for all approved, Allowed Charges. Services in any of these categories obtained at non-designated Centers will be reimbursed as Non-Network providers. For more information contact the Medical Management Unit at (800) 962-1133.

Major Diagnostic Testing

You must obtain pre- authorization from the Plan for Major Diagnostic Tests. The Plan's reimbursement amount will be reduced by 50% for unauthorized, Medically Necessary tests. Major Diagnostic Tests are diagnostic tests including, but not limited to: Magnetic Resonance Imaging (MRIs), Positron Emission Tomography (PET) scans, and Nuclear Magnetic Resonance Spectroscopies (NMRs). The following diagnostic tests DO NOT require pre- authorization:

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

- Cardiac stress tests
- Colonoscopies for Members age 50 years and older
- Mammograms for women age 40 and over, or Mammograms as follow-up after abnormal results.

Other Services

Pre-authorization is also required for:

- Hospital Inpatient Services
- Inpatient Maternity Care
- Intensive Care
- Skilled Nursing Facility Services
- Outpatient Surgery
- Inpatient Surgery
- Home Health Care
- Hospice Care
- Physical, Speech, or Occupational Therapy
- Cardiac or Pulmonary Therapy
- Mental Health and Substance Abuse Treatment Services (non-Emergency)

FOR SERVICES REQUIRING PRE-AUTHORIZATION, NO BENEFITS WILL BE PAID IF YOU OBTAIN SERVICES WITHOUT AUTHORIZATION FROM THE PLAN.

SECTION 4: SELECT POS - EXPLANATION OF COVERED SERVICES

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

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

INPATIENT SERVICES

Room and Board

Semi-private room, Intensive care unit (private room), operating, recovery and special treatment rooms;

Additional Inpatient Services

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

Physician, Surgeon and Anesthesiologist Services

Skilled Nursing Facility or Convalescent Care

Autologous Blood - administration of Blood and Blood Plasma

The processing and storage of Autologous Blood for scheduled medical procedures;

Maternity Care

Hospital and other related services, Physician and medical services for normal vaginal delivery, Caesarean Section, and complications of pregnancy. Elective termination of pregnancy coverage is limited to first and second trimester; no coverage during the third trimester unless mother's life is in jeopardy.

The Plan will not restrict Benefits for any Hospital length of stay in connection with childbirth for the mother or eligible newborn child to less than forty-eight (48) hours following a normal vaginal delivery, or less than ninety-six (96) hours following a Caesarean Section, or require that a provider obtain authorization from the Plan for prescribing a length of stay not in excess of the above 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 the newborn earlier than 48 hours (or 96 hours as applicable). In any case, the Plan may not, under Federal law, require that a provider obtain authorization from the Plan for prescribing a length of stay not in excess of 48 hours (or 96 hours);

Newborn Care

If your employer group provides dependent coverage, newborns who are born while the mother is covered under the Plan are also covered by the Plan for up to 30 days after birth. These newborns will be identified using the mother's Member ID. Newborn dependent coverage will only be extended beyond the first 30 days after birth if the child is enrolled in the Plan as a dependent within the first 30 days after birth.

Breast Reconstructive Surgery

Under the Women's Health And Cancer Rights Act, the Plan is required 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, Copays, and Coinsurance amounts that are consistent with those that apply to other Benefits under the Plan.

Inpatient Dental Care

Inpatient services associated with dental procedures under the following circumstances:

- ✓ the Member is a child, up to 6 years old, with a dental condition (such as baby bottle syndrome) that requires administration of general anesthesia in a hospital setting for dental repairs of significant complexity (e.g., multiple amalgam and/or resin-based composite restorations, pulpal therapy, extractions or any combinations of these noted or other dental procedures); or,

- ✓ the Member exhibits physical, intellectual, or medically compromising conditions, is in need of dental treatment that requires administration of general anesthesia, and for whom administration of a general anesthesia can only be safely performed in a hospital setting. Conditions include but are not limited to: mental retardation, cerebral palsy, epilepsy, cardiac problems and hyperactivity (verified by appropriate medical documentation).

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

OUTPATIENT SERVICES

Ambulance Service

Land or air;

Emergency Care Services

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

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

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

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

Specialist and Consultant Visits

Home Health Care Visits

Prenatal and Postnatal Care

Allergy Testing and Treatment

Hearing Screening when performed in a Physician's office;

Ambulatory Surgical Center

Diagnostic X-Ray and Laboratory Services

Procedures consistent with established medical practices;

Durable Medical Equipment

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

Immunizations or Vaccinations
Childhood immunizations and adult immunizations, including Hepatitis B, as required for a public employee's safety. Not covered for travel or vacation purposes.

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

Charges for Second Medical Opinion

Immunizations

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

Hearing Aid Benefit

Covered Expenses include:

- ✓ An audiological evaluation to measure the extent of hearing loss;

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

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

Family Planning Services

- ✓ Physician visits for contraceptive devices and oral contraceptive prescriptions;
- ✓ Vasectomy;
- ✓ Tubal ligation;
- ✓ Injectible contraceptives;
- ✓ Implantable contraceptives;

Well Woman Care

- ✓ Annual pelvic examination and PAP smear based on current recommendations from the US Preventive Services Task Force and your PCP's assessment of need (subject to medical review);
- ✓ Periodic clinical breast examination and annual clinical breast examination for women age 40 and above; and,
- ✓ Baseline mammogram for women of average risk starting at age 40, and annually thereafter. Mammograms may be performed earlier if clinically indicated;

OTHER SERVICES

Hospice Care

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

- ✓ Has been certified by the attending Physician to have 180 days of life expectancy or less;
- ✓ Decided to no longer pursue aggressive medical treatment; and,

The goal of treatment is to provide supportive nursing care and counseling to the Member during the terminal phase of illness, social services evaluation, and Home Health aid services.

Organ Transplants

Cost of organ procurement - when the organ is harvested from a living donor, the Plan will cover Medical and Hospital services and other costs of a donor or prospective donor when the recipient is a Member:

:

- ✓ Medical expenses incurred by the organ donor for the surgical procedure and associated Hospital stay for harvesting of the donated organ if expenses incurred exceed any benefits available through any other insurance plan. Expenses are limited to the donor's Inpatient Hospital stay for the organ harvesting, and related follow-up care for sixty (60) days following the organ harvesting.

- ✓ Costs related to a donor search - limited to a maximum benefit of $15,000 each organ transplant when the search is conducted by a special transplant facility, or $5,000 each organ transplant when the search is conducted by other facilities.

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

- ✓ Coach airfare on a public airline for the organ recipient and one companion (two companions if the organ recipient is a minor child) to travel to and from the site of the transplant. A "companion" includes the organ recipient's legal spouse, legal parent(s) or legal guardian(s);

- ✓ Reimbursement for mileage at the federal maximum rate for use of a personal car or rental car used to travel to and from the site of the transplant;

- ✓ Up to $200/day for reasonable and necessary lodging and meals for the organ recipient (while not confined) and companion(s). The $200/day maximum applies to the organ recipient and companion(s) collectively, not individually.

SECTION 5: PLAN EXCLUSIONS AND LIMITATIONS

GENERAL EXCLUSIONS

Any services not specifically included in the preceding "Schedule of Benefits" and "Explanation Of Covered Services" sections of this document;

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

- Services rendered prior to your Plan effective date or after Plan termination date.
- Services received that, based on Medical Management review, are not Medically Necessary or not required in accordance with professionally recognized standards of proven and effective medical practice recognized within the organized medical community.
- Services that are part of a treatment plan for a non-Covered Service. This may include services and supplies to treat medical conditions which are recognized by the organized medical community in the State of California, in conformance with professionally recognized standards of practice, to be direct and predictable consequences of such non-Covered Services; Medically Necessary services required to treat medical conditions that may arise but are not predictable in advance, such as unexpected complications of surgery, are not subject to this exclusion;
- Charges incurred while on active duty with the Army, Navy or Air Force of any country or international organization.
- Services rendered in excess of the benefit levels provided by the Plan.
- Charges in excess of the Plan's Allowed Charges.
- Changes submitted for which you are not obligated to pay, or for which you would not have been billed had insurance coverage not existed.

SPECIFIC EXCLUSIONS

Acupuncture, Acupressure or Biofeedback;

Ambulance Service -except when Medically Necessary or necessitated by a life-threatening emergency;

Alternative Treatments - such as aromatherapy, hypnotism, rolfing, massage therapy;

Bariatric, Gastric Bypass Surgery And Other Weight Reduction Surgeries - For further details, refer to Weight Control Programs section;

Bone Marrow Transplants – except when used to treat medical conditions which have extensive statistical results outlining the effectiveness, bone marrow transplants are not covered when determined by the Plan to be Experimental or Investigational;

Chiropractic Care;

Cosmetic Surgery - Services or supplies related to cosmetic surgery, unless required as a result of an illness or injury sustained while covered under the Plan, or to correct a functional defect resulting from a congenital abnormality or developmental anomaly;

Complications of cosmetic surgery or drugs prescribed for cosmetic purposes; cosmetic or reconstructive surgery used to alter and/or improve your physical appearance or to improve your self-esteem, which provides no improvement to a functional impairment;

Custodial or Domiciliary Care - such as homemaker services, Respite Care, convalescent care or extended care not requiring skilled nursing;

Dental Appliances;

Dental Care Services - required for prevention and treatment of diseases and disorders of the teeth, including, but not limited to:

- ✓ Oral exams, X-rays, routine fluoride treatment, plaque removal, tooth decay, dental embryonal tissue disorders, periodontal disease;
- ✓ Anesthesia, repair and restoration, tooth extraction, replacement of missing teeth, dental implants, dentures and other oral prosthetic devices;
- ✓ Dental services rendered more than six months after an accidental injury to sound natural teeth;
- ✓ Treatment, prevention or relief of pain for dysfunction of the temporomandibular joint or the muscles of mastication;

Developmental Disorders- services primarily oriented towards treating a social, developmental or learning problem rather than a medical diagnosis, including treatment for dyslexia, and behavioral modification therapy;

Disabilities Connected to Military Service - for which you are legally entitled to care through a Federal government agency, and to which you have reasonable access;

DNA Testing - if not related to a specific medical diagnosis;

Drug Testing - for a non-medical diagnosis;

Replacement of Durable Medical Equipment, corrective appliances, or Prosthetics including;

- ✓ Additional optional accessories to durable medical equipment, corrective appliances, or Prosthetics, which are primarily for your comfort or convenience;
- ✓ Personal comfort items such as electric heating or cooling units, orthopedic mattresses or support chairs, blood pressure instruments, scales, elastic bandages or support stockings, waterbeds, exercise equipment and swimming pools, motorized scooters and/or wheelchairs, home or automobile remodeling/modification. This includes Prosthetics that require surgical connection to nerves, muscles or other tissues (bionic) and Prosthetics that have electric motors to enhance motion (myoelectronic);

Experimental Or Investigational Treatment

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

- Any drug, device, treatment, or procedure shall be deemed as Experimental or Investigational treatment if, as determined solely by the Plan, any one or more of the following criteria are met:
  - ✓ It cannot be lawfully marketed without the approval of the United States Food and Drug Administration ("FDA") and such approval has not been granted at the time of its use or proposed use;
  - ✓ It is the subject of a current investigational new-drug or new-device application on file with the FDA;
  - ✓ It is being provided pursuant to a Phase I or Phase II clinical trial or as the experimental or research arm of a Phase III clinical trial, as these Phases are defined in regulations and other official actions and publications issued by the FDA and the Department of Health and Human Services ("HHS");
  - ✓ It is being provided pursuant to a written protocol that describes among its objectives determinations of safety and/or efficacy as compared with the standard means of treatment;
  - ✓ It is being delivered or should be delivered subject to the approval and supervision of an institutional review board as required and defined by Federal regulations and other official actions and publications issued by the FDA and the HHS;
  - ✓ The predominant opinion among experts as expressed in the published authoritative literature is that usage should be substantially confined to research settings;
  - ✓ The predominant opinion among experts as expressed in the published authoritative literature is that further research is necessary in order to define safety, toxicity, effectiveness or effectiveness compared with conventional alternatives;
  - ✓ It is not investigational or experimental in itself pursuant to the above, and would not be Medically Necessary, but for the provision of a drug, device, treatment, or procedure which is Investigational or Experimental.
- The exclusive sources of information to be relied upon by the Plan in determining whether a particular treatment is Experimental or Investigational, and therefore not a Covered Service under the Plan, are limited to the following:
  - ✓ The Member's medical records;
  - ✓ The protocol(s) pursuant to which the drug, device, treatment, or procedure is to be delivered;
  - ✓ Any consent document the Member, or his/her representative, has executed or will be asked to execute, in order to receive the drug, device, treatment, or procedure;
  - ✓ The published authoritative medical or scientific literature regarding the drug, device, treatment, or procedure at issue as applied to the medical condition at issue;

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

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

Eye Surgery

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

Foot Care

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

Gender Reassignment - consultation and/or surgery;

Home Birth Services;

Hypnotherapy - including behavior training, sleep therapy, education programs;

Infertility Services -, including diagnostic testing, treatment, and surgery;

Institutional Services And Supplies - Non-Eligible

- Services or supplies furnished by a non-eligible institution, which is defined as other than a legally operated hospital, outpatient surgical center, or Medicare-approved Skilled Nursing Facility, or which is primarily a place of rest, a place for the aged, a nursing home, or any similar institution, regardless of how denominated;

Non-Medical Self-Care or Self-Help - treatment for any illness or injury when not attended by a licensed physician, surgeon or health care professional;

Nursing-Private Duty - unless determined to be Medically Necessary and approved by the Plan's Medical Director;

Nutritional Supplement Formulas - such as Phenylketonuria (PKU) formula is limited to under age thirteen (13), or as Medically Necessary;

Organ Donor Services - such as medical and hospital services and other costs of a donor or prospective donor when the recipient is not a covered Member;

Organ transplants - that are not Medically Necessary and organ transplants considered Experimental or Investigational as defined herein;

Orthodontia and/or Orthodontic Injury Treatment;

Orthotic Supplies (except for diabetics);

Physical Examinations - for insurance, licensing, employment, school, camp, recreational or organizational, including appearances at hearings or court proceedings, examinations precedent to engaging in travel, or other non-preventive purposes, pre-employment physicals or vocational rehabilitation, or for pre-marital and pre-adoption purposes;

Pregnancy of Covered Dependent - services related to a non-spousal dependent's pregnancy are limited to prenatal care of the dependent. Charges for all services related to the birth/delivery of the dependent's newborn are excluded, including pediatric services;

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

Prosthetic for Sexual Dysfunction;

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

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

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

Recreational or Educational Therapy - and any related diagnostic testing except as provided as part of an otherwise covered Inpatient hospitalization;

Rehabilitation - long term, maintenance, or chronic level rehabilitation services including physical, Occupational and speech therapy provided on an Inpatient or Outpatient basis;

Reversal of Voluntary Sterilization;

Self Inflicted Injuries/Suicide Attempts - medical expenses arising from treatment of physical/medical needs related to any suicide attempt or from any intentionally self-inflicted injury;

Sex Transformations;

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

Skilled Nursing Care/Transitional Care - Skilled Nursing Facility room and board charges incurred beyond the limits outlined in the "Schedule of Benefits" section for each qualifying condition. A qualifying condition is a medical condition which requires skilled nursing services, which as a practical matter, determined by the Plan and the Member's Physician, cannot be delivered in a setting other than a Hospital or a Skilled Nursing Facility. A medical condition will not be considered a qualifying condition if during the 60 days preceding the medical condition, the Member has received skilled nursing services;

Snoring Corrective Treatments;

Surrogate Pregnancy;

Temporomandibular Joint (TMJ) Disorder;

Unlicensed Services - not supervised by a licensed professional;

Vision Care - eye refractive examinations, corrective lenses and frames, contact lenses, contact lens fitting and measurements (except post cataract extraction, keratoconus, aphakic or corneal bandages), vision correction surgery, including but not limited to, radial keratotomy and refractive keratoplasty

Vitamins - including minerals, nutritional supplements, or similar products;

Weight Control Programs (Inpatient Or Outpatient) - Eating disorder programs for dietary control, surgery or other treatment of obesity such as food and food supplements, laboratory tests in association with weight reduction programs, vitamins, gastric by-pass and bubble, Roux-en-Y gastric bypass, Laparoscopic Gastric Banding, Biliopancreatic diversion with duodenal switch or other similar procedures, or bariatric surgery related surgeries;

Work-Related Illnesses/Injuries - Injury, sickness or disease which arises out of or in the course of any employment, or which is covered under any workers' compensation law or similar law.

LIMITATIONS

Circumstances Beyond the Plan's Control

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

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

Major Disaster Or Epidemic

In the event of any major disaster or epidemic, Participating Providers shall provide or attempt to arrange for the provision of Covered Services insofar as is practical, according to their best judgment, within the limitations of such facilities and personnel as are then available, but neither the Plan, nor its Participating Providers have any liability or obligations for delay or failure to provide any such services or personnel if such lack is the result of such disaster or epidemic.

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.

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

SECTION 6: OUTPATIENT PRESCRIPTION DRUG PROGRAM

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

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

How The Program Works

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

The Drug Formulary

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

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

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

- Federal Legend Drugs: Any medicinal substance which bears the legend: "Caution: Federal law prohibits dispensing without a prescription";
- State Restricted Drugs: Any medicinal substance that may be dispensed by prescription only according to state law;
- Compounded Medication: Any medicinal substance that has at least one ingredient that is Federal Legend or State Restricted in a therapeutic amount;
- Generic Drugs: Generic Drugs will be automatically substituted for Brand- Name Drugs if available, unless the Physician has indicated "Dispense as Written" on the prescription;
- Insulin, insulin syringes, blood glucose test strips, lancets, inhaler extender devices, epipens and anakits;
- Federal Legend oral contraceptives, prescription diaphragms.

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

Pre Authorization of Non-Formulary Drugs

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

- No Formulary alternative is appropriate and the Plan determines the drug is Medically Necessary for your individual needs;

- The Formulary alternative has failed after therapeutic trial. Your prescribing Physician will be asked to provide a copy of your medical chart notes that specifically state treatment failure with the Formulary drug;
- You have been under treatment and remain stable on a non-Formulary prescription drug and conversion to a Formulary drug would be medically inappropriate;
- You have experienced a typical allergic reaction or medically established adverse reaction which are effects related to the chemical properties of the Formulary drug. These allergies and/or adverse effects are attributed to formulations or differences in absorption, distribution or elimination; and,
- Your Physician provides evidence in the form of documents, records or clinical tests, which demonstrate that use of the requested non-Formulary drug over the Formulary drug is Medically Necessary, as determined by the Plan.

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

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

Maintenance Drug Dispensing

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

- Antiarthritics
- Antiasthmatics
- Anti-clotting drugs
- Antiepileptic drugs
- Antihypertensives
- Anti-Parkinson drugs
- Birth control pills
- Cardiac drugs
- Cholesterol and lipid lowering agents
- Diuretics
- Gastrointestinals
- Glucose test strips
- Hormones
- Insulin and Insulin syringes

- Oral contraceptives
- Oral hypoglycemics
- Prenatal vitamins
- Psychotropics
- Thyroid suppressants or replacements

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

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

Mandatory Generic Substitution

All prescriptions will automatically be filled with a Generic Drug where one is available, unless your Physician indicates the Brand Name Drug must be dispensed (by writing "Dispense as Written" or "DAW" on your prescription). If your Physician does not indicate "Dispense as Written" on the prescription for the Brand-Name Drug, and you specifically request the Brand-Name Drug, you'll be responsible for paying any difference in cost between the Brand-Name Drug and the Generic Drug, as well as the Brand-Name Drug Copay.

Mail Order Service

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

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

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

Exclusions and Limitations

The Outpatient Prescription Drug Program excludes drugs, medicines and/or related items which are not covered by the Plan. These items are your financial responsibility. The following are excluded:

- Drugs or medicines not on the Formulary, unless pre authorized. Pre authorization must be obtained prior to a prescription being filled --no retro authorizations will be allowed;
- Drugs or medicines purchased and received prior to your effective date or subsequent to your coverage termination date;
- Therapeutic devices or appliances including hypodermic needles, syringes (except insulin syringes, other diabetic supplies and syringes for self-injected drugs), support garments and other non-medicinal substances;
- Non-prescription (over-the-counter) contraceptive jellies, ointments, foams and devices;
- Drugs or medicines to be taken or administered to you while you are a patient in a Hospital, rest home, nursing home or sanitarium;
- Drugs or medicines delivered or administered to you by a prescriber or the prescriber's staff;
- Dietary supplements including vitamins (except prenatal vitamins), fluoride supplements, health or beauty aids and anorexiants (i.e. diet pills);
- Drugs or medicines for which the cost is recoverable under any workers' compensation or occupational disease law, any state or government agency, or furnished by any other drug or medical service for which no charge is made to you;
- Immunizations, Vaccinations -- for the purpose of travel/vacation;
- Drugs or medicines limited to investigational use or prescribed for experimental or non-FDA approved indications, unless prescribed in a manner consistent with:
    i. A specific indication in "Drug Information Specifications for the Health Care Professional", published by the United States Pharmacopoeia Convention;
    ii. The American Hospital Formulary Services edition of Drug Information;
    iii. Any other source which reflects community practice standards;

- Drugs or medicines available without a prescription (over-the-counter) or for which there is a non-prescription equivalent available, even if ordered by a Physician;
- Drugs, medicines or cosmetic aids prescribed to primarily improve or otherwise modify your external appearance;
- Smoking cessation products are limited to one treatment course each Calendar Year when enrolled in a smoking cessation program;
- Injectible drugs (except as listed) or;

- Durable Medical Equipment that can be obtained without a prescription.

Dispensing Quantity Limitations

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

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

SECTION 7: MENTAL HEALTH/ SUBSTANCE ABUSE SERVICES

The Plan provides Benefits for Mental Health, Severe Mental Illness and Substance Abuse treatment and services.

NOTE: ALL SERVICES MUST BE PRE AUTHORIZED BY THE COUNTY OF RIVERSIDE EMPLOYEE ASSISTANCE SERVICE ("EAS"). NO BENEFITS WILL BE PROVIDED FOR TREATMENT OR SERVICES THAT ARE NOT PRE AUTHORIZED BY THE EAS OR THE PLAN, EXCEPT IN THE CASE OF EMERGENCY PSYCHIATRIC ADMISSIONS.

The EAS provides Members with confidential, professional assistance in areas such as marital/family issues, interpersonal relationship conflicts, emotional/psychological problems and alcohol/drug abuse.

Benefits for Mental Health Disorders and Substance Abuse Disorders are outlined in the "Schedule of Benefits" sections of this SPD. ***All Services Must Be Pre Authorized By the EAS***. Coverage will be provided up to the limits described in the "Schedule of Benefits".

Covered Services

The Plan will provide Benefits for the following services furnished in connection with the treatment of a Mental Health/Substance Abuse Disorder as outlined in the "Schedule of Benefits" as long as the services are incurred while you are a Member. Services must be pre authorized by the EAS as Clinically Necessary, except in the case of an emergency Psychiatric Admission:

- Individualized evaluation of needs, referral into treatment and monitoring by an EAS Clinician;
- Mental Health Services provided for Inpatient mental health treatment, treatment at a Residential Treatment Center or Residential Treatment Facility, and treatment at a Day Treatment Center;
- Behavioral Health Services provided for outpatient substance abuse treatment;
- Inpatient Detoxification - pre authorization from the EAS is required; limited to hospitalization to remove toxic substances from the system; once Detoxification has been completed, the EAS will work with the Practitioner to coordinate Rehabilitation services when requested and appropriate;
- Nursing by a Registered Nurse, a Licensed Practical Nurse, or a Licensed Vocational Nurse when Medically Necessary to accompany services provided by the attending Physician;
- Mental Health Services for individual, group, and family therapy;
- Local ambulance service to and from a facility in the event of an Emergency Condition; paid based on Allowed Charges;
- Laboratory services authorized by the EAS or an attending Physician, which are related to the approved Behavioral Health Treatment Plan;
- Psychological testing when pre authorized by an EAS Clinician and provided by a licensed psychologist;
- Emergency Treatment and services;
- Psychotherapy for marital and family problems, when determined Clinically Necessary by an EAS Clinician; and,
- Treatment for an eating disorder, as defined by the DSM-IV, when pre authorized by an EAS Clinician.

What To Do In Emergencies

Whenever possible, you should contact the EAS before obtaining Emergency Treatment and services in order to ensure any charges for treatment will be covered. In some critical emergencies, such as a serious suicide risk, it may not be possible to call an EAS Clinician before going for treatment. In the event of such an emergency, you, a

family member, or the provider must contact the EAS immediately upon admission, or as soon as reasonably possible (within 24 hours).

If you are admitted to any facility without pre authorization from the EAS, upon notification, your EAS Clinician will review the situation by telephone and conduct a further assessment as appropriate.

Exclusions And Limitations

The following services are excluded:

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

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

SECTION 8: PLAN GENERAL PROVISIONS

CLAIM PAYMENT PROCEDURES

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

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

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

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

MEMBER GRIEVANCE PROCEDURE

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

Service Authorization, Claims Review and Appeal Chart		
Type of Transaction	**Steps to Take**	
PRE AUTHORIZATION FOR URGENT HEALTH CARE SERVICES		
Pre authorizations for conditions that could jeopardize life, health, or ability to regain maximum function, or would subject you to severe pain.	**Step 1:**	The Plan has **72 hours** after receiving your initial pre authorization request to notify you if your request is approved or denied.
	Step 2:	If denied, you have **180 days** after receiving the pre authorization denial to appeal the Plan's decision.
	Step 3:	The Plan has **72 hours** after receiving your appeal to notify you of its decision.
The reasonable layperson standard is used for these claims, except that if a Physician determines the condition is urgent, the Plan must accept the Physician's determination.	**IF YOUR PRE AUTHORIZATION REQUEST IS IMPROPERLY FILED OR INCOMPLETE**	
	Step 1:	The Plan has **24 hours** after receiving your initial pre authorization request to notify you that your pre authorization request is improperly filed or incomplete.
	Step 2:	You have **48 hours** after receiving notice from the Plan to correct or complete your pre authorization request.

Service Authorization, Claims Review and Appeal Chart		
Type of Transaction	**Steps to Take**	
	Step 3:	The Plan has **48 hours** to notify you if your pre authorization request is approved or denied. The Plan must do so within the earlier of 48 hours of receiving your corrected/completed pre authorization request, or your deadline to complete the pre authorization request.
	Step 4:	If denied, you have **180 days** after receiving the pre authorization denial to appeal the Plan's decision.
	Step 5:	The Plan has **72 hours** after receiving your appeal to notify you of its decision.
PRE AUTHORIZATION FOR CERTAIN HEALTH CARE SERVICES		
Pre authorization requests for Benefits under this Plan where treatment must be authorized before it is performed.	**Step 1:**	The Plan has **15 days** after receiving your initial pre authorization request to notify you if your request is approved or denied.
	Step 2:	You have **180 days** after receiving the pre authorization denial to appeal the Plan's decision.
	Step 3:	The Plan has **30 days** after receiving your appeal to notify you of its decision.
	IF YOUR PRE AUTHORIZATION REQUEST IS IMPROPERLY FILED OR INCOMPLETE	
	Step 1:	As long as your pre authorization request is received by a person or organizational unit customarily responsible for handling pre authorizations, and it names a specific Member, a specific medical condition or symptom, and a specific treatment, service, or product for which approval is requested, the Plan has **5 days** after receiving your initial pre authorization request to notify you that your request is improper or incomplete.
	Step 2:	The Plan has **15 days** after receiving your pre authorization request to notify you of its decision to approve or deny the pre authorization request. If the Plan needs more information and provides an extension notice during the initial 15-day period, it has **30 days** after receiving the pre authorization request to notify you of its decision (the time the Plan waits for requested additional information is not counted in totals).
	Step 3:	You have **45 days** after receiving the extension notice to provide additional information or complete the pre authorization request.

Service Authorization, Claims Review and Appeal Chart		
Type of Transaction	**Steps to Take**	
	Step 4:	If your pre authorization is denied, you have **180 days** after receiving the pre authorization denial to appeal the Plan's decision.
	Step 5:	The Plan has **30 days** after receiving your appeal to notify you of its decision.
POST-SERVICE HEALTH CARE CLAIMS		
Claims for Benefits where pre authorization of certain health care services was required but where health care services have already been received by the Member.	**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 its 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 its decision.

Pre Authorization Denials / Claim Denials - Appeal Procedure

If your pre authorization request or Claim for Benefits is wholly or partially denied, any pre authorization denial/Claim denial notice you receive will:

- State the specific reasons for the decision;
- Reference specific Plan provisions on which the decision is based;
- Describe additional material or information necessary to complete the pre authorization request or Claim request, and why such information is necessary; and,

- Describe Plan procedures and time limits for appealing the decision, and your right to obtain information about those procedures.

The pre authorization denial/Claim denial notice will also:

- Disclose any internal rule, guidelines, protocol or similar criterion relied on in making the decision (or state that such information will be provided free of charge upon request);
- Provide an explanation of the scientific or clinical judgment for the decision, applying layperson terms to your medical condition, if the denial is based on Medical Necessity or Experimental or Investigational treatment (or state that such information will be provided free of charge upon request); and,
- Include a description of the expedited review process applicable to Urgent Care pre authorizations. This denial may be given orally, provided that a written or electronic notification is furnished to you no later than 3 days after the oral notification.

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

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

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

Outcome of Appeal Procedure

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

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

The appeal denial notice will also include:

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

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

Member Services Responsibilities

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

Administrative Review Committee Responsibilities

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

Physician Review Committee Responsibilities

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

Experimental or Investigational Treatment Of Terminal Illness

If the Plan's Medical Director denies a treatment as Experimental or Investigational (refer to the Plan's "Specific Exclusions" section) for a Member who has a terminal illness, the Plan, at the Member's request, will hold a Physician Review Committee within thirty (30) days of the receipt of the request to review the denial and the basis for determining that the proposed treatment or services are Experimental or Investigational. The review will be held within five (5) days if the treating Physician determines, in consultation with the Medical Director, based on standard medical practice, that the effectiveness of either the proposed

treatment or services would be materially reduced if not provided at the earliest possible date.

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

ALTERNATIVE DISPUTE RESOLUTION

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

Eligibility Issues

This matter must be referred directly to your employer group.

Malpractice

You must proceed directly to court regarding issues of malpractice.

Bad Faith

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

Neutral Binding Arbitration

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

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

State of California Laws Regarding Arbitration

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

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

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

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

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

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at **1-800-962-1133** and use your health plan's grievance process before contacting the department. Utilizing this grievance process does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the Medical Necessity of a proposed service or treatment, coverage decisions for treatments that are Experimental or Investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number **(1-888-HMO-2219)** and a TDD line **(1-877-688-9891)** for the hearing and speech impaired. The department's Internet Web site **http://www.hmohelp.ca.gov** has complaint forms, IMR application forms and instructions online.

COBRA CONTINUATION OF COVERAGE

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

Qualified Beneficiaries

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

Qualifying Events

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

- ✓ Qualifying Events for Employees:
- ✓ Voluntary or involuntary termination of employment for any reason other than gross misconduct;
- ✓ Reduction in the number of hours worked.
- ✓ Qualifying Events for Spouses:
- ✓ Voluntary or involuntary termination of the covered employee's employment for any reason other than gross misconduct;
- ✓ Reduction in the number of hours worked by the covered employee;
- ✓ Covered employee becoming entitled to Medicare;
- ✓ Divorce or legal separation of the covered employee;
- ✓ Death of the covered employee.
- ✓ Qualifying Events for Dependent Children:
- ✓ Loss of dependent child status under the Plan rules;
- ✓ Voluntary or involuntary termination of the covered employee's employment for any reason other than gross misconduct;
- ✓ Reduction in the number of hours worked by the covered employee;
- ✓ Covered employee becoming entitled to Medicare;
- ✓ Divorce or legal separation of the covered employee;
- ✓ Death of the covered employee.

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

the date of the qualifying event unless COBRA is canceled for any one of the reasons specified below under "Canceling COBRA Coverage."

COBRA Notice Requirement

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

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

COBRA Election Deadline

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

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

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 coverage is exhausted.

Canceling COBRA Coverage

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

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

COBRA Coverage - Bankruptcy Provision

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

COBRA coverage also continues under these circumstances, as follows:

- ✓ Affected retirees and surviving spouses of deceased retirees may elect lifetime COBRA coverage;
- ✓ Spouses and dependent children may continue COBRA coverage until the retiree dies;
- ✓ When the retiree dies, his/her surviving spouse and dependent children may elect an additional 36 months of COBRA coverage commencing with the date of the retiree's death. Coverage could end sooner if COBRA coverage otherwise ends (e.g., due to nonpayment of premiums or discontinuation of all group health coverage by the County); however, the maximum COBRA coverage period will not expire due to Medicare entitlement.

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

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

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

Exclusive Care – Notice of Privacy Practices

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

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

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

A. Use and Disclosure – General

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

1. **For treatment.** Exclusive Care uses and discloses health information to provide you health care and related services. For instance:

   - Nurses, doctors, or other Exclusive Care employees may record your health information, and they may share such information with other Exclusive Care employees.
   - Exclusive Care may disclose health information to people outside Exclusive Care involved in your care who provide treatment and related services.
   - Exclusive Care may use and disclose health information to contact you to remind you about appointments for treatment or health care-related services.
   - In emergencies, Exclusive Care may use or disclose health information to provide you treatment. Exclusive Care will make its best effort to obtain your permission to use or disclose your health information as soon as reasonably practical.

2. **For payment.** Exclusive Care may bill you, insurance companies, or third parties. Information on or accompanying these bills may identify you, as well as diagnoses, assessments, procedures performed, and medical supplies used.

3. **For health care operations.** Exclusive Care may use information in your health record to assess the care and outcomes in your case to improve our services, and in administrative processes such as purchasing medical devices, or for auditing financial data.

4. **For health plan administration.** As administrator of certain health plans, such as Medicare, Medi-Cal, and Exclusive Care, Exclusive Care may disclose limited health information to plan sponsors. The law only allows using such information for purposes such as plan eligibility and enrollment, benefits administration, and payment of health care expenses. The law specifically prohibits use for employment-related actions or decisions.

B. Use and Disclosure Requiring Your Authorization

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

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

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

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

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

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

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

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

- In emergency circumstances to report a crime, the location of a crime or crime victims, or the identity, description or location of a person who may have committed a crime.

7. To coroners, medical examiners and funeral directors as necessary for them to carry out their duties.

8. For organ donation once you are deceased.

9. For public health research in compliance with strict conditions approved and monitored by an Institutional Review Board.

10. To avert serious threats to the health and safety of you or others.

11. Regarding military personnel for activities deemed necessary by appropriate military command authorities to assure proper execution of a military mission.

12. To determine your eligibility for or entitlement to veterans' benefits.

13. To authorized Federal officials for the conduct of lawful intelligence, counter-intelligence, and other national security activities.

14. To correctional institutions and other law enforcement custodial situations, inmates of correctional institutions or in custody of a law enforcement official.

15. To determine your eligibility for or enroll you in government health programs.

16. For Workers Compensation or similar programs, to the minimum extent necessary.

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

E. Rights and Responsibilities

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

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

2. **Right to confidential communications**. You have the right to ask Exclusive Care to communicate with you in a certain way, or at a certain location.

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

4. **Right to amend health records**. If information Exclusive Care has about you is incorrect or incomplete, you may ask to amend it. Requests must be in writing, and provide a reason supporting your request. Exclusive Care may deny your request if it is not in writing, or does not include a reason supporting it. Exclusive Care may deny requests if the information:

    - Was not created by Exclusive Care;
    - Is not health information kept by or for Exclusive Care;
    - Is not information you are permitted to inspect and copy; or,
    - Is accurate and complete.

5. **Right to an accounting of certain disclosures**. You have the right to ask for a listing of the last six years of disclosures of your health information since April 14, 2003, not pertaining to treatment, payment or health care operations. Requests must be in writing. The first list you request in a twelve-month period is free. Exclusive Care may charge you the cost of providing or reproducing additional lists. When told the cost, you may withdraw or modify your request.

6. **Right to obtain a paper copy of the notice of privacy practices upon request**.

7. **Right to file complaints without fear of retaliation**. Under law, you cannot be penalized for filing a complaint. If you believe Exclusive Care violated your privacy rights, you may file a complaint with Exclusive Care, the County of Riverside Privacy Office, or with the U.S. Secretary of Health and Human Services.

Privacy Complaint Contacts

Exclusive Care Plan	**County of Riverside Privacy Office**	**U.S Department of Health & Human Services**
P.O. Box 1508 Riverside, CA 92502 (800) 962-1133	P.O. Box 1569 Riverside, CA 92502 (951) 955-1000	**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

Release Of Health Information

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

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

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

Certificate Of Coverage

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

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

SECTION 9: PAYMENT BY THIRD PARTIES

Third Party Recovery Process and Your Responsibilities

If you are ever injured through the actions of another (a third party) and receive compensation for your medical care, you will be required to reimburse the Plan, or its designee, for the reasonable value of medical services and benefits provided. The

amount of reimbursement shall not exceed the amount of compensation you receive from the third party.

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

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

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

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

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

Non-Duplication of Benefits with other Group Health Coverage

- **Benefits for Non-Medicare Eligible Members.** The Plan provides Benefits up to the Plan's reimbursement level when combined with benefit payments you receive from other group health coverage(s) you or your enrolled dependents may have. If you have other group health coverage(s), this "Non-Duplication of Benefits" provision may result in reduced Benefits by the Plan. If Exclusive Care's Benefits are secondary, and another plan covering you or an Eligible Dependent is the primary plan, Exclusive Care may not pay any Benefits if the primary plan's benefits are equal to or greater than Exclusive Care's Benefits. The goal of the "Non-Duplication of Benefits" rule is to maximize coverage for expenses, and to prevent any payment duplication.
- The Plan determines Benefits in accordance with the National Association of Insurance Commissioners' guidelines, and California law.
- In order to ensure proper coordination with other health coverage(s) you may have, you must inform the Plan of any other health coverage for which you or your enrolled dependents may be eligible.
- If the Plan pays more Benefits than are appropriate, the Plan may recover excess payments from you, the plan with primary responsibility, or any other person or entity that benefited from the overpayment.

Order of Benefit Determination

The rules establishing the order of benefit determination are:

- The benefits of a plan which covers the Member as an active employee will be determined before the benefits of a plan which covers the Member as a non-active employee (i.e. a retired or laid off employee, a COBRA participant, etc.), or

as a dependent. If the other plan does not have this rule, and if as a result the plans do not agree on the order of benefit determination, the rule of the other plan will prevail;

- When the Member is a dependent child and such child's parents are not separated or divorced, the benefits of the plan of the parent whose birthday falls earlier in the year are determined before those of the plan of the parent whose birthday falls later in the year, however;:
  - ✓ If both parents have the same birthday, the benefits of the plan which covered the parent longer are determined before those of the plan which covered the other parent for a shorter period of time; or
  - ✓ If the other plan does not have this rule, and if as a result the plans do not agree on the order of benefit determination, the rule of the other plan will prevail.

- When the Member is a dependent child whose father and mother are legally separated or divorced:
  - ✓ The benefits of the plan which covers the Member as a dependent child of the parent with custody will be determined first, except that if a court decree assigns financial responsibility for the health care coverage of a dependent child to one of the parents, the benefits of the assigned parent's plan will be determined first and the other parent's plan will be determined second;
  - ✓ The plan of the spouse of the parent with custody will be determined next;
  - ✓ The plan of the parent not having custody of the child will be determined last.

- If none of the above rules establish an order of benefits determination, the benefits of the plan that has covered the Member for the longer period of time are determined before those of the plan that has covered the Member for the shorter period of time.

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

Workers' Compensation

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

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

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

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

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

SECTION 10: HEALTH PLAN ADMINISTRATION AND INTERPRETATION

Funding of Benefits and administration

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

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

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

Member Rights

You and your enrolled dependents:

- Will be treated with respect and dignity by everyone that works for the Plan.
- Can obtain information about the Plan.
- Will receive Medically Necessary Covered Services without regard to race, religion, age, gender, national origin, disability, sexual identity or orientation, family composition or size, or medical condition, or state of illness.

- Can receive help making decisions about your health care.
- Can refuse medical treatment.
- Will have the privacy of your medical records and personal health information protected.
- Can address any concerns to the Plan.
- Can file a grievance with the Plan Administrative Review Committee.
- Can ask for a second opinion about your health by writing to the Plan's Medical Management Unit.
- Can disenroll from the Plan.
- Can receive Emergency Care services.

Member Responsibilities

You and your enrolled dependents are expected to:

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

SECTION 11: DEFINITION OF TERMS

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

Acute Condition/Acute Symptoms – 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.

Allowed Charge(s) – An amount on which the Plan's payment/reimbursement for a Covered Service is based; an amount which is consistent with the current rate or charge, in a certain geographical area, for identical or similar services, as determined by the Plan and subject to all other terms of this Summary Plan Document.

The Allowed Charge determined by the Plan to be payable for services rendered by non-Network (Tier 3) providers is based on allowed amounts as defined and administered by Blue Shield. A copy is available to Members on request. This amount may be modified by Exclusive Care at any time at its sole discretion.

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

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

Balance Bill –A provider requests reimbursement from a Plan Member by sending the Member a bill for an amount in addition to any Copays, Deductibles, or Coinsurance, and in addition to the amount that the Plan has paid based on the Plan's Covered Services.

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.

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

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 maximum benefit specified for each benefit under the Plan.

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

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.

Clinical Necessity/Clinically Necessary – Behavioral Health services or supplies for treatment of an active Mental Health or Substance Abuse Disorder which have been established in accordance with generally accepted professional standards and the Plan's Utilization Review Committee to be:

- Rendered for the treatment and diagnosis of a Mental Health or Substance Abuse Disorder as defined by the current *DSM-IV* and limited to impairment of a Member's mental, emotional, or behavioral functioning;
- Appropriate for the severity of symptoms, consistent with diagnosis, and otherwise in accordance with generally accepted mental health practice and professionally recognized standards;
- Not furnished primarily for the convenience of the Member, the attending 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 employed or under contract with the EAS or the Plan to perform counseling or case management services, which include assessing psychological disorders, referring to appropriate facilities and/or mental health and substance abuse providers, recommending payment, monitoring and reviewing care, participating in provider relations, and coordinating health care Benefits for Members and their Eligible Dependents.

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

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

Covered Services – Any Medically Necessary expense incurred by a Member subject to all other 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.

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.

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

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

- 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.

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

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

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

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

Domestic Partner – An individual, with whom the member has registered as a domestic partnership with the State of California, as evidenced by a signed *California Declaration of Domestic Partnership*. Such individual must live in a mutually exclusive relationship with the member, both must be jointly responsible for each other's welfare and financial obligations, and live in the same principal residence and intend to do so indefinitely. In addition, a domestic partnership must consist of two individuals who are at least 18 years of age and

are of either the same sex or of the opposite sex as long as one individual is over the age of 62. Individuals in a domestic partnership also must be unmarried and not be blood relatives close enough to bar marriage in the State of California.

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

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

EAS - The County of Riverside Employee Assistance Service.

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

Eligible Dependent(s) – A legal spouse or Domestic Partner as defined by California Law.

Eligible Spouse – A legal spouse or Domestic Partner as defined by California law.

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

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

Emergency Treatment – The immediate and unscheduled screening, examination, and evaluation of a Member by a medical or psychiatric Practitioner to determine if an

Emergency Condition exists. If an Emergency Condition is found to exist, Emergency Treatment will include the care and treatment necessary to relieve or eliminate the Emergency Condition or stabilize the Member before transfer to a facility capable of handling higher levels of care.

Exclusive Care Provider Network – The Hospitals, Medical Groups, Physicians, Specialists, clinics, pharmacies and other individual health care providers contracting with Exclusive Care to provide its Members with treatment and services.

Exclusive Care Select POS Plan – The Health Plan created by the County of Riverside as a health plan alternative for employees.

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.

FDA – Food and Drug Administration.

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

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

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

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

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

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

Hospital – An institution which is licensed under all applicable state and local laws and regulations to provide, under supervision of Physicians, diagnostic and therapeutic services for the medical diagnosis, treatment, and care of the injured, disabled or sick persons in need of acute Inpatient medical and/ psychiatric or psychological care, and which is registered as a general Hospital with the American Hospital Association and accredited by the Joint Commission on Accreditation of Healthcare Organizations. Hospital also includes:

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

Infertility – Either (1) the presence of a demonstrated bodily malfunction recognized by a licensed Doctor of Medicine as a cause of infertility or (2) because of a demonstrated bodily malfunction, the inability to conceive a pregnancy or to carry a pregnancy to a live birth after a year or more of regular sexual relations without contraception.

Inpatient – An individual confined as a bed patient in a Hospital or Skilled Nursing Facility who requires routine skilled or specialized Hospital services.

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

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 Physician, designated by the Plan, who is 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 with the Plan to provide Covered Services to Members.

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

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

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

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

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

Mental Health Services – Psychoanalysis, psychotherapy, counseling, medical management or other services most commonly provided by a psychiatrist, psychologist, licensed clinical social worker, or marriage/family/child counselor, for diagnosis or treatment of mental or emotional disorders.

National Provider Network - A health care provider network that has contracted with Exclusive Care to provide Covered Services to Members in California and in many regions of the U.S. Exclusive Care has contracted with Blue Shield of California as of January 1, 2010 to provide access to the Blue Shield national provider network.

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

Non-Formulary Drugs – Outpatient Generic and Brand Name Drugs that are not included in the Drug Formulary. These drugs are covered under the Plan but require a higher Member Copay. Most non-preferred drugs have a more cost-effective alternative on the Preferred Drug List.

Non-Network Provider(s) –A provider who is not a participating provider in the Tier 1 or Tier 2 Networks.

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.

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

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

Participating Hospital/Physician/Provider An independent provider who has a contractual agreement with Exclusive Care to provide Covered Services to Members.

Participating Pharmacy – A pharmacy contracted by Exclusive Care's Pharmacy Benefit Manager to provide Members with outpatient prescription drug services.

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

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

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

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

Plan – The Exclusive Care Select Point of Service (Pos) Plan providing Benefits for Covered Services subject to all terms and provisions of the Summary Plan Document.

Practitioner - Any licensed, qualified Health Care Professional who provides Behavioral Health Services.

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

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

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

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

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

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

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

Residential Treatment Center – An Acute care facility that provides Mental Health and Substance Abuse services in an acute, Inpatient setting, pursuant to a written Treatment Plan approved and monitored by the Plan, and which also provides 24-hour nursing and medical supervision; and is licensed, certified, or approved as such by the appropriate state agency.

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

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

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

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 to you.

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.

Substance Abuse/Substance Abuse Disorder – An addictive dependency or abuse of any drug, alcohol, or chemical substance that can be documented according to the criteria in the DSM-IV. Substance Abuse does not include addiction to or dependency on tobacco in any form; or food substances in any form.

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

Temporomandibular Joint Disorder (TMJ) – A group of problems related to pain and difficulty in function associated with the temporomandibular joint. The

temporomandibular joint is a complex joint that moves in four degrees of freedom around all three axes in the jaw.

Treatment Plan – Services or a plan of treatment pre authorized by the Plan during a contract period that must be commenced during the same contract period. To qualify for continuing treatment in a subsequent contract period, the services or plan of treatment must be reauthorized. Otherwise, only the Benefits in effect during a contract period are available or covered.

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

HEALTH PLAN ADDRESSES

&

IMPORTANT TELEPHONE NUMBERS

Member Services Department

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

Claims Department

EXCLUSIVE CARE Claims

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

Mental Health/Substance Abuse Services

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

Exclusive Care