Exclusive Care EPO

Exclusive Provider Organization

Summary Plan Document

January 2022

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

INTRODUCTION

The Exclusive Care Exclusive Provider Organization (EPO) is a Health Plan provided for employees and under age 65 retirees of the County of Riverside, their Eligible Dependent(s) and for the employees and dependents of other Qualified Public Employer Groups.

Exclusive Care provides comprehensive health care services through a Network of Participating Hospitals, Medical Groups and Physicians. This Network is called an Exclusive Provider Organization (EPO). The Plan's Benefits include preventative care and services, specialty services, hospitalization and prescription drugs, with only a low Copay required from you. You must receive all your services through the Network for Benefits to be paid (except in certain emergencies, described in this Summary Plan Document). Members of Exclusive Care will receive an identification card that must be presented each time a Member receives services.

This plan does provide an Out-of-Area Schedule Of Benefits under Exclusive Care's Out-of-Area coverage for your eligible qualified dependents living outside the EPO Plan Service Area. The qualified dependent may receive treatment and services and seek reimbursement through the Plan according to the Member Coinsurance and limitations indicated in the Summary Plan Document. Plan Benefits are paid according to the reimbursements and limitations shown in the "Out-of-Area Schedule of Benefits" section.

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

Beginning in 2014, the Affordable Care Act requires most people of have health care coverage that qualifies as "minimum essential coverage". This plan meets or exceeds the requirements for minimum essential coverage.

In addition, the Affordable Care Act establishes a minimum standard of benefits for a health plan. The plan must pay a minimum of 60% of the cost of benefits. This plan meets or exceeds the requirements for minimum value standard.

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

Exclusive Care EPO	
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 Members 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 in 1999.
SPD Effective Date	The effective date of this SPD is January 1, 2022

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

SECTION 1: ELIGIBILITY AND ENROLLMENT

Health Plan Eligibility

You are eligible to enroll in the EPO Health 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 EPO Plan, and you reside or work in the Exclusive Care EPO Plan Service Area;
- you are a County of Riverside retiree under age 65.

You are eligible for the Out-of-Area Schedule Of Benefits if:

- you are a qualified, Eligible Dependent of a County of Riverside employee or Qualified Public Employer Group employee living outside the EPO Plan Service Area

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 may enroll in the same Health Plan if they meet one 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 Exclusive Care Plan. Carry your identification card with you at all times. Present your identification card whenever you receive services.

Mid-Year Changes

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

- Marriage;
- Divorce or legal separation;
- Birth or adoption of a child;
- Death of an Eligible Dependent;
- Change in an Eligible Spouse's employment that would affect medical coverage or a significant change in an Eligible Spouse's employer-offered medical coverage;
- Loss of a dependent's eligibility under another plan; 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 your employer group of the status change; however, newborns or newly adopted dependents are covered as of the date of their birth or adoption contingent upon the timely completion of the enrollment paperwork.

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

- **Loss of Dependent Eligibility:** If your Eligible Spouse or Eligible Dependent Child(ren) lose coverage for any of the following reasons, you may only cancel coverage for the affected dependent:
    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 ceases 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 identification card;
- fails to cooperate with Exclusive Care's Third Party Lien and Non Duplication of Benefits Rights;
- has his/her coverage terminated at the request of the employer group;
- engages in an act of gross misconduct, which causes the interruption of the normal operations of the Plan.

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

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

Reinstatement

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

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

The maximum retroactive reinstatement period is 60 days.

Keeping Enrollment Information Up-to-Date

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

Cost of Enrollment in the Plan

You are responsible for the payment of the entire premium for health care coverage for yourself and your enrolled dependents. It is your responsibility to stay informed about your 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 EPO PLAN WORKS

The Plan provides Covered Services to Plan Members with virtually no paperwork. To obtain services, contact your Primary Care Provider (PCP), schedule an appointment, and show your Member identification card. If additional care or specialty services are needed, your Primary Care Provider will coordinate with Exclusive Care for approval, authorization and claim processing.

Choice of Providers

PLEASE READ THE FOLLOWING INFORMATION SO YOU WILL KNOW THOSE PROVIDERS (OR GROUP OF PROVIDERS) THROUGH WHICH YOU MAY OBTAIN HEALTH CARE SERVICES. IT IS YOUR RESPONSIBILITY TO KNOW WHERE TO OBTAIN SERVICES. THIS WILL ENSURE THAT NO OUT-OF-POCKET EXPENSES WILL BE INCURRED BY YOU.

A unique feature of the Plan is your ability to choose a private practice Physician who practices in your community, a County of Riverside-employed Physician at Riverside County Regional Medical Center, or a County of Riverside Public Health Clinic, as your Primary Care Provider (PCP). You may choose whichever PCP you prefer from the provider Network. The provider you choose can be convenient to your home or workplace. Our Member Services staff can assist you with finding your nearest PCP.

To be covered, services must be provided by Exclusive Care Physicians, Hospitals, Specialists or other medical facilities assigned to you (except in the case of life-threatening emergency services).

All Exclusive Care providers are listed in the Exclusive Care provider directory. You select a PCP from the provider directory, and this provider coordinates all your health care services. You may obtain a copy of the provider directory by contacting Exclusive Care's Member Services Department, or by accessing the Plan's website at www.exclusivecare.com.

When selecting your PCP:

- The PCP you choose must be a Participating Provider and within a 30-mile radius of your primary residence or workplace;
- You and your Eligible Dependents may each choose a different PCP;
- The name of the PCP you choose must be indicated using the provider ID number listed in the directory on your Benefit Election Form/Enrollment Form;
- If you do not select a PCP at the time of your enrollment, one will be selected for you. Please refer to the "Changing Primary Care Provider" section of this document for detailed information about changing your provider after your initial enrollment;
- Your PCP will be listed on your identification card. Always present your card wherever you attend appointments or receive treatment.

The Plan contracts with Medical Groups and individual Physicians to provide primary care services to Members, and with Hospitals to provide hospitalization services. These Participating Medical Groups, Physicians and Hospitals, in turn, may employ or contract with individual Physicians.

The Plan's Participating Hospitals are paid on a discounted fee-for-service or fixed charge basis for Covered Services. Most acute care, sub-acute care, transitional Inpatient care and Skilled Nursing Facilities are paid on a fixed charge basis for each day of Inpatient care.

Changing Primary Care Providers

You may change your Primary Care Provider (PCP) by calling the Member Services Department at (800) 962-1133, ext 1. Your change will be effective the same business day.

Requests for a change of Primary Care Provider may be denied if:

- The Plan determines the transfer would have an adverse effect on the quality of care given to you;
- The requested provider is closed to new patients.

The Plan may require that you select a new Primary Care Provider if there is a breakdown in resolving conflicts between you and your existing Primary Care Provider. In this event, you will be required to select a new Primary Care Provider within thirty-one (31) days of receiving notice from the Plan. If it is determined by the Plan's Medical Management Unit that a provider change would adversely impact your medical care, the Plan will make every effort to enable you to continue your relationship with your current Primary Care Provider wherever possible.

IT IS IMPORTANT TO KNOW WHEN YOU ENROLL IN THE EPO PLAN THAT SERVICES ARE PROVIDED THROUGH THE PLAN'S DELIVERY SYSTEM OF PARTICIPATING PROVIDERS AND FACILITIES. THE CONTINUED PARTICIPATION OF ANY INDIVIDUAL PHYSICIAN, HOSPITAL, OR OTHER PROVIDER CANNOT BE GUARANTEED.

Scheduling Appointments

Once you have selected your PCP, appointments are simply a phone call away. For routine office visits, call for an appointment at least 48 hours in advance. For preventative care appointments, such as a periodic health evaluation, or a well woman care visit, call at least four weeks in advance. These appointments are scheduled based on availability.

If you need more immediate attention, call your PCP and request the next available appointment. If your PCP is unavailable, please refer to your provider directory or contact the Member Services Department for assistance locating contracted urgent care facilities. If you use a non-Network urgent care facility, the services may not be covered by the Plan and you will be responsible for the Billed Charges.

If you need to cancel an appointment, please contact your PCP as soon as possible.

Referrals to Specialists

Your PCP will coordinate all of your health care needs. If your PCP determines that you need to see a Specialist, he/she will request an appropriate Specialist referral on your behalf by contacting the Plan's Medical Management Unit. A member of this unit's staff will contact your PCP with the outcome of the request. You will also receive notification from the Plan of approval for a Specialist appointment, along with the address and phone number for scheduling your appointment, and any other necessary instructions.

The Specialist is usually pre-authorized to treat you for a specific number of visits for a given condition, but may request additional visits or diagnostic studies if needed.

IMPORTANT: Prior authorization is not required for many services, and your PCP may make a direct referral to a contracted provider. Annual well woman exams, OB/GYN consultations and office visits, mammograms, bone mineral density testing, initial chiropractic evaluation, mental health services, family planning, and several other services may be referred directly by your PCP without prior authorization. The direct referral form and a list of services covered under the direct referral policy may be viewed at:
http://www.exclusivecare.com/Portals/19/DirectReferralrev052316.pdf?ver=2016-05-23-1355757-327

A referral request may also be reviewed by the Plan's Physician Review Committee. The Physician Review Committee meets on a regular basis, depending on the volume of special requests or care issues, and authorization or referral requests that require review. Decisions may be made by the Medical Management Unit and/or Exclusive Care's Medical Director, outside of a formal committee meeting to assure a timely response to emergency or urgent requests.

Second Medical Opinion

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

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

SECTION 3: EPO PLAN BENEFITS

Schedule of Benefits

As a Member of the Plan, you should coordinate all your health care services through your Primary Care Provider (PCP). The Schedule of Benefits below summarizes the services that are covered, the amount the Plan will pay, and your Copay amounts.

Schedule of Benefits – EPO Plan

Choice of Physician	Any Participating Primary Care Physician
Deductible – Individual	None
Deductible – Family	None
Out-of-Pocket Maximum	$1,500/Member, maximum $3,000/Family per Calendar Year
Lifetime Maximum Benefit	Unlimited
Pre-existing Condition	Fully Covered
Outpatient/Office Visits	**Coverage Level**
Physician Office Visits	100% after $15 Copay
Hospital Clinic Visits	100% after $15 Copay
Immunizations	100%
Maternity Care	100%
Periodic Health Evaluations	100%
Diagnostic X-ray & Lab	100%
Well Baby Care	100%
Well Woman Care	100%
Vision Exams (screening and refraction)	100%, 1 Vision Exam per Calendar Year

Outpatient Prescription Drugs

- ***Prescription Drug Coverage is administered by the Plan's Pharmacy Benefit Manager (PBM)***
- ***Pharmacy Benefit Manager (PBM): Navitus Health Solutions. Up to 90 Days***

Navitus

www.navitus.com
Phone: (866) 333-2757

FORMULARY DRUGS	1-34 days	35-90 days
Tier 1; Generic Drugs	$10 Copay	$20 Copay
Tier 2; Preferred Brand Name Drugs	$25 Copay	$50 Copay
Tier 3; Non-Preferred Brand Name Drugs	$50 Copay	$100 Copay

Significant or new therapeutic class drugs: 50% copay. Some formulary and all non-formulary drugs require pre-authorization.

Members with Diabetes and Members who use Antihyperlipidemic and Antihypertensive drugs have no copays for Tier 1 and Tier 2 Supplies and Medication.

RUHS - Mail Order Service Medical Center Retail Pharmacy 26520 Cactus Ave. Moreno Valley, Ca 92555 Phone (951) 486-4515, option 5 www.ruhealth.org/services/pharmacy (mail order prescriptions only)	**FORMULARY DRUGS** / **90 days** Tier 1; Generic Drugs — $20 Copay Tier 2; Preferred Brand Name Drugs — $50 Copay Tier 3; Non-Preferred Brand Name Drugs — $100 Copay Significant or new therapeutic class drugs: 50% copay. Some formulary and all non-formulary drugs require pre-authorization. Members with Diabetes and Members who use Antihyperlipidemic and Antihypertensive drugs have no copays for Tier 1 and Tier 2 Supplies and Medication.
Hospital & Emergency Room	
Ambulance	100%
Ambulatory Surgical Center	100% at Network facility only
Physician Hospital Visits	100%
Inpatient Hospital Services	$100 per admission at Network or non-Network facilities; non-Network facility coverage for emergency only (services subject to medical review)
Outpatient Hospital Services	100% at Network facility only; non-Network facilities not covered
Hospital Emergency Room (Copay waived if admitted)	100% after $100 Copay at Network or Non-Network facilities; non-Network facility coverage for emergency only (services subject to medical review)
Urgent Care/Urgently Needed Services	100% after $20 Copay at Network or non-network facility. (services subject to medical review)
Severe Mental Health Treatment	
Inpatient Care	$100 per admission at Network or non-Network facilities; non-Network facility coverage for emergency only (services subject to medical review)
Outpatient Care	100% after $15 Copay
Non-Severe Mental Health Treatment	
Inpatient Care	$100 per admission at Network or non-Network facilities; non-Network facility coverage for emergency only (services subject to medical review)
Outpatient Care - Individual	100% after $15 Copay
Outpatient Care - Group	100% after $15 Copay
Substance Abuse Treatment	
Inpatient Care	$100 per admission at Network or non-Network facilities; non-Network facility coverage for emergency only (services subject to medical review)

Inpatient Detoxification	$100 per admission at Network or non-Network facilities; non-Network facility coverage for emergency only (services subject to medical review)
Outpatient Hospital Services	100% at Network facility only
Outpatient Office Visit	100% after $15 Copay
Other Benefits	
Allergy Testing & Treatment	100% after $15 Copay
Chiropractic Care	100% after $15 Copay; benefits limited to 12 visits/Calendar Year
Members Requiring Diabetes Care	Pharmacy Copays are waived for all Generic and Preferred Brand Name injectable and oral antidiabetic medications and diabetic supplies (testing strips, syringes, etc.)
Members taking Antihyperlipidemic and Antihypertensive Drugs	Pharmacy Copays are waived for all Generic and Preferred Brand Name antihyperlipidemic and antihypertensive drugs
Durable Medical Equipment	50% Copay (services subject to medical review)
Other Medical Equipment (As defined in Section 4: Outpatient Services)	100%
Family Planning Elective Pregnancy Termination Infertility Services Tubal Ligation Vasectomy	 100% after $50 Copay for 1st trimester; $100 Copay for 2nd trimester; (3rd trimester only covered if pregnancy life threatening to mother) 50% Copay; up to a maximum of $10,000 lifetime benefit (services subject to medical review) 100% 100%
Home Health Care	100%
Hospice Care	100%
Physical Therapy	100% after $15 Copay up to 30 visits/Disability within a 90-day period
Skilled Nursing Facility	$100 per admission up to 100 days/Disability
Hearing Aid Instrument	$3,000/Member; once every 36 months
Bariatric Surgery	$100 per admission at Network facility only (services subject to medical review)

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

Pre-Existing Conditions

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

Medically Necessary

The Plan only covers Medically Necessary health care services. See Section 13 - Definition of Terms, for a more detailed explanation. Certain services provided by non-Network facilities require a medical review by the Plan's Medical Management Unit, to establish whether or not the services were Medically Necessary.

Copay

These are the amounts that you pay for certain Covered Services. For office visits, prescription drugs and other basic services, you are required to pay a dollar amount at the time you receive services (e.g. $15 Copay for an office visit). After you pay this Copay, the Plan pays for Covered Expenses up to the Allowed Charge, subject to all other terms and limitations described in the Schedule of Benefits, General Provisions, or Exclusions and Limitations sections of this SPD. For Inpatient services and some Copays you pay that are a percentage of the cost, you normally pay your share after the provider bills the Plan and the Plan has paid its portion of the covered costs.

Deductible – Individual/Family

The Deductible is the portion of the cost of medical expenses you must pay each Calendar Year before the Plan will pay any Benefits**. There are no individual or family Deductibles required with the Exclusive Care EPO Plan.**

Out-of-Pocket Maximum

The Plan helps protect you from costly medical expenses by limiting the total amount you pay out of your own pocket for certain services in any one Calendar Year. When the amount that you or any enrolled dependent has paid for these services reaches the designated level (the Out-of-Pocket Maximum), that covered member will pay nothing further for Covered Services for the rest of the Calendar Year (up to any benefit maximums that may apply). Out-of-Pocket amounts you pay which do not count towards each Member's Out-of-Pocket Maximum include:

- Deductibles (in the case of the EPO Plan, there are no Deductibles);
- Charges in excess of the Allowed Charges covered by the Plan;
- Charges for services that are not covered by 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;

Lifetime Maximum Benefit

Unlimited

SECTION 4: 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, and all Members of the EPO admitted to a non-Network facility will be transferred to a Network facility when medically stabilized.

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

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 spousal 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 60 days after birth.

Breast Reconstructive Surgery

Coverage will be provided to a Member who is receiving Benefits for a Medically Necessary mastectomy and who elects breast reconstruction after mastectomy for:

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

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

Inpatient Dental Care

Inpatient services associated with dental procedures under the following circumstances:

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

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

Emergency Care/Urgent Care/Urgently Needed 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;

Urgent Care/Urgently Needed Services

Urgent Care or Urgently Needed Services are Medically Necessary services required after regular business hours to prevent serious deterioration of your health resulting from unforeseen illness or injury manifesting itself by acute symptoms of sufficient severity which may include severe pain, such that the treatment cannot be delayed until your Primary Care Provider is available;

Urgent Care or Urgently Needed Services are provided for less serious medical conditions than Emergency Care Services, such as:

- ✓ Non life-threatening cuts which nevertheless require immediate suturing to ensure proper healing;
- ✓ Acute illnesses where a delay in care would result in a serious deterioration in your health;

Follow-Up Care

If you require additional services following Emergency Care or Urgent Care/Urgently Needed Services, you must obtain these services from your Primary Care Provider. If additional services or a referral to a Specialist is necessary, your Primary Care Provider can make this request on your behalf. Follow-up care provided in an emergency room is not a covered expense;

Non-Qualifying Services (EPO Plan ONLY)

Medical or Hospital services which do not qualify as Emergency Care or Urgent Care/Urgently Needed Services received from non-Participating Providers are not covered by the Plan. For example, medical care provided outside the Plan's Service Area will not be covered if the need for care is for a known or Chronic Condition that is not manifesting itself by acute symptoms as defined Emergency Care or Urgent Care/Urgently Needed Services section;

Outpatient Services

PCP 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.

Other Medical Equipment

- ✓ Corrective appliances, artificial aids, Prosthetics and Orthotics that are part of a corrective appliance; therapeutic footwear (limits may apply);
- ✓ Urinary catheters (covered for a Member who has permanent urinary incontinence or permanent urinary retention).

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

Charges for Second Medical Opinion

Immunizations

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

Hearing Aid Benefit

To access your hearing aid benefit, first consult your Primary Care Provider who will determine if an evaluation is needed and will submit the referral request on your behalf. Once authorized, you may schedule an appointment with an audiologist. 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 once every thirty-six (36) months 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 at no charge for a one-year period following the provision of a covered hearing aid.

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

- ✓ Infertility testing and treatment - procedures consistent with established medical practices in the treatment of Infertility when authorized through your Primary Care Provider, but limited to diagnosis, diagnostic tests, medication and surgery;
- ✓ Physician visits for contraceptive devices and oral contraceptive prescriptions;
- ✓ Vasectomy;
- ✓ Tubal ligation;
- ✓ Injectable 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 for each organ transplant when the search is conducted by a special transplant facility, or $5,000 for 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.

Bariatric, Gastric Bypass and other Weight Reduction Surgeries

For additional Plan Exclusions and Limitations, refer to Weight Control Programs section.

SECTION 5: PLAN EXCLUSIONS AND LIMITATIONS

General Exclusions

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

Any services requiring approval and authorization by the Plan and/or your Primary Care Provider where pre-authorization was not obtained (except for Emergency Care or Urgent Care/Urgently Needed Services);

All services prior to your effective date of coverage or subsequent to your coverage termination date;

If you are a Member of the EPO Plan, Services rendered by non-Participating Providers where you have refused treatment available, or where authorized by the Plan and/or your Primary Care Provider within the Plan Service Area;

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

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

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

Charges submitted for which the Member is not obligated to pay, or for which the Member would not have been billed had insurance coverage not existed.

Specific Exclusions

Acupuncture, Acupressure, Biofeedback

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

Bone Marrow Transplants (when Experimental or Investigational)

Cosmetic Surgery

- ✓ Services or supplies related to cosmetic surgery, unless required as a result of an illness or injury sustained while covered under the Plan, or to correct a functional defect resulting from a congenital abnormality or developmental anomaly;
- ✓ Complications of cosmetic surgery or drugs prescribed for cosmetic purposes;
- ✓ Surgery to alter and improve your physical appearance or to improve your self-esteem, which provides no improvement to a functional impairment;

Custodial Or Domiciliary Care

Homemaker services, Respite Care, convalescent care or extended care not requiring skilled nursing;

Dental Care, Dental Appliances

All 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;

Disabilities Connected To Military Services

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

Durable Medical Equipment, Corrective Appliances, Prosthetics:

- ✓ Replacement of lost Durable Medical Equipment, corrective appliances, or prosthetics;
- ✓ Additional optional accessories to Durable Medical Equipment, corrective appliances, or prosthetics, which are primarily for your comfort or convenience;
- ✓ Personal comfort items such as electric heating or cooling units, orthopedic mattresses or support chairs, blood pressure instruments, scales, elastic bandages or stockings, waterbeds, exercise equipment and swimming pools including home and car remodeling or modification. This includes prosthetics that require surgical connection to nerves, muscles or other tissues (bionic) and prosthetics that have electric motors to enhance motion (myoelectronic);

Emergency Care Services - Non-Network Facility

If you are enrolled in the EPO, Emergency Care services are covered in a non-Network facility only as long as a life-threatening condition exists, and a transfer to a Network facility would be medically inappropriate. Routine follow-up care, including treatments, procedures, X-rays, lab work, Physician visits, Rehabilitation, and skilled nursing care will not be authorized once it is determined by the Plan that it is medically reasonable for you to obtain these services from a Participating Provider. Members should contact the Plan within twenty-four (24) hours of receiving treatment in the event of an Emergency Care situation. Failure to do so may result in a reduction or denial of Benefits;

Experimental Or Investigational Treatment

Unless otherwise dictated by Federal or state law, decisions as to whether a particular treatment is Experimental or Investigational, and therefore not a covered 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 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;

Genetic Testing

If not related to a specific medical diagnosis for a covered Member;

Institutional Services And Supplies - Non-Eligible

Any services or supplies furnished by a non-eligible institution, which is defined as other than a legally operated Hospital, Ambulatory Surgical Center, or Medicare-approved Skilled Nursing Facility, or which is primarily a place of rest, a place for the aged, a nursing home, or any similar institution, regardless of how denominated;

Non-Licensed Professionals

Treatment for any illness or injury when not attended by a licensed Physician, surgeon or other licensed Health Care Professional;

Nursing - Private Duty

Unless determined to be Medically Necessary and ordered by your Primary Care Provider and approved by the Plan's Medical Director;

Nutritional Supplement Formulas

Phenylketonuria (PKU) formula is limited to under age thirteen (13), or as Medically Necessary;

Organ Donor Services

Medical and Hospital services and other costs of a donor or prospective donor when the recipient is not a Member of the Plan;

Organ Transplants

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

Outpatient Prescription Drugs

The "Outpatient Prescription Drug Program" section of this SPD describes how Outpatient prescription drugs are covered by the Plan;

Out-Of-Area Emergency Care services

For EPO Plan Members, coverage is limited to the Benefits outlined in the "Emergency Care and Urgently Needed Services" section of this document. The Member will be responsible for the bill if services are obtained out-of-area and are not determined to be a life-threatening emergency.

Physical Examinations

Routine physical examinations for insurance, licensing, employment, school, camp, recreational or organizational, including appearances at hearings or court proceedings, examinations

precedent to engaging in travel, or other non-preventative purposes, pre-employment physicals or vocational Rehabilitation, or for pre-marital and pre-adoption purposes;

Pregnancy Of Covered Dependent

Services related to a non-spousal dependent's pregnancy are limited to prenatal care/normal delivery of the covered dependent. Charges for all services provided to the newborn, incurred after the birth/delivery of the dependent's newborn are excluded, including pediatric services;

Private Rooms And Comfort Items

Personal or comfort items and private rooms during Inpatient hospitalization, unless Medically Necessary, such as cable television, telephones, communication devices, exercise equipment, air purifiers, humidifiers, saunas, hot tubs, therapeutic mattresses, and supplies or any other similar devices or appliances;

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 and Urgent Care/Urgently Needed Services required after participating in a criminal act (covered only until the Member is stabilized and placed on a police hold);

Notwithstanding the foregoing, in compliance with California Health & Safety Code section 1374.12, nothing in this provision shall be deemed to restrict the liability of the Plan with respect to Covered Services solely because such services were provided while the Member was in a state Hospital;

Random Drug Testing

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

Recreational, Educational, Hypnotic Therapy

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

Rehabilitation

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

Reversal of Voluntary Sterilization

Sexual Dysfunction

Treatment for sexual dysfunctions or inadequacies unless pre-authorized by the Plan;

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 Primary Care Provider, 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.

Social Disorders

Services which are primarily oriented towards treating a social, educational or learning disorder, rather than a medical diagnosis, including treatment for dyslexia, and behavioral modification therapy;

Surrogate Pregnancy

Third-Party Liability Services

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

Vision Care

Eye refractive examination, corrective lenses and frames, contact lenses, contact lens fitting and measurements (except post cataract extraction, keratoconus, aphakic or corneal bandages);

Weight Control Programs (Inpatient or Outpatient)

Eating disorder programs for dietary control, or other treatment of obesity such as food and proprietary food supplements, vitamins and laboratory tests in association with weight reduction programs. The Plan does cover certain Medically Necessary Bariatric Surgery procedures ordered by your Primary Care Provider and approved by the Plan's Medical Director.

Work-Related Illnesses/Injuries

Injury, sickness or disease which arises out of or in the course of any employment, or which is covered under any workers' compensation law or similar law.

Limitations

Circumstances Beyond Control

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

Major Disaster Or Epidemic

In the event of any major disaster or epidemic, Participating Providers shall provide or attempt to arrange for the provision of Covered Services insofar as is practical, according to their best judgment, within the limitations of such facilities and personnel as are then available, but neither

the Plan, nor its Participating Providers have any liability or obligations for delay or failure to provide any such services or personnel if such lack is the result of such disaster or epidemic.

SECTION 6: OUTPATIENT PRESCRIPTION DRUG PROGRAM

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

The Plan provides Benefits for Outpatient prescription drugs on the Navitus (The Plan's Pharmacy Benefit Manager) Formulary ("Drug Formulary" or "Formulary"), when prescribed by a Participating Physician or licensed dentist, or a non-Participating Physician in certain emergency situations, or for a Member with Out-of-Area coverage.

How The Program Works

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

The Drug Formulary

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

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

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

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

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

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

Pre-Authorization of Non-Formulary Drugs

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

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

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

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

Maintenance Drug Dispensing

Maintenance drugs will be dispensed for up to a 90-day supply through Navitus Participating Pharmacies, or 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

You may receive up to a 90-day supply of these medications through a participating pharmacy or mail order service for two Copays (saving you one Copay). It is your responsibility to pay the Copay amount required each time a prescription is filled.

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:

For Mail Order: Please dial the RUHS Medical Center Pharmacy main line at 951-486-4515 and choose Option 5. Mail order turnaround time is usually 3 to 5 business days.

Online Order: Click for Online 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 unless approved on a prior authorization as part of the Outpatient Prescription Drug Program;
- 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;
- Drugs or medicines prescribed by non-Participating Physicians (except for prescriptions required as a result of an Urgent Care/Urgently Needed Service for an Acute Condition or prescribed by a licensed dentist);
- Smoking cessation products are limited to one treatment course each Calendar Year when enrolled in a smoking cessation program;

- Injectable drugs (except as listed) or;
- Durable Medical Equipment that can be obtained without a prescription.

Dispensing Quantity Limitations

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

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 PLAN'S MEDICAL MANAGEMENT UNIT. NO BENEFITS WILL BE PROVIDED FOR TREATMENT OR SERVICES THAT ARE NOT PRE-AUTHORIZED BY THE PLAN, EXCEPT IN THE CASE OF PSYCHIATRIC EMERGENCY ADMISSIONS.

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 Plan's Medical Management Unit.*** 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 Plan's Medical Management Unit as Clinically Necessary, except in the case of an emergency Psychiatric Admission.

- Individualized evaluation of needs, referral into treatment and monitoring by a Participating Mental Health/Substance Abuse Provider;
- Behavioral Health Services provided for Inpatient treatment, treatment at a Residential Treatment Center or Residential Treatment Facility, and treatment at a Day Treatment Center;
- Behavioral Health Services provided by a Participating Provider, which are received at a Participating Facility; Outpatient services provided by a Participating Provider, except in the case of an emergency Psychiatric Admission;
- Inpatient Detoxification; pre-authorization from the Plan's Medical Management Unit is required; limited to hospitalization to remove toxic substances from the system;

- Nursing by a Registered Nurse, a Licensed Practical Nurse, or a Licensed Vocational Nurse when Medically Necessary to accompany services provided by a Participating Provider;
- Participating Practitioner 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 Plan's Medical Management Unit or a Participating Provider, which are related to the approved Behavioral Health Treatment Plan;
- Psychological testing when pre-authorized by the Plan's Medical Management Unit and provided by a licensed, participating psychologist;
- Emergency Treatment;
- Psychotherapy for marital and family problems, when determined Clinically Necessary by a Participating Mental Health/Substance Abuse Provider; and,
- Treatment for an eating disorder, as defined by the DSM-IV, when pre-authorized by the Plan's Medical Management Unit.

What To Do In Emergencies

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

If you are admitted to any facility without pre-authorization from the Plan's Medical Management Unit, upon notification, the Plan's Medical Management Unit will review the situation by telephone and conduct a further assessment as appropriate. For Members of the EPO Plan, if the facility is a non-Participating Facility, you may be transferred to a Participating Facility as soon as it is medically safe to do so.

Exclusions And Limitations

The following services are excluded:

- Any confinement, treatment, service or supply not pre-authorized by the Plan's Medical Management Unit, except for Behavioral Health Services for Emergency Treatment;
- Any confinement, treatment, service or supply provided by a non-Participating Provider, 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, 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;
- Sex therapy, including without limitation, therapy for sexual addiction, in the absence of a psychiatric diagnosis generally recognized and accepted by the medical community and limited to a DSM-IV psychiatric diagnosis;
- Pastoral or spiritual counseling;
- Dance, poetry, music or art therapy;
- Non-organic therapies including, but not limited to the following: bio-energetic therapy, confrontation therapy, crystal healing therapy, educational remediation, Eye Movement Desensitization and Reprocessing (EMDR), guided imagery, marathon therapy, primal therapy, Rolfing, sensitivity training, transcendental meditation, Z therapy;
- Organic therapies including, but not limited to the following: aversion therapy, carbon dioxide therapy, environmental ecological treatment or remedies, herbal therapies, massage therapy, hemodialysis for schizophrenia, vitamin or orthomolecular therapy, narcotherapy with LSD, sedative action electrostimulation therapy;
- Private rooms and private duty nursing unless Clinically Necessary as determined by the Plan's Medical Management Unit;
- Custodial Care;
- Treatment for caffeine intoxication or dependency on any food substance, in the absence of a psychiatric diagnosis generally recognized and accepted by the medical community and limited to a DSM-IV psychiatric diagnosis;
- 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 or non-Participating 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; or

- 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: CHIROPRACTIC CARE BENEFIT

The Plan provides you and your enrolled dependents with a Chiropractic Care Benefit. Chiropractic services are provided to you through the Plan's chiropractic provider Network.

How The Chiropractic Care Benefit Works

To begin a course of chiropractic treatment, simply make an initial appointment with the Participating Chiropractor of your choice. A listing of the Participating Chiropractors can be found in the provider directory. **A referral from your Primary Care Provider is not required for the initial consultation**. At the initial appointment, your chiropractor will collect your Copay. Your chiropractor will bill the Plan for the remaining charges.

Covered Services

The Chiropractic Care Benefit covers the services described in this section when performed by a Participating Chiropractor and authorized when necessary by the Plan, up to the annual maximum benefit listed in the Schedule of Benefits section of this SPD. The following treatment and services are covered:

- An initial examination and any subsequent examinations, up to a limit of 12 visits per Calendar Year, with a Participating Chiropractor to determine the nature of your presenting problem and, if necessary, to prepare a Treatment Plan;
- X-rays and laboratory tests, when prescribed by a Participating Chiropractor,
- X-ray second opinions, only when performed by a Participating Radiologist for verification of suspected tumors or fractures, and not for routine care;

Exclusions And Limitations

The following items and services are not covered:

- Visits in excess of twelve (12) visits each Calendar Year;
- Service or treatment not authorized by a Participating Chiropractor after the initial consultation;
- Service or treatment delivered by a non-Participating Chiropractor;
- Services for examination and /or treatment of strictly non neuro-musculoskeletal disorders;

- Conjunctive Physical Therapy not associated with spinal or joint adjustment;
- Services not documented as Medically Necessary and appropriate, or classified as Experimental or Investigational Chiropractic Care;
- Thermography and diagnostic scanning, including Magnetic Resonance Imaging (MRI), CAT scans, and/or other types of diagnostic scanning;
- Services or treatment for Temporomandibular Joint Disease (TMJ); TMJ is a condition of the jaw joint which commonly causes headaches, tenderness of the jaw muscles, or dull aching facial pain;
- Hypnotherapy, behavior training, sleep therapy and weight programs;
- Education programs, non-medical self-care or self-help, or any self-help physical exercise training, or related diagnostic testing;
- Vitamins, minerals, nutritional supplements or other similar type products;
- Manipulation under anesthesia, hospitalization, anesthesia or any other related services.

SECTION 9: OUT-OF-AREA COVERAGE FOR QUALIFIED DEPENDENTS

How the Out-of-Area Coverage Works

Qualified dependents living outside the EPO Plan Service Area are eligible for the Out-of-Area Schedule Of Benefits. The qualified dependent may receive treatment and services and seek reimbursement through the Plan according to the Member Coinsurance and limitations indicated in the Summary Plan Document. Plan Benefits are paid according to the reimbursements and limitations shown in the "Out-of-Area Schedule of Benefits" section.

Choice of Providers

As a Member enrolled in this coverage, you may receive treatment and services from any licensed and qualified provider; then you or your provider may seek reimbursement for Covered Services by sending the bill to the Plan's Claims Department. Instructions are included on your identification card. Be sure to show the provider your identification card when you receive health care services. The bill will be paid based on the Allowed Charges for the services or treatment provided. Exclusive Care has contracted with a national re-pricing clearinghouse, to help you limit your out-of-pocket costs. This re-pricing clearinghouse has contracts with national networks of participating Hospitals, Physicians and other providers, giving you and Exclusive Care a discount if your provider participates in one of these networks.

Second Medical Opinion

If you need a second medical opinion, you do not need pre-authorization from Exclusive Care. However, the second medical opinion must be obtained from an appropriate medical Specialist and this provider must submit the bill to the Plan with documentation from your initial consultation. Second medical opinions can only be rendered by a Physician qualified to review and treat the medical condition in question. If a second medical opinion is deemed not to be

Medically Necessary and reimbursement is denied, you may appeal the denial by following the procedures outlined in the "Member Grievance Procedure" section of this SPD. For more information, please contact the Member Services Department.

The Schedule of Benefits below summarizes the Covered Services that are eligible for reimbursement and any benefit limitations that apply. Each Member is responsible for payment of Deductible and Coinsurance amounts as set forth below.

Schedule of Benefits – Out-of-Area Qualified Dependents

Choice of Provider	Any licensed and qualified provider
Deductible – Individual	$300/Member/Calendar Year
Deductible - Family	Not Applicable
Out-of-Pocket-Maximum	$5,000/Member/ Calendar Year
Lifetime Maximum Benefit	Unlimited
Pre-existing Condition	Fully Covered
Outpatient/Office Visits	**Member Responsibility**
Physician Office Visits	20% of Allowed Charges (and any amount in excess of Allowed Charges)
Hospital Clinic Visits	20% of Allowed Charges (and any amount in excess of Allowed Charges)
Periodic Health Evaluations	No member responsibility (member pays nothing)
Maternity Care	No member responsibility (member pays nothing)
Well Woman Care	No member responsibility (member pays nothing)
Well Baby Care	No member responsibility (member pays nothing)
Immunizations	No member responsibility (member pays nothing)
Diagnostic X-ray & Lab	20% of Allowed Charges (and any amount in excess of Allowed Charges)
Vision Exams (screening and refractions)	No member responsibility (member pays nothing) 1 Vision Exam per Calendar Year
Outpatient Prescription Drugs	
• ***Prescription Drug Coverage is administered by the Plan's Pharmacy Benefit Manager (PBM)*** • ***Pharmacy Benefit Manager (PBM): Navitus Health Solutions. Up to 90 Days***	

<table>
<tr>
<td><u>Navitus</u>

<u>www.navitus.com</u>
Phone: (866) 333-2757</td>
<td>
<table>
<tr><th>FORMULARY DRUGS</th><th><u>1-34 days</u></th><th><u>35-90 days</u></th></tr>
<tr><td>Tier 1; Generic Drugs</td><td>$10 Copay</td><td>$20 Copay</td></tr>
<tr><td>Tier 2; Preferred Brand Name Drugs</td><td>$25 Copay</td><td>$50 Copay</td></tr>
<tr><td>Tier 3; Non-Preferred Brand Name Drugs</td><td>$50 Copay</td><td>$100 Copay</td></tr>
</table>
Significant or new therapeutic class drugs: 50% copay. Some formulary and all non-formulary drugs require pre-authorization.

Members with Diabetes and Members who use Antihyperlipidemic and Antihypertensive drugs have no copays for Tier 1 and Tier 2 Supplies and Medication.
</td>
</tr>
<tr>
<td><u>RUHS - Mail Order Service</u>

Medical Center Retail Pharmacy
26520 Cactus Ave.
Moreno Valley, Ca 92555
Phone (951) 486-4515, option 5
<u>www.ruhealth.org/services/pharmacy</u>
(mail order prescriptions only)</td>
<td>
<table>
<tr><th>FORMULARY DRUGS</th><th><u>90 days</u></th></tr>
<tr><td>Tier 1; Generic Drugs</td><td>$20 Copay</td></tr>
<tr><td>Tier 2; Preferred Brand Name Drugs</td><td>$50 Copay</td></tr>
<tr><td>Tier 3; Non-Preferred Brand Name Drugs</td><td>$100 Copay</td></tr>
</table>
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Members with Diabetes and Members who use Antihyperlipidemic and Antihypertensive drugs have no copays for Tier 1 and Tier 2 Supplies and Medication.
</td>
</tr>
<tr><th>Hospital & Emergency Room</th><th>Member Responsibility</th></tr>
<tr><td>Ambulance (when Medically Necessary)</td><td>20% of Allowed Charges (and any amount in excess of Allowed Charges)</td></tr>
<tr><td>Ambulatory Surgical Center</td><td>20% of Allowed Charges (and any amount in excess of Allowed Charges)</td></tr>
<tr><td>Physician Hospital Visits</td><td>20% of Allowed Charges (and any amount in excess of Allowed Charges)</td></tr>
<tr><td>Inpatient Hospital Services</td><td>20% of Allowed Charges (and any amount in excess of Allowed Charges)</td></tr>
<tr><td>Outpatient Hospital Services</td><td>20% of Allowed Charges (and any amount in excess of Allowed Charges)</td></tr>
<tr><td>Hospital Emergency Services</td><td>20% of Allowed Charges (and any amount in excess of Allowed Charges)</td></tr>
<tr><td>Urgent Care/Urgently Needed Services</td><td>20% of Allowed Charges (and any amount in excess of Allowed Charges)</td></tr>
<tr><th>Severe & Non-Severe Mental Health Treatment</th><th>Member Responsibility</th></tr>
<tr><td>Inpatient Care</td><td>20% of Allowed Charges (and any amount in excess of Allowed Charges)</td></tr>
</table>

Outpatient Care - Individual	20% of Allowed Charges (and any amount in excess of Allowed Charges)
Outpatient Care - Group	
Substance Abuse Treatment	**Member Responsibility**
Inpatient Care	20% of Allowed Charges (and any amount in excess of Allowed Charges)
Inpatient Detoxification	20% of Allowed Charges (and any amount in excess of Allowed Charges)
Outpatient Hospital Services	20% of Allowed Charges (and any amount in excess of Allowed Charges)
Outpatient Office Visit	

Other Benefits	**Member Responsibility**
Allergy Testing & Treatment	20% of Allowed Charges (and any amount in excess of Allowed Charges)
Chiropractic Care	20% of Allowed Charges (and any amount in excess of Allowed Charges); Benefits limited to 12 visits/Calendar Year
Members Requiring Diabetes Care	Pharmacy Copays are waived for all Generic and Preferred Brand Name Formulary injectable and oral antidiabetic medications and diabetic supplies (testing strips, syringes, etc.)
Members Taking Antihyperlipidemic and Antihypertensive Drugs	Pharmacy Copays are waived for all Generic and Preferred Brand Name antihyperlipidemic and antihypertensive Drugs
Durable Medical Equipment	50% of Allowed Charges (and any amount in excess of Allowed Charges);
Other Medical Equipment	20% of Allowed Charges
Family Planning	
➢ Elective Pregnancy Termination	20% of Allowed Charges (and any amount in excess of Allowed Charges) ; (3rd trimester only covered if pregnancy life-threatening to mother)
➢ Infertility Services	50% of Allowed Charges (and any amount in excess of Allowed Charges); up to a maximum of $10,000 lifetime benefit
➢ Tubal Ligation	20% of Allowed Charges (and any amount in excess of Allowed Charges)
➢ Vasectomy	20% of Allowed Charges (and any amount in excess of Allowed Charges)
Home Health Care	20% of Allowed Charges (and any amount in excess of Allowed Charges)

Hospice Care	20% of Allowed Charges(and any amount in excess of Allowed Charges)
Physical Therapy	20% of Allowed Charges (and any amount in excess of Allowed Charges); up to 30 visits/Disability within a 90day period
Skilled Nursing Facility	20% of Allowed Charges (and any amount in excess of Allowed Charges); up to 100 days/Disability
Hearing Aid Instrument	$3,000/Member; once every 36 months

An explanation of terms used in this Schedule of Benefits follows below, to help you get the most from your Out-Of-Area coverage:

Pre-Existing Conditions

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

Medically Necessary

The Plan only covers Medically Necessary health care services. See the Section "Definition of Terms" in this SPD for a more detailed explanation. Certain services require a medical review by the Plan's Medical Management Unit, to establish whether or not the services were Medically Necessary.

Allowed Charges

For services provided by a non-Participating Provider, 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.

Copay

The amount you are required to pay for certain Covered Services identified in the Schedule of Benefits above. You may be required to pay the Copay amount to the provider before the provider submits a bill to the Plan. In the case of outpatient prescription drugs, you are always required to pay the Copay amount at the time a prescription is filled. The Plan pays for Covered Expenses up to the Allowed Charge, subject to all other terms and limitations described in the Schedule of Benefits, General Provisions, or Exclusions and Limitations sections of this SPD.

Deductible – Individual/Family

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

Out-of-Pocket Maximum

The Plan helps protect you from costly medical expenses by limiting the total amount you pay out of your own pocket for certain services in any one Calendar Year. When the 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). Out-of-Pocket amounts you pay which do not count towards each Member's Out-of-Pocket Maximum include:

- Deductibles
- Charges in excess of the Allowed Charges covered by the Plan;
- Charges for services that are not covered by 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;

Lifetime Maximum Benefit

Unlimited

Member Liability

In the event the Plan fails to pay a provider for Covered Services, you will not be liable to the provider for any sums owed by the Plan based on the Summary Plan Document. You will be financially liable for any amounts owed to a provider who does not accept payment based on the Allowed Charges reimbursed by the Plan for services rendered. In addition, all Member Deductibles, the percentage amounts listed (e.g. 20% of Allowed Charges), and dollar Copay amounts (e.g. $15 Copay), are always your responsibility.

If you have any questions about your Out-of-Area coverage, contact the Member Services Department: (800) 962-1133, option 1, 8:00 a.m. - 5:00 p.m. Monday through Friday, Pacific Coast Time.

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

SECTION 10: PLAN GENERAL PROVISIONS

Claim Payment Procedures

The Plan is designed to eliminate claim forms and limit your out-of-pocket expenses other than required Deductibles. In some circumstances, you may incur expenses for Covered Services (such as for out-of-area Emergency Care services). If this happens, submit a copy of the bill and your receipt to the Claims Department, and the Plan will reimburse you for those expenses according to the Plan's Benefits, minus any applicable Copay amounts that are your responsibility.

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

EXCLUSIVE CARE Claims Department
P.O. Box 1508
Riverside CA 92502

Failure to submit bills within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to submit the bill within that time, provided proof of the billing is furnished as soon as reasonably possible. However a bill will not be accepted, except in the absence of legal capacity, later than one year from the time proof of the billing is otherwise required.

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. *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.*	**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.
	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 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.
	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		

Service Authorization, Claims Review and Appeal Chart		
Type of Transaction	**Steps to Take**	
Claims for Benefits where healthcare 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 person other 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 Urgent Care, a request for an expedited appeal may be submitted orally or in writing and all necessary information shall be transmitted between the Plan and you by telephone, fax, or other similar method.

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 document, 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 alternative dispute resolution options", such as Neutral Binding Arbitration. 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 cannot 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 other 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.

Independent Medical Review of Grievances Involving Disputed Health Care Services

You may request an independent medical review ("IMR") of disputed health care services if you believe that health care services eligible for coverage and payment under your Exclusive Care Plan have been improperly denied, modified or delayed by Exclusive Care or one of its contracting providers. A "Disputed Health Care Service" is any health care service eligible for coverage and payment under your Exclusive Care Plan that has been denied, modified or delayed by Exclusive Care or one of its contracting providers, in whole or in part because the service is not Medically Necessary.

The IMR process is in addition to any other procedures or remedies that may be available to you. You pay no application or processing fees of any kind for IMR. You have the right to provide information in support of the request for IMR. Exclusive Care will provide you with an IMR application form and Exclusive Care's grievance response letter that states its position on the Disputed Health Care Service. A decision not to participate in the IMR process may cause you to forfeit any statutory right to pursue legal action against Exclusive Care regarding the Disputed Health Care Service.

Eligibility for Independent Medical Review

Your application for IMR will be reviewed by the IMR organization to confirm that it meets all the eligibility requirements of the law for IMR which are set out below:

1. Your provider has recommended a health care service as Medically Necessary; or you have received urgent or Emergency Care that a provider determined to have been Medically Necessary. In the absence of the provider recommendation described above, you have been seen by an Exclusive Care Member Physician for the diagnosis or treatment of the medical condition for which you seek IMR;

2. The Disputed Health Care Service has been denied, modified or delayed by Exclusive Care or one of its contracting providers, based in whole or in part on a decision that the health care service is not Medically Necessary; and

3. You have filed a grievance with Exclusive Care and the disputed decision is upheld by Exclusive Care or the grievance remains unresolved after 30 days. Within the next six months, you may apply for IMR or later, if the IMR agrees to extend the application

deadline. If your grievance requires expedited review you may bring it immediately to the attention of the IMR. The IMR may waive the requirement that you follow Exclusive Care's grievance process in extraordinary and compelling cases. If your case is eligible for IMR, the dispute will be submitted to a medical specialist who will make an independent determination of whether or not the care is Medically Necessary.

You will receive a copy of the assessment made in your case from the IMR. If the IMR determines the service is Medically Necessary, Exclusive Care will provide benefits for the Disputed Health Care Service. If your case is not eligible for IMR, the IMR will advise you of your alternatives.

For non-urgent cases, the IMR organization must provide its determination within 30 days of receipt of the application for review and the supporting documents. For urgent cases involving imminent and serious threat to your health, including, but not limited to, serious pain, the potential loss of life, limb or major bodily function or the immediate and serious deterioration of your health, the IMR organization must provide its determination within three business days. For more information regarding the IMR processor to request an application form, please call Exclusive Care's Member Services Department at the telephone number on your Exclusive Care ID Card.

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.

If you have a grievance against Exclusive Care, you should first telephone Exclusive Care at **1-800-962-1133** and use Exclusive Care's grievance process. Utilizing this grievance process does not prohibit any potential legal rights or remedies that may be available to you. 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 Exclusive Care 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.

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 reasons other than gross misconduct;
- ✓ Reduction in the number of hours of employment.

Qualifying Events for Spouses:

- ✓ Voluntary or involuntary termination of the covered employee's employment for any reason other than gross misconduct;
- ✓ Reduction in the 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 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 it 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 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 which Exclusive Care is required by federal law to provide to its Members:

Exclusive Care – Notice of Privacy Practices

Exclusive Care creates records of health care to provide quality care and comply with legal requirements. Exclusive Care understands your health information is personal and private, and commits to safeguarding it to the extent reasonably possible. This individually identifiable health information is known as "protected health information" (PHI). Exclusive Care is required by law to:

- Assure that health information that identifies you is kept private;
- Give you notice of Exclusive Care's legal duties and privacy practices with respect to your health information;
- Notify you if you are affected by a breach of unsecured PHI; and
- Follow the terms of this notice currently in effect.

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 with 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. Exclusive Care may combine health information about many plan members in summary format with the purpose of analyzing plan coverage for plan sponsors.

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.
3. Use or disclosure of your health information for marketing purposes.
4. Disclosures of PHI that are considered a sale.

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.

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 the facility, general condition, and religious affiliation in a facility directory while you are a patient so your family, friends and clergy can visit you and know how you are doing.
2. To individuals assisting with your treatment or payment.
3. To assist with disaster relief 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, we are unable to obtain the person's agreement;
    - About a death we believe may be the result of criminal conduct;
    - About criminal conduct at the Hospital; or,
    - In emergency circumstances to report a crime, the location of a crime or crime victims, or the identity, description or location of a person who may have committed a crime.
7. To coroners, medical examiners and funeral directors as necessary for them to carry out their duties.
8. For organ donation once you are deceased.
9. For public health research in compliance with strict conditions approved and monitored by an Institutional Review Board.
10. To avert serious threats to the health and safety of you or others.
11. Regarding military personnel for activities deemed necessary by appropriate military command authorities to assure proper execution of a military mission.

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

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

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

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

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

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 including PHI maintained in an electronic format. If your PHI is available in an electronic format, you may request electronic access.

   Requests may be required in writing, and Exclusive Care may charge you a fee for the costs of fulfilling your request. This fee is limited to the cost of labor involved in responding to your request if you requested access to an electronic health record. 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 an "accounting of disclosures", including a disclosure involving an electronic health record. This is a list of disclosures of your PHI that Exclusive Care has made to others, except those necessary to carry out health care treatment, payment, or operations (does not include electronic records); disclosures made by you; or in certain other situations. 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**. You have a right to a paper copy of this notice, even if you received this notice previously or agreed to receive this notice electronically.

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 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 11: 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.
- The Plan shall be entitled to the payment and reimbursement as provided in this Section 11 regardless of whether the total amount of the recovery of the Member (or his or her estate, parent or legal guardian) on account of the injury is less than the actual loss suffered by the Member (or his or her estate, parent or legal guardian). The proceeds of any judgment or settlement obtained by the Plan (or its designee) or the Member (or his or her estate, parent or legal guardian) on account of the injury shall first be applied to satisfy Plan's (or its designee's) claims, liens, and other rights under this Section 11.

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 EPO or Out-of-Area 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:

1. 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;
2. 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:

1. 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;
2. The plan of the spouse of the parent with custody will be determined next;

3. The plan of the parent not having custody of the child will be determined last.

If none of the above rules establish an order of benefits determination, the benefits of the plan which has covered the Member for the longer period of time are determined before those of the plan which 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 which includes payment of future medical costs, you may be liable for reimbursing the Plan.

SECTION 12: 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 which 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.

The County of Riverside refrains from any conduct that constitutes fraud and dishonest dealing or unfair competition, as defined by Section 17200 of the Business and Profession Code.

Members may file a complaint with the State of California Department of Managed Health Care regarding violations of Section 17200 of the Business and Profession Code.

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.

SECTION 13: DEFINITION OF TERMS

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

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

Allowed Charges - 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.

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

Billed Charges - The amount the provider actually charges for services provided to a Member.

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

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

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

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

Chiropractic Care - Chiropractic services billed by any participating, licensed provider which will apply toward the chiropractic benefit Calendar Year maximum.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Durable Medical Equipment - Equipment intended for repeated use, which is primarily and customarily used to serve a medical purpose, and generally is not useful to a person in the absence of an illness or injury. Items considered "Other Medical Equipment" is defined in a separate entry in the Definition of Terms.

Eligible Child(ren) - Dependent natural children, adopted children, foster children, grandchildren, and stepchildren under your employer group's limiting age; any child, who is under your employer group's limiting age, 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 if the child is incapable of self-

support because of a mental or physical handicap and you continue to claim the child as a dependent on your federal income tax return.

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

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

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

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

Emergency 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 Participating Practitioner at a Participating Facility to determine if an Emergency Condition exists. If an Emergency Condition is found to exist, Emergency Treatment will include the care and treatment by the Participating Practitioner and Participating Facility necessary to relieve or eliminate the Emergency Condition, within the capacity of the Participating Facility.

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

Experimental or Investigational - Any treatment, therapy, procedure, drug or drug usage, facility or facility usage, equipment or equipment usage, device or device usage, or supplies which are not recognized as being in accordance with generally accepted professional medical standards, or if safety and efficacy have not been determined for use in the treatment of a particular illness, injury or medical condition for which it is recommended or prescribed (see pages 26-27).

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

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

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

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

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

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

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 or specialized Hospital services. Also refers to services rendered in Hospital or Skilled Nursing Facility while confined as a bed patient.

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

Medical Group - A group of Physicians practicing in a professional corporation or association which has entered into a written agreement with the Plan to provide Covered Services to Members.

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

Medically Necessary/Medical Necessity – Drugs, devices, procedures, treatments, services or supplies provided by a provider facility or individual provider which are required for treatment of an Exclusive Care member's illness, injury, diseased condition or impairment and are:

- Consistent with the symptoms or diagnosis and the member is an appropriate candidate for the proposed treatment; and
- Appropriate treatment, according to generally accepted standards of medical practice; and
- Not furnished primarily for the convenience of the patient, the attending Physician or another provider; and
- Not considered investigational or experimental, or
- Not excessive in scope, duration, or intensity to provide safe, adequate and appropriate treatment. Any service or supply provided at a facility will not be considered medically necessary if the symptoms or condition indicate that it would be safe to provide the service or supply in a less comprehensive setting.

The fact that any particular provider individual may prescribe, order, recommend or approve a service, supply or level of care does not, of itself, make such treatment medically necessary or make the charge a Covered Expense.

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 Participating Practitioner according to the criteria in the DSM-IV and limited to impairment of a Member's mental, emotional or behavioral functioning on a daily basis.

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

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.

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.

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

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

Other Medical Equipment - 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).

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

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

Participating Facility - A facility that is under contract with Exclusive Care to provide Inpatient, residential, day treatment, partial hospitalization, or Outpatient care for the diagnosis and/or treatment of Mental Health Disorders or Substance Abuse Disorders.

Participating Mental Health/Substance Abuse Provider - A Participating Facility or Participating Practitioner who provides Mental Health Services.

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

Participating Practitioner - Any licensed qualified Health Care Professional who has entered into a contractual agreement with Exclusive Care to provide Behavioral Health Services.

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

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

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

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

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

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

Plan Service Area - The County of Riverside and such adjacent communities as are designated by Exclusive Care.

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

Prosthetics – Devices (other than dental) which replace all or part of an internal body organ (including contiguous tissue), or replace all or part of the function of a permanently inoperative or malfunctioning internal body organ.

Psychiatric Admission - The scheduled and unscheduled admission of a Member by a Participating Practitioner to a Participating 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.

Qualified Public Employer Group

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

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

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

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

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

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

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

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

Schedule Of Benefits - A summary of the Covered Services/Benefits provided by the Plan, the amount that the Plan will pay towards the cost, and the Copay and other amounts, if any, that the Member pays towards the cost.

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

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

Specialist - Any duly licensed Physician, osteopath, psychologist or other Practitioner (as

defined by Medicare) who provides health care services for a specific disease or body part and to whom your Primary Care Provider may refer you. Also, any duly licensed emergency room Physician who provides Emergency Care services to you.

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

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

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

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

Treatment Plan – Services or a plan of treatment preauthorized 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.

Urgent Care/Urgently Needed Services – Urgent Care or Urgently Needed Services are Medically Necessary services required after regular business hours to prevent serious deterioration of your health resulting from unforeseen illness or injury manifesting itself by acute symptoms of sufficient severity which may include severe pain, such that the treatment can not be delayed until your Primary Care Provider is available;

Urgent Care or Urgently Needed Services are provided for less serious medical conditions than Emergency Care Services, such as:

- ✓ Non life-threatening cuts which nevertheless require immediate suturing to ensure proper healing;
- ✓ Acute illnesses where a delay in care would result in a serious deterioration in your health;

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

HEALTH PLAN ADDRESSES AND IMPORTANT TELEPHONE NUMBERS

Member Services Department:

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

Claims Department:

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

Mental Health/Substance Abuse Services:

EXCLUSIVE CARE Medical Management
P.O. Box 1508
Riverside, CA 92502-1508
(800) 962-1133, press option 3
8:00 a.m. - 5:00 p.m. Monday – Friday


Exclusive
Care