PLEASE READ THIS DISCLOSURE BROCHURE CAREFULLY. IT CONTAINS IMPORTANT INFORMATION YOU SHOULD KNOW BEFORE YOU ENROLL.

THIS DISCLOSURE FORM IS ONLY A SUMMARY.* * THE EVIDENCE OF COVERAGE CONTAINS THE TERMS AND CONDITIONS OF COVERAGE AND SHOULD BE CONSULTED TO DETERMINE GOVERNING CONTRACTUAL PROVISIONS. * *

YOU HAVE A RIGHT TO VIEW THE EVIDENCE OF COVERAGE PRIOR TO ENROLLMENT IN THIS PLAN. YOU MAY REQUEST THE EVIDENCE OF COVERAGE FROM YOUR EMPLOYER GROUP OR BY CONTACTING AETNA U. S. HEALTHCARE OF CALIFORNIA.

THIS DISCLOSURE BROCHURE AND THE ACCOMPANYING SAMPLE EVIDENCE OF COVERAGE SHOULD BE READ COMPLETELY AND CAREFULLY. INDIVIDUALS WITH SPECIAL HEALTH CARE NEEDS SHOULD READ CAREFULLY THOSE SECTIONS THAT APPLY TO THEM.

ADDITIONAL INFORMATION ABOUT THE BENEFITS OF THIS PLAN MAY BE OBTAINED BY CALLING 1-800-756-7039.

*THE ATTACHED SAMPLE EVIDENCE OF COVERAGE AND THIS DISCLOSURE FORM ARE FOR YOUR INFORMATION ONLY, THE ACTUAL EVIDENCE OF COVERAGE APPLICABLE TO YOUR PLAN MAY CONTAIN ADDITIONAL OPTIONAL BENEFITS SELECTED BY YOUR EMPLOYER.

A STATEMENT DESCRIBING AETNA HEALTH OF CALIFORNIA'S POLICIES AND PROCEDURES FOR PRESERVING THE CONFIDENTIALITY OF MEDICAL RECORDS IS AVAILABLE AND WILL BE FURNISHED TO MEMBERS UPON REQUEST.

SOME HOSPITALS AND OTHER PROVIDERS DO NOT PROVIDE ONE OR MORE OF THE FOLLOWING SERVICES THAT MAY BE COVERED UNDER YOUR PLAN CONTRACT AND THAT YOU OR YOUR FAMILY MEMBER MIGHT NEED: FAMILY PLANNING; CONTRACEPTIVE SERVICES, INCLUDING EMERGENCY CONTRACEPTION; STERILIZATION, INCLUDING TUBAL LIGATION AT THE TIME OF LABOR AND DELIVERY; INFERTILITY TREATMENTS; OR ABORTION. YOU SHOULD OBTAIN MORE INFORMATION BEFORE YOU ENROLL. CALL YOUR PROSPECTIVE DOCTOR, MEDICAL GROUP, INDEPENDENT PRACTICE ASSOCIATION, OR CLINIC, OR CALL THE HEALTH PLAN AT THE TOLL FREE MEMBER SERVICES NUMBER LISTED ON YOUR ID CARD TO ENSURE THAT YOU CAN OBTAIN THE HEALTH CARE SERVICES THAT YOU NEED.
INTRODUCTION

The information which follows provides general information regarding Aetna Health health plans. You should refer to your specific plan documents for additional information regarding the operation of your plan. Additional important information regarding

- Your Primary Care Physician (PCP),
- Participating providers
- Referrals and authorization,
- Requesting continuity of care or standing referrals,
- Facilities, and
- Grievance Procedures

may be found in the attached sample Evidence of Coverage (EOC).

Information about how the HMO determines medical necessity may be found at the beginning of the “Covered Benefits” section of the attached sample Evidence of Coverage.

You can find additional information including provider directories, the prescription drug formulary, coverage policy bulletins and other important information at our website, www.aetna.com. You can contact the California Department of Managed Care at http://www.hmohelp.ca.gov.

Eligibility, covered benefits, medical necessity, precertification, concurrent review, retrospective record review and all other terms and conditions of your health plan are determined at the sole discretion of Aetna Health (or its designee). This means that some services recommended by your health professional may not be deemed covered benefits as determined by Aetna Health.

Certain PCPs are affiliated with integrated delivery systems, independent practice associations (“IPAs”) or other provider groups, and members who select these PCPs will generally be referred to specialists and hospitals within that system, association or group. However, if your medical needs extend beyond the scope of the affiliated providers, you may request coverage for services provided by non-affiliated network physicians and facilities. In order to be covered, services provided by non-affiliated network providers may require pre-approval from Aetna Health® and/or the integrated delivery systems or other provider groups.

To find a primary care physician (PCP), go to our online provider directory, DocFind®, located at http://www.aetna.com/docfind/custom/select. DocFind is available 24 hours a day, 7 days a week and is updated three times a week. With DocFind’s easy to use format, you can search for a provider online by name, specialty, gender and/or hospital affiliation. A printed directory will also be available.

ROLE OF PRIMARY CARE PHYSICIANS (“PCP”)

You should consult your primary care physician (“PCP”) when you are sick or injured to help determine the care that is needed. You should refer to your plan documents to determine covered benefits, exclusions and limitations under your benefits plan. Except for those benefits described in the plan documents as direct access benefits, or in an emergency, you need to obtain a referral authorization (“referral”) from your PCP before seeking covered non-emergency specialty or hospital care. The following points are important to remember regarding referrals:

- The referral is how your PCP arranges for you to be covered for necessary, appropriate specialty care and follow-up treatment.

HMO/CA DISCLOSURE BROCHURE 3/01: PART I 01.28.302.1-CA (01/04)
• You should discuss the referral with your PCP to understand what specialist services are being recommended and why.

• If the specialist recommends any additional treatments or tests that are covered benefits, you must get another referral from your PCP prior to receiving the services. If you do not get another referral for these services, you will be responsible for payment.

• Except in emergencies, all hospital admissions and outpatient surgery require a prior referral from your PCP and prior approval by the plan.

• If it is not an emergency and you go to a doctor or facility without a referral, you must pay the bill.

• Referrals are valid for 90 days as long as the individual remains an eligible member of the plan.

• Coverage for services from nonparticipating providers requires prior approval by Aetna Health in addition to a special “nonpar” referral from the PCP. These services are only covered when Aetna Health has determined that there is no participating provider with appropriate training and experience for your particular needs. When properly authorized, these services are fully covered, less the applicable copayment.

• The referral provides that, except for applicable copayments, you will not have to pay the charges for covered benefits, as long as you are a member at the time the services are provided.

**HEALTH CARE PROVIDER NETWORK**

When you use the Provider Directory or DocFind, you will note that certain health care providers are affiliated with other providers through systems, associations or groups. These systems, associations or groups (“organization”) or, their affiliated providers may be compensated by Aetna Health through a capitation arrangement or other global payment method. The organization then pays the treating provider directly through various methods. You should ask your provider how that provider is being compensated for providing health care services to you and if the provider has any financial incentive to control costs or utilization of health care services by members.

A summary of any agreement or contract between HMO and any health care provider will be made available upon request by calling the Member Services telephone number on your ID card. The summary will not include financial agreements as to actual rates, reimbursements, charges, or fees negotiated by HMO and the provider. The summary will include a category or type of compensation paid by HMO to each class of health care provider under contract with HMO.

**COVERED BENEFITS**

In order to be covered, all services, including the location (type of facility), duration and costs of services, must be medically necessary as defined in the plan documents and as determined solely by Aetna Health. Please consult the section at the beginning of the Covered Benefits section in the Sample EOC included in this Disclosure Brochure for additional information about how the HMO determines medical necessity.

**MEDICAL NECESSITY**

In order to be covered, all services, including the location (type of facility), duration and costs of services, must be medically necessary as defined in the plan documents and as determined solely by Aetna Health. Please consult the section at the beginning of the Covered Benefits section in the Sample EOC attached to this document for additional information about how the HMO determines medical necessity.
DIRECT ACCESS PROGRAM*

This program allows female members to visit any participating gynecologist for a routine well-woman exam, including a Pap smear (if appropriate) and an unlimited number of visits for gynecologic problems and follow-up care as described in your benefits plan. Gynecologists may also refer a woman directly for covered gynecologic services without the patient’s having to go back to her participating primary care physician. Women may also choose to receive the care described in the Direct Access Program from their primary care physician.

* If your Ob/Gyn is part of an Independent Practice Association (IPA), a Physician Medical Group (PMG) or a similar organization, you must select your participating gynecologist or obstetrician in the IPA, the PMG or the similar organization.

MENTAL HEALTH/SUBSTANCE ABUSE

Behavioral health care benefits (e.g., coverage for treatment or care for mental disease or illness, alcohol abuse and/or substance abuse) are managed by Aetna Health or an independently contracted organization. Aetna Health or the independently contracted organization makes initial coverage determinations and coordinates referrals. Any behavioral health care referrals will generally be made to providers affiliated with the organization, unless your needs for covered services extend beyond the capability of the affiliated providers. Your coverage will not exceed the maximum number of visits in your Schedule of Benefits or allowed in your Evidence of Coverage.

Aetna Health or its contracted organization may use prior authorizations and ongoing reviews to limit the number of outpatient mental health visits or inpatient days to the minimum it deems to be covered benefits that are medically necessary independent of the maximum number of visits described in your Schedule of Benefits. This means that you may not receive coverage for the maximum number of visits or days specified in your Schedule of Benefits, or the number of visits or days that you and your health professional believe to be appropriate, for a single course of treatment or episode. For example, psychotherapeutic outpatient treatment for depression may be considered a covered benefit for eight individual visits, but Aetna Health or its contracted organization may, through concurrent review, decide it will not cover any further treatment, even when the Schedule of Benefits states that the maximum number of outpatient visits is up to twenty (20) sessions per year.

Effective July 1, 2000, treatment(s) for “serious mental illness” and “serious emotional disturbances of a child,” as defined in Health & Safety Code, Section 1374.72, are not subject to the annual maximums shown on your Schedule of Benefits. These treatments are still subject to: a) prior authorizations and ongoing review to determine coverage; and, b) your plan’s maximum lifetime benefits, copayments and individual and family deductibles, if any.

You can receive information regarding the appropriate way to access the behavioral health care services that are covered under your specific plan by calling the toll-free number on your I.D. card. As with other coverage determinations, you may appeal behavioral health care coverage decisions in accordance with the provisions of your health plan, and applicable state law.

DIRECT ACCESS UNDER QPOS AND USACCESS PLANS ONLY

Under USAccess and QPOS plans, you may go directly to a specialist or hospital without a referral for certain covered benefits. However, you will generally be responsible for a deductible and coinsurance under these plans. Even so, you may be able to reduce your out-of-pocket expenses considerably by using the participating providers listed in your directory. Please refer to your specific plan documents for information on the non-referred benefits included in the USAccess and QPOS plans.
If your plan does not specifically cover self-referred or out-of-network benefits and you go directly to a specialist or hospital for non-emergency or non-urgent care without a referral, you must pay the bill yourself unless the services is specifically identified as a direct access benefit in your plan documents.

EMERGENCY CARE AND URGENT CARE BENEFITS.

Emergency Care Benefits:

If you need emergency care, you are covered 24 hours a day, 7 days a week anywhere in the world. Aetna Health has adopted the following definition of any emergency medical condition from the federal Balanced Budget Act of 1997:

An emergency medical condition is “one manifesting itself by acute symptoms of sufficient severity such that a prudent layperson, who possesses average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in serious jeopardy to the person’s health, or with respect to a pregnant woman the health of the woman and her unborn child.”

Whether you are in or out of one of Aetna Health’s service area, the following procedures apply:

- **Go to the nearest emergency facility or call 911 or any available area emergency response service.** If a delay would not be detrimental to your health, call your Primary Care Physician. Your primary care physician is required to provide emergency coverage 24 hours a day, including weekends and holidays.

- After assessing and stabilizing your condition, the emergency facility should contact your primary care physician so your PCP can assist the treating physician by supplying information about your medical history.

- If you are admitted to an inpatient facility, you or a family member or friend on your behalf should notify your primary care physician and the HMO as soon as possible.

- All follow-up care should be coordinated by your primary care physician. Follow up care with non-participating providers is only covered with a referral from your primary care physician and pre-approval by HMO. Whether you were treated inside or outside your Aetna Health service area, you must obtain a referral before any follow-up care can be covered. Examples of follow-up care are suture removal, cast removal, X-rays, and clinic and emergency room revisits.

- **Members** are encouraged to appropriately use the 911 emergency response system, if available, when a Medical Emergency requires emergency response transportation.

Urgent Care Benefits

Members who are traveling outside their HMO service area or students who are away at school are covered for emergency and urgently needed care. Emergency or urgent care may be obtained from a private practice physician, a walk-in clinic, an urgent care center or an emergency facility. Certain conditions, such as severe vomiting, earaches, sore throats or fever, are considered “urgent care” outside your HMO service area and can be treated in any of the above settings.

Additional information about Medical Emergencies and Urgent Care can be found in the “Covered Benefits” section of the Evidence of Coverage, in Item K “Emergency Care/Urgent Care Benefits”.

Members are encouraged to appropriately use the 911 emergency response system, if available, when a Medical Emergency requires emergency response transportation.
PATIENT MANAGEMENT

Aetna Health has developed a patient management program to assist in determining what health care services are covered and payable under the health plan and the extent of such coverage and payments. The program assists members in receiving the appropriate healthcare and maximizing coverage for those healthcare services.

Only medical directors make decisions denying coverage for services for reasons of medical necessity. Coverage denial letters delineate any unmet criteria, standards and guidelines, and inform the provider and member of the appeal process.

Our patient management staff uses nationally recognized guidelines and resources to guide the precertification, concurrent review and retrospective review processes. Using information obtained from providers, patient management staff applies Milliman & Robertson Health Care Management Guidelines when conducting concurrent review. If there is no applicable Milliman & Robertson Guideline, patient management staff utilizes InterQual ISD criteria. To the extent certain patient management functions are delegated to integrated delivery systems, independent practice associations or other provider groups (“Delegates”), such Delegates utilize criteria that they deem appropriate.

COVERAGE POLICY BULLETINS

Aetna Health Coverage Policy Bulletins (“CPBs”) also are used as a guide when making certain coverage determinations. CPBs are developed to address approaches to care, including new technologies. CPBs are based on peer-reviewed medical literature, the recommendations of leading medical organizations, and where appropriate, the Health Care Financing Administration’s Medicare coverage policies. Aetna Health has placed its CPBs on its website at www.aetna.com. Members may also request Coverage Policy Bulletins by calling the member services number listed on their ID card, or the number on the first page of this Disclosure Brochure. Since CPBs can be highly technical and are designed to be used by our professional staff in making coverage determinations, you may want to review the CPBs of interest with their physicians so you may fully understand them. CPBs do not constitute medical advice and treating providers are solely responsible for medical advice and treatment of members. CPBs contain only a partial, general description of benefits and do not constitute a contract, and are subject to change.

PRECERTIFICATION

Certain healthcare services, such as hospitalization, outpatient surgery and outpatient mental health services, require precertification with Aetna Health (or its designee) to ensure coverage for those services. If you do not obtain precertification, you may be financially responsible for services that require such a precertification. When you are to obtain services requiring precertification through a participating provider, this provider should precertify those services prior to treatment. If your plan covers self-referred benefits (QPOS and USAccess Plans) and you may self-refer for covered services, it is your responsibility to contact Aetna Health to precertify those services which require precertification.

Concurrent Review

The concurrent review process assesses the necessity for continued stay, level of care, and quality of care for members receiving inpatient services. All inpatient services extending beyond the initial certification period will require Concurrent Review.
Discharge Planning

Discharge planning may be initiated at any stage of the patient management process and begins immediately upon identification of post discharge needs during precertification or concurrent review. The discharge plan may include initiation of a variety of services/benefits to be utilized by the member upon discharge from an inpatient stay.

Retrospective Record Review

The purpose of retrospective review is to retrospectively analyze potential quality and utilization issues, initiate appropriate follow-up action based on quality or utilization issues, and review all appeals of inpatient concurrent review decisions. HMO’s effort to manage the services provided to members includes the retrospective review of claims submitted for payment, and medical records submitted for potential quality and utilization concerns.

GRIEVANCES, APPEALS AND EXTERNAL REVIEW

Please refer to the Grievance section of the attached sample EOC for important information regarding the grievance and appeals process and your rights to Independent Medical Review.

MEMBER RIGHTS AND RESPONSIBILITIES

As a member you have a right to:

- Get up-to-date information about the health care professionals and hospitals that participate in the plans.
- Obtain primary and preventive care from the PCP you chose from the plan’s network for covered services.
- Change the PCP you selected to another available PCP who participates in the plan.
- Obtain covered medically necessary care from participating specialists, hospitals and other providers.
- Be referred to participating specialists who are experienced in treating your chronic illness for covered benefits.
- Be told by the your health care professional how to make appointments and get health care during and after office hours.
- Be told how to get in touch with your PCP or a back-up physician 24 hours a day, every day.
- Call 911 (or any available are emergency response services). Go to the nearest emergency facility in a situation that might be life or limb threatening.
- Be treated with respect for your privacy and dignity.
- Have Aetna only use your medical/mental health records for plan purposes and maintain privacy of those records (as described in the Confidentiality Section).
- Help your health care professional make decisions about the member’s health care.
- Have a doctor decide when coverage for treatment should be denied for lack of medical necessity.
• Discuss with your health care professional your condition and all care alternatives, including potential risks and benefits, even if a care option is not covered.

• Know that your health care professional cannot be penalized for filing a complaint or appeal.

• Know how you plan decides what services are covered.

• Know how your health care professionals are paid for providing services.

• Get up-to-date information about the services covered or not covered by your plan, and any applicable limitations or exclusions.

• Get information about copayments and fees you must pay.

• Be told how to file a complaint, grievance, or appeal with the plan.

• Receive a prompt reply when you ask the plan questions or request information.

• Have your health care professional’s help in decisions about the need for services and in the grievance process.

• Suggest changes in the plan’s policies and services.

As a member of the HMO a member has the responsibility to:

• Choose a PCP from the plan’s network and form an ongoing patient-health care professional relationship.

• Help your health care professional make decisions about your health care.

• Tell the member’s PCP if you do not understand the treatment you receive and to ask if you do not understand how to care for your illness.

• Follow the directions and advice you and your health care professionals have agreed upon.

• Tell your health care professional promptly when you have unexpected problems or symptoms.

• Consult with your PCP for referrals to non-emergency specialist or hospital care.

• See the specialists to whom your PCP refers you.

• Understand that participating doctors and other health care providers who care for you are not employees of Aetna Health and that Aetna Health does not control them.

• Show your member ID card to providers before getting care from them.

• Pay the copayments required by your plan.

• Call member services about the member’s plan if you do not understand how to use the member’s benefits.

• Promptly follow the member’s plan’s grievance procedures if you believe you need to submit a grievance.

• Give correct and complete information to physicians and other health care providers who care for you.

• Treat doctors and all providers, their staff, and the staff of the plan with respect.

• Advise Aetna Health about other medical insurance coverage you or your family members may have.
• Not be involved in dishonest activity directed to the plan or any provider.
• Read and understand the member’s plan and benefits. Know the copayments and what services are covered and what services are not covered.

You may have additional rights and responsibilities depending upon the state law applicable to your plan.

INDEPENDENT CONTRACTOR RELATIONSHIP

➢ No participating provider or other provider, institution, facility or agency is an agent or employee of the HMO. Neither the HMO nor any member of the HMO is an agent or employee of any participating provider or other provider, institution, facility or agency.

➢ Neither the Contract Holder nor a member is the agent or representative of the HMO, its agents or employees, or an agent or representative of any participating provider or other person or organization with which the HMO has made or hereafter shall make arrangements for services under the Evidence of Coverage.

➢ Participating physicians maintain the physician-patient relationship with members and are solely responsible to member for all medical services, which are rendered by participating physicians.

➢ The HMO cannot guarantee the continued participation of any provider or facility with the HMO. In the event a PCP terminates its contract or is terminated by the HMO, the HMO shall provide notification to members in the following manner:

CONFIDENTIALITY

Aetna Health protects the privacy of confidential member medical/mental health information. We contractually require that participating providers keep member information confidential in accordance with applicable laws. Furthermore, you have the right to access your medical/mental health records from participating providers, at any time. Aetna Health and its agents and affiliates (collectively “Aetna Health”) and participating network providers require access to member medical/mental health information for a number of purposes, including claims payment and fraud prevention; coordination of care, data collection, performance measurement, fulfilling state and federal requirements, quality management, utilization review, research and accreditation activities preventive health, early detection and disease management programs; Accordingly, members must authorize the sharing of member medical information about themselves and their dependents between Aetna Health and any hospital, physician, or other health care provider or health delivery system as Aetna Health and such participating providers may require. Members or member’s individuals entitled to act on their behalf are entitled to receive a copy of the authorization upon request and agree that a photocopy is as valid as the original.

As of July 1, 2001, a statement describing the HMO’s policies and procedures for preserving the confidentiality of medical records is available and will be furnished to members upon request.

DRUG FORMULARY

If the plan purchased by your employer or group includes the pharmacy plan for outpatient prescription drug coverage, your prescription benefit may include a drug formulary. A formulary is a list of preferred prescription drugs available in your prescription drug benefit plan. This list is distributed to participating providers and is subject to periodic review and modification by the HMO or an affiliate. Throughout the year the Pharmacy and Therapeutics (P&T) Committee may evaluate new drugs once they are approved
by the FDA and may re-evaluate the drugs on the current formulary in light of new FDA, manufacturer and peer reviewed information. The P&T Committee reviews the entire formulary at least annually. An updated copy of the Drug formulary is available at any time upon request by a member.

Medically necessary outpatient prescription drugs and insulin are covered when listed on the drug formulary. The drug formulary is subject to change at the sole discretion of HMO or an affiliate. In addition, generic and brand non-formulary drugs approved by HMO, except those listed on the Drug Formulary Exclusions List, are also covered, subject to the Limitations and Exclusions section of this rider and the Certificate. Coverage of these Non-formulary drugs is subject to change from time to time at the sole discretion of HMO. Some items are covered only with prior authorization from HMO.

Prescriptions must be written by a provider licensed to prescribe federal legend prescription drugs subject to the terms, HMO policies, and the “Limitations and Exclusions” section described in the Prescription Drug Rider. Coverage of prescription drugs may, in HMO’s sole discretion, be subject to Precertification, Step Therapy, Therapeutic Interchange Programs or other HMO requirements or limitations. Items covered by a prescription rider are subject to drug utilization review by HMO and/or member's participating pharmacy. Not all brand name prescription drugs are covered.

Member’s participating physician or participating retail or mail order pharmacy may seek a medical exception to obtain coverage for drugs listed on the Drug Formulary Exclusions List or drugs for which coverage is denied through Step Therapy, Precertification, and Therapeutic Interchange Programs or other HMO limitations or requirements. Such exception requests shall be made by the provider to the Precertification Department of Aetna Health’s Pharmacy Management Department. The Pharmacy Management Department will respond to complete exception requests within 24 hours of receipt. In urgent or emergent situations the providers may request same day response. Coverage granted as a result of a medical exception shall be based on an individual, case-by-case medical necessity determination and coverage will not apply or extend to other members.

The Formulary Guide contains drugs that have been reviewed by Aetna Health’s Pharmacy and Therapeutics (P&T) Committee. The P&T Committee reviews information from a variety of sources, including peer review journals and other independently developed materials. Using this information, the P&T Committee periodically evaluates the therapeutic effectiveness of prescription medications and places them into one of three categories:

- **Category I** — The drug represents an important therapeutic advance.
- **Category II** — The drug is therapeutically similar to other available products.
- **Category III** — The drug has significant disadvantages in safety or efficacy when compared to other similar products.

The drugs in Category I are always included on the Aetna Health Formulary, and the drugs placed in Category III are always excluded from the Aetna Health Formulary. For therapeutically similar drugs in Category II, Aetna Health selects drugs for the Formulary based on the recommendations of the P&T Committee, the cost effectiveness of the medication, and other factors.

A copy of the Aetna Health Formulary, or information about the availability of a specific drug may be requested by calling 1-888-792-8742, (TDD 800-501-9863 for hearing impaired only) or may be accessed through our Internet website at www.aetna.com. (Click on “members” and then “prescription plans” to reach the Formulary information.) Be aware that the presence of a drug on Aetna U. S. Healthcare’s Formulary does not guarantee that a member will receive a prescription for that drug from their prescribing provider for a particular medical condition.
Members should consult with their treating physician regarding questions about specific medications.

MEMBER SERVICES

Representatives from Member Services are trained to answer your questions and to assist you in using the Aetna Health plan properly and efficiently. After you receive your ID card, you can call the Member Services toll-free number on the card when you need to:

- Ask questions about benefits and coverage.
- Notify us of changes in your name, address or telephone number.
- Change your primary care physician or office.
- Obtain information about how to file a grievance.

Non-English Speaking Needs

A foreign language interpretation service provided through the phone company is available for non-English speaking members.

Illiterate and Special Needs Members

Aetna Health recognizes that it may have members who are illiterate and assists these members by providing, upon request, recorded marketing materials. Marketing Representatives conduct on-site employer group benefit management meetings and assist members with special needs in understanding and completing their benefit information. Member Services has a teletype relay toll free number 1-800-628-3321 to assist hearing impaired members.

ORGAN DONATION

Every year in the United States thousands of people die waiting for a life-saving organ transplant. For every 55 people who receive a donated organ, 10 die waiting for organs that never become available. The need for donor organs is critical.

A single donor can help as many as 50 individuals in need of organs or tissues. Medical suitability for donation is determined at the time of death, and the donor’s family must give consent. Unfortunately, many families do not consent because they were not aware of their loved one’s wishes.

If you would like to become an organ donor, please take the following steps:

1. Indicate your interest to be an organ and tissue donor on your driver’s license (ask the motor vehicles department service representative for information when you have your photograph taken for your driver’s license).
2. Carry an organ donor card in your wallet. (Call the Coalition on Donation at 800-355-SHARE for a free brochure on donation and donor card.)
3. Most importantly, discuss your decision with family members and loved ones.

Aetna Health® is proud to be a partner of the California Transplant Donor Network (CTDN) in its mission to raise public awareness of organ and tissue donation and link potential organ and tissue donors to individuals awaiting organ and tissue transplantation.
Setting the Record Straight – Debunking Some Common Myths about Organ Donation

• The decision to be an organ donor does not affect the quality of medical care you will receive.

• Donation does not disfigure the body or interfere with funeral plans, including open casket services.

• All mainstream organized religions approve of organ donation, and consider it an act of charity, according to the U.S. Department of Health and Human Services.

• Everyone can choose to be an organ or tissue donor. People of all ages, and even people with medical conditions, may be able to donate tissues such as corneas or heart valves.
Health Insurance Portability and Accountability Act Member Notice*
* While this member notice is believed to be accurate as of the publication date, it is subject to change. Please contact the Member Services Department if you have any questions.

The following information is provided to inform the member of certain provisions contained in the Group Health Plan, and related procedures that may be utilized by the member in accordance with Federal law.

Pre-existing Conditions Exclusion Provision (only for plans containing such provision)
This is to advise you that a pre-existing conditions exclusion period may apply to you, if a pre-existing conditions exclusion provision is included in the Group Plan that you are or become covered under. If your plan contains a pre-existing conditions exclusion, such exclusion may be waived for you if you have prior Creditable Coverage.

Creditable Coverage
Creditable coverage includes coverage under a group health plan (including a governmental or church plan), health insurance coverage (either group or individual insurance), Medicare, Medicaid, military-sponsored health care (CHAMPUS), a program of the Indian Health Service, a State health benefit risk pool, the FEHBP, a public health plan as defined in the regulations, and any health benefit plan under section 5(c) of the Peace Corps Act. Not included as Creditable Coverage is any coverage that is exempt from the law (e.g., dental only coverage or dental coverage that is provided in a separate plan or even if in the same plan as medical, is separately elected and results in additional premium).

If you had prior creditable coverage within the 90 days immediately before the date you enrolled under this plan, then the pre-existing conditions exclusion in your plan, if any, will be waived. The determination of the 90 day period will not include any waiting period that may be imposed by your employer before you are eligible for coverage.

If you had no prior creditable coverage within the 90 days prior to your enrollment date (either because you had no prior coverage or because there was more than a 90 day gap from the date your prior coverage terminated to your enrollment date), we will apply your plan’s pre-existing conditions exclusion (to a maximum period of 12 months).

Please Note: If a state law mandates a gap period greater than 90 days, that longer gap period will be used to determine creditable coverage.

If you have any questions regarding the determination of whether or not a pre-existing conditions exclusion applies to you, please call the Member Services telephone number on your ID card.

Providing Proof of Creditable Coverage
Generally, you will have received a Certification Of Prior Group Health Plan Coverage from your prior medical plan as proof of your prior coverage. You should retain that Certification until you submit a medical claim. When a claim for treatment of a potential pre-existing condition is received, the claim office will request from you that Certification Of Prior Group Health Plan Coverage, which will be used to determine if you have Creditable Coverage at that time.

You may request a Certification Of Prior Group Health Plan Coverage from your prior carrier(s) with whom you had coverage within the past two years. Our Service Center can assist you with this and can provide you with the type of information that you will need to request from your prior carrier.

The Service Center may also request information from you regarding any pre-existing condition for which you may have been treated in the past, and other information that will allow them to determine if you have creditable coverage.
Special Enrollment Periods

Due to Loss of Coverage

If you are eligible for coverage under your employer’s medical plan but do/did not enroll in that medical plan because you had other medical coverage, and you lose that other medical coverage, you will be allowed to enroll in the current medical plan during special enrollment periods after your initial eligibility period, if certain conditions are met. These Special Enrollment Rules apply to employees and/or dependents who are eligible, but not enrolled for coverage, under the terms of the plan.

An employee or dependent is eligible to enroll during a special enrollment period if each of the following conditions is met:

• When you declined enrollment for you or your dependent, you stated in writing that coverage under another group health plan or other health insurance was the reason for declining enrollment, if the employer required such written notice and you were given notice of the requirement and the consequences of not providing the statement; and

• When you declined enrollment for you or your dependent, you or your dependent had COBRA continuation coverage under another plan and that COBRA continuation coverage has since been exhausted, or

If the other coverage that applied to you or your dependent when enrollment was declined was not under a COBRA continuation provision, either the other coverage has been terminated as a result of the loss of eligibility or employer contributions toward that coverage have been terminated. Loss of eligibility includes a loss of coverage as a result of legal separation, divorce, death, termination of employment, or reduction in hours of employment.

For Certain Dependent Beneficiaries

If your Group Health Plan offers dependent coverage, it is required to offer a dependent special enrollment period for persons becoming a dependent through marriage, birth, or adoption or placement for adoption. The dependent special enrollment period will last for 31 days from the date of the marriage, birth, adoption or placement for adoption. The dependent may be enrolled during that time as a dependent of the employee. If the employee is eligible for enrollment, but not enrolled, the employee may also enroll at this time. In the case of the birth or adoption of a child, the spouse of the individual also may be enrolled as a dependent of the employee if the spouse is otherwise eligible for coverage but not already enrolled. If an employee seeks to enroll a dependent during the special enrollment period, the coverage would become effective as of the date of birth, of adoption or placement for adoption, or marriage.

Special Enrollment Rules

To qualify for the special enrollment, individuals who meet the above requirements must submit a signed request for enrollment no later than 31 days after one of the events described above. The effective date of coverage for individuals who lost coverage will be the date of the qualifying event. If you seek to enroll a dependent during the special enrollment period, coverage for your dependent (and for you, if also enrolling) will become effective as of the date that the qualifying event occurred, (for marriage, as of the enrollment date) once the completed request for enrollment is received.
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AETNA HEALTH OF CALIFORNIA INC.
EVIDENCE OF COVERAGE

This Evidence of Coverage ("EOC") is part of the Group Agreement ("Group Agreement") between Aetna Health of California Inc., hereinafter referred to as HMO, and the Contract Holder. The Group Agreement determines the terms and conditions of coverage. The EOC describes health care benefits. Provisions of this EOC include the Schedule of Benefits, any riders and any amendments, endorsements, inserts, or attachments. Amendments, riders or endorsements may be delivered with the EOC or added thereafter.

"HMO" means Aetna Health of California Inc. a California corporation operating pursuant to Chapter 2.2 of Division 2 of the Health and Safety Code (commencing with Section 1340), commonly known as the Knox-Keene Health Care Service Plan of 1975.

HMO agrees with the Contract Holder to provide coverage for benefits, in accordance with the conditions, rights, and privileges as set forth in this EOC. Members covered under this EOC are subject to all the conditions and provisions of the Group Agreement.

Coverage is not provided for any services received before coverage starts or after coverage ends, except as shown in the Continuation and Conversion section of this EOC. Certain words have specific meanings when used in this EOC. The defined terms appear in bold type with initial capital letters. The definitions of those terms are found in the Definitions section of this EOC.

This EOC is not in lieu of insurance for Workers' Compensation. This EOC is governed by applicable federal law and the laws of California.

PLEASE READ THE FOLLOWING INFORMATION SO YOU WILL KNOW FROM WHOM OR WHAT GROUP OF PROVIDERS HEALTH CARE MAY BE OBTAINED.

READ THIS ENTIRE EOC CAREFULLY. IT DESCRIBES THE RIGHTS AND OBLIGATIONS OF MEMBERS AND HMO. IT IS THE CONTRACT HOLDER'S AND THE MEMBER'S RESPONSIBILITY TO UNDERSTAND THE TERMS AND CONDITIONS IN THIS EOC.

IN SOME CIRCUMSTANCES, CERTAIN MEDICAL SERVICES ARE NOT COVERED OR MAY REQUIRE PRE-AUTHORIZATION BY HMO.

NO SERVICES ARE COVERED UNDER THIS EOC IN THE ABSENCE OF PAYMENT OF CURRENT PREMIUMS SUBJECT TO THE GRACE PERIOD AND THE PREMIUMS SECTION OF THE GROUP AGREEMENT.

THIS EOC APPLIES TO COVERAGE ONLY AND DOES NOT RESTRICT A MEMBER'S ABILITY TO RECEIVE HEALTH CARE SERVICES THAT ARE NOT, OR MIGHT NOT BE, COVERED BENEFITS UNDER THIS EOC.

PARTICIPATING PROVIDERS, NON-PARTICIPATING PROVIDERS, INSTITUTIONS, FACILITIES OR AGENCIES ARE NEITHER AGENTS NOR EMPLOYEES OF HMO. HMO IS NOT THE AGENT OF ANY PARTICIPATING PROVIDER OR OTHER PROVIDER, INSTITUTION, FACILITY, OR AGENCY. NEITHER HMO NOR THE CONTRACT HOLDER (YOUR EMPLOYER OR GROUP) IS THE AGENT OF EACH OTHER.

A STATEMENT DESCRIBING AETNA HEALTH OF CALIFORNIA'S POLICIES AND PROCEDURES FOR PRESERVING THE CONFIDENTIALITY OF MEDICAL RECORDS IS AVAILABLE AND WILL BE FURNISHED TO MEMBERS UPON REQUEST.

SOME HOSPITALS AND OTHER PROVIDERS DO NOT PROVIDE ONE OR MORE OF THE FOLLOWING SERVICES THAT MAY BE COVERED UNDER YOUR PLAN CONTRACT AND THAT YOU OR YOUR FAMILY MEMBER MIGHT NEED:
FAMILY PLANNING; CONTRACEPTIVE SERVICES, INCLUDING EMERGENCY CONTRACEPTION; STERILIZATION, INCLUDING TUBAL LIGATION AT THE TIME OF LABOR AND DELIVERY; INFERTILITY TREATMENTS; OR ABORTION. YOU SHOULD OBTAIN MORE INFORMATION BEFORE YOU ENROLL. CALL YOUR PROSPECTIVE DOCTOR, MEDICAL GROUP, INDEPENDENT PRACTICE ASSOCIATION, OR CLINIC, OR CALL THE HEALTH PLAN AT THE TOLL FREE MEMBER SERVICES NUMBER LISTED ON YOUR ID CARD TO ENSURE THAT YOU CAN OBTAIN THE HEALTH CARE SERVICES THAT YOU NEED.

Important

Unless otherwise specifically provided, no Member has the right to receive the benefits of this plan for health care services or supplies furnished following termination of coverage. Benefits of this plan are available only for services or supplies furnished during the term the coverage is in effect and while the individual claiming the benefits is actually covered by the Group Agreement. Benefits may be modified during the term of this plan as specifically provided under the terms of the Group Agreement or upon renewal. If benefits are modified, the revised benefits (including any reduction in benefits or elimination of benefits) apply for services or supplies furnished on or after the effective date of the modification. There is no vested right to receive the benefits of the Group Agreement.

| Contract Holder: [ ] |
| Contract Holder Number: [ ] |
| Contract Holder Group Agreement Effective Date: [ ] |
| [Subscriber Number: [ ] |
| Subscriber Name: [ ] |
| Coverage Type: [ ] |
| Subscriber Effective Date: [ ] ]
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HMO PROCEDURE

PLEASE READ THE FOLLOWING INFORMATION SO YOU WILL KNOW FROM WHOM OR WHAT GROUP OF PROVIDERS HEALTH CARE MAY BE OBTAINED.

IN SOME CIRCUMSTANCES, CERTAIN MEDICAL SERVICES ARE NOT COVERED OR MAY REQUIRE PREAUTHORIZATION BY HMO.

ELIGIBILITY, COVERED BENEFITS, MEDICAL NECESSITY, PRECERTIFICATION, CONCURRENT REVIEW, RETROSPECTIVE RECORD REVIEW AND ALL OTHER TERMS AND CONDITIONS OF THE MEMBER’S HEALTH PLAN ARE DETERMINED AT THE SOLE DISCRETION OF THE HMO (OR ITS DESIGNEE). THIS MEANS THAT SOME SERVICES RECOMMENDED BY THE MEMBER’S HEALTH PROFESSIONAL MAY NOT BE COVERED BENEFITS AS DETERMINED BY HMO.

A. Selecting a Participating Primary Care Physician.

HMO uses a network of independent Participating Providers, comprised of Physicians, Hospitals and other Health Professionals and facilities located in the Service Area. Certain PCP offices are affiliated with Medical Groups (i.e. integrated delivery systems, Independent Practice Associations (IPAs) and Physician-Hospital Organizations), and Members who select these PCP’s will generally be referred to Specialists and Hospitals within that Medical Group. Each Primary Care Physician (PCP) is associated with a Participating Hospital. Members must use the Hospital with which the Member’s Primary Care Physician is associated except when it is Medically Necessary to receive services elsewhere or when obtaining certain direct access Specialist benefits as described in this EOC.

At the time of enrollment, each Member should select a Participating Primary Care Physician (PCP) from HMO’s Directory of Participating Providers to access Covered Benefits as described in this EOC. The choice of a PCP is made solely by the Member. If the Member is a minor or otherwise incapable of selecting a PCP, the Subscriber should select a PCP on the Member’s behalf. If the Member does not select a PCP within a reasonable time after being eligible for Covered Benefits, HMO will designate a PCP for the Member and notify the Member of such selection. The Member can change the selection of the PCP thereafter. The PCP is not an agent or employee of HMO and the selection of a PCP by HMO is merely a convenience for Members to assure access to Covered Benefits.

PCPs and Providers may be paid in any of the following ways: depending upon the type of contract they have with HMO.

1. A fixed price per service.
2. A fixed price per day.
3. A fee for each service set by a fee schedule.
4. A fixed monthly amount per Member.

Providers contracted with HMO have no requirement to comply with specified numbers, targeted averages or maximum duration for patient visits. Compensation arrangements are designed to encourage the provision of the most appropriate care for each Member and to discourage the provision of unnecessary, and potentially detrimental services. When Providers are paid a fixed monthly amount per Member, HMO incorporates specific “quality factors” into the compensation process. Provider compensation is adjusted based on results in various areas, including: appropriate diagnostic testing, specialty and Hospital utilization; Member satisfaction survey results; thoroughness of medical chart documentation; clinical care measures for diabetes, asthma and other conditions; number of scheduled office hours; range of office procedures offered; around the clock coverage; and participation in continuing education programs. Members are encouraged to ask Physicians and other Providers how they are compensated in their individual cases, including whether their arrangements include any financial incentives.
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B. The Primary Care Physician.

The PCP coordinates a Member’s medical care, as appropriate, either by providing treatment or by issuing Referrals to direct the Member to another Participating Provider. The PCP can also order lab tests and x-rays, prescribe medicines or therapies, and arrange hospitalization. Except in a Medical Emergency, for Urgent Care services received outside the HMO Service Area or for certain direct access Specialist benefits as described in this EOC, only those services which are provided by or referred by a Member’s PCP will be covered. Covered Benefits are described in the Covered Benefits section of this EOC. It is a Member’s responsibility to consult with the PCP in all matters regarding the Member’s medical care.

In certain situations where a Member requires ongoing care from a Specialist, the Member may receive a Standing Referral to such Specialist. Please refer to “Requesting a Standing Referral” in this section for additional information.

If the Member’s PCP performs, suggests, or recommends a Member for a course of treatment that includes services that are not Covered Benefits, the entire cost of any such non-covered services will be the Member’s responsibility.

C. Availability of Providers.

HMO cannot guarantee the availability or continued participation of a particular Provider or Participating Medical Group. However, changes to the Provider network do not affect the Member’s plan benefits, cost sharing or Premiums. Either HMO or any Participating Provider may terminate the Provider contract or limit the number of Members that will be accepted as patients. If the PCP initially selected cannot accept additional patients the Member will be notified and given an opportunity to make another PCP selection. If the Member does not select a PCP within a reasonable time after being notified they must choose a different PCP, HMO will designate a PCP for the Member and notify the Member of such selection. The Member can change the selection of the PCP thereafter. If a Member’s PCP terminates, the Member will be notified of the termination. Members must notify the HMO of their new choice of PCP prior to the date of the PCP’s termination, or HMO will assign a new PCP to the Member. The Member may change their PCP selection if they do not wish to utilize the PCP assigned to the Member. For additional information about the notification process when PCPs and other types of Providers terminate, the Member may refer to the General Provisions section “Independent Contractor Relationship” in this EOC.

D. Changing a PCP.

A Member may submit a request to change their PCP at any time by calling the Member Services toll-free telephone number listed on the Member’s identification card or by written or electronic submission of the HMO’s change form. A Member may contact HMO to request a change form or for assistance in completing that form. The change will become effective on the 1st or the 15th of the month, or if the Member is in an Active Course of Treatment, when the change is coordinated between the Member’s old and new PCPs.

E. Ongoing Reviews.

HMO conducts ongoing reviews of those services and supplies which are recommended or provided by Health Professionals to determine whether such services and supplies are consistent with established coverage guidelines and therefore are Covered Benefits under this EOC. In making these decisions HMO uses nationally recognized industry guidelines, and internally developed Coverage Policy Bulletins (CPBs). HMO reviews new medical technologies (devices, procedures and techniques) and new applications of established technologies to decide whether they are safe and effective and therefore should be Covered Benefits when determined to be Medically Necessary for a Member. Members may access the CPBs at the website, www.aetna.com. However, CPBs are technical discussions of available published research, and position statements and clinical practice guidelines of medical associations and government agencies. Members are encouraged to discuss CPBs of interest with their PCP. If HMO determines that the
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recommended services and supplies are not Covered Benefits, the Member will be notified. If a Member wishes to appeal such determination, the Member may then contact HMO to seek a review of the determination. Please refer to the Complaints and Appeals/Independent Medical Review sections of this EOC.

The management of a Member’s healthcare through ongoing reviews employs a consistent set of integrated medical management tools. The process consists of the management of a Member’s Referrals by the PCP to other Health Professionals; the review of the Medical Necessity and appropriateness of inpatient admissions as well as outpatient tests and procedures; monitoring of inpatient services once admitted; and the transitioning from inpatient to outpatient services. For additional information about this process please contact the HMO Member Services at the toll-free number listed on the ID card.

Additional information about the timeframes for decisions and notifications of HMO decisions regarding Ongoing Reviews is provided in the Claim Procedure section of the EOC.

F. Referrals and Pre-Authorization.

Certain services and supplies under this section require pre-authorization by HMO to determine if they are Covered Benefits under this EOC.

Member’s PCP is responsible for coordinating Member’s healthcare, either by treating Member directly or by referring Member to a Participating Specialist. Members must contact their PCP before seeking Medical Services unless the Member is seeking Emergency Services, Urgent Care services, or covered direct access Specialist benefits. For all other services, Member must first obtain an authorized Referral from Member’s PCP. When Member needs a Specialist, Member’s PCP will provide Member with an authorized Referral to a Participating Provider within the PCP’s associated Medical Group, unless it is Medically Necessary to refer Member to an Appropriately Qualified Specialist outside of the PCP’s Medical Group. If there is no Appropriately Qualified Participating Provider in the network, the HMO will authorize a Referral to an Appropriately Qualified Provider outside the network. For certain services, Member’s PCP must also obtain pre-authorization from HMO. If the Specialist visited by Member on Referral from Member’s PCP wants to refer Member to another Specialist, an additional written authorized Referral must be obtained. Member’s PCP may decide to see Member again before making a Referral to another Specialist.

If the Member’s approved Referral is to a nonparticipating Provider, services provided pursuant to the Referral will be provided at no extra cost to the Member beyond what the Member would otherwise pay for services received within the HMO network of Participating Providers.

Additional information about Referrals and pre-authorizations is located in the Covered Benefits sections regarding Mental Health and Substance Abuse.

For additional information regarding the pre-authorization process, Members may contact a Member Service Representative at the toll-free number listed on the identification card.

Information regarding timeframes for decisions and notification of decisions is located in the Claim Procedure section of the EOC.

G. Second Opinion.

Upon request by a Member HMO or Member’s PCP will authorize a second medical opinion regarding a diagnosis, proposed surgery or course of treatment recommended or provided by Member’s PCP or a Specialist. If the Member requests a second opinion regarding care provided or recommended by the PCP, the second opinion must be obtained from an Appropriately Qualified Specialist of the Member’s choice within the PCP’s affiliated Medical Group. If the Member requests a second opinion regarding care recommended or provided by a Specialist, the Member must choose an Appropriately Qualified Specialist.
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Specialist from within the HMO network of Participating Providers. If there is no Appropriately Qualified Participating Provider in the network, the HMO will authorize a Referral to an Appropriately Qualified Provider outside the network. To request a second opinion, Members should contact their PCP for a Referral. In cases where access to a second opinion should be expedited due to imminent and serious health threat, HMO will respond to Member’s request for a second opinion within 72 hours of receiving the request. For additional information regarding second opinions including copies of the HMO’s timelines for responding to requests for second opinions, Members may contact Member Services at the toll free telephone number listed on their ID card.

H. Requesting a Standing Referral

Members with (i) a Life-Threatening or Seriously Debilitating Condition or (ii) a degenerative and disabling condition or disease, either of which requires specialized medical care over a prolonged period of time may request that a Specialist or Specialty Care Center assume responsibility for providing or coordinating the Member’s medical care, including primary and specialty care. A Member may make this request through the Member’s PCP or Specialist. The Member or Physician will be sent a form to be completed and returned to the HMO for review. If HMO, or the PCP, in consultation with an HMO medical director and Specialist, if any, determine that a Member’s care would most appropriately be coordinated by a Specialist or Specialty Care Center, PCP will authorize a Standing Referral to such Specialist or Specialty Care Center for up to 12 months. Such determination will be made within 3 business days of the date that all appropriate medical records and other items of information necessary to make the determination are provided and, once a determination is made the Referral shall be issued within 4 business days.

Any authorized Referral shall be made pursuant to a treatment plan approved by HMO in consultation with the PCP (if appropriate), the Specialist or Specialty Care Center, the Member or the Member’s designee. The approved Specialist or Specialty Care Center will be permitted to treat the Member without further Referral from the Member’s PCP and may authorize such Referrals, procedures, tests and other Medical Services as the Member’s PCP would otherwise be permitted to provide or authorize, subject to the terms of the treatment plan. For the purposes of this coverage, a Specialty Care Center means only centers that are accredited or designated by an agency of the state or federal government or by a voluntary national health organization as having expertise in treating the Life-Threatening or Seriously Debilitation Condition for which it is accredited or designated.

Members will receive Standing Referrals to an Appropriately Qualified Specialist within the PCP’s affiliated Medical Group if available, or to an Appropriately Qualified Participating Specialist. HMO is not required to permit a Member to elect to have a Standing Referral to a non-participating Specialist, unless an Appropriately Qualified Specialist is not available within HMO’s network of Participating Providers. If the Member’s approved Standing Referral is to a nonparticipating Provider, services provided pursuant to the approved treatment plan will be provided at no extra cost to the Member beyond what the Member would otherwise pay for services received within the HMO network of Participating Providers. Members may call Member Services at the toll-free number listed on the ID card for additional information regarding Appropriately Qualified Participating Specialists.

I. Requesting Continuity of Care

In order to provide for the transition of Members with minimal disruption, HMO permits Members who meet certain requirements to continue an Active Course of Treatment with a terminated or (for new members) a non-participating Provider for a transitional period. In the case of new Members, benefits will be provided at the new plan benefit level in this EOC. Throughout this section “continuation care” refers to the services which the Member may be eligible to receive.

1. Members who are undergoing an Active Course of Treatment are eligible to receive continuation of care as specified below.
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- the Member has an acute, serious, or chronic mental health condition.
- the Member has an acute condition or a serious chronic medical condition.
- the Member is in the second or third trimester of pregnancy.
- the Member is in any stage of a high risk pregnancy.

2. The length of continuation care will be determined as specified below:

   - for Members with an acute, serious, or chronic mental health condition the length of the transition period will be determined by the HMO on a case by case basis taking into account the severity of the Member’s condition and the amount of time reasonably necessary to affect a safe transfer of care.

   - for Members with an acute condition or a serious chronic medical condition the length of continuation of care will be up to 90 days or longer if necessary for a safe transfer of care. The HMO will determine the length of continuation care in consultation with the terminated Provider, consistent with good professional practice.

   - for Members in the second or third trimester, or in any stage of a high risk pregnancy the length of continuation care will be until the postpartum services related to the delivery are completed or for a longer period if necessary for a safe transfer of care. The HMO will determine the length of continuation care in consultation with the terminated Provider, consistent with good professional practice.

3. In order for continuation care to be a Covered Benefit under this EOC the following conditions must be met.

   - The Member must be enrolling as a new Member, or renewing in a different Aetna Health of California Inc. plan that has a different provider network, or a current Member receiving an Active Course of Treatment from a terminated provider. If the other requirements listed in this section are met Members and their current treating Providers may request continuing coverage according to the conditions of this Continuity of Coverage section.

   - With regard to continuing care for new Members with acute, serious, or chronic mental health conditions, Members are not eligible for continuing care if their coverage under this EOC includes the Non-Referred Benefits Rider or if the Member had the option to continue coverage under their previous health plan or provider and instead voluntarily chose to change health plans.

   - Member must be eligible for continuation care as described in item number 1 above.

   - The Member must have begun an Active Course of Treatment prior to Effective Date Of Coverage with the new plan, or prior to the date the formerly Participating Provider was terminated.

   - The terminated Provider must have been terminated by HMO for reasons other than medical disciplinary action, fraud or other criminal activity.

   - The transition request must be submitted to HMO within 90 days after the enrollment or re-enrollment period, or within 90 days from the date of discontinuation of the Provider’s contract and prior to receiving services (except in an emergency) from the
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non-participating Provider; and

- If services are received prior to the approval of transition of benefits, the services must be approved by HMO Medical Director in order for coverage to be extended at the new benefit plan level.

4. In order for a Provider to continue treating HMO members during a transition period, the Provider must agree in writing to:

- provide or continue to provide the Member’s treatment and follow-up care;
- share or continue to share information regarding the treatment plan with HMO;
- use or continue to use HMO network for any necessary Referrals, diagnostic tests or procedures or hospitalizations;
- accept or continue to accept HMO capitation rates and/or similar fee schedules as other non-capitated Providers serve in a geographic area for similar services; and in the case of a terminated Provider to,
- continue to abide by the terms and conditions of the prior contract.

Members may request a “Continuity of Care Form” at the time of enrollment in the new plan or by calling the member services telephone number listed on their ID card and requesting the form. The Member and the Member’s treating Provider fill out and submit the Continuity of Care Form within the time frames described above. This continuity of care provision shall not be construed to require HMO to provide coverage for services not otherwise covered by HMO under this EOC.

J. Facilities

Member’s selection of a Primary Care Physician also determines the Hospital to which Member will be admitted unless it is Medically Necessary to receive Hospital services elsewhere.

A provider directory listing Participating Physicians and their affiliated Medical Groups, Hospitals, laboratories, pharmacies, Skilled Nursing Facilities, home health agencies and other ancillary health care and subacute facilities will be distributed to Members. If another copy of the directory is needed, a Member may call the Contract Holder or HMO member services at the toll-free telephone number listed on Member’s identification card. The list of Participating Providers is subject to change.

K. Liability of Member for Payment

All non-Emergency Services or Urgent Care services must be provided by Member’s Primary Care Physician, Member’s PCP’s on-call Physician, or a Participating Provider referred by Member’s PCP except for certain direct access Specialist benefits as described in the EOC.

If Member seeks care, other than covered direct access Specialist benefits, from a Provider other than Member’s PCP without a Referral, HMO will not pay the costs. Coverage for services of a Physician or other Health Professional who is not a Participating Provider requires prior authorization before the service or supply is obtained, except for Emergency Services or Urgent Care services received outside the HMO Service Area. If HMO denies payment to a non-Participating Provider, Member will be liable to the Provider for the cost of services.

HMO’s contracts with its Participating Providers specify that, except for Copayments, Members are not
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liable for payment for Medically Necessary Covered Benefits which have the appropriate pre-authorization, even if HMO fails to pay the Participating Provider.

**FEES AND CHARGES**

**A. Premiums.**

*Contract Holder* is responsible for advance payment of *Premiums* for HMO coverage in accordance with the *Group Agreement*. *Members* may be required to pay a portion of such premiums. If so, *Members* will be notified by *Contract Holder*.

Coverage is only provided for *Members* whose *Premiums* have been received by HMO. Coverage extends only for the period for which such payment is received, subject to any allowances stated in the *Group Agreement*.

**B. Copayments.**

*Member* will be required to make certain *Copayments* for *Covered Benefits* as specified in the Schedule of Benefits. *Copayments* must be paid by the time the *Covered Benefits* are rendered. The total aggregate amount of *Copayments* a *Member* is required to pay per year, for basic services is specified in the Schedule of Benefits.

*Member* will also be responsible for any charges made by Participating Providers for scheduled appointments that are missed without notice to the Participating Providers or without good cause. Personal administrative service costs such as copying *Member* medical records or completing forms for school, camp, employment, etc. are also *Member*’s responsibility.

**C. Maximum Out-of-Pocket Limit.**

If a *Member’s Copayments* reach the Maximum Out-of-Pocket Limit set forth on the HMO Schedule of Benefits, HMO will pay 100% of the contracted charges for *Covered Benefits* for the remainder of that calendar year. *Copayments* for certain *Covered Benefits* specified in the HMO Schedule of Benefits do not count towards satisfying the Maximum Out-of-Pocket Limit, and those *Covered Benefits* are not eligible for 100% reimbursement after the Maximum Out-of-Pocket Limit is reached.

**ELIGIBILITY AND ENROLLMENT**

**A. Eligibility.**

1. To be eligible to enroll as a *Subscriber*, an individual must:
   a. meet all applicable eligibility requirements agreed upon by the *Contract Holder* and HMO; and
   b. live or work in the *Service Area*.

2. To be eligible to enroll as a *Covered Dependent*, the *Contract Holder* must provide dependent coverage for *Subscribers*, and the dependent must be:
   a. the legal spouse of a *Subscriber* under this EOC; or
   b. a dependent unmarried child (including natural, foster, step, legally adopted children, children placed for adoption, a child under court order who meets the eligibility requirements described on the Schedule of Benefits).

3. A *Member* who resides outside the *Service Area* is required to choose a PCP and return to the
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Service Area for Covered Benefits. The only services covered outside the Service Area are Emergency Services and Urgent Care.

B. Enrollment.

Unless otherwise noted, an eligible individual and any eligible dependents may enroll in HMO regardless of health status, age, or requirements for health services within 31 days from the eligibility date.

1. Newly Eligible Individuals and Eligible Dependents.

An eligible individual and any eligible dependents may enroll within 31 days of the eligibility date.

2. Open Enrollment Period.

Eligible individuals or dependents who are eligible for enrollment but do not enroll as stated above, may be enrolled during any subsequent Open Enrollment Period upon submission of complete enrollment information and Premium payment to HMO.

3. Enrollment of Newly Eligible Dependents.

a. Newborn Children.

A newborn child is covered for 31 days from the date of birth. To continue coverage beyond this initial period, the child must be enrolled in HMO within the initial 31 day period. If coverage does not require the payment of an additional Premium for a Covered Dependent, the Subscriber must still enroll the child within 31 days after the date of birth.

The coverage for newly born, adopted children, and children placed for adoption consists of coverage of injury and sickness, including the necessary care and treatment of congenital defects and birth abnormalities, and within the limits of this EOC. Coverage includes necessary transportation costs from place of birth to the nearest specialized Participating treatment center.

b. Adopted Children.

A legally adopted child or a child for whom a Subscriber is a court appointed legal guardian, and who meets the definition of a Covered Dependent, will be treated as a dependent from the date of adoption or upon the date the child was placed for adoption with the Subscriber. “Placed for adoption” means the assumption and retention of a legal obligation for total or partial support of a child in anticipation of adoption of the child. The Subscriber must make a written request for coverage within 31 days of the date the child is adopted or placed with the Subscriber for adoption.

4. Special Rules Which Apply to Children.

a. Qualified Medical Child Support Order.

Coverage is available for a dependent child not residing with a Subscriber and who resides outside the Service Area, if there is a qualified medical child support order requiring the Subscriber to provide dependent health coverage for a non-resident child. The child must meet the definition of a Covered Dependent, and the Subscriber must make a written request for coverage within 31 days of the court order.
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b. Handicapped Children.

Coverage is available for a child who is chiefly dependent upon the Subscriber for support and maintenance, and who is 19 years of age or older but incapable of self-support due to mental or physical incapacity. The incapacity must have commenced prior to the age the dependent would have lost eligibility. In order to continue coverage for a handicapped child, the Subscriber must provide evidence of the child’s incapacity and dependency to HMO within 31 days of the date the child’s coverage would otherwise terminate. Proof of continued incapacity, including a medical examination, must be submitted to HMO as requested, but not more frequently than annually beginning after the 2 year period following the child’s attainment of the age specified on the Schedule of Benefits. This eligibility provision will no longer apply on the date the dependent’s incapacity ends.

5. Notification of Change in Status.

It shall be a Member’s responsibility to notify HMO of any changes which affect the Member’s coverage under this EOC, unless a different notification process is agreed to between HMO and Contract Holder. Such status changes include, but are not limited to, change of address, change of Covered Dependent status, and enrollment in Medicare or any other group health plan of any Member. Additionally, if requested, a Subscriber must provide to HMO, within 31 days of the date of the request, evidence satisfactory to HMO that a dependent meets the eligibility requirements described in this EOC.

6. Special Enrollment Period

An eligible individual and eligible dependents may be enrolled during a special enrollment period. A special enrollment period may apply when an eligible individual or eligible dependent loses other health coverage or when an eligible individual acquires a new eligible dependent through marriage, birth, adoption or placement for adoption.

Special Enrollment Period for Certain Individuals Who Lose Other Health Coverage:
An eligible individual or an eligible dependent may be enrolled during special enrollment periods, if requirements (a), (b), (c), and (d) are met:

a. the eligible individual or the eligible dependent was covered under another group health plan or other health insurance coverage when initially eligible for coverage under HMO;

b. the eligible individual or eligible dependent declines coverage in writing under HMO;

c. the eligible individual or eligible dependent loses coverage under the other group health plan or other health insurance coverage for one of the following reasons:

i. the other group health coverage is COBRA continuation coverage under another plan, and the COBRA continuation coverage under that other plan has since been exhausted, or

ii. the other coverage is a group health plan or other health insurance coverage, and the other coverage has been terminated as a result of loss of eligibility for the coverage or employer contributions towards the other coverage have been terminated.

Loss of eligibility includes a loss of coverage as a result of legal separation, divorce, death, termination of employment, reduction in the number of hours of employment, and any loss of eligibility after a period that is measured by reference to any of the foregoing.
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Loss of eligibility does not include a loss due to failure of the individual or the participant to pay Premiums on a timely basis or due to termination of coverage for cause as referenced in the Termination of Coverage section of this EOC; and

d. the eligible individual or eligible dependent enrolls within 30 days of the loss.

The Effective Date of Coverage will be the first day of the first calendar month following the date the completed request for enrollment is received.

The eligible individual or the eligible dependent enrolling during a special enrollment period will not be subject to late enrollment provisions, if any, described in this EOC.

Special Enrollment Period When a New Eligible Dependent is Acquired:

When a new eligible dependent is acquired through marriage, birth, adoption or placement for adoption, the new eligible dependent (and, if not otherwise enrolled, the eligible individual and other eligible dependents) may be enrolled during a special enrollment period.

The special enrollment period is a period of 30 days, beginning on the date of the marriage, birth, adoption or placement for adoption (as the case may be). If a completed request for enrollment is made during that period, the Effective Date of Coverage will be:

- In the case of marriage, the first day of the first calendar month following the date the completed request for enrollment is received.
- In the case of a dependent’s birth, adoption or placement for adoption, the date of such birth, adoption or placement for adoption.

The eligible individual or the eligible dependents enrolling during a special enrollment period will not be subject to late enrollment provisions, if any, described in this EOC.

C. Effective Date of Coverage.

Coverage shall take effect at 12:01 a.m. on the Member’s effective date. Coverage shall continue in effect from month to month subject to payment of Premiums made by the Contract Holder and subject to the Termination section of the Group Agreement and the Termination of coverage section of this EOC.

Hospital Confinement on Effective Date of Coverage.

If a Member is an inpatient in a Hospital on the Effective Date of Coverage, the Member will be covered as of that date. Such services are not covered if the Member is covered by another health plan on that date and the other health plan is responsible for the cost of the services. HMO will not cover any service that is not a Covered Benefit under this EOC. To be covered, the Member must utilize Participating Providers and is subject to all the terms and conditions of this EOC.

D. Renewal Provisions

If Contract Holder has renewed the Group Agreement, Members still eligible for coverage under this HMO may renew coverage under the same Group Agreement, if all Premiums have been properly paid and the Member meets the eligibility requirements. Such annual renewal is automatic and reapplication is not necessary. Premiums may change upon renewal. If coverage for Subscriber and Covered Dependents is terminated, Subscriber must submit a new application.
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**COVERED BENEFITS**

A **Member** shall be entitled to the **Covered Benefits** as specified below, in accordance with the terms and conditions of this **EOC**. Unless specifically stated otherwise, in order for benefits to be covered, they must be **Medically Necessary**. For the purpose of coverage, **HMO** may determine whether any benefit provided under the **EOC** is **Medically Necessary**, and **HMO** has the option to only authorize coverage for a **Covered Benefit** performed by a particular **Provider**. Preventive care, as described below, will be considered **Medically Necessary**.

ALL SERVICES ARE SUBJECT TO THE EXCLUSIONS AND LIMITATIONS DESCRIBED IN THIS **EOC**.

To be **Medically Necessary**, the service or supply must:

- be care or treatment as likely to produce a significant positive outcome as, and no more likely to produce a negative outcome than, any alternative service or supply, both as to the disease or injury involved and the **Member**’s overall health condition;
- be care or services related to diagnosis or treatment of an existing illness or injury, except for covered periodic health evaluations and preventive and well baby care, as determined by **HMO**;
- be a diagnostic procedure, indicated by the health status of the **Member** and be as likely to result in information that could affect the course of treatment as, and no more likely to produce a negative outcome than, any alternative service or supply, both as to the disease or injury involved and the **Member**’s overall health condition;
- include only those services and supplies that cannot be safely and satisfactorily provided at home, in a **Physician**’s office, on an outpatient basis, or in any facility other than a **Hospital**, when used in relation to inpatient **Hospital** services; and
- as to diagnosis, care and treatment be no more costly (taking into account all health expenses incurred in connection with the service or supply) than any equally effective service or supply in meeting the above tests.

In determining if a service or supply is **Medically Necessary**, **HMO**’s Patient Management Medical Director or its **Physician** designee will consider:

- information provided on the **Member**’s health status;
- reports in peer reviewed medical literature;
- reports and guidelines published by nationally recognized health care organizations that include supporting scientific data;
- professional standards of safety and effectiveness which are generally recognized in the United States for diagnosis, care or treatment;
- the opinion of **Health Professionals** in the generally recognized health specialty involved;
- the opinion of the attending **Physicians**, which have credence but do not overrule contrary opinions; and
- any other relevant information brought to **HMO**’s attention.

All **Covered Benefits** will be covered in accordance with the guidelines determined by **HMO**.
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If a Member has questions regarding coverage under this EOC, the Member may call the Member Services toll-free telephone number listed on the Member’s identification card.

THE MEMBER IS RESPONSIBLE FOR PAYMENT OF THE APPLICABLE COPAYMENTS LISTED ON THE SCHEDULE OF BENEFITS.

EXCEPT FOR DIRECT ACCESS SPECIALIST BENEFITS OR IN A MEDICAL EMERGENCY OR URGENT CARE SITUATION AS DESCRIBED IN THIS EOC, THE FOLLOWING BENEFITS MUST BE ACCESSED THROUGH THE PCP’S OFFICE THAT IS SHOWN ON THE MEMBER’S IDENTIFICATION CARD, OR ELSEWHERE UPON PRIOR REFERRAL ISSUED BY THE MEMBER’S PCP.

A. Primary Care Physician Benefits.

1. Office visits during office hours.

2. Home visits.

3. After-hours PCP services. PCPs are required to provide or arrange for on-call coverage 24 hours a day, 7 days a week. If a Member becomes sick or is injured after the PCP’s regular office hours, the Member should:
   a. call the PCP’s office; and
   b. identify himself or herself as a Member; and
   c. follow the PCP’s or covering Physician’s instructions.

If the Member’s injury or illness is a Medical Emergency, the Member should follow the procedures outlined under the Emergency Care/Urgent Care Benefits section of this EOC.

4. Hospital visits.

5. Periodic health evaluations to include:
   a. well child care from birth including immunizations and booster doses of all immunizing agents used in child immunizations which conform to the standards of the Advisory Committee on Immunization Practices of the Centers for Disease Control, U.S. Department of Health and Human Services. Screening tests for blood lead levels of a Covered Dependent child at risk for lead poisoning are also covered.
   b. routine physical examinations, including, 1) services related to the diagnosis, treatment and appropriate management of osteoporosis and 2) the screening and diagnosis of prostate cancer, including but not limited to, prostate-specific antigen testing and digital rectal examinations, when Medically Necessary and consistent with good medical practice.
   C. routine gynecological examinations, including Pap smears and related laboratory services, for routine care, administered by the PCP. The Member may also go directly to a Participating gynecologist without a Referral for routine GYN examinations and pap smears. See the Direct Access Specialist Benefits section of this EOC for a description of these benefits.
   d. routine hearing screenings.
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e. immunizations (but not if solely for the purpose of travel or employment).

f. annual routine vision screenings for the purpose of determining vision loss.

6. Injections, including allergy desensitization injections.

7. Casts and dressings.

8. Health Education Counseling and Information, including health education services and guidance, including information regarding personal health behavior and health care, and recommendations regarding the optimal use of health care services.

B. Diagnostic Services Benefits.

Services include, but are not limited to, the following:

1. Diagnostic, laboratory, and x-ray services.

2. Mammograms, by a Participating Provider. The Member is required to obtain a Referral from their PCP or gynecologist, or obtain pre-authorization from HMO to a Participating Provider, prior to receiving this benefit.

Sample

Screening mammogram benefits for female Members are provided as follows:

- ages 35 to 39, one baseline mammogram;
- age 40 and older, one routine mammogram every year; or
- when Medically Necessary.

3. Medically Necessary cancer screening tests which are generally accepted by the Medical Community.

C. Specialist Physician Benefits.

Covered Benefits include outpatient and inpatient services.

D. Direct Access Specialist Benefits.

1. The following services are covered without a Referral when rendered by a Participating Provider other than the Member’s PCP. The Member must select a Participating gynecologist or obstetrician in her PCP’s Medical Group or IPA.

- Routine Gynecological Examination(s). Routine gynecological visit(s) and Pap smear(s). The maximum number of visits, if any, is listed on the Schedule of Benefits.

- Direct Access to Gynecologists. Benefits are provided to female Members for services performed by a Participating gynecologist for diagnosis and treatment of gynecological problems.

2. Routine Eye Examinations are covered as shown below without a Referral when rendered by a Provider identified in the Provider Directory as participating in the Direct Access Eye program.

- Routine Eye Examinations, including refraction, as follows:
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a. if Member is age 1 through 18 and wears eyeglasses or contact lenses, 1 exam every 12-month period.

b. if Member is age 19 and over and wears eyeglasses or contact lenses, 1 exam every 24-month period.

c. if Member is age 1 through 45 and does not wear eyeglasses or contact lenses, 1 exam every 36-month period.

d. if Member is age 46 and over and does not wear eyeglasses or contact lenses, 1 exam every 24-month period.

E. Maternity Care and Related Newborn Care Benefits.

Outpatient and inpatient pre-natal and postpartum care and obstetrical services provided by Participating Providers are a Covered Benefit, including prenatal genetic testing of a fetus associated with high risk pregnancies, and voluntary participation in the State of California’s Expanded Alpha Feto Protein (AFP) program, which is a California statewide prenatal testing program administered by the State Department of Health Services. The Participating Provider is responsible for obtaining any required pre-authorizations for all non-routine obstetrical services from.

Coverage does not include routine maternity care (including delivery) received while outside the Service Area unless the Member receives pre-authorization from HMO. As with any other medical condition, Emergency Services are covered when Medically Necessary.

As an exception to the Medically Necessary requirements of this EOC, the following coverage is provided for a mother and newly born child:

1. a minimum of 48 hours of inpatient care in a Participating Hospital following a vaginal delivery;

2. a minimum of 96 hours of inpatient care in a Participating Hospital following a cesarean section; or

3. a shorter Hospital stay, if requested by a mother, and if determined to be medically appropriate by the Participating Providers in consultation with the mother.

If a Member requests a shorter Hospital stay, the Member will be covered for one home health care visit scheduled to occur within 24 hours of discharge. An additional visit will be covered when prescribed by the Participating Provider. This benefit is in addition to the home health maximum number of visits, if any, shown on the Schedule of Benefits. A Copayment will not apply for home health care visits.

F. Inpatient Hospital & Skilled Nursing Facility Benefits.

A Member is covered for services only at Participating Hospitals and Participating Skilled Nursing Facilities except in a Medical Emergency, as outlined under the Emergency Care/Urgent Care Benefits section of this EOC. All services are subject to pre-authorization by HMO. In the event that the Member elects to remain in the Hospital or Skilled Nursing Facility after the date that the Participating Provider and/or the HMO Medical Director has determined and advised the Member that the Member no longer meets the criteria for continued inpatient confinement, the Member shall be fully responsible for direct payment to the Hospital or Skilled Nursing Facility for such additional Hospital, Skilled Nursing Facility, Physician and other Provider services, and HMO shall not be financially responsible for such additional services.
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Inpatient Hospital cardiac and pulmonary rehabilitation services are covered by Participating Providers upon Referral issued by the Member’s PCP and pre-authorization by HMO.

Coverage for Skilled Nursing Facility benefits is subject to the maximum number of days, if any, shown on the Schedule of Benefits.

G. Transplant Benefits.

Transplants which are non-experimental or non-investigational are a Covered Benefit. Transplants which are Experimental or Investigational may be covered if approved in advance by HMO. For additional information about the criteria and process for approval of Experimental and Investigational transplants call member Services at the toll free number listed on the ID Card.

Once it has been determined that a Member may require a Transplant, the Member or the Member’s Physician must call the Member Services number on the Member’s identification card to discuss entrance into the National Medical Excellence Program. Non-experimental or non-investigational Transplants coordinated through the National Medical Excellence Program and performed at an Institute of Excellence, (IOE), are Covered Benefits. The IOE facility must be specifically approved and designated by HMO to perform the Transplant required by the Member.

Covered Benefits include the following when provided by an IOE.

- Inpatient and outpatient expenses directly related to a Transplant.
- Charges for Transplant-related services, including pre-Transplant evaluations, testing and post-Transplant follow-up care.
- Charges made by an IOE Physician or Transplant team.
- Compatibility testing of prospective organ donors who are immediate family members.
- Charges for activating the donor search process with national registries.
- Charges made by a Hospital and/or Physician for the medical and surgical expenses of a live donor, but only to the extent not covered by another plan or program.
- Related supplies and services provided by the IOE facility during the Transplant process. These services and supplies may include: physical, speech and occupational therapy; bio-medicals and immunosuppressants; Home Health Services and home infusion services.
- Travel and lodging expenses incurred by the Member receiving the Transplant, the organ donor and Traveling Companion for travel between the Member’s home and the IOE facility, when the IOE facility is 100 miles or more from the Member’s home. Round trip coach class air, train, or bus travel are covered. Travel and lodging expenses are subject to any maximums set forth in the Schedule of Benefits.

Any Copayments associated with Transplants are set forth in the Schedule of Benefits.

H. Outpatient Surgery Benefits.

Coverage is provided for outpatient surgical services and supplies in connection with a covered surgical procedure when furnished by a Participating outpatient surgery center. All services and supplies are subject to pre-authorization by HMO.

I. Substance Abuse Benefits.

Substance Abuse Benefits are managed by HMO or an independently contracted organization. HMO or the independently contracted organization makes initial coverage determinations and coordinates referrals. Any behavioral health care referrals will generally be made to Providers affiliated with the contracted organization, unless the Member’s needs for covered services extend beyond the capability of Participating Providers.
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A Member is covered for the following services as authorized and provided by Participating Behavioral Health Providers.

1. Outpatient care benefits are covered for Detoxification. Benefits include diagnosis, medical treatment and medical referral services (including referral services for appropriate ancillary services) by the Member’s PCP for the abuse of or addiction to alcohol or drugs. Substance Abuse Rehabilitation services are not covered.

   Member is entitled to outpatient visits to a Participating Behavioral Health Provider upon Referral by the PCP for diagnostic, medical or therapeutic Substance Abuse Rehabilitation services. Coverage is subject to the limits, if any, shown on the Schedule of Benefits.

   The HMO, or its contractor, will use prior authorizations and ongoing reviews (see HMO Procedure Sections; Ongoing Reviews, and Referrals and Pre-Authorizations) to limit the number of outpatient Substance Abuse Rehabilitation visits to the minimum it deems to be Covered Benefits that are Medically Necessary services regardless of the maximum number of visits described in the Schedule of Benefits. This means the Member may not receive the maximum number of visits specified in the Schedule of Benefits, or the number of visits the Member and the treating provider believe to be appropriate, for a single course of treatment or episode.

2. Inpatient care benefits are covered for Detoxification. Benefits include medical treatment and referral services for Substance Abuse or addiction. The following services shall be covered under inpatient treatment: lodging and dietary services; Physicians, psychologist, nurse, certified addictions counselor and trained staff services; diagnostic x-ray; psychiatric, psychological and medical laboratory testing; and drugs, medicines, equipment use and supplies. Substance Abuse Rehabilitation services are not covered.

   Member is entitled to medical, nursing, counseling or therapeutic Substance Abuse Rehabilitation services in an inpatient, or non-hospital residential facility, appropriately licensed by the Department of Health, upon referral by the Member’s Participating Behavioral Health Provider for alcohol or drug abuse or dependency. Coverage is subject to the limits, if any, shown on the Schedule of Benefits.

   The HMO, or its contractor, will use prior authorizations and ongoing reviews (see HMO Procedure Sections; Ongoing Reviews, and Referrals and Pre-Authorizations) to limit the number of inpatient Substance Abuse Rehabilitation days to the minimum it deems to be Covered Benefits that are Medically Necessary services regardless of the maximum number of days described in the Schedule of Benefits. This means the Member may not receive the maximum number of days specified in the Schedule of Benefits, or the number of days the Member and the treating provider believe to be appropriate, for a single course of treatment or episode.

J. Mental Health Benefits.

The diagnosis and Medically Necessary inpatient and outpatient treatment of Serious Mental Illness and Serious Emotional Disturbances of a Child are covered under the same terms and conditions as any other medical condition.

Mental Health Benefits are managed by HMO or an independently contracted organization. HMO or the independently contracted organization makes initial coverage determinations and coordinates referrals. Any behavioral health care referrals will generally be made to Providers affiliated with the contracted organization, unless the Member’s needs for covered services extend beyond the capability of Participating Providers.
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A Member is covered for services for the limited treatment of Non-Serious Mental Illness through Participating Behavioral Health Providers.

1. Outpatient benefits are covered for short-term, outpatient evaluative and crisis intervention or home health mental health services, and are subject to the maximum number of visits, if any, shown on the Schedule of Benefits. The HMO, or its contractor, will use prior authorizations and ongoing reviews (see HMO Procedure Sections; Ongoing Reviews, and Referrals and Pre-Authorizations above) to limit the number of outpatient or home health mental health visits to the minimum it deems to be Covered Benefits that are Medically Necessary mental health services regardless of the maximum number of visits described in the Schedule of Benefits. This means the Member may not receive the maximum number of visits specified in the Schedule of Benefits, or the number of visits the Member and the treating provider believe to be appropriate, for a single course of treatment or episode.

2. Inpatient benefits may be covered for medical, nursing, counseling or therapeutic services in an inpatient, non-hospital residential facility, appropriately licensed by the Department of Health or its equivalent and are subject to the maximum number of days, if any, shown on the Schedule of Benefits. The HMO, or its contractor, will use prior authorizations and ongoing reviews (see HMO Procedure Sections; Ongoing Reviews, and Referrals and Pre-Authorizations above) to limit the number of inpatient days to the minimum it deems to be Covered Benefits that are Medically Necessary regardless of the maximum number of days described in the Schedule of Benefits. This means the Member may not receive the maximum number of days specified in the Schedule of Benefits, or the number of days the Member and the treating provider believe to be appropriate for a single course of treatment or episode.

K. Emergency Services/Urgent Care Benefits.

1. A Member is covered for Emergency Services, provided the service is a Covered Benefit, and HMO’s medical review determines that the Member’s symptoms were such that a prudent layperson, possessing average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in serious jeopardy to the Member’s health, or with respect to a pregnant Member, the health of the woman and her unborn child.

The Copayment for an emergency room visit as described on the Schedule of Benefits will not apply either in the event that the Member was referred for such visit by the Member’s PCP for services that should have been rendered in the PCP’s office or if the Member is admitted into the Hospital.

The Member will be reimbursed for the cost for Emergency Services rendered by a non-participating Provider located either within or outside the HMO Service Area, for those expenses, less Copayments, which are incurred up to the time the Member is determined by HMO and the attending Physician to be medically able to travel or to be transported to a Participating Provider. In the event that transportation is Medically Necessary, the Member will be reimbursed for the cost as determined by HMO, minus any applicable Copayments. Reimbursement may be subject to payment by the Member of all Copayments which would have been required had similar benefits been provided during office hours and upon prior Referral to a Participating Provider.

Medical transportation is covered during a Medical Emergency if the Member reasonably believed that the medical condition was a Medical Emergency and reasonably believed that the condition required ambulance transport services.

Members are encouraged to appropriately use the 911 emergency response system when a Medical Emergency requires emergency response. If the situation is not a Medical Emergency please, call your PCP for instructions. Your PCP is required to provide coverage 24 hours a day, including weekends and holidays.
2. Urgent Care

Urgent Care Within the HMO Service Area. If the Member needs Urgent Care while within the HMO Service Area, but the Member’s illness, injury or condition is not serious enough to be a Medical Emergency, the Member should first seek care through the Member’s PCP. If the Member’s PCP is not reasonably available to provide services for the Member, the Member may access Urgent Care from a Participating Urgent Care facility within the HMO Service Area.

Urgent Care Outside the HMO Service Area. The Member will be covered for Urgent Care obtained from a Physician or licensed facility outside of the HMO Service Area if the Member is temporarily absent from the HMO Service Area and receipt of the health care service cannot be delayed until the Member returns to the HMO Service Area.

A Member is covered for any follow-up care. Follow-up care is any care directly related to the need for Emergency Services or Urgent Care which is provided to a Member after the Medical Emergency or Urgent Care situation has terminated. All follow-up and continuing care must be provided or arranged by a Member’s PCP. The Member must follow this procedure, or the Member will be responsible for payment for all follow-up services received.

L. Outpatient Rehabilitation Benefits.

The following benefits are covered by Participating Providers upon Referral issued by the Member’s PCP and pre-authorized by HMO.

1. A limited course of cardiac rehabilitation following an inpatient Hospital stay is covered when Medically Necessary angioplasty, cardiovascular surgery, congestive heart failure or myocardial infarction.

2. Pulmonary rehabilitation following an inpatient Hospital stay is covered when Medically Necessary for the treatment of reversible pulmonary disease states.

3. Cognitive therapy associated with physical rehabilitation is covered for acute illnesses and injuries and the acute phase of chronic conditions if treatment is expected to result in significant improvement, as part of a treatment plan coordinated with HMO.

4. Physical therapy is covered for acute illnesses and injuries and the acute phase of chronic conditions if treatment is expected to result in significant improvement. Coverage is subject to the limits, if any, shown on the Schedule of Benefits.

5. Occupational therapy (except for vocational rehabilitation or employment counseling) is covered for acute illnesses and the acute phase of chronic conditions if treatment is expected to result in significant improvement. Coverage is subject to the limits, if any, shown on the Schedule of Benefits.

6. Speech therapy is covered for acute illnesses and injuries and the acute phase of chronic conditions if treatment is expected to result in significant improvement. Services rendered for the treatment of delays in speech development, unless resulting from disease, injury, or congenital defects, are not covered. Coverage is subject to the limits, if any, shown on the Schedule of Benefits.

7. Additional outpatient rehabilitation benefits beyond the limits, if any, shown on the Schedule of Benefits may be approved by the HMO if the Medical Director determines that the services in a,
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b, c, or d above, when directed and monitored by a Participating Provider, will result in significant improvement to the Member's condition.

M. **Home Health Benefits.**

The following services are covered when rendered by a Participating home health care agency. Pre-authorization must be obtained from the Member’s attending Participating Physician. HMO shall not be required to provide home health benefits when HMO determines the treatment setting is not appropriate, or when there is a more cost effective setting in which to provide appropriate care.

1. **Skilled Care** nursing services for a Homebound Member. Treatment must be provided by or supervised by a registered nurse.

2. Services of a home health aide. These services are covered only when the purpose of the treatment is Skilled Care.

3. Medical social services. Treatment must be provided by or supervised by a qualified medical Physician or social worker, along with other Home Health Services. The PCP must certify that such services are necessary for the treatment of the Member’s medical condition.

4. Short-term physical, speech, or occupational therapy is covered. Coverage is limited to those conditions and services under the Outpatient Rehabilitation section of this EOC.

Coverage is subject to the maximum number of visits, if any, shown on the Schedule of Benefits.

N. **Hospice Benefits.**

Hospice Care services for a terminally ill Member are covered when pre-authorized by HMO. Services may include home and Hospital visits by nurses and social workers; pain management and symptom control; instruction and supervision of a family Member; inpatient care; counseling including bereavement counseling and emotional support; and other home health benefits listed in the Home Health Benefits section of this EOC.

Nursing care services are covered on a continuous basis during periods of crisis as necessary to maintain Member at home. Homemaker or home health aide services may be covered, but the care provided must be predominantly nursing care. A period of crisis is a period in which the Member requires continuous care to achieve palliation or management of acute medical symptoms. Hospitalization will be covered if skilled nursing care is required at a level that cannot be provided in the home.

Respite care will be provided only when necessary to relieve the family members or other persons caring for the Member. Coverage of respite care will be limited to an occasional basis and to no more than five consecutive days at a time.

Coverage is not provided for funeral arrangements, pastoral counseling, financial or legal counseling. Except as needed to maintain Member at home during periods of crisis, homemaker or caretaker services, and any service not solely related to the care of the Member, including but not limited to, sitter or companion services for the Member or other Members of the family, transportation, house cleaning, and maintenance of the house are not covered.

O. **Prosthetic and Orthotic Appliances.**

The Member’s initial provision or Medically Necessary replacement of a prosthetic device or custom fitted orthotics that temporarily or permanently replaces all or part of an external body part lost or impaired as a result of disease or injury or congenital defects is covered, when such device is prescribed by a Participating Provider, administered through a Participating or designated prosthetic Provider, and pre-authorized by HMO. This benefit includes the provision of prosthetic devices a to restore and achieve
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symmetry incident to a mastectomy due to diagnosed breast cancer or other breast disease or, b) subsequent to a laryngectomy. Coverage does not include electronic voice producing machines. Coverage includes repair and replacement when due to congenital growth. Instruction and appropriate services required for the Member to properly use the item (such as attachment or insertion) are covered. Covered prosthetic appliances include those items covered by Medicare unless excluded in the Exclusions and Limitations section of this EOC. HMO reserves the right to provide the most cost efficient and least restrictive level of service or item which can be safely and effectively provided.

P. Injectable Medications Benefits.

Medically Necessary Injectable medications, including those medications intended to be self administered, are a Covered Benefit. Medications must be prescribed by a Provider licensed to prescribe federal legend prescription drugs or medicines, and pre-authorized by HMO. If the drug therapy treatment is approved for self-administration, the Member is required to obtain covered medications at an HMO Participating pharmacy designated to fill injectable prescriptions.

Injectable drugs or medication used for the treatment of cancer or HIV are covered when the off-label use of the drug has not been approved by the FDA for that indication, provided that such drug is recognized for treatment of such indication in one of the standard reference compendia (the United States Pharmacopoeia Drug Information, the American Medical Association Drug Evaluations, or the American Hospital Formulary Service Drug Information) and the safety and effectiveness of use for this indication has been adequately demonstrated by at least one study published in a nationally recognized peer reviewed journal.

Q. Mastectomy and Reconstructive Breast Surgery Benefits.

Coverage for a mastectomy shall include a) coverage for all complications from a mastectomy including Medically Necessary physical therapy to treat the complications of mastectomy, including lymphedema, b) prosthetic devices, or c) reconstruction of the breast on which the mastectomy is performed including areolar reconstruction and the insertion of a breast implant and surgery and reconstruction performed on the non-diseased breast to establish symmetry when reconstructive breast surgery on the diseased breast has been performed.

The length of Hospital stay for mastectomies and lymph node dissections shall be determined by the attending Physician and surgeon in consultation with the patient and consistent with sound clinical practices.

R. Reconstructive Surgery Benefits.

Reconstructive Surgery, performed to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease is covered when:

1. pre-authorization is requested by the Member’s PCP in consultation with the Member’s Specialist and approved by HMO.

2. the requested surgery will improve function or create a normal appearance to the extent possible,

3. there is no more appropriate surgical procedure which will be approved for the Member,

4. the proposed surgery or surgeries offer more than a minimal improvement in the appearance of the Member.

Pre-authorization decisions, including determining whether Reconstructive Surgery will produce more than a minimal improvement in the appearance of the Member, shall be made by HMO Medical Director
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or delegate who is a licensed Physician competent to evaluate the specific clinical issues involved in the care requested, based upon the standards of care practiced by Physicians specializing in the type of reconstructive surgery. This means, for example, that for a treatment request submitted by a podiatrist or an oral and maxillofacial surgeon, the request will be reviewed by a similarly licensed individual, competent to evaluate the specific clinical issues involved in the care requested.

S. Limited General Anesthesia for Dental Procedures

General anesthesia and associated facility charges for dental procedures rendered in a hospital or surgery center are covered when:

1. pre-authorized by HMO,

2. the clinical status or underlying medical condition of the Member requires dental procedures that ordinarily would not require general anesthesia to be rendered in a hospital or surgery center, and

3. the Member for whom the treatment is proposed
   a. is under seven years of age, or
   b. is developmentally disabled, regardless of age, or
   c. has a health condition which makes the general anesthesia Medically Necessary, regardless of age.

Coverage does not include charges for the dental procedure itself, including, but not limited to, the professional fees of the dentist. Coverage is subject to the applicable Copayments for applicable services, if any, listed in the Schedule of Benefits.

T. Diabetes Treatment

Treatment, education for outpatient self management, and equipment and supplies are covered when Medically Necessary. Coverage includes, but is not limited to:

1. Diabetic daycare self management and education programs, provided by appropriately licensed participating Health Care Professionals. Training shall include self-management training, education, and medical nutrition therapy necessary to enable Members to properly use the equipment, supplies, and medications prescribed or referred by the Member’s Participating Provider.

2. Diabetic equipment, supplies and medications:
   a. Insulin,
   b. Prescriptive medications for the treatment of diabetes,
   c. Glucagon,
   d. Blood glucose monitors and blood glucose testing strips,
   e. Blood glucose monitors designed to assist the visually impaired,
   f. Insulin pumps and all related necessary supplies,
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g. Ketone urine testing strips,

h. Lancets and lancet puncture devices.

i. Pen delivery systems for the administration of insulin,

j. Podiatric devices to prevent or treat diabetes-related complications.

k. Insulin syringes.

l. Visual aids, excluding eyewear, to assist the visually impaired with proper dosing of insulin.

If coverage under this EOC includes a Prescription Drug Rider, the medications and supplies listed in the Prescription Drug Rider will be covered under the Prescription Drug Rider. Copayments for these medications and supplies are shown on the Prescription Drug Rider.

U. Phenylketonuria Benefit

In addition to coverage for the testing and treatment of Phenylketonuria (PKU), coverage for treatment of Phenylketonuria includes those formulas and special food products that are part of a diet prescribed by a Participating Provider and managed by a Health Care Professional in consultation with a Participating Specialist who specializes in metabolic disease to avert the development of serious physical or mental disabilities or to promote normal development or function as a consequence of PKU. For purposes of this section, “special food product” means a food product that is prescribed by the Member’s Participating Provider and used in place of normal food products used by the general population. “Special food product” does not include foods that are naturally low in protein, but may include a food product that is specially formulated to have less than one gram of protein per serving.

Refer to the Schedule of Benefits for applicable copayments. A Copayment and a maximum annual out-of-pocket payment, may apply to this service.

V. Temporomandibular Joint Syndrome (TMJ) Services.

Coverage for the treatment for temporomandibular joint dysfunction shall include pre-authorized Medically Necessary surgical procedures. Dental procedures, including but not limited to, the extraction of teeth and orthodontic devices and splints are excluded unless covered under a Rider attached to this EOC.

W. Durable Medical Equipment Benefits.

Durable Medical Equipment will be provided when pre-authorized by HMO. The wide variety of Durable Medical Equipment and continuing development of patient care equipment makes it impractical to provide a complete listing, therefore, the HMO Medical Director has the authority to approve requests on a case-by-case basis. Covered Durable Medical Equipment includes those items covered by Medicare unless excluded in the Exclusions and Limitations section of this EOC. HMO reserves the right to provide the most cost efficient and least restrictive level of service or item which can be safely and effectively provided. The decision to rent or purchase is at the discretion of HMO.

Instruction and appropriate services required for the Member to properly use the item, such as attachment or insertion, is also covered upon pre-authorization by HMO. Replacement, repairs and maintenance are covered only if it is demonstrated to the HMO that:

1. it is needed due to a change in the Member’s physical condition; or
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2. it is likely to cost less to buy a replacement than to repair the existing equipment or to rent like equipment.

All maintenance and repairs that result from a misuse or abuse are a Member's responsibility.

A Copayment, an annual maximum out-of-pocket payment, and an annual maximum benefit may apply to this service. Refer to the Schedule of Benefits attached to this EOC.

X. Additional Benefits.

• Clinical Cancer Trials, Phase I, II, II or IV: As an exception to the exclusion of treatments determined to be Experimental or Investigational, routine health care services are covered for Members whose treating Provider determines that a clinical cancer trial has a meaningful potential to benefit the Member and recommends participation. The clinical trial must involve a drug that is exempt under federal regulations from a new drug application and approved by the National Institute of Health, the FDA, the US Department of Defense or the Veteran's Administration. Routine health care services include the provision of drugs, items, devices and services which would be Covered Benefits provided other than in connection with an approved clinical trial program, including health care services which are:

a. typically provided absent a clinical trial;

b. required solely for the provision of the investigational drug, item, device, or service;

c. required for the clinically appropriate monitoring of the investigational item or service; or;

d. provided for the prevention or treatment of complications arising from the provision of the investigational drug, item device, or service;

Routine health care services do not include:

a. drugs or devices that have not been approved by the federal Food and Drug Administration and that are associated with the clinical trial;

b. travel, housing, companion expenses, and other non clinical expenses that a Member may require as a result of the treatment being provided in the clinical trial;

c. items or services provided solely to satisfy data collection and analysis and not used in the clinical management of the patient;

d. services that are not Covered Benefits under the plan, if provided other than as part of the clinical trial; and

e. services customarily provided free of charge for participants in the clinical trial.

The HMO may restrict coverage for clinical trials to Participating Hospitals and Physicians in California unless the protocol for the clinical trial is not provided for a California Hospital or by a California Physician.

The copayments applied to services delivered in a clinical trial will be the same as those applied to the same services if not delivered in a clinical trial.
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• Basic Infertility Services Benefits. Benefits include only those Infertility services provided to a Member: a) by a Participating Provider to diagnose Infertility; and b) by a Participating Infertility Specialist to surgically treat the underlying cause of Infertility.

EXCLUSIONS AND LIMITATIONS

A. Exclusions.

The following are not Covered Benefits except as described in the Covered Benefits section of this EOC or by a rider and/or an amendment attached to this EOC:

• Ambulance services, for routine transportation to receive outpatient or inpatient services.

• Biofeedback, except as pre-authorized by HMO.

• Care for conditions that state or local law require to be treated in a public facility, including but not limited to, mental illness commitments.

• Care furnished to provide a safe surrounding, including the charges for providing a surrounding free from exposure that can worsen the disease or injury.

• Cosmetic Surgery, or other services intended primarily to improve the Member’s appearance or treatment relating to the consequences of, or as a result of, Cosmetic Surgery. This exclusion does not apply to:

• Medically Necessary reconstructive surgery as described in the Covered Benefits sections Mastectomy and Reconstructive Breast Surgery or Reconstructive Surgery.

• surgery to correct the results of injuries causing an impairment;

• surgery as a continuation of a staged reconstruction procedure, including but not limited to post-mastectomy reconstruction;

• surgery to correct congenital defects necessary to restore normal bodily functions, including but not limited to, cleft lip and cleft palate;

• Emergency Services necessary to treat life-threatening complications resulting from Cosmetic Surgery.

• Court ordered services, or those required by court order as a condition of parole or probation.

• Custodial Care.

• Dental services including but not limited to, services related to the care, filling, removal or replacement of teeth and treatment of injuries to or diseases of the teeth, dental services related to the gums, apicoectomy (dental root resection), orthodontics, root canal treatment, soft tissue impactions, alveolectomy, augmentation and vestibuloplasty, treatment of periodontal disease, false teeth, prosthetic restoration of dental implants, and dental implants. This exclusion does not apply to:

• removal of bony impacted teeth, bone fractures, removal of tumors, and biopsy or excision of oral cysts.

• Emergency Services stabilize an acute injury to sound natural teeth, the jawbone or surrounding structures, if provided within 48 hours of the injury.
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- Surgical treatment of TMJ as described in the Covered Benefits Section “Temporomandibular Joint Syndrome (TMJ) Services”

- Dental anesthesia when provided according to the conditions described in the Covered Benefits Section, “Limited General Anesthesia for Dental Procedures”.

- Educational services and treatment of behavioral disorders, together with services for remedial education including evaluation or treatment of learning disabilities, minimal brain dysfunction, developmental and learning disorders including developmental and learning disorders associated with mental retardation, behavioral training, and cognitive rehabilitation. This includes services, treatment or educational testing and training related to behavioral (conduct) problems, learning disabilities, or developmental delays. Special education, including lessons in sign language to instruct a Member, whose ability to speak has been lost or impaired, to function without that ability, are not covered. This exclusion does not apply to Serious Emotional Disturbances of a Child as defined in Section 1374.72(e) of the California Health and Safety Code. Pervasive developmental disorder or autism is covered as Serious Mental Illness.

- Experimental or Investigational Procedures, or ineffective surgical, medical, psychiatric, or dental treatments or procedures, research studies, or other experimental or investigational health care procedures or pharmacological regimes as determined by HMO, unless pre-authorized by HMO.

This exclusion will not apply with respect to drugs:

1. that have been granted treatment investigational new drug (IND) or Group c/treatment IND status;
2. that are being studied at the Phase III level in a national clinical trial sponsored by the National Cancer Institute; or
3. HMO has determined that available scientific evidence demonstrates that the drug is effective or the drug shows promise of being effective for the disease.

- Hair analysis.

- Hearing aids.

- Home births.

- Home uterine activity monitoring.

- Household equipment, including but not limited to, the purchase or rental of exercise cycles, water purifiers, hypo-allergenic pillows, mattresses or waterbed, whirlpool or swimming pools, exercise and massage equipment, central or unit air conditioners, air purifiers, humidifiers, dehumidifiers, escalators, elevators, ramps, stair glides, emergency alert equipment, handrails, heat appliances, improvements made to a Member’s house or place of business, and adjustments to vehicles.

- Hypnotherapy, except when pre-authorized by HMO.

- The treatment of male or female Infertility, including but not limited to:
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1. The purchase of donor sperm and any charges for the storage of sperm;

2. The purchase of donor eggs and any charge associated with care of the donor required for donor egg retrievals or transfers or gestational carriers;

3. Charges associated with cryopreservation or storage of cryopreserved embryos (e.g., office, Hospital, ultrasounds, laboratory tests, etc.);

4. Home ovulation prediction kits;

5. Injectable Infertility medications, including but not limited to, menotropins, hCG, GnRH agonists, IVIG;

6. Artificial Insemination, including in vitro fertilization (IVF), gamete intrafallopian tube transfer (GIFT), zygote intrafallopian tube transfer (ZIFT), and intracytoplasmic sperm injection (ICSI), and any advanced reproductive technology (“ART”) procedures or services related to such procedures;

7. Any charges associated with care required for ART (e.g., office, Hospital, ultrasounds, laboratory tests, etc.);

8. Donor egg retrieval or fees associated with donor egg programs, including but not limited to fees for laboratory tests;

9. Any charge associated with a frozen embryo transfer including but not limited to thawing charges;

10. Reversal of sterilization surgery; and

11. Any charges associated with obtaining sperm for ART procedures.

- Military service related diseases, disabilities or injuries for which the Member is legally entitled to receive treatment at government facilities and which facilities are reasonably available to the Member.

- Missed appointment charges.

- Non-medically necessary services, including but not limited to, those services and supplies:

  1. which are not Medically Necessary, as determined by HMO, for the diagnosis and treatment of illness, injury, restoration of physiological functions, or covered preventive services;

  2. that do not require the technical skills of a medical, mental health or a dental professional;

  3. furnished mainly for the personal comfort or convenience of the Member, or any person who cares for the Member, or any person who is part of the Member’s family, or any Provider;

  4. furnished solely because the Member is an inpatient on any day in which the Member’s disease or injury could safely and adequately be diagnosed or treated while not confined;
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5. furnished solely because of the setting if the service or supply could safely and adequately be furnished in a Physician’s or a dentist’s office or other less costly setting.

- Orthotics and Orthopedic shoes or other supportive devices of the feet, except special footwear needed by a Member to prevent or treat diabetes related complications or special footwear needed by a Member with bony abnormalities and deformities with significant disfigurement preventing the use of conventional standard foot gear in cases of cerebral palsy, arthritis, polio, traumatic injuries, and congenital deformities.

- Outpatient supplies (except diabetic supplies), including but not limited to, outpatient medical consumable or disposable supplies such as syringes, incontinence pads, elastic stockings, and reagent strips.

- Payment for benefits for which Medicare or a third party payer is the primary payer.

- Personal comfort or convenience items, including those services and supplies not directly related to medical care, such as guest meals and accommodations, barber services, telephone charges, radio and television rentals, homemaker services, travel expenses, take-home supplies, and other like items and services.

- Prescription of non-prescription drugs and medicines, except as provided on an inpatient basis.

- Private duty or special nursing care, unless pre-authorized by HMO.

- Recreational, educational, and sleep therapy, including any related diagnostic testing except for the diagnosis and Medically Necessary treatment of sleep apnea.

- Religious, marital and sex counseling, including services and treatment related to religious counseling, marital/relationship counseling, and sex therapy.

- Reversal of voluntary sterilizations, including related follow-up care and treatment of complications of such procedures.

- Routine foot/hand care, including routine reduction of nails, calluses and corns.

- Services for which a Member is not legally obligated to pay in the absence of this coverage.

- Services for the treatment of sexual dysfunctions or inadequacies, including therapy, supplies, or counseling for sexual dysfunctions or inadequacies that do not have a physiological or organic basis.

- Services, including those related to pregnancy, rendered before the effective date or after the termination of the Member’s coverage, unless coverage is continued under the Continuation and Conversion section of this EOC.

- Services performed by a relative of a Member for which, in the absence of any health benefits coverage, no charge would be made.

- Services required by third parties, including but not limited to, physical examinations, diagnostic services and immunizations in connection with obtaining or continuing employment, obtaining or maintaining any license issued by a municipality, state, or federal government, securing insurance coverage, travel, school admissions or attendance, including examinations required to participate in athletics, except when such examinations are considered to be part of an appropriate schedule of wellness services.
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- Services which are not a **Covered Benefit** under this **EOC**, even when a prior **Referral** has been issued by a **PCP**.

- Specific non-standard allergy services and supplies, including but not limited to, skin titration (wrinkle method), cytotoxicity testing (Bryan’s Test), treatment of non-specific candida sensitivity, and urine autoinjections.

- Special medical reports, including those not directly related to treatment of the **Member**, e.g., employment or insurance physicals, and reports prepared in connection with litigation.

- Surgical operations, procedures or treatment of obesity, except when pre-authorized by **HMO**.

- Therapy or rehabilitation, including but not limited to, primal therapy, chelation therapy, rolfing, psychodrama, megavitamin therapy, purging, bioenergetic therapy, vision perception training, and carbon dioxide.

- **Thermograms and thermography**.

- **Transplant**-related services and supplies obtained from an **Institutes of Excellence**, including the harvesting of organs, bone marrow, tissue or stem cells for storage purposes.

- Transsexual surgery, sex change or transformation, including any procedure or treatment or related service designed to alter a **Member’s** physical characteristics from the **Member’s** biologically determined sex to those of another sex, regardless of any diagnosis of gender role or psychosexual orientation problems.

- Treatment in a federal, state, or governmental entity, including care and treatment provided in a non-participating **Hospital** owned or operated by any federal, state or other governmental entity, except to the extent required by applicable laws.

- Treatment of occupational injuries and occupational diseases, including those injuries that arise out of (or in the course of) any work for pay or profit, or in any way results from a disease or injury which does. If a **Member** is covered under a Workers’ Compensation law or similar law, and submits proof that the **Member** is not covered for a particular disease or injury under such law, that disease or injury will be considered “non-occupational” regardless of cause.

- Treatment and services provided by **Chiropractors**.

- Unauthorized services, including any service obtained by or on behalf of a **Member** without **Referral** issued by the **Member’s PCP** or pre-authorized by **HMO**. This exclusion does not apply in a **Medical Emergency**, in an **Urgent Care** situation, or when it is a direct access benefit.

- Vision care services and supplies, including orthoptics (a technique of eye exercises designed to correct the visual axes of eyes not properly coordinated for binocular vision) and radial keratotomy, including related procedures designed to surgically correct refractive errors except as provided in the **Covered Benefits** section of this **EOC**.

- **Weight reduction programs**, or dietary supplements.

- **Acupuncture and acupuncture therapy**, except when performed by a **Participating Provider** as a form of anesthesia in connection with covered surgery.
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- Temporomandibular joint disorder treatment (TMJ) including treatment performed by prosthesis placed directly on the teeth except as covered in the Covered Benefits Section.

B. Limitations.

- In the event there are 2 or more alternative Medical Services which in the sole judgment of HMO are equivalent in quality of care, HMO reserves the right to provide coverage only for the least costly Medical Service, as determined by HMO, provided that HMO approves coverage for the Medical Service or treatment in advance. Members may appeal HMO determinations as explained in the Complaints and Appeals and Independent Medical Review sections of this EOC.

- Determinations regarding eligibility for benefits, coverage for services, benefit denials and all other terms of this EOC are at the sole discretion of HMO, subject to the terms of this EOC. Determinations as to coverage for services and benefits will be made based upon Medical Necessity consistent with commonly accepted clinical practice guidelines. Members may appeal HMO determinations as explained in the Complaints and Appeals and Independent Medical Review sections of this EOC.

TERMINATION OF COVERAGE

A Member’s coverage under this EOC will terminate upon the earliest of any of the conditions listed below.

A. Termination of Subscriber Coverage.

A Subscriber’s coverage will terminate for any of the following reasons:

1. employment terminates;
2. the Group Agreement terminates;
3. the Subscriber is no longer eligible as outlined on the Schedule of Benefits; or
4. the Subscriber becomes covered under an alternative health benefit plan or under any other plan which is offered by, through, or in connection with, the Contract Holder in lieu of coverage under this EOC.

B. Termination of Dependent Coverage.

A Covered Dependent’s coverage will terminate for any of the following reasons:

1. a Covered Dependent is no longer eligible, as outlined in the Eligibility and Enrollment section of the EOC or in the Schedule of Benefits;
2. the Group Agreement terminates; or
3. the Subscriber’s coverage terminates;

C. Termination For Cause.

HMO may terminate coverage for cause:

1. upon 15 days advance written notice, if the Member has failed to make any required Premium payment which the Member is obligated to pay, as specified by Contract Holder. Member will
receive a written notice from HMO stating the amount of such required Premium payment and the date upon which the Member will be terminated if the required Premium payment is not received within the time frame specified in the notice. Upon the effective date of such termination, prepayments received by HMO from Contract Holder or Member on account of such terminated Member or Members for periods after the effective date of termination shall be refunded to the sender of such prepayments.

2. immediately, upon written notice, upon discovering a material misrepresentation by the Member in applying for or obtaining coverage or benefits under this EOC or discovering that the Member has committed fraud against HMO. This may include, but is not limited to, furnishing incorrect or misleading information to HMO, or allowing or assisting a person other than the Member named on the identification card to obtain HMO benefits. In the absence of fraud or material misrepresentation, all statements made by any Member or any person applying for coverage under this EOC will be deemed representations and not warranties. No statement made for the purpose of obtaining coverage will result in the termination of coverage or reduction of benefits unless the statement is contained in writing and signed by the Member, and a copy of same has been furnished to the Member prior to termination.

3. upon 15 days advance written notice, if a Member threatens the safety of HMO employees, Providers, Members, or other patients, or if the Member's repeated behavior has substantially impaired the HMO's ability to furnish or arrange services for the Member or other Members, or substantially impaired a Provider's ability to provide services to other patients.

D. Disenrollment by Member

If Member elects coverage under an alternative health benefits plan offered by or through Contract Holder as an option to coverage under HMO, Member's coverage terminates automatically at the time and date the alternate coverage becomes effective. Member and Contract Holder agree to notify HMO immediately that coverage has been elected elsewhere.

Members may voluntarily disenroll from HMO. Member may disenroll by notifying Contract Holder and/or HMO in writing of Member's intent to cancel Membership. Member's coverage terminates at midnight on the last day of the month during which HMO receives notice of intent to disenroll, or at midnight on the last day of the month for which Member requested cancellation.

E. Effective Date of Termination

Coverage as a Member ceases on the earlier of the following dates:

1. At midnight on the last day of the month in which Member was eligible for coverage according to the eligibility requirements as specified in the Eligibility and Enrollment section of the EOC and in the Schedule of Benefits.

2. At midnight on the termination date specified in the written notice of cancellation which will provide at least 15 days notice;

3. On the termination date established by HMO and Contract Holder as specified in the Group Agreement or as otherwise agreed by Contract Holder.

HMO shall have no further liability or responsibility under this EOC except for coverage for Covered Benefits provided prior to the date of termination of coverage.

The fact that Members are not notified by the Contract Holder of the termination of their coverage due to the termination of the Group Agreement shall not deem the continuation of a Members' coverage beyond the date coverage terminates.
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F. Member’s Right to Review

A Member may register a Complaint with HMO, as described in the Claim Procedures/Complaints and Appeals section of this EOC, after receiving notice that HMO has or will terminate the Member’s coverage as described in the Termination For Cause subsection of the EOC. HMO will continue the Member’s coverage in force until a final decision on the Complaint is rendered, provided the Premium is paid throughout the period prior to the issuance of that final decision. HMO may rescind coverage, to the date coverage would have terminated had the Member not registered a Complaint with HMO, if the final decision is in favor of HMO. If coverage is rescinded, HMO will refund any Premiums paid for that period after the termination date, minus the cost of Covered Benefits provided to a Member during this period.

Coverage will not be terminated on the basis of a Member’s health status or health care needs, nor because a Member has exercised the Member’s rights under the EOC’s Claim Procedures/Complaints and Appeals section to register a Complaint with HMO. If a Member believes their membership was terminated because of the Member’s health status or requirements for health care services, the Member may request a review by the Director of the California Department of Managed Health Care. The Complaint process described in the preceding paragraph pertains to those terminations affected pursuant to the Termination for Cause subsection of this EOC.

Members with questions concerning HIPAA may contact the Centers for Medicare & Medicaid Services (CMS) (formerly HCFA) at the following telephone number 1-800-633-4227. CMS has posted at its website a publication entitled: “Commonly Asked Questions and Answers for Consumers about the Provisions of Health Insurance Portability and Accountability Act of 1996” at the following Internet address: http://www.hcfa.gov/regs/hipaacer.htm. CMS may be contacted directly, by mail, at: Centers for Medicare & Medicaid Services, Attention: HIPAA Unit, 75 Hawthorne Street, Suite 401, San Francisco, CA 94105.

A. Continued Group Coverage (COBRA and Cal-COBRA)

Members may continue group health coverage under certain circumstances where coverage would otherwise terminate (“continuation coverage”). The Federal law pertaining to this coverage is the Consolidated Omnibus Reconciliation Act (“COBRA”). COBRA applies to employers with twenty (20) or more eligible employees. The California state law is the California Continuation Benefits Replacement Act (“Cal-COBRA”). Cal-COBRA applies to California small employers with fewer than twenty (20) eligible employees. Many of the provisions of COBRA and Cal-COBRA are the same, however some differences do exist.

B. COBRA Continuation Coverage.

COBRA is the Consolidated Omnibus Budget Reconciliation Act of 1985 and related amendments (“COBRA”). The description of COBRA which follows is intended only to summarize the Member’s rights under the law. Coverage provided under this EOC offers no greater COBRA rights than COBRA requires and should be construed accordingly. COBRA permits eligible Members or eligible Covered Dependents to elect to continue group coverage as follows:

Employees and their Covered Dependents will not be eligible for the continuation of coverage provided by this section if the Contract Holder is exempt from the provisions of COBRA.

1. Minimum Size of Group:
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The **Contract Holder** must have normally employed 20 or more employees on a typical business day during the preceding calendar year. This refers to the number of employees employed, not the number of employees covered by a health plan, and includes full-time and part-time employees.

2. Loss of coverage due to termination (other than for gross misconduct) or reduction of hours of employment:

   **Member** may elect to continue coverage for 18 months after eligibility for coverage under this EOC would otherwise cease.

3. Loss of coverage due to:

   a. divorce or legal separation, or
   
   b. **Subscriber's** death, or
   
   c. **Subscriber's** entitlement to Medicare benefits, or,
   
   d. cessation of **Covered Dependent** child status under the Eligibility and Enrollment section of this EOC:

   The **Member** may elect to continue coverage for 36 months after eligibility for coverage under this EOC would otherwise cease.

4. Continuation coverage ends at the earliest of the following events:

   a. the last day of the 18-month period.
   
   b. the last day of the 36-month period.
   
   c. the first day on which timely payment of **Premium** is not made subject to the Premiums section of the **Group Agreement**.
   
   d. the first day on which the **Contract Holder** ceases to maintain any group health plan.
   
   e. the first day, after the day COBRA coverage has been elected, on which a **Member** is actually covered by any other group health plan. In the event the **Member** has a preexisting condition, and the **Member** would be denied coverage under the new plan for a preexisting condition, continuation coverage will not be terminated until the last day of the continuation period, or the date upon which the **Member's** preexisting condition becomes covered under the new plan, whichever occurs first.
   
   f. the date, after COBRA coverage had been elected, when the **Member** is entitled to Medicare.

5. Extensions of Coverage Periods:

   a. The 18-month coverage period may be extended if an event which would otherwise qualify the **Member** for the 36-month coverage period occurs during the 18-month period, but in no event may coverage be longer than 36 months from the event which qualified the **Member** for continuation coverage initially.
   
   b. In the event that a **Member** is determined, within the meaning of the Social Security Act, to be disabled and notifies the **Contract Holder** within 60 days of the Social Security determination and before the end of the initial 18-month period, continuation
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Sample coverage for the Member and other qualified beneficiaries may be extended up to an additional 11 months for a total of 29 months. The Member must have become disabled during the first 60 days of the COBRA continuation coverage.

6. Responsibility of the Contract Holder to provide Member with notice of Continuation Rights:

   The Contract Holder is responsible for providing the necessary notification to Members, within the defined time period, as required by COBRA.

7. Responsibility to pay Premiums to HMO:

   The Subscriber or Member will only have coverage for the 60 day initial enrollment period if the Subscriber or Member pays the applicable Premium charges due within forty-five days of submitting the application to the Contract Holder.

8. Premiums due HMO for the continuation of coverage under this section shall be due in accordance with the procedures of the Premiums section of the Group Agreement and shall be calculated in accordance with applicable State laws and regulations.

9. Members whose coverage under COBRA is exhausted prior to 36 months from the date their COBRA continuation coverage began, may be eligible to continue coverage under Cal-COBRA for the remainder of 36 months from the date their COBRA coverage began. Members whose COBRA coverage terminated for reasons other than exhaustion of coverage, (for example if Member’s COBRA coverage was terminated for non-payment of premium) are not eligible for extension of benefits under Cal-COBRA. Notification of the opportunity to continue coverage under Cal-COBRA and instructions for application will be included in the notice to Members of the termination of their COBRA coverage. Additional information regarding eligibility and application for Cal-COBRA continuation coverage is provided in Section C “Cal-COBRA Continuation Coverage”.

C. Cal-COBRA Continuation Coverage

Under Cal-COBRA, a health plan such as HMO that contracts with California small employers who have 2-19 eligible employees, is required to provide Members with the opportunity to elect Cal-COBRA continuation coverage in certain circumstances where coverage would otherwise terminate (“qualifying events”). HMO will administer or contract for the administration of continuation coverage under Cal-COBRA. In order to obtain Cal-COBRA continuation coverage, Member and Contract Holder must provide HMO with certain notices as described below in Sections C2 and C3.

For a Member who begins receiving COBRA coverage on or after January 1, 2003, HMO will offer a Member who has exhausted continuation coverage under COBRA (if such coverage was for less than 36 months) the opportunity to continue coverage under Cal-COBRA for up to 36 months from the date the Member’s COBRA continuation coverage began. HMO will administer continuation coverage under Cal-COBRA. The notification requirements set forth in C2, do not apply to extension of COBRA under Cal-Cobra. Additional information about the opportunity to continue coverage under Cal-COBRA, notification requirements and instructions for application will be included in the notice to Members of the termination of their COBRA coverage.

Throughout this section the term “qualified beneficiaries” refers to Subscribers and/or Covered Dependents who, on the day before a qualifying event, are covered under this EOC.

1. Eligibility for Cal-COBRA Continuation Coverage
   a. Members may be Cal-COBRA qualified beneficiaries and eligible to continue group coverage for up to 36 months if Member’s group coverage terminates because of one or more of the following qualifying events:
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i. Termination of Subscriber’s employment (except when based on gross misconduct); or

ii. Reduction of Subscriber’s work hours below the minimum required to participate in the employer’s plan.

b. Covered Dependents may be Cal-COBRA qualified beneficiaries and eligible to continue group coverage if termination occurs because of the following qualifying events:

i. Subscriber’s death (coverage for Covered Dependents);

ii. Subscriber’s divorce or legal separation;

iii. Subscriber’s entitlement to benefits under the Federal Medicare program;

iv. Covered Dependent child’s loss of dependent status.

c. Additional qualifying events. An additional qualifying event occurs when

• a Member’s coverage under this EOC terminates according to the Termination of Coverage section of this EOC,

• the Member is already a qualified beneficiary and is continuing coverage under this EOC according to the provisions of this Cal-COBRA section

• and the reason for the termination is listed above under 1(b).

If a qualified beneficiary’s coverage terminates and the reason for the termination is an additional qualifying event, the qualified beneficiary is again eligible for continuation coverage. However, the Member must provide written notification of the additional qualifying event as described in section C2. Examples of additional qualifying events are:

i. Member is a qualified beneficiary as a Covered Dependent of a Subscriber eligible under item a. above, and later experiences an additional qualifying event as listed under item b.,

ii. Subscriber is determined within the meaning of the Social Security Act, to have become disabled within the first 60 days of continuation coverage and receives such notice while covered under Cal-COBRA.

iii. A Covered Dependent child is a qualified beneficiary because of the death of the Subscriber and looses eligibility because of age.

d. COBRA Coverage Is Exhausted. Members whose COBRA coverage began on or after January 1, 2003 and whose coverage under COBRA is exhausted prior to 36 months from the date their COBRA continuation coverage began may be eligible to continue coverage under Cal-COBRA for up to 36 months from the date their COBRA coverage began. Members whose COBRA coverage terminated for reasons other than exhaustion of coverage, (if Member’s COBRA coverage was terminated for non-payment of premium, for example) are not eligible for extension of benefits under Cal-COBRA.
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e. Childbirth or Adoption. Children born to or placed for adoption with a Subscriber who is a qualified beneficiary covered under Cal-COBRA may be enrolled for coverage within 30 days of birth or placement for adoption.

Under Cal-COBRA qualified beneficiaries receive the same benefits as other HMO Members in Member’s group, but may be required to pay health plan premiums.

For qualified beneficiaries whose coverage under Cal-COBRA began prior to January 1, 2003, coverage under Cal-COBRA will not extend beyond 18 months from the date a qualified beneficiary first becomes eligible for coverage under Cal-COBRA even if the qualified beneficiary experiences a second qualifying event. Coverage for children born to or placed for adoption with a Subscriber who is a qualified beneficiary will end 18 months from the date coverage began for their parent. The only exception is if the Subscriber is determined to have become disabled under Title II or Title XVI of the Social Security Act within the first 60 days of continuation coverage, in which case the continuation coverage may be extended to 29 months.

For qualified beneficiaries whose coverage under Cal-COBRA or COBRA began on or after January 1, 2003, coverage under Cal-COBRA will not extend beyond 36 months from the date a qualified beneficiary first becomes eligible for coverage under Cal-COBRA or COBRA, even if the qualified beneficiary experiences a second qualifying event. For example, if a Covered Dependent became covered under Cal-COBRA due to termination of the Subscriber’s employment, and 6 months later was divorced from the Subscriber, coverage would not extend beyond 36 months from the initial date of coverage under Cal-COBRA. Coverage for children born to or placed for adoption with a Subscriber who is a qualified beneficiary will end 36 months from the date coverage began for their parent.

2. Cal-COBRA Notification Requirements

If Subscriber’s coverage and/or coverage for Subscriber's Covered Dependents will terminate due to a reduction of Subscriber's work hours or termination of Subscriber’s employment, the Subscriber's employer must notify HMO within 30 days of the qualifying event. Notice will be sent by the employer to the HMO’s last known address. Subscriber and Covered Dependents will be disqualified from receiving Cal-COBRA benefits if Subscriber's employer does not provide HMO with notification as required by law and summarized in the Group Agreement.

If a Covered Dependent becomes eligible for continuation coverage for any reason other than the Subscriber's loss of coverage due to termination of employment or reduction in hours, the Covered Dependent must notify HMO in writing of the qualifying event, within 60 days of the qualifying event. Notification should be sent to

Aetna Health of California Inc.
Plan Sponsor Services CalCOBRA
1385 East Shaw Avenue
Fresno, CA 93710.

The request must be sent via first-class mail or other reliable means of delivery. Other reliable means of delivery may include personal delivery, express mail or private courier company.

If Covered Dependent(s) do not notify HMO within sixty (60) days of the qualifying event(s), Covered Dependent(s) will not receive Cal-COBRA benefits.
If a **Covered Dependent** is a qualified beneficiary due to a qualifying event under C.1.a. and subsequently experiences an additional qualifying event as listed in C.1.b., the **Covered Dependent** must provide written notification of the additional qualifying event as described above in order to remain eligible for coverage under Cal-COBRA.

If the **Subscriber** who is eligible for continuation coverage as described at C.1.a, is determined to have become disabled under Title II or Title XVI of the Social Security Act at any time during the first 60 days of continuation coverage, the **HMO** must be notified within 60 days of the date of the Social Security determination letter and prior to the end of the continuation coverage period in order for the **Subscriber** to continue to be eligible for Cal-COBRA continuation coverage. If **Subscriber** is eligible for extended continuation coverage as a result of a determination of disability, **Subscriber** must notify the **HMO** within thirty (30) days of a determination that the **Subscriber** is no longer disabled.

3. **Cal-COBRA Formal Election**

Within fourteen (14) days of receiving notification of a qualifying event, **HMO** will mail a Cal-COBRA information package to the last known address of the qualified beneficiary. The package will contain premium information, enrollment forms and the disclosures necessary to allow the qualified beneficiary(ies) to formally elect Cal-COBRA continuation benefits and will be sent to the qualified beneficiary’s last known address.

To continue group coverage under Cal-COBRA **Subscriber** or the qualified beneficiary(ies) must make a formal election by submitting a written request (returning the forms in the information packet) to **HMO** at

Aetna Health of California Inc.
Plan Sponsor Services CalCOBRA
1385 East Shaw Avenue
Fresno, CA 93710.

The request must be sent via first-class or other reliable means of delivery to ensure that it is received by **HMO** within sixty (60) days of the later of the following dates:

a. the date the qualified beneficiary receives notice of the ability to continue group coverage (the enrollment packet from the **HMO**); or;

b. the date the qualified beneficiary receives notice of the ability to continue group coverage as discussed above; or

c. the date coverage under the employer’s group health plan terminates or will terminate by reason of the qualifying event.

Other reliable means of delivery may include personal delivery, express mail or private courier company. If a formal election is not received by **HMO** within this time period, the otherwise qualified beneficiary(ies) will not receive Cal-COBRA benefits.

4. **Cal-COBRA Premium Payments**

Qualified beneficiaries who elect Cal-COBRA continuation coverage are required to pay health plan **Premiums** to **HMO**. The **Contract Holder** will no longer be making payments on the individuals’ behalf. **Premium** payments must be submitted in a timely fashion to satisfy all amounts due. The exact **Premium** amount required will be included in the information package sent by **HMO** after **HMO** receives notification from **Member** that a qualifying event has
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occurred. The first Cal-COBRA Premium payment must be received by HMO within forty-five (45) days of the date the qualified beneficiary(ies) formally elect(s) to continue coverage under Cal-COBRA. The first Premium payment must satisfy any required Premiums and all Premiums due. Failure to submit the correct premium amount within forty-five (45) days of formal written election will preclude the otherwise qualified beneficiary from receiving Cal-COBRA continuation coverage.

5. Termination of Cal-COBRA Coverage

Continuation coverage under Cal-COBRA will terminate when the first of the following occurs:

a. for qualified beneficiaries continuing coverage under Cal-COBRA because COBRA coverage has been exhausted, 36 months after the date the qualified beneficiaries’ coverage under COBRA began.

b. for qualified beneficiaries continuing coverage under Cal-COBRA according to any other qualification listed under C-1, 36 months from the date coverage under this EOC would have terminated. is qualified beneficiaries covered by reason of a determination of disability, whose coverage began prior to January 1, 2003. For these qualified beneficiaries will extend to 29 months from the date coverage under this EOC would have terminated.

c. at the end of the period for which premiums were made, if the qualified beneficiary ceases to make premium payments, or fails to make timely premium payments.

d. coverage terminates as set forth under the Termination of Coverage Section of this EOC.

e. the Contract Holder ceases to provide any group benefit plan to its employees.

f. the qualified beneficiary moves out of the Service Area or commits fraud or deception in the use of plan services.

g. the group contract between HMO and Contract Holder is terminated prior to the date the qualified beneficiary’s coverage would terminate. See section 6, “Cal-COBRA Continuation Coverage Upon Termination of Prior Group Health Plan” for information about electing continuation coverage under the subsequent group plan, if any.

6. Cal-COBRA Continuation Coverage Upon Termination of Prior Group Health Plan

If Subscriber and/or Covered Dependent(s) elect Cal-COBRA continuation coverage under Subscriber’s current plan, and it is later replaced by another group health plan, Subscriber and/or Covered Dependent(s) may continue Cal-COBRA for the period that would have remained covered under the prior group health plan had it not terminated. To continue coverage under the new group health plan, the qualified beneficiary(ies) must comply with the requirements pertaining to enrollment in, and payment of premiums to, the new group health plan within thirty (30) days of receiving notice of termination of the prior group health plan. Contract Holder is responsible for notifying all qualified beneficiaries at least thirty (30) days prior to terminating a group health plan under which qualified beneficiaries are receiving Cal-COBRA continuation coverage. Contract Holder must further provide all qualified beneficiaries with the premium information, enrollment forms, and disclosures necessary to allow qualified beneficiaries to continue coverage under other available group health plans.
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D. Continuation Coverage for Retired Subscribers and Spouses

When coverage under COBRA or Cal-COBRA ends, former employees and their spouses or former spouses who are qualified beneficiaries under COBRA or Cal-COBRA may be eligible for continuation of their coverage under the same terms and conditions as if the COBRA or Cal-COBRA coverage had remained in effect if:

- the former employee was employed by the Contract Holder for at least 5 years prior to termination of coverage, and
- the former employee is at least 60 years old.

The Contract Holder is required to notify the qualified former employee and their spouse or former spouse of their right to this continuation at least 180 days prior to the date coverage under COBRA or Cal-COBRA will end. The former employee, spouse or former spouse must notify the HMO in writing of their decision to elect to continue their health care coverage within 30 days prior to the date the COBRA or Cal-COBRA coverage ends.

Continuation of this coverage will end if the former employee, spouse, or former spouse fails to pay the required premiums by the date they are due, subject to the applicable grace period.

Coverage will also end on the earlier of:

- the date the Member reaches age 65;
- the date the Member is covered under any group health plan not maintained by the employer, regardless of whether that coverage is less valuable;
- the date the former employee becomes entitled to Medicare;
- for a spouse or former spouse, five years from the date on which the continuation coverage under COBRA or Cal-COBRA was scheduled to end for the spouse;
- the date on which the former employer terminates its Group Agreement with the HMO and ceases to provide coverage for any active employees.

E. Extension of Benefits Upon Total Disability.

Any Member who is Totally Disabled on the date coverage under this EOC terminates due to the termination of the contract between HMO and Contract Holder is covered in accordance with the EOC.

This extension of benefits shall only:

1. provide Covered Benefits that are necessary to treat medical conditions causing or directly related to the disability as determined by HMO; and

2. remain in effect until the earlier of the date that:
   a. the Member is no longer Totally Disabled;
   b. the Member has exhausted the Covered Benefits available for treatment of that condition;
   c. the Member has become eligible for coverage from another health benefit plan which does not exclude coverage for the disabling condition;
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d. after a period of 12 months in which benefits under such coverage are provided to the Member.

The extension of benefits shall not extend the time periods during which a Member may enroll for continuation or conversion coverage, expand the benefits for such coverage, nor waive the requirements concerning the payment of Premium for such coverage.

F Conversion Privilege.

The conversion privilege does not continue coverage under the Group Agreement. It permits the issuance of an individual health care coverage agreement (conversion coverage) under certain conditions.

Conversion is not initiated by HMO. The conversion privilege set forth in this subsection must be initiated by the eligible Member. The Contract Holder is responsible for giving notice of the conversion privilege in accordance with its normal procedures within 15 days of the termination of group coverage; however, in the event continuation coverage ceases pursuant to expiration of COBRA benefits as described in the COBRA Continuation Coverage section of this EOC, the Contract Holder shall notify the Member at some time during the 180-day period prior to the expiration of coverage.

1. Eligibility.

In the event a Member ceases to be eligible for coverage under this EOC and has been continuously enrolled for 3 months under HMO, such person may, within 63 days after termination of coverage under this EOC, convert to individual coverage with HMO, effective as of the date of such termination, without evidence of insurability provided that Member's coverage under this EOC terminated for one of the following reasons:

a. Coverage under this EOC was terminated, and was not replaced with continuous and similar coverage by the Contract Holder;

b. The Subscriber ceased to meet the eligibility requirements as described in the Eligibility and Enrollment section of this EOC, in which case the Subscriber and Subscriber's dependents who are Members pursuant to this EOC, if any, are eligible to convert;

c. A Covered Dependent ceased to meet the eligibility requirements as described in the Eligibility and Enrollment section of this EOC and on the Schedule of Benefits because of the Member's age or the death or divorce of Subscriber;

d. Continuation coverage ceased under any Continuation Coverage section of this EOC.

Any Member who is eligible to convert to individual coverage, may do so in accordance with the rules and regulations governing items such as initial payment, the form of the agreement and all terms and conditions thereunder as HMO may have in effect at the time of Member's application for conversion, without furnishing evidence of insurability. The conversion coverage will provide benefits no less than what is then required by, and no benefits contrary to, any applicable law or regulation. However, the conversion coverage may not provide the same coverage, and may be less than what is provided under the Group Agreement. Upon request, HMO or the Contract Holder will furnish details about conversion coverage.

2. A spouse has the right to convert upon the death of or divorce from the Subscriber and a Covered Dependent child has the right to convert upon reaching the age limit or upon death of the Subscriber (subject to the ability of minors to be bound by contract).
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3. **Members** who are eligible for Medicare at the time their coverage under this **EOC** is terminated are not eligible for conversion.

**CLAIM PROCEDURES**

**REVIEW OF REQUESTS FOR HEALTH CARE SERVICES**

The “Claims Procedures” section explains how the **HMO** complies with Federal Department of Labor (DOL) regulations for claim determinations and appeals, (CFR 29 2560). Additional California-specific information regarding complaints and appeals is provided in the Complaints and Appeals and Independent Medical Review sections which follow. The DOL Regulations define a claim as occurring whenever a **Member** or the **Member’s** authorized representative:

- requests pre-authorization as required by the plan from **HMO**;
- requests a **Referral** as required by the plan from a **Participating Provider**;
- requests payment for services or treatment; or
- requests concurrent or retrospective utilization review.

For an **HMO Member**, most claims do not require that the **Member** submit any forms. However, if a **Member** receives a bill for **Covered Benefits**, the bill must be submitted promptly to the **HMO** for payment. Send the itemized bill for payment with the **Member’s** identification number clearly marked to the address shown on the **Member’s** ID card, within 90 days of the date the **Covered Benefit** was received, unless it is not reasonably possible to do so. To be eligible for consideration as a **Covered Benefit**, the bill for any service or supply sought or received by a **Member** must submitted to and received by **HMO** no later than 12 months after the date the service was provided unless it can be shown that it was not reasonably possible to submit the bill and that the bill was submitted as soon as was reasonably possible.

The **HMO** will make a decision on the claim. For urgent care claims and pre-service claims, the **HMO** will send the **Member** written notification of the determination, whether adverse or not adverse. For retrospective review claims, the **HMO** will notify the member of the decision in writing no later than 30 days from the receipt of the information reasonably necessary to make the determination. For other types of claims, the **Member** may only receive notice if the **HMO** makes an adverse benefit determination.

Under Department of Labor regulations adverse benefit determinations are decisions made by the **HMO** that result in denial, reduction, or termination of a benefit or the amount paid for it. Adverse benefit determination also means a decision not to provide or to modify or delay a benefit or service. Adverse benefit determinations can be made for one or more of the following reasons:

- **Utilization Review.** **HMO** determines that the service or supply is not **Medically Necessary** or is an **Experimental or Investigational Procedure**; (Additional information about utilization review is located in the HMO Procedure section, item F, ‘Referrals and Pre-Authorization’.)

- **No Coverage.** **HMO** determines that a service or supply is not covered by the plan. A service or supply is not covered if it is not included in the list of **Covered Benefits**;

- A service or supply is excluded from coverage;

- An **HMO** benefit limitation has been reached; or

- **Eligibility.** **HMO** determines that the **Subscriber** or **Subscriber’s Covered Dependents** are not eligible to be covered by the **HMO**.
Written notice of an adverse benefit determination will be provided to the **Member** and/or **Member’s Provider** within the time frames provided below. The times are measured from the **HMO’s** receipt of the information reasonably necessary and requested by the **HMO** to make the determination. These time frames may be extended, if the **HMO** has requested information which has not been received or, consistent with good medical practice, has requested consultation with an expert reviewer, or requested an additional examination or additional tests. In these cases the **HMO** will notify the provider and the enrollee in writing of the reasons why a decision cannot be made within the required timeframes and the anticipated date the decision can be made. The notice of adverse benefit determination will provide the information required by California law that will assist the **Member** in making an **Appeal** of the adverse benefit determination, if the **Member** wishes to do so. Additional information regarding the **Member’s** rights to Independent Medical Review for regarding denial of services determined to be **Experimental** or **Investigative** may be found in the Independent Medical Review section, Item A.

California laws and rules regulate adverse benefit determinations as **Disputed Health Care Services** or **Coverage Determinations**. Please see the Complaints and Appeals section of this **EOC** for more information about **Complaints and Appeals**.

<table>
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<th>Type of Claim</th>
<th>HMO Time Frame for Decision</th>
<th>HMO Time Frame for Notification of an Adverse Benefit Determination</th>
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| Urgent Care Claim. A claim for medical care or treatment where delay could seriously jeopardize the life or health of the **Member**, the ability of the **Member** to regain maximum function; or subject the **Member** to severe pain that cannot be adequately managed without the requested care or treatment. | In a timely fashion appropriate to the nature of the condition not to exceed **72 hours** of HMO’s receipt of the information reasonably necessary to make decision. | 1. If HMO is in receipt of the information reasonably necessary to make a decision when claim is submitted, **as soon as possible but not later than 72 hours**.  
2. **HMO** will request any additional information necessary within 24 hours of receipt of claim. If information is received within 48 hours, **within 48 hours of receipt of information**.  
3. If information not received within 48 hours, **within 72 hours of the receipt of the initial request**. If notification of decision is provided orally, written or electronic notification provided within 3 calendar days after initial oral notification. |
| Pre-Service Claim. A claim for a benefit that requires pre-authorization of the benefit in advance of obtaining medical care. | In a timely fashion appropriate to the nature of the condition not to exceed **5 business days** of HMO’s receipt of the information reasonably necessary to make decision. | **Provider** notified within 24 hours of decision: **Member** notified of decision in writing within 2 business days, |
| Concurrent Care Claim Extension, Reduction or Termination. A request to extend, | In a timely fashion appropriate to the nature of the condition not to exceed **5 business days** | **Provider** notified within 24 hours of decision: **Member** notified in writing within 2 business days, |
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<td>reduce or terminate a course of treatment previously pre-authorized by HMO.</td>
<td>of HMO’s receipt of the information reasonably necessary to make decision.</td>
<td>In the case of decisions to terminate or reduce treatment, Member must be notified with adequate time for the Member to appeal, which time may be shorter than described above.</td>
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<tr>
<td>Post-Service Claim. A claim for a benefit that is not a pre-service claim.</td>
<td>Within 30 days of HMO’s receipt of the information reasonably necessary to make decision.</td>
<td>Within 30 calendar days is writing</td>
</tr>
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HMO has procedures for Members to use if they are dissatisfied with a decision that the HMO has made or with the operation of the HMO. The procedure the Member needs to follow will depend on the type of issue or problem the Member has.

- **Appeal.** An Appeal is a request to the HMO to reconsider an adverse benefit determination. The Appeal procedure for an adverse benefit determination has one level. An Appeal is a type of Complaint. If the Member is appealing a Disputed Health Care Service, the Member has the right to independent medical review in addition to the processes described in the Complaints and Appeals Section.

- **Complaint.** A Complaint is a written or oral expression of dissatisfaction regarding the HMO or the operation of the HMO and/or a Provider including quality of care concerns, and includes a grievance, dispute, request for reconsideration or Appeal made by an enrollee or the enrollee’s representative.

A. **Complaints.**

If the Member is dissatisfied with the administrative services the Member receives from the HMO, or wants to complain about a Participating Provider, call or write Member Services within 180 calendar days of the incident. The Member will need to include a detailed description of the matter and include copies of any records or documents that the Member thinks are relevant to the matter. The HMO will review the information and provide the Member with a written response within 30 calendar days of the receipt of the Complaint. The response will tell the Member what the Member needs to do to seek an additional review.

B. **Appeals of Adverse Benefit Determinations.**

The Member will receive written notice of an adverse benefit determination (including Coverage Decisions and Disputed Health Care Service decisions) from the HMO. The notice will include the reason for the decision and it will explain what steps must be taken if the Member wishes to Appeal. The notice will also identify the Member’s rights to receive additional information that may be relevant to an Appeal. Requests for an Appeal must be made in writing within 180 calendar days from the date of the notice.
A Member may also choose to have another person (an authorized representative) make the Appeal on the Member’s behalf by providing the HMO with written consent. However, in case of an urgent care claim or a pre-service claim, a Physician may represent the Member in the Appeal.

The following chart summarizes some information about how the Appeals are handled for different types of claims.

<table>
<thead>
<tr>
<th>Type of Claim</th>
<th>HMO Response Time from Receipt of Appeal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urgent Care Claim</td>
<td>Within 36 hours Review provided by personnel not involved in making the adverse benefit determination.</td>
</tr>
<tr>
<td>Pre-Service Claim</td>
<td>Within 15 calendar days Review provided by personnel not involved in making the adverse benefit determination.</td>
</tr>
<tr>
<td>Concurrent Care Claim Extension</td>
<td>Treated like an urgent care claim or a pre-service claim depending on the circumstances</td>
</tr>
<tr>
<td>Post-Service Claim</td>
<td>Within 30 calendar days Review provided by personnel not involved in making the adverse benefit determination.</td>
</tr>
</tbody>
</table>

C. Exhaustion of Process.

The foregoing procedures and process are mandatory and must be exhausted prior to: the establishing of any litigation or arbitration, or any administrative proceeding regarding either any alleged breach of the Group Agreement or EOC by HMO, or any matter within the scope of the Complaints and Appeals process.

D. Record Retention.

HMO shall retain the records of all Complaints and Appeals for a period of at least 7 years.

E. Fees and Costs.

Nothing herein shall be construed to require HMO to pay counsel fees or any other fees or costs incurred by a Member in pursuing a Complaint or Appeal.
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F. Review by Governmental Agencies.

The following is a notice that the HMO is required to provide to Members that tells how to contact the HMO and the Department of Managed Health Care. A Member has the right to submit unresolved Complaints and Appeals to the California Department of Managed Health Care for review after either completing the complaints and appeals process described above or participating in the process for at least 30 days.

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

INDEPENDENT MEDICAL REVIEW

Members have the right to an independent review of decisions by the HMO to deny, modify or delay coverage for health care service(s) based on Medical Necessity (Disputed Health Care Services). Members have the right to an independent medical review of decisions by the HMO to deny coverage for health care services which have been determined by the HMO to be excluded as Experimental and Investigative. Additional information about treatments which will not be excluded as Experimental and Investigational can be found under item G Transplant Benefits and Item X Additional Benefits – Clinical Cancer Trials, in the Covered Benefits section of the EOC. Section A below describes how Members may request Independent Medical Review for certain Experimental and Investigative treatments related to Life-Threatening or Seriously Debilitating Illnesses. The Department of Managed Health Care will manage the independent medical review process, which is available to Members when they meet the criteria developed by the Department of Managed Health Care. Members are not required to pay any application or processing fees to request or receive independent medical review. Independent medical review is available in addition to HMO Complaint and Appeal procedures and any other remedies available to the Member by law. Members should be aware that the decision not to participate in the independent medical review process may cause the Member to forfeit any statutory right to pursue legal action against the HMO regarding a Disputed Health Care Service.

A. Independent Medical Review Procedure for Experimental and Investigational Treatment

Members have the right to request an independent medical review when coverage is denied as an Experimental or Investigational Procedure and the following conditions are met:

1. The Member has a Life-Threatening or Seriously Debilitating Illness; and

2. The Member’s Physician certifies that the Member has a condition, described in 1. above, for which
   a) standard therapies have not been effective in improving the condition of the Member, or
   b) standard therapies would not be medically appropriate, or
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c) there is no more beneficial standard therapy covered by the plan than the therapy proposed by the Physician, and

3) the Member’s Participating Physician has certified in writing that the proposed procedure, device, drug or other therapy is more likely to be more beneficial to the Member than any available standard therapies, or

4) the Member, or the Member’s Physician (who is a licensed, board-certified or board-eligible Physician, qualified to practice in the area of practice appropriate to treat the Member’s condition) has provided to HMO a written statement which certifies that, based on two documents from Medical and Scientific Evidence the requested, drug, device, procedure or therapy is likely to be more beneficial to the Member than any available standard therapy. The Physician or the Member must identify the documents relied upon as Medical and Scientific Evidence as part of the written certification.

When coverage for a requested service is denied as Experimental and Investigative, the HMO must notify the Member in writing, within five business days of the date of the decision to deny coverage, of the Member’s right to request independent medical review, of the forms and instructions necessary to apply to the Department of Managed Health Care for independent medical review of the HMO’s decision. The Member will need to demonstrate to the Department of Managed Health Care that they meet criteria (1), (2) and (3), or criteria (1) and (4).

The independent medical review will be a review of the specific medical and scientific reasons cited by the HMO for the denial of coverage. The review will be done at no cost to the Member. The Department of Managed Health Care will evaluate the Member’s request and decide whether the Complaint qualifies for independent medical review. The Department of Managed Health Care will notify the Member and the HMO of its decision. Within three business days of notification from the Department of Managed Health Care that the Member’s request for independent medical review has been approved, the HMO must provide the independent entity performing the review with the medical records relevant to the Member’s condition, a copy of the relevant documents used by the HMO in determining whether the proposed treatment is covered, and any other information submitted to the HMO by the Member or the Member’s Physician in support of the request for coverage.

If the Member’s Provider determines that the effectiveness of either the proposed treatment or any alternative treatment covered under this EOC would be materially reduced if not provided at the earliest possible date, the review shall be done within 7 business days of the date of the request and the HMO shall submit the above referenced documents within 24 hours of the Department of Managed Health Care’s notification to the HMO that the Member’s Complaint qualifies for expedited independent medical review.

B. Independent Medical Review Procedure for Disputed Health Care Services

As part of the Complaint and Appeal process, Members have the right to an independent medical review of their Appeal, when they believe that health care services have been improperly denied, modified, or delayed because they are not Medically Necessary (a Disputed Health Care Service), and the conditions listed below are met.

1. The Member has filed an Appeal regarding a Disputed Health Care Service.

2. The Member has participated in the HMO Complaint and Appeal process for 30 days or the HMO has responded to the Member’s Appeal by upholding the HMO’s denial of the Disputed Health Care Service. In cases involving an expedited complaint or appeal the Member is not required to participate in the HMO Complaint and Appeal process for more than three days.
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3. Either, the Member’s Provider (who may be a non-participating Provider, subject to the conditions noted below) must have recommended the health care service as medically necessary; or the Member received Urgent Care or Emergency Services that a Provider deemed medically necessary,

4. Or, the Member has been seen by a Participating Provider for the diagnosis or treatment of the medical condition for which the Member seeks independent review. Upon request by a Member, HMO will expedite access to a Participating Provider. Note that the Member may request independent medical review for the Disputed Health Care Service whether or not the Participating Provider recommends the service.

Members may request an independent medical review for services recommended or performed by a Non-Participating Provider, but the HMO has no liability to pay for the services of a Non-Participating Provider unless the Member has been referred to the Non-Participating Provider according to the requirements set forth in this EOC.

When the HMO receives notice from the Department of Managed Health Care approving the Member’s request for an independent medical review, it will submit the documents required by Health and Safety section 1374.30(n) within 3 business days. HMO will concurrently provide a copy of these documents to the Member and the Member’s Provider.

In the event of the imminent and serious threat to the health of the Member, the HMO will deliver the required documents to the Independent Medical Review Organization within 24 hours of receipt of notification of the Department of Managed Health Care’s approval of the Member’s request.

C  Department of Managed Health Care and Independent Medical Review.

If the Member wishes to pursue independent medical review the Member should complete the form which the Member will have received from the HMO and send it (in the envelope provided with the form and instructions) to the Department of Managed Health Care. The Department will review the Member’s request and determine whether the Member meets the criteria for independent medical review and therefore, is eligible for independent medical review. If the Department of Managed Health Care approves the Member’s request, the Member’s Appeal will be submitted to the Independent Medical Review Organization for review by a medical specialist, or a panel of medical specialists. The designated specialist or panel of specialists will make an independent determination of whether or not the care which is the subject of the Appeal is medically necessary, or does not qualify for exclusion as an Experimental and Investigative Procedure. The Member will receive a copy of the independent medical review assessment of the Appeal. If the outcome of the independent medical review is that the care requested is medically necessary or does not qualify as Experimental and Investigative, the HMO will cover the provision of the health care services which were the subject of the Appeal.

For non urgent cases, the independent medical review organization must provide its determination within 30 days of receiving the Member’s application and supporting documents. For cases which qualify for expedited review, the Independent Medical Review Organization must provide its determination within 3 business days.

Upon notification of an independent medical review decision that the health care services under review are medically necessary, HMO will promptly take the actions necessary to comply with the decision.

BINDING ARBITRATION

Binding arbitration is the final process for resolving any disputes between Interested Parties arising from or related to HMO coverage, whether stated in tort, contract or otherwise. This includes (but is not limited to) disputes involving alleged professional liability or medical malpractice (that is, whether any medical services were
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unnecessary or unauthorized or were improperly, negligently or incompetently rendered). Interested Parties are Contract Holder, Members, the heirs-at-law or personal representative(s) of a Member, a Participating Provider and HMO, including any affiliates agents, employees or subcontractors of an Interested Party. This agreement to arbitrate shall be specifically enforced even if a party to the arbitration is also a party to another proceeding with a third party arising out of the same matter. All Interested Parties are giving up their constitutional right to have their dispute decided in a court of law before a jury, and instead are accepting the use of binding arbitration. This means that Interested Parties will not be able to try their case in court.

Unless otherwise agreed by the parties to the arbitration, all disputes shall be submitted to neutral arbitration within the HMO Service Area to the American Arbitration Association (AAA) or such other neutral dispute resolution organization as mutually agreed by the parties. The AAA can be reached by calling (213) 383-6516 (Los Angeles), (415) 981-3901 (San Francisco), or (619) 239-3051 (San Diego). If the AAA declines the case or the parties do not agree on an alternative organization, then a neutral arbitrator shall be appointed upon petition to the court under California Code of Civil Procedure Section 1281.6. The arbitration shall occur in the Member's choice of Los Angeles, San Francisco, or San Diego unless otherwise agreed or determined by the arbitrator.

The parties will share equally the arbitrator's fee, if any, as well as any administrative fee, unless otherwise assessed by the arbitrator. If AAA is chosen as the neutral arbitrator, it shall follow AAA rules regarding payment of fees. In cases of extreme hardship to a Member, the Member may request at any time that the arbitrator or dispute resolution organization may allocate all or a portion of the Member's share of the arbitrator's fees and expenses to HMO. For more information regarding this arbitration process, please call the HMO phone number located on the Member's ID card.

The arbitrator will establish the procedures which will govern the arbitration, including procedures concerning discovery. The arbitrator is bound by applicable state and federal law and regulations and shall issue a written opinion setting forth findings of fact, conclusions of law and the basis of the decision. The arbitrator is authorized to award equitable as well as legal relief to the extent permitted by law. The parties expressly agree and covenant to be bound by the decision of the arbitrator as a final determination of the matter in dispute, subject only to such grounds as are available to challenge an arbitration decision under California law. This arbitration provision is subject to enforcement and interpretation under the Federal Arbitration Act.

LIMITATIONS ON REMEDIES

A. No Jury Trial

In any dispute arising from or related to HMO coverage, there shall be no right to a jury trial. The right to trial by a jury is expressly waived.

B. Medical Malpractice Claims

Any claim alleging wrongful acts or omissions of Participating Providers shall not include HMO and shall include only Participating Providers subject to the allegation. Members waive their right to bring any such claim against HMO as a party in any such claim.

C. Punitive Damages

Any award of punitive damages must be authorized by and recoverable under all applicable law, be based upon clear and convincing evidence of outrageous conduct by HMO, and bear reasonable relationship to actual recoverable damages. No punitive damages related to the denial or the reduction of benefits or payment shall be recoverable where the Member has not pursued external independent medical review where available, the External Reviewer has confirmed the HMO's decision, or the HMO has abided by the decision of the External Reviewer.

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D. Class Actions

No Member may participate in a representative capacity or as a member of any class of claimants in any proceeding arising from or related to HMO coverage. Claims brought by any Member (including his/her Covered Dependents) may not be joined or consolidated with claims brought by any other Member(s) unless otherwise agreed to in writing by HMO. Any right to participate in a class or in a representative capacity, or to join or consolidate claims with other parties, is expressly waived.

COORDINATION OF BENEFITS

Definitions. When used in this provision, the following words and phrases have the following meaning:

Allowable Expense. A health care service or expense, including coinsurance and Copayments, that is covered at least in part by any of the Plans covering the Member. When a Plan provides benefits in the form of services the reasonable cash value of each service will be considered an Allowable Expense and a benefit paid. An expense or service that is not covered by any of the Plans is not an Allowable Expense. The following are examples of expenses and services that are not Allowable Expenses:

1. If a Member is confined in a private Hospital room, the difference between the cost of a semi-private room in the Hospital and the private room (unless the Member’s stay in the private Hospital room is Medically Necessary in terms of generally accepted medical practice, or one of the Plans routinely provides coverage of Hospital private rooms) is not an Allowable Expense.

2. If a Member is covered by 2 or more Plans that compute their benefit payments on the basis of Reasonable Charge, any amount in excess of the highest of the Reasonable Charges for a specific benefit is not an Allowable Expense.

3. If a Member is covered by 2 or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable Expense.

4. The amount a benefit is reduced by the Primary Plan because a Member does not comply with the Plan provisions. Examples of these provisions are second surgical opinions, pre-authorization of admissions, and preferred provider arrangements.

If a Member is covered by 1 Plan that calculates its benefits or services on the basis of Reasonable Charges and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary Plan’s payment arrangements shall be the Allowable Expense for all the Plans.

Claim Determination Period. The calendar year.

Closed Panel Plan(s). A Plan that provides health benefits to Members primarily in the form of services through a panel of Providers that have contracted with or are employed by the Plan, and that limits or excludes benefits for services provided by other Providers, except in cases of Emergency Services or Referral by a panel Provider.

Coordination of Benefits (COB). A provision that is intended to avoid claims payment delays and duplication of benefits when a person is covered by 2 or more plans. It avoids claims payment delays by establishing an order in which plans pay their claims and providing the authority for the orderly transfer of information needed to pay claims promptly. It may avoid duplication of benefits by permitting a reduction of the benefits of a plan when, by the rules established by this provision, it does not have to pay its benefits first.

Custodial Parent. A parent awarded custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than one half of the calendar year without regard to any temporary visitation.

Medicare. The health insurance provided by Title XVIII of the Social Security Act, as amended. It includes HMO or similar coverage that is an authorized alternative to Parts A and B of Medicare.
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**Plan(s).** Any Plan providing benefits or services by reason of medical or dental care or treatment, which benefits or services are provided by one of the following:

1. Group, blanket, or franchise health insurance policies issued by insurers, including health care service contractors;
2. Other prepaid coverage under service plan contracts, or under group or individual practice;
3. Uninsured arrangements of group or group-type coverage;
4. Labor-management trusted plans, labor organization plans, employer organization plans, or employee benefit organization plans;
5. Other group-type contracts. Group type contracts are those which are not available to the general public and can be obtained and maintained only because membership in or connection with a particular organization or group.

If the contract includes both medical and dental benefits or services, will be considered separate Plans. The Medical/Pharmacy coverage will be coordinated with other Medical/Pharmacy Plans. In turn, the dental coverage will be coordinated with other dental Plans.

**Plan Expenses.** Any necessary and reasonable health expenses, part or all of which are covered under this Plan.

**Primary Plan/Secondary Plan.** The order of benefit determination rules state whether coverage under this EOC is a Primary Plan or Secondary Plan as to another Plan covering the Member.

When coverage under this EOC is a Primary Plan, its benefits are determined before those of the other Plan and without considering the other Plan's benefits.

When coverage under this EOC is a Secondary Plan, its benefits are determined after those of the other Plan and may be reduced because of the other Plan's benefits.

When there are more than 2 Plans covering the person, coverage under this EOC may be a Primary Plan as to 1 or more other Plans, and may be a Secondary Plan as to a different Plan(s).

This Coordination of Benefits (COB) provision applies to this EOC when a Subscriber or the Covered Dependent has medical and/or dental coverage under more than 1 Plan.

**The Order of Benefit Determination Rules below determines which Plan will pay as the Primary Plan.** The Primary Plan pays first without regard to the possibility that another Plan may cover some expenses. A Secondary Plan pays after the Primary Plan and may reduce the benefits it pays so that payments from all group Plans do not exceed 100% of the total Allowable Expense.

**Order of Benefit Determination.**

When 2 or more Plans pay benefits, the rules for determining the order of payment are as follows:

A. The Primary Plan pays or provides its benefits as if the Secondary Plan(s) did not exist.

B. A Plan that does not contain a COB provision that is consistent with this provision is always primary. There is one exception: coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits may provide that the supplementary coverage shall be excess to any other parts of the Plan provided by the Contract Holder. Examples of this type of exception are major medical coverage's that are superimposed over base plan providing Hospital and surgical services.
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benefits, and insurance type coverage’s that are written in connection with a Closed Panel Plan to provide out-of-network benefits.

C. A Plan may consider the benefits paid or provided by another Plan in determining its benefits only when it is secondary to that other Plan.

D. The first of the following rules that describes which Plan pays its benefits before another Plan is the rule which will govern:

1. Non-Dependent or Dependent. The Plan that covers the person other than as a dependent, for example as an employee, Subscriber or retiree is primary and the Plan that covers the person as a dependent is secondary. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering the person as a dependent; and primary to the Plan covering the person as other than a dependent (e.g. a retired employee); then the order of benefits between the 2 Plans is reversed so that the Plan covering the person as an employee, Subscriber or retiree is secondary and the other Plan is primary.

2. Dependent Child Covered Under More Than One Plan. The order of benefits when a child is covered by more than one Plan is:
   a. The Primary Plan is the Plan of the parent whose birthday is earlier in the year if:
      • The parents are married;
      • The parents are not separated (whether or not they ever have been married); or
      • A court decree awards joint custody without specifying that 1 party has the responsibility to provide health care coverage.

     If both parents have the same birthday, the Plan that covered either of the parents longer is primary.

   b. If the specific terms of a court decree state that one of the parents is responsible for the child’s health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to Claim Determination Periods or Plan years commencing after the Plan is given notice of the court decree.

   c. If the parents are not married, or are separated (whether or not they ever have been married) or are divorced, the order of benefits is:
      • The Plan of the Custodial Parent;
      • The Plan of the spouse of the Custodial Parent;
      • The Plan of the non-custodial parent; and then
      • The Plan of the spouse of the non-custodial parent.

3. Active or Inactive Employee. The Plan that covers a person as an employee who is neither laid off nor retired, is the Primary Plan. That Plan is also the Primary Plan if a person is a dependent of a person covered as a retiree and an employee, who is neither laid off nor retired. This means that a Plan that covers a Member as an employee, or the Covered Dependent of the Member is the Primary Plan in relation to a Plan that covers the Member as a laid-off or retired employee or dependent of the Member. If the other Plan does not have this rule, and if, as a
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result, the Plans do not agree on the order of benefits, this rule is ignored. Coverage provided to an individual as a retired worker and as a dependent of an actively working spouse will be determined under the above rule labeled D(1).

4. **Continuation Coverage.** If a person whose coverage is provided under a right of continuation provided by federal or state law also is covered under another Plan, the Plan covering the person as an employee, Member, Subscriber or retiree (or as that person’s dependent) is primary, and the continuation coverage is secondary. If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule is ignored.

5. **Longer or Shorter Length of Coverage.** The Plan that covered the person as an employee, Member or Subscriber longer is primary.

6. **If the preceding rules do not determine the Primary Plan,** the Allowable Expenses shall be shared equally between the Plan’s meeting the definition of Plan under this section. In addition, this Plan will not pay more than it would have paid had it been primary.

Effect On Benefits Of This EOC.

A. When this Plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Plans during a Claim Determination Period are not more than 100% of total Allowable Expenses. The difference between the benefit payments that this Plan would have paid had it been the Primary Plan, and the benefit payments that it actually paid or provided shall be recorded as a benefit reserve for the Member and used by this Plan to pay any Allowable Expenses not otherwise paid during the claim determination period. As each claim is submitted, this Plan will:

1. Determine its obligation to pay or provide benefits under its contract;
2. Determine whether a benefit reserve has been recorded for the Member; and
3. Determine whether there are any unpaid Allowable Expenses during that Claims Determination Period.

B. If a Member is enrolled in 2 or more Closed Panel Plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by 1 Closed Panel Plan, COB shall not apply between that Plan and other Closed Panel Plans.

Multiple Coverage Under This Plan.

If a Member is covered under this Plan both as a Subscriber and a Covered Dependent or as a Covered Dependent of 2 Subscribers, the following will also apply:

• The Member’s coverage in each capacity under this Plan will be set up as a separate “Plan”.

• The order in which various Plans will pay benefits will apply to the “Plans” set up above and to all other Plans.

• This provision will not apply more than once to figure the total benefits payable to the person for each claim under this Plan.

Right to Receive and Release Needed Information.

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits under this Plan and other Plans. Any person claiming benefits under this Plan shall furnish such information as may be necessary to implement this provision. HMO has the right to release or obtain any information it considers necessary in order to administer this provision.

Facility of Payment.
Any payment made under another Plan may include an amount which should have been paid under coverage under this EOC. If so, HMO may pay that amount to the organization, which made that payment. That amount will then be treated as though it were a benefit paid under this EOC. HMO will not have to pay that amount again. The term “payment made” includes reasonable cash value of the benefits provided in the form of services.

Right of Recovery.

If the amount of the payments made by HMO is more than it should have paid under this COB provision, it may recover the excess from one or more of the persons it has paid or for whom it has paid; or any other person or organization that may be responsible for the benefits or services provided for the Member. The “amount of the payments made” includes the reasonable cash value of any benefits provided in the form of services.

EFFECT OF MEDICARE ON COVERAGE UNDER THIS EOC

When the Member is eligible for Medicare, benefits under this EOC are reduced by any benefits the Member is entitled to under Medicare or would have been entitled to if enrolled in Medicare, in accordance with Medicare’s rules regarding whether Medicare is the primary or secondary payor.

A Member is eligible for Medicare any time the Member is covered or eligible for coverage under Medicare. Members are considered to be eligible for Medicare if they:

1. Are covered under Medicare;
2. Are eligible for Medicare and have refused to enroll.
3. Have terminated coverage under Medicare; or
4. Have failed to make proper request for coverage under Medicare.

THIRD PARTY LIABILITY AND RIGHT OF RECOVERY

If HMO provides health care benefits under this EOC to a Member for injuries or illness for which a third party is or may be responsible, then HMO retains the right to repayment (a lien), to the extent permitted by law, for the value of all benefits provided by HMO that are associated with the injury or illness for which the third party is or may be responsible, plus the costs to perfect the lien. This right of recovery applies to any recoveries made by or on behalf of the Member from the following third-party sources, as allowed by law, including but not limited to: payments made by a third-party tortfeasor or any insurance company on behalf of the third-party tortfeasor; any payments or awards under an uninsured or underinsured motorist coverage policy; any Workers’ Compensation or disability award or settlement; medical payments coverage under any automobile policy, premises or homeowners medical payments coverage or premises or homeowners insurance coverage; any other payments from a source intended to compensate a Member for injuries resulting from alleged negligence of a third party. In some cases, Participating Providers may also assert the HMO’s lien. Some Providers also have lien rights that are independent of the HMO’s rights stated in this section.

The Member specifically acknowledges HMO’s right of reimbursement. This right of reimbursement attaches, to the fullest extent permitted by law, when HMO has provided health care benefits for injuries or illness for which a third party is or may be responsible and the Member and/or the Member’s representative has recovered any amounts from the third party or any party making payments on the third party’s behalf. By using any benefit under this EOC, Member grants, to the extent permitted by law, an assignment of the proceeds of any settlement, judgment or other payment received by the Member to the extent of the value of all benefits provided by HMO.

The Member and the Member’s representatives further agree to:
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A. Notify HMO promptly and in writing when notice is given to any third party of the intention to investigate or pursue a claim to recover damages or obtain compensation due to injuries or illness sustained by the Member that may be the legal responsibility of a third party; and

B. Cooperate with HMO and do whatever is necessary to secure HMO's rights of reimbursement under this EOC; and

C. Give HMO a first-priority lien on any recovery, settlement or judgment or other source of compensation, which may be had from a third party to the extent permitted by law of the value of all benefits associated with injuries or illness provided by HMO for which a third party is or may be responsible (regardless of whether specifically set forth in the recovery, settlement, judgment or compensation agreement); and

D. Pay, as the first priority, from any recovery, settlement or judgment or other source of compensation, the portion of any and all amounts due HMO as permitted by law as reimbursement for the value of all benefits associated with injuries or illness provided by HMO for which a third party is or may be responsible (regardless of whether specifically set forth in the recovery, settlement, judgment, or compensation agreement), unless otherwise agreed to by HMO in writing; and

E. Do nothing to prejudice HMO's rights as set forth above. This includes, but is not limited to, refraining from making any settlement or recovery which specifically attempts to reduce or exclude the full cost of all benefits provided by HMO.

RESPONSIBILITY OF MEMBERS

A. Members or applicants shall complete and submit to HMO such application or other forms or statements as HMO may reasonably request. Members represent that all information contained in such applications, forms and statements submitted to HMO incident to enrollment under this EOC or the administration herein shall be true, correct, and complete to the best of the Member's knowledge and belief.

B. The Member shall notify HMO immediately of any change of address for the Member or any of the Member's Covered Dependents, unless a different notification process is agreed to between HMO and Contract Holder.

C. The Member understands that HMO is acting in reliance upon all information provided to it by the Member at time of enrollment and afterwards and represents that information so provided is true and accurate.

D. By electing coverage pursuant to this EOC, or accepting benefits hereunder, all Members who are legally capable of contracting, and the legal representatives of all Members who are incapable of contracting, at time of enrollment and afterwards, represent that all information so provided is true and accurate and agree to all terms, conditions and provisions hereof.

E. Members are subject to and shall abide by the rules and regulations of each Provider from which benefits are provided.

GENERAL PROVISIONS

A. Identification Card. The identification card issued by HMO to Members pursuant to this EOC is for identification purposes only. Possession of an HMO identification card confers no right to services or benefits under this EOC, and misuse of such identification card may be grounds for termination of Member's coverage pursuant to the Termination of Coverage section of this EOC. If the Member who misuses the card is the Subscriber, coverage may be terminated for the Subscriber as well as any of the Covered Dependents. To be eligible for services or benefits under this EOC, the holder of the card must...
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be a Member on whose behalf all applicable Premium charges under this EOC have been paid. Any person receiving services or benefits which such person is not entitled to receive pursuant to the provisions of this EOC shall be charged for such services or benefits at billed charges.

If any Member permits the use of the Member’s HMO identification card by any other person, such card may be retained by HMO, and all rights of such Member and their Covered Dependents, if any, pursuant to this EOC shall be terminated immediately, subject to the Complaint procedure set forth in the Complaints and Appeals/Independent Medical Review sections of this EOC.

B. Reports and Records. HMO is entitled to receive from any Provider of services to Members, information reasonably necessary to administer this EOC subject to all applicable confidentiality requirements as defined in the General Provisions section of this EOC. By accepting coverage under this EOC, the Subscriber, for himself or herself, and for all Covered Dependents covered hereunder, authorizes each and every Provider who renders services to a Member hereunder to:

1. disclose all facts pertaining to the care, treatment and physical condition of the Member to HMO, or a medical, dental, or mental health professional that HMO may engage to assist it in reviewing a treatment or claim;

2. render reports pertaining to the care, treatment and physical condition of the Member to HMO, or a medical, dental, or mental health professional that HMO may engage to assist it in reviewing a treatment or claim; and

3. permit copying of the Member’s records by HMO.

C. Refusal of Treatment. A Member may, for personal reasons, refuse to accept procedures, medicines, or courses of treatment recommended by a Participating Provider. If the Participating Provider (after a second Participating Provider’s opinion, if requested by Member) believes that no professionally acceptable alternative exists, and if after being so advised, Member still refuses to follow the recommended treatment or procedure, neither the Participating Provider, nor HMO, will have further responsibility to provide any of the benefits available under this EOC for treatment of such condition or its consequences or related conditions. HMO will provide written notice to Member of a decision not to provide further benefits for a particular condition. This decision is subject to the Complaint procedure set forth in the Complaints and Appeals/Independent Medical Review sections of this EOC. Coverage for treatment of the condition involved will be resumed in the event Member agrees to follow the recommended treatment or procedure.

D. Assignment of Benefits. All rights of the Member to receive benefits hereunder are personal to the Member and may not be assigned.

E. Legal Action. No claim in law or in equity may be maintained against HMO for any expense or bill prior to the expiration of 60 days after written submission of claim has been furnished in accordance with requirements set forth in this Group Agreement. No action shall be brought after the expiration of 3 years after the time written submission of claim is required to be furnished.

F. Independent Contractor Relationship.

1. Participating Providers, non-participating Providers, institutions, facilities or agencies are neither agents nor employees of HMO. Neither HMO nor any Member of HMO is an agent or employee of any Participating Provider, non-participating Provider, institution, facility or agency. Members shall not include HMO as a party in any legal proceeding alleging medical malpractice.
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2. Neither the **Contract Holder** nor a **Member** is the agent or representative of HMO, its agents or employees, or an agent or representative of any **Participating Provider** or other person or organization with which HMO has made or hereafter shall make arrangements for services under this EOC.

3. **Participating Physicians** maintain the physician-patient relationship with **Members** and are solely responsible to **Member** for all **Medical Services** which are rendered by **Participating Physicians**.

4. HMO cannot guarantee the continued participation of any **Provider** or facility with HMO.

   a. In the event the HMO terminates its contract with a PCP, Medical Group or Individual Practice Association, HMO shall provide notification to **Members** in the following manner:

      i. At least 30 days prior to the termination date the HMO will send written notification to **Members** who are currently enrolled in the PCP’s office; or are receiving an **Active Course of Treatment** from other terminating **Providers**.

      ii. **Members** must notify the HMO of their new choice of PCP prior to the date of the PCP’s termination, or HMO will assign a new PCP to the **Member**.

   b. In the event a PCP, Provider Group, or Independent Practice Associations terminates its contract with the HMO, or the HMO terminates a PCP contract without notice for endangering the health and safety of patients, committing criminal or fraudulent acts, or engaging in grossly unprofessional conduct, the HMO will notify **Members** as soon as possible, but no later than within 30 days of the termination date. **Medically Necessary Services** rendered by a PCP or **Provider** shall continue to be **Covered Benefits** during the period between the date of termination of the contract and 5 business days after notification of the contract termination is mailed to **Members** at their last known address. Services rendered by a PCP or **Hospital** to an enrollee between the date of termination of the Provider Agreement and five business days after notification of the contract termination is mailed to the **Member** at the **Member’s** last known address shall continue to be **Covered Benefits**.

   **Members** undergoing an **Active Course of Treatment** may refer to the HMO Procedure section, “Requesting Continuity of Care”, for information about how to continue treatment with a terminated **Provider** for a limited time.

5. **Restriction on Choice of Providers:** Unless otherwise approved by HMO, **Members** must utilize **Participating Providers** and facilities who have contracted with HMO to provide services. When **Member** needs a **Specialist**, **Member’s PCP** will provide member with an authorized **Referral** to a **Participating Provider** within the PCP’s associated medical group or IPA, unless it is **Medically Necessary** to refer **Member** to a **Specialist** outside of the PCP’s associated medical group or IPA or to a non-**Participating Provider**. **Referral** to a non-participating **Provider** must be pre-authorized by HMO. For certain services, **Member’s PCP** must also obtain prior authorization from HMO.

G. **Medical Malpractice Claims.** In no event shall HMO be liable for the negligence, wrongful acts or omissions of **Participating Providers**. ANY CLAIM ALLEGING SUCH NEGLIGENCE, WRONGFUL ACTS OR OMISSIONS (INCLUDING BUT NOT LIMITED TO MEDICAL MALPRACTICE) SHALL NOT INCLUDE HMO AND SHALL INCLUDE ONLY THE PROVIDERS SUBJECT TO THE ALLEGATION. BY ENROLLING IN THIS PLAN, **MEMBERS** WAIVE THEIR RIGHT TO BRING
Inability to Provide Service. If due to circumstances not within the reasonable control of HMO, including but not limited to, major disaster, epidemic, complete or partial destruction of facilities, riot, civil insurrection, disability of a significant part of the Participating Provider Network, the provision of medical or Hospital benefits or other services provided under this EOC is delayed or rendered impractical, HMO will make a good-faith effort to provide or arrange for the provision of services, taking into account the impact of the event. Under these circumstances, medical groups and hospitals will do their best to provide services, but if Participating Providers are not available, Members should go the nearest Provider or Hospital for emergency services. The HMO will provide appropriate reimbursement later.

Confidentiality. Information contained in the medical records of Members and information received from any Provider incident to the provider-patient relationship shall be kept confidential in accordance with applicable law. Information may be used or disclosed by HMO when necessary for a Member’s care or treatment, the operation of HMO and administration of this EOC, or other activities, as permitted by applicable law. Members can obtain a copy of HMO’s Notice of Information Practices by calling the Member Services toll-free telephone number listed on the Member’s identification card.

Limitation on Services. Except in cases of Emergency Services or Urgent Care, as provided under this EOC, services are available only from Participating Providers and HMO shall have no liability or obligation whatsoever on account of any service or benefit sought or received by a Member from any Physician, Hospital, Skilled Nursing Facility, home health care agency, or other person, entity, institution or organization unless prior arrangements are made by HMO.

Incontestability. In the absence of fraud, all statements made by a Member shall be considered representations and not warranties, and no statement shall be the basis for voiding coverage or denying a claim after the Group Agreement has been in force for 2 years from its effective date, unless the statement was material to the risk and was contained in a written application.

This EOC applies to coverage only, and does not restrict a Member’s ability to receive health care services that are not, or might not be, Covered Benefits.

Contract Holder hereby makes HMO coverage available to persons who are eligible under the Eligibility and Enrollment section of this EOC. However, this EOC shall be subject to amendment, modification or termination in accordance with any provision hereof, by operation of law, by filing with and approval by the state Department of Managed Health Care. This can also be done by mutual written agreement between HMO and Contract Holder without the consent of Members.

HMO may adopt policies, procedures, rules and interpretations to promote orderly and efficient administration of this EOC.

No agent or other person, except an authorized representative of HMO, has authority to waive any condition or restriction of this EOC, to extend the time for making a payment, or to bind HMO by making any promise or representation or by giving or receiving any information. No change in this EOC shall be valid unless evidenced by an endorsement to it signed by an authorized representative.

This EOC, including the Schedule of Benefits, any Riders, and any amendments, endorsements, inserts, or attachments, constitutes the entire EOC between the parties hereto pertaining to the subject matter hereof and supersedes all prior and contemporaneous arrangements, understandings, negotiations and discussions of the parties with respect to the subject matter hereof, whether written or oral; and there are no warranties,
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representations, or other agreements between the parties in connection with the subject matter hereof, except as specifically set forth in this EOC. No supplement, modification or waiver of this EOC shall be binding unless executed in writing by authorized representatives of the parties.

Q. This EOC has been entered into and shall be construed according to applicable state and federal law.

R. The Public Policy Committee is a panel of representatives from employer groups, HMO Members, the Board of Directors and the HMO’s Medical Director. The committee meets on a quarterly basis to discuss policies and issues of concern to Members. For additional information about the committee, please direct inquiries to Member Services at the toll-free number shown on the ID Card.

S. From time to time HMO may offer or provide Members access to discounts on health care related goods or services. While HMO has arranged for access to these goods, services and/or third party provider discounts, the third party service providers are liable to the Members for the provision of such goods and/or services. HMO is not responsible for the provision of such goods and/or services nor is it liable for the failure of the provision of the same. Further, HMO is not liable to the Members for the negligent provision of such goods and/or services by third party service providers. These discounts are subject to modification or discontinuance without notice.

The following words and phrases when used in this EOC shall have, unless the context clearly indicates otherwise, the meaning given to them below:

- **Active Course of Treatment.** A planned program of services rendered by a Physician or Provider, starting on the date a Physician first renders a service to correct or treat the diagnosed condition, covering a defined number of services or period of treatment.

- **Appropriately Qualified.** A Health Professional, acting within the scope of their license, who possesses a clinical background, including training and expertise, related to the particular illness, disease, condition or conditions associated with the Member.

- **Behavioral Health Provider.** A licensed organization or professional providing diagnostic, therapeutic or psychological services for behavioral health conditions.

- **Complex Imaging Services.** Complex imaging services include: Computer Axial Tomography (C.A.T. Scans); Magnetic Resonance Imaging (MRIs); Positron Emission Tomography (PET Scans) and any other outpatient diagnostic imaging service costing over $500.

- **Contract Holder.** An employer or organization who agrees to remit the Premiums for coverage under the Group Agreement payable to HMO. The Contract Holder shall act only as an agent of HMO Members in the Contract Holder’s group, and shall not be the agent of HMO for any purpose.

- **Contract Year.** A period of 1 year commencing on the Contract Holder’s Effective Date of Coverage and ends at 12:00 midnight on the last day of the one year period.

- **Coordination of Benefits.** A provision that is intended to avoid claims payment delays and duplication of benefits when a person is covered by two or more plans providing benefits or services for medical, dental or other care or treatment. It avoids claims payment delays by establishing an order in which plans pay their claims and providing the authority for the orderly transfer of information needed to pay claims promptly. It may avoid duplication of benefits by permitting a reduction of the benefits of a plan when, by the rules established by this provision, it does not have to pay its benefits first. Refer to the Coordination of Benefits section of this EOC for a description of the Coordination of Benefits provision.
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- **Copayment.** A specified dollar amount or percentage required to be paid by or on behalf of a Member in connection with benefits, if any, as set forth in the Schedule of Benefits. Copayments may be changed by HMO upon 30 days written notice to the Contract Holder.

- **Copayment Maximum.** The maximum annual out-of-pocket amount for payment of Copayments, if any, to be paid by a Subscriber and any Covered Dependents, if any.

- **Cosmetic Surgery.** Any non-medically necessary surgery or procedure whose primary purpose is to improve or change the appearance of any portion of the body to improve self-esteem, but which does not restore bodily function, correct a diseased state, correct disfigurement caused by an accident or birth defect, or correct or naturally improve a physiological function or provide more than a minimal improvement in the appearance of the Member. Cosmetic Surgery includes, but is not limited to, ear piercing, rhinoplasty, lpectomy, surgery for sagging or extra skin, any augmentation or reduction procedures (e.g., liposuction, keloids, rhinoplasty and associated surgery) or treatment relating to the consequences or as a result of Cosmetic Surgery.

- **Coverage Decision.** The approval or denial of health care services by HMO substantially based on a finding that the provision of a particular service is included or excluded as a covered benefit under the terms and conditions of this EOC. A Coverage Decision is not an HMO decision regarding a Disputed Health Care Service.

- **Covered Dependent.** Any person in a Subscriber's family who meets all the eligibility requirements of the Eligibility and Enrollment section of this EOC and the Dependent Eligibility section of the Schedule of Benefits, has enrolled in HMO, and is subject to Premium requirements set forth in the Premiums section of the Group Agreement.

- **Covered Benefits.** Those Medically Necessary Services and supplies set forth in this EOC, which are covered subject to all of the terms and conditions of the Group Agreement and EOC.

- **Creditable Coverage.** Coverage of the Member under a group health plan (including a governmental or church plan), a health insurance coverage (either group or individual insurance), Medicare, Medicaid, a military-sponsored health care (CHAMPUS), a program of the Indian Health Service, a State health benefits risk pool, the Federal Employees Health Benefits Program (FEHBP), a public health plan, and any health benefit plan under section 5(e) of the Peace Corps Act. Creditable Coverage does not include coverage only for accident; Workers’ Compensation or similar insurance; automobile medical payment insurance; coverage for on-site medical clinics; or limited-scope dental benefits, limited-scope vision benefits, or long-term care benefits that is provided by a separate policy.

- **Custodial Care.** Any type of care provided in accordance with Medicare guidelines, including room and board, that a) does not require the skills of technical or professional personnel; b) is not furnished by or under the supervision of such personnel or does not otherwise meet the requirements of post-hospital Skilled Nursing Facility care; or c) is a level such that the Member has reached the maximum level of physical or mental function and such person is not likely to make further significant improvement. Custodial Care includes, but is not limited to, any type of care where the primary purpose of the type of care provided is to attend to the Member's daily living activities which do not entail or require the continuing attention of trained medical or paramedical personnel. Examples of this include, but are not limited to, assistance in walking, getting in and out of bed, bathing, dressing, feeding, using the toilet, changes of dressings of non infected, post operative or chronic conditions, preparation of special diets, supervision of medication which can be self-administered by the Member, general maintenance care of colostomy or ileostomy, routine services to maintain other service which, in the sole determination of HMO, based on medically accepted standards, can be safely and adequately self-administered or performed by the average non-medical person without the direct supervision of trained medical or paramedical personnel, regardless of who actually provides the service, residential care and adult day care, protective and
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supportive care including educational services, rest cures, convalescent care.

- **Detoxification.** The process whereby an alcohol or drug intoxicated or alcohol or drug dependent person is assisted, in a facility licensed by the appropriate regulatory authority, through the period of time necessary to eliminate, by metabolic or other means, the intoxicating alcohol or drug, alcohol or drug dependent factors or alcohol in combination with drugs as determined by a licensed **Physician**, while keeping the physiological risk to the patient at a minimum.

- **Disputed Health Care Service.** Any health care service eligible for coverage and payment that has been denied, modified, or delayed by a decision of the **HMO**, or one of its contracting **Providers**, in whole or in part due to a finding that the service is not **Medically Necessary**.

- **Durable Medical Equipment.** Equipment, as determined by **HMO**, which is a) made to withstand prolonged use; b) made for and mainly used in the treatment of a disease or injury; c) suited for use while not confined as an inpatient in the **Hospital**; d) not normally of use to persons who do not have a disease or injury; e) not for use in altering air quality or temperature; and f) not for exercise or training.

- **Effective Date of Coverage.** The commencement date of coverage under this **EOC** as shown on the records of **HMO**.

- **Emergency Service(s).** Medical screening, examination and evaluation by a **Physician**, or, to the extent permitted by applicable law, by other **Health Professionals**, to determine if an emergency medical condition, psychiatric emergency medical condition, and/or active labor exists. If such conditions are determined to exist, the care and treatment to relieve or eliminate the emergency medical or psychiatric condition, within the capability of the facility.

- **Evidence of Coverage EOC.** This **Evidence of Coverage**, including the Schedule of Benefits, and any riders, amendments, or endorsements, which outlines coverage for a **Subscriber** and **Covered Dependents** according to the **Group Agreement**.

- **Experimental or Investigational Procedures.** Services or supplies that are, as determined by **HMO**, experimental. A drug, device, procedure or treatment will be determined to be experimental if:
  1. there is not sufficient outcome data available from controlled clinical trials published in the peer reviewed literature to substantiate its safety and effectiveness for the disease or injury involved; or
  2. required FDA approval has not been granted for marketing; or
  3. a recognized national medical or dental society or regulatory agency has determined, in writing, that it is experimental or for research purposes; or
  4. the written protocol or protocol(s) used by the treating facility or the protocol or protocol(s) of any other facility studying substantially the same drug, device, procedure or treatment or the written informed consent used by the treating facility or by another facility studying the same drug, device, procedure or treatment states that it is experimental or for research purposes; or
  5. it is not of proven benefit for the specific diagnosis or treatment of a **Member's** particular condition; or
  6. it is not generally recognized by the **Medical Community** as effective or appropriate for the specific diagnosis or treatment of a **Member's** particular condition; or
  7. it is provided or performed in special settings for research purposes.

- **Group Agreement.** The **Group Agreement** between **HMO** and the **Contract Holder**, including the Group
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Application, Cover Sheet, this EOC, the Schedule of Benefits, any Riders, any amendments, any endorsements, and any attachments, as subsequently amended by operation of law and as filed with and approved by the applicable public authority.

- **Health Professionals.** A Physician or other professional who is properly licensed or certified to provide medical care under the laws of the state where the individual practices, and who provides Medical Services which are within the scope of the individual’s license or certificate.

- **HMO.** Aetna Health of California Inc. a California corporation operating pursuant to Chapter 2.2 of Division 2 of the Health and Safety Code (commencing with Section 1340), commonly known as the Knox-Keene Health Care Service Plan of 1975.

- **Homebound Member.** A Member who is confined to the home due to an illness or injury which makes leaving the home medically contraindicated or which restricts the Member's ability to leave the Member's place of residence except with the aid of supportive devices, the use of special transportation, or the assistance of another person.

- **Home Health Services.** Those items which are provided by Participating Providers as an alternative to hospitalization, and approved and coordinated in advance by HMO.

- **Hospice Care.** A program of care that is provided by a Hospital, Skilled Nursing Facility, hospice, or a duly licensed Hospice Care agency, and is approved by HMO, and is focused on a palliative rather than curative treatment for Members who have a medical condition and a prognosis of less than 6 months to live.

- **Hospital(s).** An institution rendering inpatient and outpatient services, accredited as a Hospital by the Joint Commission on Accreditation of Health Care Organizations, the Bureau of Hospitals of the American Osteopathic Association, or as otherwise determined by HMO as meeting reasonable standards. A Hospital may be a general, acute care, rehabilitation or specialty institution.

- **Infertile or Infertility.** The condition of a presumably healthy Member who is unable to conceive or produce conception after a period of 1 year of timed, unprotected coitus, or 12 cycles of artificial insemination (for Members less than 35 years of age), or 6 months or more of timed unprotected coitus, or 6 cycles of artificial insemination (for Members age 35 years of age or older). Infertile or Infertility does not include conditions for male Members when the cause is a vasectomy or orchiectomy or for female Members when the cause is a tubal ligation or hysterectomy.

- **Inquiry.** A Member’s request for administrative service, information, or to express an opinion, including but not limited to, claims regarding scope of coverage for health services, denials, cancellations, terminations or renewals, and the quality of services provided.

- **Institute of Excellence™ (IOE).** One of a network of facilities within the National Medical Excellence Program® specifically contracted with by HMO to provide certain Transplants to Members. A facility is considered a Participating Provider only for those types of Transplants for which it has been specifically contracted.

**Life-Threatening Or Seriously Debilitating Condition.** A disease or condition (including the diagnosis of HIV or AIDS):

1. where the likelihood of death is high unless the course of the disease is interrupted;

2. with potentially fatal outcome, where the end point of clinical intervention is survival; or

3. that causes major irreversible morbidity.
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- **Medical Community.** A majority of **Physicians** who are Board Certified in the appropriate specialty.

- **Medical and Scientific Evidence** means any as listed below:

  1. Peer-reviewed scientific studies published in or accepted for publication by medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts who are not part of the editorial staff;

  2. Peer-reviewed literature, biomedical compendia, and other medical literature that meet the criteria of the National Institute of Health’s National Library of Medicine for indexing in Index Medicus, Excerpta Medicus (EMBASE), Medline, and MEDLARS database Health Services Technology Assessment Research (HSTAR).

  3. Medical journals recognized by the Secretary of Health and Human Services, under Section 1861(t)(2) of the Social Security Act.

  4. The following standard reference compendia: The American Hospital Formulary Service-Drug Information, the American Association for Accreditation of HealthCare Evaluation, the American Dental Association Accepted Dental Therapeutics, and the United States Pharmacopoeia-Drug Information.

  5. Findings, studies, or research conducted by or under the auspices of federal government agencies and nationally recognized federal research institutes including the Federal Agency of Health Care Policy and Research, National Institutes of Health, National Cancer Institute, National Academy of Sciences, Health Care Financing Administration, Congressional Office of Technology Assessment, and any national board recognized by the National Institutes of Health for the purposes of evaluating the medical value of health services.

  6. Peer-reviewed abstracts accepted for presentation at major medical association meetings.

- **Medical Emergency.** The existence of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in (i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman and her unborn child) in serious jeopardy; (ii) serious impairment to bodily functions; or (iii) serious dysfunction of any bodily organ or part.

- **Medical Services.** The professional services of **Health Professionals**, including medical, surgical, diagnostic, therapeutic, preventive care and birthing facility services.

- **Medically Necessary, Medically Necessary Services, or Medical Necessity.** Services that are appropriate and consistent with the diagnosis in accordance with accepted medical standards as described in the Covered Benefits section of this **EOC**. **Medical Necessity**, when used in relation to services, shall have the same meaning as **Medically Necessary Services**. This definition applies only to the determination by **HMO** of whether health care services are **Covered Benefits** under this **EOC**.

- **Member(s).** A **Subscriber** or **Covered Dependent** as defined in this **EOC**.

- **National Medical Excellence Program.** Coordinating **HMO** services team for **Transplant** services and other specialized care.
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- **Non-Serious Mental Illness.** A condition which manifests signs and/or symptoms which are primarily mental or behavioral, for which the primary treatment is psychotherapy, psychotherapeutic methods or procedures, and/or the administration of psychotropic medication, regardless of any underlying physical or medical cause. **Non-Serious Mental Illnesses** are mental conditions which are not diagnosed as **Serious Mental Illness** but nevertheless require **Medically Necessary** treatment.

- **Non-Hospital Facility.** A facility, licensed by the appropriate regulatory authority, for the care or treatment of alcohol or drug dependent persons or mental illness treatment program, except for transitional living facilities.

- **Open Enrollment Period.** A period each calendar year, when eligible employees of the **Contract Holder** may enroll in HMO without a waiting period or exclusion or limitation based on health status or, if already enrolled in HMO, may transfer to an alternative health plan offered by the **Contract Holder**.

- **Partial Hospitalization.** The provision of medical, nursing, counseling or therapeutic services on a planned and regularly scheduled basis in a **Hospital** or **Non-Hospital Facility** which is licensed as an alcohol or drug abuse or mental illness treatment program by the appropriate regulatory authority, and which is designed for a patient or client who needs a higher level of care from more intensive services than are offered in outpatient treatment but who does not require inpatient care.

- **Participating.** A description of a **Provider** that has entered into a contractual agreement with HMO for the provision of services to **Members**.

- **Participating Infertility Specialist.** A **Specialist** who has entered into a contractual agreement with HMO for the provision of **Infertility** services to **Members**.

- **Physician.** A duly licensed member of a medical profession, who has an M.D. or D.O. degree, who is properly licensed or certified to provide medical care under the laws of the state where the individual practices, and who provides **Medical Services** which are within the scope of the individual’s license or certificate.

- **Premium(s).** The amount the **Contract Holder** or **Member** is required to pay to HMO to continue coverage.

- **Primary Care Physician (PCP).** A **Participating Physician** who supervises, coordinates and provides initial care and basic **Medical Services** as a general or family care practitioner, or in some cases, as an internist, obstetrician, gynecologist or a pediatrician to **Members**, initiates their **Referral** for **Specialist** care, and maintains continuity of patient care.

- **Provider(s).** A **Physician, Health Professional, Hospital, Skilled Nursing Facility**, home health agency or other recognized entity or person licensed to provide **Hospital** or **Medical Services** to **Members**.

- **Reasonable Charge.** The charge for a **Covered Benefit** which is determined by the HMO to be the prevailing charge level made for the service or supply in the geographic area where it is furnished. HMO may take into account factors such as the complexity, degree of skill needed, type or specialty of the **Provider**, range of services provided by a facility, and the prevailing charge in other areas in determining the **Reasonable Charge** for a service or supply that is unusual or is not often provided in the area or is provided by only a small number of providers in the area.

- **Reconstructive Surgery.** Surgery performed to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease to do either of the following: a) improve function and b) create a normal appearance, to the extent possible.
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- **Referral.** Specific directions or instructions from a **Member's PCP**, in conformance with HMO’s policies and procedures, that direct a **Member** to a **Participating Provider** for **Medically Necessary** care.

- **Respite Care.** Care furnished during a period of time when the **Member’s** family or usual caretaker cannot, or will not, attend to the **Member’s** needs.

- **Serious Emotional Disturbances of a Child.** A mental disorder as identified in the most recent edition of Diagnostic and Statistical Manual of Mental Disorders, other than a primary substance use disorder or developmental disorder, which results in behavior inappropriate to the child's age according to expected developmental norms. A “child” is a minor under the age of 18. **Serious Emotional Disturbances of a Child** include but are not limited to: (a) psychotic features, (b) risk of suicide, and (c) risk of violence due to a mental disorder.

- **Serious Mental Illness.** Includes the following conditions that meet the diagnostic criteria described in the most recent edition of Diagnostic and Statistical Manual of Mental Disorders: (a) schizophrenia, (b) schizoaffective disorder, (c) bipolar disorder, (d) major depressive disorders, (e) panic disorder, (f) obsessive-compulsive disorder, (g) pervasive developmental disorder or autism, (h) anorexia nervosa, or (i) bulimia nervosa.

- **Service Area.** The geographic area, established by HMO and approved by the appropriate regulatory authority.

- **Skilled Care.** Medical care that requires the skills of technical or professional personnel.

- **Skilled Nursing Facility.** An institution or a distinct part of an institution that is licensed or approved under state or local law, and which is primarily engaged in providing skilled nursing care and related services as a **Skilled Nursing Facility**, extended care facility, or nursing care facility approved by the Joint Commission on Accreditation of Health Care Organizations or the Bureau of Hospitals of the American Osteopathic Association, or as otherwise determined by HMO to meet the reasonable standards applied by any of the aforesaid authorities.

- **Specialist.** A **Physician** who provides medical care in any generally accepted medical or surgical specialty or subspecialty.

- **Specialty Care Center.** Center that is accredited or designated by an agency of the state or federal government or by a voluntary national health organization as having special expertise in treating the life-threatening disease or condition or degenerative and disabling disease or condition for which it is accredited or designated.

- **Standing Referral.** A **Referral** by a **PCP** to a **Specialist** for more than one visit to the specialist, as indicated in the treatment plan, if any, without the **PCP** having to provide a specific **Referral** for each visit.

- **Subscriber.** A person who meets all applicable eligibility requirements as described in this **EOC** and on the Schedule of Benefits, has enrolled in **HMO**, and is subject to **Premium** requirements as set forth in the Premiums section of the **Group Agreement**.

- **Substance Abuse.** Any use of alcohol and/or drugs which produces a pattern of pathological use causing impairment in social or occupational functioning or which produces physiological dependency evidenced by physical tolerance or withdrawal.

- **Substance Abuse Rehabilitation.** Services, procedures and interventions to eliminate dependence on or abuse of legal and/or illegal chemical substances, according to individualized treatment plans.

- **Transplant.** Replacement of solid organs; stem cells; bone marrow or tissue. Includes related services such as pre-procedure evaluations, testing and follow-up care.
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- **Traveling Companion.** A person whose presence as a companion or caregiver is necessary to enable a Member to receive services in connection with a Transplant on an inpatient or outpatient basis; or to travel to and from the IOE facility where treatment is provided.

- **Totally Disabled or Total Disability.** A Member shall be considered Totally Disabled if:
  1. the Member is a Subscriber and is prevented, because of injury or disease, from performing any occupation for which the Member is reasonably fitted by training, experience, and accomplishments; or
  2. the Member is a Covered Dependent and is prevented because of injury or disease, from engaging in substantially all of the normal activities of a person of like age and sex in good health.

- **Urgent Care.** Non-preventive or non-routine health care services which are Covered Benefits and are required in order to prevent serious deterioration of a Member's health following an unforeseen illness, injury or condition if: (a) the Member is temporarily absent from the HMO Service Area and receipt of the health care service cannot be delayed until the Member returns to the HMO Service Area; or, (b) the Member is within the HMO Service Area and receipt of the health care services cannot be delayed until the Member's Primary Care Physician is reasonably available.