SANTA BARBARA COUNTY
BOARD AGENDA LETTER

Clerk of the Board of Supervisors
105 E. Anapamu Street, Suite 407
Santa Barbara, CA 93101
(805) 568-2240

Agenda Number:	
Prepared on:	11/30/04
Department Name:	Social Services
Department No.:	044
Agenda Date:	12/14/04
Placement:	Administrative
Estimate Time:	
Continued Item:	NO
If Yes, date from:	

TO: Board of Supervisors

FROM: Kathy Gallagher
Social Services Department

STAFF CONTACT: Davida Willis
x 1251

SUBJECT: Award A Contract To Santa Barbara Regional Health Authority To Provide Health Insurance to Qualifien In-Home Care Givers.

Recommendation(s):

That the Board of Supervisors: Execute an agreement with the Santa Barbara Regional Health Authority to provide health benefits to qualified in-home care givers who provide care to customers of the In-Home Supportive Services program. The term of the initial agreement is from January 1, 2005 through December 31, 2005, in an amount not to exceed $1,338,225.

Alignment with Board Strategic Plan:

The provision of health care benefits is aligned with the Board of Supervisors' strategic plan goal number II: A Safe and Healthy Community in Which to Live, Work, and Visit.

Executive Summary and Discussion:

Pursuant to a Memorandum of Understanding with United Domestic Workers of America dated June 1, 2004, the In-Home Supportive Services Public Authority is required to offer health and dental benefits to qualified care givers. The Santa Barbara Regional Health Authority has designed "Caradigm Health" specifically for the Santa Barbara In-Home Supportive Services Public Authority as a vehicle to provide the health benefits. Caradigm Health meets, and in some cases, exceeds all the requirements of the Knox-Keene requirements for health insurance.

Health care providers are located County-wide, through Sansum-Santa Barbara Medical Foundation and Central Coast Family Care. All hospitals in the County are also contracted to Caradigm Health. Major pharmacy chains are under contract with the Santa Barbara Regional Health Authority for prescription drugs.

Care givers qualify for benefits by working a minimum of 70 hours per month for two (2) consecutive months, and then maintaining that level of work in order to continue the benefit.

The current monthly premium is $335, and each insured will pay 10% or $33.50 monthly toward the total cost of the health insurance premium.

Mandates and Service Levels:

The Public Authority was created by AB 2235, which mandates that the Public Authority is the employer of record for all in-home care givers. As the employer of record, the Public Authority is charged with negotiating wages and benefits with the assigned bargaining unit.

Fiscal and Facilities Impacts:

This contract will be funded with Federal, State and Tobacco Settlement funds. The respective funding levels are approximately 38%, 40%, and 22% depending on the eligibility of each specific IHSS case and activity. Appropriations of $583,599 for the 2004/2005 fiscal year have been included in Department's approved budget under the IHSS Public Authority sub-division, located with the Social Programs Division, Page D220. Appropriations of $754,626 for July 1, 2005 - December 31, 2005 will be included in the Department's Fiscal Year 2005/2006 requested budget.

Special Instructions:

After execution by the Chair, please return one (1) certified copy of the agreement for the contractor, one (1) copy for the Public Authority, and one (1) copy of the minute order, attention: Andrea McGrath.

Concurrence:

County Counsel

Contract Summary Form: Contract Number : - - - -

Complete data below, print, obtain signature of authorized departmental representative, and submit this form (and attachments) to the Clerk of the Board (>$25,000) or Purchasing (≤$25,000). *See also "Contracts for Services" policy. Form not applicable to revenue contracts.*

D1. Fiscal Year .....: FY 04-05 and 05-06
D2. Budget Unit Number ***(****plus -Ship/-Bill codes in paren's****)***: 044
D3. Requisition Number .....:
D4. Department Name.....: Social Services
D5. Contact Person .....: Davida Willis
D6. Phone .....: 1251

K1. Contract Type *(check one)*: [x] Personal Service [ ] Capital Project/Construction
K2. Brief Summary of Contract Description/Purpose .: provides health insurance for qualified IHSS caregivers
K3. Original Contract Amount .....: $1,338,225
K4. Contract Begin Date.....: 1-1-05
K5. Original Contract End Date.....: 12-31-05
K6. Amendment History *(leave blank if no prior amendments)*: N/A

Seq#	*EffectiveDate*	*ThisAmndtAmt*	*CumAmndtToDate*	*NewTotalAmt*	*NewEndDate*	*Purpose (2-4 words)*

K7. Department Project Number .....:

B1. Is this a Board Contract? *(Yes/No)* .....: Yes
B2. Number of Workers Displaced *(if any)*.....: none
B3. Number of Competitive Bids *(if any)* .....: none
B4. Lowest Bid Amount *(if bid)* .....: $
B5. If Board waived bids, show Agenda Date.....:
B6. ... and Agenda Item Number.....: #
B7. Boilerplate Contract Text Unaffected? *(Yes / or cite ¶¶)*:

F1. Encumbrance Transaction Code .....: 1701
F2. Current Year Encumbrance Amount .....: $ 0
F3. Fund Number.....: 0056
F4. Department Number.....: 044
F5. Program Number.....: 3048
F6. Account Number.....: 7662
F7. Org. Unit Number .....: 5328
F8. Payment Terms ..... Net 30

V1. Vendor Numbers *(A=uditor; P=urchasing)* .....: A 425183
V2. Payee/Contractor Name.....: Santa Barbara Regional Health Authority
V3. Mailing Address.....: 110 Castilian Dr.
V4. City State *(two-letter)* Zip *(include +4 if known)*: Goleta. CA 93117
V5. Telephone Number.....: 805-685-9525
V6. Contractor's Federal Tax ID Number *(EIN or SSN)*:
V7. Contact Person.....: Donna Slimak
V8. Workers Comp Insurance Expiration Date.....:
V9. Liability Insurance Expiration Date[s] *(G=enl; P=rofl)*:
V10. Professional License Number.....: # N/A
V11. Verified by *(name of County staff)* .....: Davida Willis
V12. Company Type *(Check one)*: [ ] Individual [ ] Sole Proprietorship [ ] Partnership [x] Corporation
[ ] Educational Institution

I certify: information complete and accurate; designated funds available; required concurrences evidenced on signature page.

..... *Davida Willis*

Authorized Signature: _____

(Co of SB Std Terms Ver 4-21-95)

SANTA BARBARA REGIONAL HEALTH AUTHORITY

GROUP MEMBER AGREEMENT

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SANTA BARBARA REGIONAL HEALTH AUTHORITY GROUP MEMBER AGREEMENT

THIS AGREEMENT (the "Agreement") is made and entered into effective January 1, 2005 (the "Effective Date") by and between Santa Barbara Regional Health Authority, ("Health Plan" or "Plan"), and the In-Home Supportive Services Public Authority of Santa Barbara County ("Public Authority" or "Group").

WHEREAS, Health Plan is a prepaid health care service plan, subject to the licensing requirements and operational regulatory standards of the Knox-Keene Health Care Service Plan Act of 1975, ("Act") as amended, which arranges for the provision of health care services for Members;

WHEREAS, Group wishes to participate in said program;

NOW THEREFORE, Group engages Health Plan to arrange for the provision of Medically Necessary Covered Services to Members in accordance with the following Declarations and all terms and conditions hereinafter provided.

DECLARATIONS

1. The Initial Term of this Agreement is January 1, 2005 ("Effective Date"), through December 31, 2005, with the anniversary date being January 1, 2006. Thereafter, this Agreement will automatically renew from year to year, unless terminated as provided herein.

2. The periodic prepayment fees ("Prepayment Fees") for Health Plan membership are specified in the Rate Schedule Attachment (1) to this Agreement. Subject to changes in rates or other terms as provided in Section 3 (Fees and Charges), the rates shall remain in effect for the Initial Term of this Agreement, and may be changed thereafter on the anniversary date as provided herein.

3. This Agreement is made in reliance upon the information provided by Group in its application; upon the statements of each Member in his or her application for coverage and upon Group's existing eligibility requirements and composition of Members.

4. This Agreement is not effective until executed in writing by the duly authorized officer of Health Plan named below. No other employee or agent is authorized to bind coverage.

5. No representative of Health Plan is authorized to waive or change any provision of this Agreement except in a writing signed by a duly authorized Health Plan officer.

6. The following specifications apply to this Agreement. In the event of a conflict between these specifications and the following text of the Agreement, these specifications prevail.

A. "Full-time Employee" means an employee who meets the following requirements:

1. has worked two (2) consecutive months in which he or she works a minimum of seventy (70) hours per month;

2. works or resides in the Service Area;

3. has not been previously terminated by the Plan for fraud or deception or failing to provide complete information; and

4. has submitted the required enrollment information to the Group.

B. Group Waiting Period: **None**

C. The minimum employee participation in Health Plan is: **Not applicable**

D. The following designated non-employees are eligible to enroll: **N/A**

E. The following retired beneficiaries are eligible to enroll: **N/A**

Other Group specific provisions.

1. Dependents are not eligible for benefits under this Agreement.

2. Health Plan will administer COBRA benefits on behalf of Group, but Group will be responsible to administer or contract with another person or entity to administer COBRA. Premiums for any Members whose benefits are COBRA benefits will be paid to Health Plan together with premiums of other, non-COBRA Members.

IN WITNESS WHEREOF, Health Plan and Group have caused this Agreement to be executed by duly authorized representatives as of the Effective Date hereof.

NOTICE: Any dispute arising from or related to this Agreement will be determined by submission to binding arbitration, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. The agreement to arbitrate includes, but is not limited to, disputes involving alleged professional liability or medical malpractice, that is, whether any medical services covered by this Agreement were unnecessary or were unauthorized by the Member or were improperly, negligently or incompetently rendered. See Section 8 of this Agreement for further information about arbitration. This Agreement also precludes the award of punitive damages. See Section 9.

The undersigned representative of Group understands that Group and any Subscribers who enroll under this Health Plan are giving up their right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of binding arbitration. This means that Group, Subscribers and other interested parties will not be able to try their case in court.

In Home Supportive Services Public Authority	
of Santa Barbara County	Santa Barbara Regional Health Authority
By (see signature page at end of document)	By:
Name	Name
Title	Title
Date	Date
Address	Address
City, State and Zip Code	City, State and Zip Code

SECTION 1– ELIGIBILITY

1.1 MEMBER ELIGIBILITY

An In-Home Supportive Services (IHSS) worker is eligible to enroll for coverage after working two (2) consecutive months in which he or she works a minimum of seventy (70) hours per month. In addition, the IHSS worker must:

(A) reside in the Service Area on a full-time basis; or

(B) work in the Service Area; and

(C) not have been previously terminated by the Plan for fraud or deception or failing to complete required information; and

(D) have submitted the required enrollment information to the Public Authority; and

(E) have met the Public Authority's eligibility requirements.

OTHER RULES OF ELIGIBILITY

To be eligible to enroll and to continue enrollment as a Subscriber, the person must reside or work in the Health Plan Service Area and must not be on active duty with the Armed Forces.

No person is eligible to enroll or re-enroll if such person's coverage under this Agreement or under any other agreement with Health Plan has been terminated for:

(A) Knowingly failing to furnish material information;

(B) Knowingly furnishing incorrect or incomplete material information;

(C) Fraud or deception;

(D) Nonpayment by such person; or

(E) Disruptive or abusive behavior toward Participating Providers, their employees or Health Plan employees.

No person who is otherwise eligible will be refused enrollment because of his or her health status, requirements for health services, blindness, or the existence of a pre-existing physical or mental disorder at the time of his or her enrollment.

A Member's entitlement to Medi-Cal benefits under Chapter 7 (commencing with §1400) or Chapter 8 (commencing with § 14200) of Part 3 of Division 9 of the California Welfare and Institutions Code will not preclude the Member from enrollment.

1.2 FAMILY MEMBER ELIGIBILITY

Family Members are not eligible for benefits under this Agreement.

1.3 GROUP'S ELIGIBILITY RULES; OBLIGATIONS

Group's eligibility requirements for coverage in effect on the Effective Date are material to the execution of this Agreement by Health Plan. No change in Group's eligibility or participation requirements will affect the requirements for eligibility or enrollment under this Agreement unless such changes are agreed to in writing by Health Plan.

Group agrees to accept the responsibility for furnishing current eligibility information and Health Plan may rely upon the latest information received as correct without further verification. Health Plan will not credit Group for any Prepayment Fees paid for an ineligible person if the request for such credit is made after the first of the month for which the premium was paid.

Member eligibility will be for one-year terms, which will automatically be renewed unless the Member is terminated. New hires will be eligible from the effective date of coverage determined by Group, through the end of the calendar year at which time their eligibility will automatically be renewed unless the Member is terminated. Unless they elect coverage under COBRA, terminated Members will lose their coverage as of the termination date.

1.4 ENROLLMENT

(A) To initially qualify for health coverage, IHSS workers must meet the eligibility requirements set forth in § 1.1, and complete the enrollment form.

(B) Eligibility for health care coverage will continue as long as the Member continues to receive authorization to work and does work at least seventy (70) hours per month.

1.5 COMMENCEMENT OF COVERAGE

The effective date of coverage for a Member who is an IHSS worker of the Public Authority will be the first day of the month following the month in which the Member's application is processed and found to meet the Public Authority's eligibility requirements stated in § 1.1 and Prepayment Fees are received by the Health Plan.

SECTION 2 –CHOICE OF PHYSICIANS AND PROVIDERS

2.1 REQUIRED USE OF PARTICIPATING PROVIDERS

The benefits described in this Agreement are Covered Services only if, and to the extent, they are Medically Necessary and meet the following requirements:

(A) They are provided by, or prescribed or referred in advance by, the Member's designated Primary Care Physician unless they are Self Referral Services; and

(B) They are obtained, unless they are Self Referral Services, from a Participating Provider located within the Service Area.

The only exceptions to the requirement to use Participating Providers are:

(1) In an Emergency or for out of Service Area Urgent Care Services; or

(2) Where the requested service is Medically Necessary and Prior Authorization is granted.

Certain services or supplies within the Service Area also require Prior Authorization. Members must identify themselves to the Participating Provider as a Health Plan Member before receiving any service or supply.

2.2 SELECTION OF A PRIMARY CARE PHYSICIAN

At enrollment, Members will receive a Provider Directory that lists all of the hospitals and physicians that make up the Plan's network of providers. The Directory contains the names, addresses and telephone numbers of Primary Care Physicians to help Members select providers that are convenient to them. The Directory also contains additional information that Members will find useful in selecting a Primary Care physician. Health Plan requires each Member to designate a Primary Care Physician located within the Service Area where the Member lives or works. If a Member does not designate a Primary Care Physician, Health Plan will assign the Member to a Primary Care Physician. Physicians are then notified of the selection. A Primary Care Physician is one who is identified by Health Plan as such and who is willing to assume responsibilities regarding continuity of care, recordkeeping and referrals to specialist physicians.

Once the Primary Care Physician is designated, the Member must contact his/her Primary Care Physician before seeking medical or Hospital services unless an Emergency exists or the service is a Self Referral Service. In an Emergency, the Member may obtain the nearest available medical care. If a health care matter is beyond the normal practice of the Primary Care Physician, he or she may refer the patient to a Participating specialist Physician. The Primary Care Physician will manage referrals and ongoing care supplied by other providers and institutions.

In most cases, a Referral Authorization Form (RAF) must be issued by the Primary Care Physician when a referral is made. Services obtained from or prescribed by Participating specialist Physicians or other Participating Providers without the RAF from the Primary Care Physician will not be covered by Health Plan except as listed below.

Covered Services not requiring a referral include, but are not limited to:

(A) Medically Necessary Emergency or Urgent Care Services;

(B) On-call physicians who are providing care in the Primary Care Physician's place;

(C) OB-GYN services obtained from a Participating OB/GYN Physician, family practitioner, nurse practitioner or nurse midwife.;

(D) Services from a specialist in which the Member has a standing referral based on a treatment plan developed by the Member's Primary Care Physician, the specialist and the Member;

(E) Family Planning Services from a Participating Provider;

(F) Abortion services from a participating provider;

(G) AIDS/HIV testing;

(H) Sexually transmitted disease testing and treatment

(I) Nutrition Education (first visit) under the diabetes management benefit and for those receiving treatment for phenylketonuria

Health Plan does not cover services provided by non-Participating Physicians unless a RAF has been issued, (except for Emergency Services and other services listed above in 2.2 (A) – (I)), or if required Prior Authorization has been obtained. If a Member self-refers for health care services, other than for the Self Referral services listed above, without obtaining a referral from the Primary Care Physician or Prior Authorization from Health Plan, the services will not be covered.

2.3 CHANGING PRIMARY CARE PHYSICIANS

If a Member wishes to change his/her Primary Care Physician, the Member must first contact Health Plan's Member Services Department and follow the instructions provided. When notified before the 15th of the month, Health Plan will facilitate a change of Primary Care Physician consistent with continuity of care,

effective as of the first day of the calendar month following the Member's request. The physician may decide to refuse the relationship at any time when allowed by medical ethics and contract, and may require the Member to change his/her Primary Care Physician designation for good cause

Once the Member is assigned to a new Primary Care Physician, the Member may receive Covered Services only from the Participating Providers, or non-Participating Providers when Medically Necessary, as referred by the new Primary Care Physician and subject to Prior Authorization when necessary. Failure to comply with any of the provisions regarding selection and changing of Primary Care Physicians will result in the Member being responsible for the charges.

2.4 PROVIDER NETWORK CHANGES OR TERMINATIONS

Health Plan's network of Participating Providers is made up of both group/clinic physicians and independently practicing physicians, allied health providers and hospitals, and may change by the decision of the provider or Health Plan. Whenever there is a contract termination of a physician, a Member who at that time is receiving a course of treatment from the terminated physician will be given the opportunity to select a new physician. Health Plan will assist the Member in transitioning to the new provider so that treatment may continue without interruption.

If a physician's contract is terminated by Health Plan, the Member will be notified in writing as soon as possible, but no later than thirty (30) days prior to the termination. However, if the physician's contract is terminated immediately due to endangering the health and safety of patients, committing criminal or fraudulent acts, or engaging in grossly unprofessional conduct, then Health Plan will provide written notice to the Member immediately upon notification of such termination but no later than thirty (30) days prior to the effective date of the specialist termination. If Health Plan terminates a Primary Care Physician responsible for directing a Member's referral to specialty physicians, Health Plan will provide instructions on selecting a new PCP. Further, Health Plan will remain financially responsible for any care obtained by Members through self-referrals for a period of sixty (60) days following the termination of the Member's PCP if notice under this section was not properly provided to the Member.

If Health Plan terminates a physician contract for any reason other than reasons relating to medical discipline, fraud or criminal activity, Members who are receiving treatment from the terminated physician for an acute condition, a serious chronic condition, a high-risk pregnancy, or pregnancy in the second or third trimester, may request to continue treatment with the terminated physician for up to ninety (90) days, or longer if necessary for a safe transfer to another provider, subject to the following: (i) the terminated provider must comply with the contract terms and conditions in effect at the time of the terminations; and (ii) the terminated provider must agree to accept an amount and method of payment similar to those provided by Health Plan to other contracted providers as payment in full, subject to any applicable Copayments. This provision does not apply if the physician voluntarily terminates his contract with Health Plan. For assistance in requesting this continuity of care provision, Members should call a Health Plan Member Service Representative at (877) 814-1861**.**

2.5 REIMBURSEMENT PROVISIONS

A Member should not make payments to any provider for the Covered Services under this Agreement except for applicable Copayments and for Emergency care when obtained outside the Service Area. Participating Providers are prohibited by contract from billing Members for Covered Services (other than Copayments). If a Participating Provider requests payment from the Member, other than Copayments, the Member should ask that he/she bill Health Plan directly. If for some reason the Member does pay a Participating Provider, the Member will be reimbursed by Health Plan for amounts paid for Covered Services (other than Copayments), not to exceed amounts which Participating Provider is under contract to accept as payment for services. Claims for reimbursement should be submitted to Health Plan at the address below.

If a Member pays a non-Participating Provider for Covered Services (e.g., Emergency services outside the Service Area), the Member must furnish evidence satisfactory to Health Plan that payment to such person or institution has been made for Covered Services. Health Plan will reimburse Member for such charges

less applicable Copayments and less any payments made by Health Plan prior to receipt of Member's evidence of payment.

Requests for reimbursement for out-of-area Emergency or Urgent Care Services, along with proof of payment, should be mailed to: Santa Barbara Regional Health Authority, 110 Castilian Drive, Goleta, CA 93117-3028. Attn: Claims Dept.

If a Member obtains prescription drugs from a non-participating pharmacy due to an emergency, the Member should contact the Member Services Department to obtain a "prescription drug claim form". The completed claim should be sent to the above address: Attn: Member Services.

The Member or Member's representative must notify Health Plan Member Services Department within forty-eight (48) hours, or as soon as reasonably possible, of any Covered Services rendered for which reimbursement will be claimed. Written proof of charges incurred must be submitted to the Health Plan within one hundred and eighty (180) days after the service is incurred, or as soon as reasonably possible.

All such charges will be paid within forty-five (45) working days of Health Plan's receipt of the satisfactory evidence described above, provided that all required information has been supplied and that Health Plan does not contest the claim. If Health Plan contests the claim, Health Plan will notify the Member within thirty (30) calendar days. Information required of Member may include but is not limited to reports, statements, releases, consents and assignments. Proof of payment is required.

SECTION 3 – FEES AND CHARGES

3.1 PREPAYMENT FEES

Public Authority will pay on or prior to the Effective Date the applicable Period Prepayment Fees/Premium for each Member entitled to receive benefits as of the date as reflected in the eligibility report. Thereafter, the Periodic Prepayment Fees/Premium shall be remitted to the Health Plan's offices on or before the twenty fifth (25th) day of each month ("due date") during the term of the Agreement. Such Prepayment Fee shall be payment for coverage for the succeeding calendar month. The Periodic Prepayment Fee set forth in Attachment 1, Rate Schedule, of this Agreement shall remain in effect for the term of this Agreement unless modified in writing by the parties hereto. Any contributions required of Members shall be arranged with Members solely by Public Authority. Retroactive deletions or additions are not allowed under this Agreement.

If the required Prepayment Fees are not paid in full on the due date, then Group will be in default and Health Plan may deem the failure of Group to pay the Prepayment Fees as action by Group to cancel the Agreement in accordance with Section 5 (Term, Cancellation and Related Provisions), subject to the reinstatement provisions as set forth in that section. Further, Health Plan will notify Group, on or after the twenty-fifth (25^{th}) day of the month, that it has failed to make the required prepayment and will immediately notify the Member(s) of such failure.

3.2 MEMBER COPAYMENTS

Members will be required to make certain Copayments for the Covered Services as indicated in Attachment 2 (Evidence of Coverage and Disclosure Form ((EOC)), which Member receives. Copayments must be paid at the time the Covered Services are rendered. Members will be required to pay Copayments as specified in the EOC. The total aggregate amount of Copayments per contract year for services shall also be specified in EOC and may vary by Plan type. Copayments for the following services shall not be included in the Annual Copayment Maximum amounts: Prescription Drugs, Durable Medical Equipment, and any Coinsurance charges that Member is required to pay. Within one hundred and eighty (180) days after the end of any contract year, a Member may apply to Health Plan for a refund of the excess of Copayments paid over the contract year.

Members who schedule appointments but fail to keep said appointments and who do not notify the Provider's office at least twenty-four (24) hours in advance to cancel said appointment may be charged by the Provider up to the Copayment amount. Copayments are set forth in the EOC, which is attached as Attachment 2 to this Agreement.

3.3 CHANGES IN FEES AND CHARGES

Health Plan will have the right to change the Prepayment Fees or Copayments as of any date to the extent or nature of the risk under this Agreement is changed by reason of any provision of law or change in any governmental program (including Medicare) or regulation. Health Plan will give Group written notice by certified mail thirty (30) days before such change in Prepayment Fees or Copayments takes effect.

Notwithstanding the foregoing, if a state or other taxing authority imposes upon Health Plan a tax or license fee which is levied upon or measured by Prepayment Fees or by Health Plan's gross receipts or any portion of either, then Group and Health Plan will meet and discuss additional fees to be paid by Group to offset said tax or license fee. Payment of any Prepayment Fees as changed in accordance with this section constitutes acceptance of continued coverage at the changed Prepayment Fees.

SECTION 4-– RECORDS

4.1 MAINTENANCE OF RECORDS

Health Plan will keep a record of Members. Group will forward the information periodically required by Health Plan in connection with the administration of this Agreement. Health Plan's liability for the fulfillment of any obligation dependent on information to be furnished by Group or Member will not arise prior to receipt of that information in the form requested by Health Plan. Nor will Health Plan be liable for any obligation due to information incorrectly supplied by Group or Member. All records of Group relating to coverage will be open for inspection by Health Plan at any reasonable time.

4.2 SUBMISSION OF CORRECT INFORMATION BY MEMBER

Members or applicants for membership must complete and submit to Health Plan such applications, medical review questionnaires, or other forms or statements as Health Plan may reasonably request. Members warrant that all information contained in such applications, questionnaires, forms or statements submitted to Health Plan incident to enrollment under this Agreement or the administration hereof will be true, correct and complete. Any breach of this warranty may give rise to termination of coverage as provided in Section 5 (Term, Cancellation and Related Provisions).

4.3 AUTHORIZATION OF DISCLOSURE

Health Plan is entitled to receive from any provider of services to Member, information reasonably necessary in connection with the administration of this Agreement. By acceptance of coverage under this Agreement, and as allowed pursuant to Health Insurance Portability and Accountability Act of 1996 (HIPAA), each Member authorizes every provider of medical services to Member to disclose all facts pertaining to such care and treatment, and physical condition of Member, to Health Plan upon request, to render reports pertaining to the same, and permit copying of records by Health Plan.

4.4 CONFIDENTIALITY

Information from medical records of Members and information received from physicians, surgeons or hospitals pursuant to the doctor-patient relationship will be kept confidential; and, except for use incident to *bona fide* medical research or education, or reasonably necessary in connection with the administration of this Agreement, or otherwise excepted under law, may not be disclosed without the consent of Member. Additionally, information concerning a Member's outpatient psychotherapy treatment will not be released to another unless the person requesting the information submits a signed, written request to the Member and to the provider as required by law. Members are entitled to a copy of the Health Plan's confidentiality policy

upon request. Health Plan and Group shall make any and all efforts and take any and all actions necessary to comply with statutory and regulatory requirements of HIPAA ("HIPAA requirements"), whether existing now or in the future within a reasonable time prior to the effective date of such requirements, but not later than the time permitted by the applicable HIPAA requirement after date of finalization.

SECTION 5 – TERM, CANCELLATION AND RELATED PROVISIONS

5.1 TERM

This Agreement will continue in effect for the term indicated in the Declarations; provided however, that Health Plan reserves the right to change the Prepayment Fees set forth in the Rate Schedule, Attachment 1, and the benefits and coverages herein, on each anniversary date of this Agreement. If Employer meets the applicable eligibility requirements as set forth in Section 1 (Eligibility), then this Agreement will renew automatically from year to year on the anniversary date unless terminated pursuant to this Section, and subject to any changes in Prepayment Fees, other charges, benefits and coverages pursuant to Section 3 (Fees and Charges) and the paragraph entitled "Change in Agreement" under Section 10 (General Provisions).

5.2 EFFECT OF CANCELLATION

Upon cancellation or expiration of the term, this Agreement and/or a Member's coverage and rights under this Agreement (referred to as "coverage") are terminated subject to any applicable provisions for reinstatement, conversion to individual membership, temporary continuation of benefits, continuation coverage or extension of benefits. This Agreement and/or a Member's coverage may be canceled for the reasons identified below. When canceled, all coverage and rights hereunder will terminate at the time indicated below. Any benefits or services received after the effective cancellation date will be directly chargeable to the Member.

5.3 CANCELLATION OF INDIVIDUAL MEMBERS

5.3.1 Loss of Eligibility

If a Member ceases to meet the eligibility requirements of Section 1 (Eligibility), then (subject to any applicable provisions for continuation or conversion of benefits) the Member's coverage terminates at midnight on the last day of the month in which loss of eligibility occurs. Group and Members agree to notify Health Plan Member Services Department, either electronically or by letter, immediately if a Member ceases to meet the eligibility requirements. Health Plan will provide written notice to the Member at least fifteen (15) days prior to the termination.

5.3.2 Disenrollment by Member

If a Member elects coverage under an alternative health benefits plan offered by or through Group as an option in lieu of coverage under this Agreement, then coverage for such Member terminates automatically at the time and date the alternate coverage becomes effective. In such event, Group agrees to notify Health Plan immediately that the Member has elected coverage elsewhere.

Member may voluntarily disenroll from Health Plan at any time for any reason by notifying the Public Authority of the intent to cancel membership. The Member's coverage terminates at midnight on the last day of the month during which the Member notified the Public Authority of the Member's intent to disenroll.

5.3.3 Cancellation of Member for Good Cause

(A) **Failure to Furnish or Furnishing Incorrect or Incomplete Information**. If a Member knowingly fails to furnish material information required in connection with this Agreement, or furnishes materially incorrect or misleading enrollment or required updated information,

then Health Plan may cancel coverage of the Member effective fifteen (15) days after receipt by the Member of written notice of cancellation from the Health Plan, unless the Member furnishes Health Plan with the required information within such fifteen (15) day period.

(B) **Fraud or Deception**. If a Member engages in fraud or deception in the use of the services or facilities of Health Plan or permits such fraud or deception by another, including but not limited to the unauthorized use of an Health Plan identification card or making a material misrepresentation on an Health Plan enrollment document, then Health Plan may cancel the coverage of the Member(s) involved effective the date Health Plan mails notice of cancellation to such Member(s). However, if such fraud or deception is material to Health Plan's underwriting risk, then such cancellation will be retroactive to the date the fraud or deception was made. Fraud or misrepresentation concerning eligibility will be deemed to have occurred if, at any time, the employer Group or the enrollee knowingly enrolls, disenrolls or denies enrollment of any person on the basis of eligibility requirements which are not consistent with or are in violation of the eligibility requirements specified in this Agreement.

(C) **Disruptive or Abusive Behavior**. If a Member acts in a materially threatening, disruptive, abusive, or illegal manner toward a Participating Provider or their employees or a Health Plan employee, to the extent that normal operations of the Provider or the Health Plan are adversely impacted, Health Plan may cancel coverage for that Member.

(D) **Medicare Enrollment**. If a non-TEFRA Member (see Section 11.6.1 – Medicare Eligible Members) fails to enroll for Medicare coverage when eligible to purchase Medicare, Health Plan may cancel coverage of that Member.

5.4 CANCELLATION OF ENTIRE AGREEMENT

5.4.1 Nonpayment

If Group fails to pay when due any monthly Prepayment Fees on behalf of each Member, then Health Plan may cancel this Agreement. Health Plan shall mail to Group a prospective notice of cancellation, after the due date for the payment of Prepayment Fees/Premium payments to Health Plan. Health Plan shall also send a prospective notice of cancellation of the Health Plan contract to each Member. Upon such default, all rights to benefits terminate for all Members, subject to compliance with notice requirements, including those who are hospitalized or undergoing treatment for an ongoing condition unless Member may be covered under Section 6.4, Extension of Benefits (due to Total Disability) no less than fifteen (15) days after notification, but in no case later than midnight of the last calendar day of the following month. For example, if Health Plan sends notification of cancellation to the Group and each Member on April 28, benefits for Members will cease at midnight on May 31.

5.4.2 Fraud

If Group knowingly furnishes materially incorrect, incomplete or misleading enrollment or other requested information regarding Group, its business, or any Member, or if Group knowingly permits fraud or deception by any of its Members, Health Plan will give Group written notice of termination, which termination will be effective retroactive to the date such information was provided or omitted.

5.4.3 Cancellation by Group

This Agreement may be terminated by Group by giving ninety (90) days prior written notice to Health Plan. In such event, all rights to benefits hereunder cease as of the effective date of termination of this Agreement regardless of whether a condition or course of treatment commenced while coverage was in effect. Health Plan has no obligation to notify Members in the event of such termination by Group.

5.4.4 Cancellation by Health Plan for Good Cause

If Group is not a "small employer" (as that term is defined in California law), Health Plan may decline to renew or may terminate this Agreement for cause, to the extent permitted by law, and if any of the following events occur: (i) any change in Group's eligibility requirements, employer contribution or other material information stated in Group's application, without Health Plan's prior written approval and (ii) termination of Health Plan, a particular product type, or withdrawal from the market as permitted by law.

In the event of such termination, Health Plan will give written notice to Group by mail (postage pre-paid) or hand delivery at least one hundred and eighty (180) days in advance of the effective date of such termination. Group will promptly mail to each Member a legible, true copy of the notice of termination.

5.5 NOTICE OF CANCELLATION

5.5.1 Notice Where Individual Member is Canceled

In the event that Health Plan cancels or refuses to renew an individual Member's enrollment under this Agreement, Health Plan will mail notice thereof to the Member at the Member's address of record with Health Plan or hand deliver such notice to the Member.

5.5.2 Notice Where Agreement with Group is Canceled

When Health Plan mails or hand delivers a notice of cancellation to Group (by address or delivery to the person signing this Agreement on behalf of Group or such person's successor) Health Plan will also promptly mail a legible, true copy of such notice to each Member under this Agreement at the Member's current address. Health Plan shall instruct Group to promptly mail to each subscriber a legible, true copy of any confirming notice of cancellation of the Agreement between the Health Plan and the Group. Said notice of cancellation shall also include information, in clear and easily understandable language, regarding the conversion rights of Members covered under said Agreement upon termination of the Agreement. Group must promptly provide to Health Plan proof of the mailing and the date thereof.

5.6 CESSATION OF COVERAGE

Health Plan does not cover any services or supplies provided after the effective date of termination of this Agreement or of a Member. Coverage ceases regardless of whether a condition or course of treatment commenced while coverage was in effect. The only exceptions are the provisions set forth in Section 6 (Individual Continuation of Group Benefits and Individual Conversion), where applicable. Where termination is for fraud or for any of the reasons set forth in Paragraph 5.3.3 (Cancellation of Members for Good Cause), Members are not entitled to individual continuation of group benefits or individual conversion set forth in Section 6.

5.7 LIMITATIONS ON INDIVIDUAL CONVERSION

If Group terminates this Agreement for any reason, or if Health Plan terminates this Agreement because of nonpayment by Group of the Prepayment Fees or for fraud or deception by Group, coverage for all Members enrolled through Group terminates on the date this Agreement terminates. However, Members may convert to individual non-group coverage without regard to health status or requirements for health care services if the Group does not replace the Agreement for similar coverage within fifteen (15) days of the termination of this Group Agreement.

5.8 REINSTATEMENT IF THE AGREEMENT IS CANCELED FOR NON PAYMENT OF PREMIUMS.

5.8.1 Receipt by Health Plan of the proper monthly Prepayment Fees after termination of Group for non-payment of Prepayment Fees will reinstate Group as though there never was a termination, if such payment is received on or before the due date for the succeeding monthly Prepayment Fees, unless: (i) in the notice of termination, Health Plan notifies Group that if payment is not received within fifteen (15) days of the notice of cancellation, a new application is required and the conditions on which a new contract will be issued or the original contract reinstated; (ii) such payment is received more than fifteen (15) days after issuance of the notice of termination, and Health Plan refunds such payment within twenty (20) business days; or (iii) such payment is received more than fifteen (15) days after issuance of the notice of termination, and Health Plan issues to Group within twenty (20) business days of receipt of such payment, a new contract accompanied by written notice stating clearly those aspects in which the new contract differs from the canceled contract in benefits, coverage or otherwise.

5.8.2 Members have no individual rights to renewal or reinstatement of this Agreement if the Agreement is terminated by Health Plan or Group, or by operation of law.

5.9 REFUNDS IN THE EVENT OF CANCELLATION

In the event of cancellation by either Health Plan or Group, Health Plan will return to Group, within thirty (30) days of the effective cancellation date, the pro rata portion of the monthly Prepayment Fees paid to Health Plan which correspond to any unexpired period for which payment had been received together with amounts due Members on claims for reimbursement of charges (for Covered Services) incurred prior to the effective date of cancellation, if any, less any amounts due Health Plan or Participating Providers, and neither Health Plan nor Participating Providers has any further liability or responsibility under this Agreement. However, no such refund will be made where cancellation is in the case of fraud or deception in the use of services or facilities of Health Plan or knowingly permitting such fraud or deception by another.

5.10 MEMBER'S RIGHT TO REVIEW OF CERTAIN CANCELLATIONS

A Member who alleges that Member's coverage, subscription or enrollment has been canceled or not renewed because of the Member's health status or requirements for health care services, may request a review by the California Director of the Department of Managed Health Care (DMHC).

SECTION 6 – INDIVIDUAL CONTINUATION OF GROUP BENEFITS AND INDIVIDUAL CONVERSION

6.1 CONTINUED GROUP COVERAGE (COBRA and Cal-COBRA)

Group is obligated under both federal and state law with regard to the continuation of health coverage for Members under certain circumstances where coverage would otherwise terminate ("continuation coverage"). The federal law is the Consolidated Omnibus Budget 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 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. The provisions of COBRA and Cal-COBRA are summarized below.

6.1.1 Group Obligations Under COBRA

Under federal law, an employer with twenty (20) or more employees on a typical business day during the prior calendar year must provide Members with the opportunity to elect COBRA continuation coverage in certain circumstances where coverage would otherwise terminate. Such employers and their group health plan's administrators (in certain cases, the employer may be the plan administrator) have the obligation to: (i) provide Members with notice of the opportunity to elect continuation coverage; and (ii) administer the continuation coverage. The obligation to

provide notice includes both general notification to Members of their right to elect continuation coverage and specific notification of the right to continuation coverage within a specific time period after the occurrence of the event which triggers the continuation coverage option.

Group hereby acknowledges its legal obligations and agrees to abide by applicable legal requirements with respect to COBRA continuation coverage. Group also agrees to forward to Health Plan in a timely manner copies of any and all notices provided to Members regarding COBRA continuation coverage.

6.1.2 Group Obligations Under Cal-COBRA

Under California law, a health care service plan that contracts with employers who employ two (2) through nineteen (19) eligible employees on a typical business day during the prior calendar year is required to provide Members with the opportunity to elect Cal-COBRA continuation coverage in certain circumstances where coverage would otherwise terminate. Health Plan will administer or contract for the administration of continuation coverage under Cal-COBRA. Nonetheless, Group must provide certain notices to Health Plan and to Members as described below.

Group must notify Health Plan in writing of any employee who has a qualifying event defined in sections 6.1.3 within thirty (30) days of the qualifying event. Such notice must be separate from other communications from Group and must specifically reference Cal-COBRA. Notations of additions and/or deletions on monthly invoices will not constitute sufficient notice. Group must further provide written notice to Health Plan within thirty (30) days of the date Group becomes subject to § 4980B of the United States Internal Revenue Code or Chapter 18 of the Employee Retirement Income Security Act, 29 U.S.C. § 1161 et seq.

Group must also notify qualified beneficiaries of the ability to continue coverage prior to terminating a group agreement (such as this Agreement) under which a qualified beneficiary is receiving continuation coverage. This notification shall be provided either thirty (30) days prior to the agreement termination or when all other enrolled employees are notified, whichever is greater. Group must notify any successor plan in writing of the qualified beneficiaries currently receiving continuation coverage to enable the successor plan, contracting employer, or administrator to provide such qualified beneficiaries with the premium information, enrollment forms, and disclosures necessary to allow the qualified beneficiaries to continue coverage under other available group plans.

If Group fails to meet these obligations, Health Plan will not provide continuation coverage to qualified beneficiaries under Cal-COBRA. Group hereby acknowledges its obligations and agrees to comply with all applicable legal requirements with respect to Cal-COBRA continuation coverage. Group also agrees to forward to Health Plan in a timely manner copies of any notice provided to Members regarding Cal-COBRA continuation coverage.

6.1.3 Eligibility for Continuation of Coverage

The following persons are entitled to elect continuation coverage in the following situations ("qualifying events"): Members whose coverage under this Agreement ends because of termination of Member's employment (unless employment is terminated because of gross misconduct), or whose coverage terminates because of a reduction in hours of employment, have the right to elect continuation coverage for themselves.

6.1.4 Maximum Time Periods of Coverage

Continuation coverage begins on the date of the event that would otherwise trigger the loss of coverage under this Agreement and terminates no later than thirty-six (36) months thereafter except if coverage for the Member ends because of the termination or reduction in hours of Member's employment. In that instance, continuation coverage will terminate no later than eighteen (18) months thereafter; provided, however, that if the Member notifies the plan administrator within sixty (60) days after the date of a determination, under Titles II or XVI of the

Social Security Act, that he or she was disabled at any time within the first sixty (60) days of continuation coverage, coverage will terminate no later than twenty-nine (29) months thereafter.

Members who reach the maximum federal COBRA coverage may have rights to additional coverage under Cal-COBRA, not to exceed a total of 36 months of continuation coverage.

6.1.5 Exceptions to Maximum Time Periods of Coverage

Notwithstanding the maximum time periods set forth above, continuation of coverage will end upon the occurrence of any one of the following events:

(1) On the date Group ceases to provide any group health plan to any employee of an employer. For purposes of this Section 0, the term "employer" is that term as defined under the applicable statutes;

(2) On the date Member becomes covered under another health plan which does not contain any exclusion or limitation with respect to any pre-existing condition of the Member;

(3) On the date Member becomes entitled to Medicare benefits;

(4) On the date Member fails to make timely payment of any premium required under this Agreement; or

(5) In the case of the eleven (11) month extended coverage provided due to a disability, on the first (1st) day of the month which starts at least thirty (30) days after a final determination, under the Social Security Act, that Member is no longer disabled.

6.1.6 Type of Coverage

Coverage provided under the continuation of coverage option must be identical to the coverage Group provides to similarly situated persons who have not lost group coverage under this Agreement. Continued coverage cannot be conditioned on evidence of insurability.

6.1.7 Prepayment Fees

(A) **Under COBRA**

Group may require the Member to pay for COBRA continuation coverage, so long as the amount does not exceed one hundred and two percent (102%) of the applicable premium and in the case of a Member who is entitled to the eleven (11) month extended coverage period as a result of a disability, does not exceed one hundred and fifty percent (150%) of the applicable premium for the coverage during that extended period of coverage. Applicable premium for any twelve (12) month period of continuation coverage is defined as a reasonable estimate of the cost of providing coverage during the period for similarly situated persons who did not lose group coverage under this Agreement.

Group shall remit to Health Plan all premiums for Members who continue group coverage in monthly installments with Group's regular monthly payment. If Group requires a Member's COBRA continuation coverage to pay all or any part of the premiums for such coverage, Group shall be solely responsible for collecting those premiums. Group agrees that COBRA continuation coverage shall be provided only for persons eligible for such coverage under applicable law and regulations and for whom applicable premiums have been received by Health Plan.

For COBRA premium payments, Health Plan will provide Group a grace period of thirty (30) days prior to terminating coverage for failure to pay premium. However, Group shall immediately notify Health Plan if Group fails to receive the Member's premiums on the due date.

If a Member elects COBRA continuation coverage after the date of the event which entitles him or her to continuation coverage, Group must remit the first premium retroactive to the date coverage would otherwise have terminated within forty-five (45) days of the date of the election. No grace period applies to this first premium.

(B) **Under Cal-COBRA**

Health Plan may require the Member to pay for Cal-COBRA continuation coverage, so long as the amount does not exceed one hundred and ten percent (110%) of the applicable premium and in the case of a Member who is entitled to the eleven (11) month extended coverage period as a result of a disability, does not exceed one hundred and fifty percent (150%) of the applicable premium for the coverage during that extended period of coverage.

Members who continue group coverage under Cal-COBRA must remit all premiums directly to Health Plan, or its designated administrator. Member's first premium payment under Cal-COBRA must include the entire amount due retroactive from the date of the qualifying event and be received by Health Plan on or before the due date. No grace period applies to Member's first premium payment. With regard to subsequent Cal-COBRA premium payments, however, Health Plan will provide Members a grace period of fifteen (15) days prior to terminating coverage for failure to pay premiums.

6.1.8 Notice of Qualifying Event

(A) **Under COBRA**

The COBRA plan administrator is designated in the document establishing Group's health benefits plan. In the absence of such designation, the administrator is the employer.

Group must notify the plan administrator (if Group and plan administrator are not the same) within thirty (30) days of the occurrence of any qualifying event. In turn, the plan administrator is obligated to notify Member of the opportunity to elect COBRA continuation coverage within fourteen (14) days after receiving notice of the qualifying event.

(B) **Under Cal-COBRA**

In the event of eligibility for Cal-COBRA continuation coverage due to termination of Member's employment (except when based on gross misconduct) or reduction of Member's work hours, Group must notify Health Plan of such qualifying event and to which Member(s) such event applies within thirty-one (31) days after the date of such event. If Group fails to provide such notice within the thirty-one (31) day period allowed, Health Plan will not provide Cal-COBRA continuation coverage to such Member(s).

In the event of eligibility for Cal-COBRA continuation coverage due to qualifying events, except those due to termination of Member's employment or reduction of Member's work hours, Member has the responsibility to notify Health Plan of such qualifying event within sixty (60) days of the event. If Member fails to provide such notice within the sixty (60) day period allowed, Health Plan will not provide Cal-COBRA continuation coverage to such Members.

6.1.9 Replacement Coverage

When the Health Plan replaces another carrier, any eligible person enrolled under such prior carrier's continued coverage COBRA providers shall be eligible to continue benefits with the Health Plan only for the remaining continuation period under COBRA.

6.1.10 Nonliability of Health Plan

Health Plan will cooperate with Group to assist Group in meeting its obligations regarding continued Group coverage, provided that, except as otherwise set forth in the following subsection, Health Plan assumes no responsibility for Group's compliance with Group's obligations under federal laws or regulations concerning continuation of group coverage. Group hereby indemnifies and holds Health Plan harmless from any and all claims, liability and expenses arising out of Group's failure to comply with its obligations under federal laws or regulations regarding continuation of group coverage.

6.1.11 Coordination of Benefits

If a Member who has elected continuation of coverage under this Agreement subsequently becomes covered under another group health care plan or policy which has an exclusion for pre-existing conditions, the coverage under this Agreement will be secondary to coverage under such other plan or policy; except that the coverage under this Agreement will be primary with respect to the pre-existing conditions which are excluded under such other group plan or policy.

6.1.12 Conversion Option

Subject to the terms of the provisions regarding individual conversion, individual non-group conversion coverage will be available to persons whose group continuation coverage terminates at the end of the applicable continuation period solely due to the expiration of the coverage period provided by law.

6.1.13 Regulations

In the event federal or state laws or regulations are enacted or issued governing continuation of group coverage and the application of such laws or regulations would modify this section regarding benefits under COBRA, such laws or regulations will supersede any contrary provision herein.

6.2 CONTINUED GROUP COVERAGE AFTER TERMINATION OF COBRA

If a Member elects to extend group health benefits under COBRA, the Member may be entitled to an extension of those group health benefits after COBRA benefits terminate. Group must notify the Member, if he or she is eligible for extended benefits upon termination of coverage under COBRA. The Member will be eligible for this extension if the Member: (i) worked for Group for at least five (5) years prior to the date employment terminated; (ii) is at least sixty (60) years old on the date employment terminated; and (iii) is entitled to and elected benefits under COBRA for himself or herself.

Under this extension of benefits, the Member will receive the same benefits as under COBRA, but the Member will be required to pay Prepayment Fees to Health Plan. Continued coverage under this paragraph will end automatically on the earlier of the date: (i) the Member reaches age 65; (ii) the Member is covered under any group health plan not maintained by Group, regardless of whether that coverage is less valuable; (iii) the Member becomes eligible for Medicare; or (iv) on which Group terminates this Agreement with Health Plan.

6.3 CONVERSION TO INDIVIDUAL NON-GROUP MEMBERSHIP

In the event a Member ceases to be covered under this Agreement solely as a result of leaving the Group through which he or she had enrolled in Health Plan, then such person may convert his/her membership to individual non-group membership for him or herself without regard to health status or requirements for health care services. However, conversion is not available if:

(A) This Agreement terminated or the Member's Group terminated participation in this Agreement for any reason and this Group contract is replaced by similar coverage under another group contract within fifteen (15) days of the date of termination of the Group coverage or the Member's participation;

(B) The Member fails to pay amounts due to Health Plan;

(C) The Member is terminated by Health Plan for cause;

(D) The Member is eligible for benefits under Medicare or any other Federal or State law;

(E) The Member is eligible for health benefits under any form of group coverage, or is covered for health benefits under an individual policy or contract; or

(F) The Member has not been continuously covered during the three (3) month period immediately preceding the date of termination of group coverage.

Notwithstanding any other provision to the contrary, no Member is eligible to convert to individual non-group coverage where the Member's group coverage was terminated for cause.

Member will convert to non-group membership by submitting a written application and the first premium payment no later than sixty-three (63) days after termination from the Group, after which Health Plan will issue a conversion contract effective on the day following the termination of coverage under the Group Agreement.

It is the sole responsibility of Group to notify Members of the availability, terms and conditions of the non-group conversion coverage within fifteen (15) days of the termination of group continuation coverage.

6.4 EXTENSION OF BENEFITS

Except as expressly provided in this Section, all rights to services and other benefits hereunder terminate as of the effective date of termination of this Agreement.

If, when this Agreement is terminated as to the entire Group, a Member is receiving treatment for a condition for which benefits are available under this Agreement and which condition has caused Total Disability as determined by Health Plan, then such Member will be covered, subject to all limitations and restrictions of this Agreement, including payment of Copayments and the monthly Prepayment Fees, for Covered Services directly relating to the condition causing Total Disability. This extension of benefits terminates upon the earlier of: (i) the end of the twelfth (12^{th}) month after termination of this Agreement; (ii) the date the Member is no longer Totally Disabled as determined by Health Plan; or (iii) the date Member's coverage becomes effective under any replacement contract or policy without limitation as to the disabling condition. A person is Totally Disabled if he or she satisfies the definition of Totally Disabled in this Agreement.

Determinations regarding the existence of a Total Disability will be made by a Participating Provider and approved by Health Plan Medical Director. A medical examination performed by a physician specified by Health Plan may be required to determine the existence of a Total Disability.

If Health Plan terminates this Agreement for cause as specified in Paragraph 5.4.4 (Cancellation by Health Plan for Cause), any Member who is a registered bed patient in a Hospital at the effective date of termination will, subject to payment of the periodic prepayment fees and applicable Copayments, receive all benefits otherwise available hereunder to institutionalized patients for the condition under treatment during the remainder of the particular episode of institutionalization, until either the earlier of: (i) the expiration of such benefits; or (ii) determination by Health Plan that hospitalization is no longer Medically Necessary.

If prior to termination there has been no default in the payment of the monthly Prepayment Fees or those made on the Member's behalf, and the Member is receiving inpatient obstetrical care at the date of termination, Health Plan will continue coverage of the obstetrical care for the mother until discharge from the hospital.

6.5 CONTINUATION COVERAGE

As a result of a being enrolled in the Health Plan, a Member has guaranteed access to continued coverage under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). In order to qualify for such continued coverage, the Member must elect and exhaust COBRA or Cal-COBRA benefits.

SECTION 7– MEMBER SATISFACTION AND GRIEVANCE PROCESSES

7.1 MEMBER SATISFACTION

If a Member has a concern about the services received from a Participating Provider, the Member is encouraged to speak with the provider as soon as possible. If the Member does not feel comfortable discussing the issue with the provider, the Member may contact the Health Plan at (805) 685-9525, or outside of Santa Barbara, toll-free at (877) 814-1861. No discriminatory action will be taken against any Member for filing a grievance. The following disclosure is required to be placed in all Agreements, in the EOC, in complaint forms, etc. Use of "you" or "your/yours" refers to a Member.

The California Department of Managed Health Care ("department") is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your Plan by calling **1-877-814-1861or** our **TDD line 1-805-685-4131** for the hearing and speech impaired 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 unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number **(1-888-HMO-2219)** and a TDD line **(1-877-688-9891)** for the hearing and speech impaired. The department's Internet Web site **http://www.hmohelp.ca.gov** has complaint forms, IMR application forms and instructions online.

7.2 GRIEVANCE PROCESSES

Members may report a grievance in person, mail, e-mail, fax, by telephone or through the Plan's website at http://www.sbrha.org. Additionally, grievance forms are available at Health Plan provider offices. Ordinarily, Health Plan will provide written acknowledgment of the Member's grievance within five (5) business days of receipt of the grievance. A written statement of the resolution of the grievance will be sent to the Member within thirty (30) business days of the Plan's receipt of the grievance.

A grievance will be treated as "urgent" if it involves an imminent and serious threat to the health of the patient, including but not limited to severe pain, potential loss of life, limb, or major bodily function. In the case of an urgent grievance, Health Plan will provide the Member with a written statement on the disposition or pending status of the "urgent" grievance within three (3) business days of receipt.

7.2.1 Member Dissatisfaction

If the Member is dissatisfied with the Health Plan's decision, the Member may appeal by calling the Health Plan's Grievance Coordinator at (805) 685-9525, or outside Santa Barbara, toll-free at (877) 814-1861**.**

7.2.2 Independent Medical Reviews

Members are entitled to an Independent Medical Review (IMR) of disputed health care services or to examine Health Plan's coverage decisions regarding certain experimental or investigational

therapies as required by law. A "disputed health care service" is any health care service eligible for coverage and payment under this Agreement that has been denied, modified, or delayed by the Health Plan or one of its Participating Providers, in whole or in part because the service is not Medically Necessary.

The IMR process, administered by DMHC, is in addition to any other procedures or remedies that may be available. There is no application or processing fee for IMR. Members have the right to provide information in support of their request for IMR. Health Plan will provide Members with an IMR application form with any grievance disposition letter that denies, modifies, or delays health care services. A decision not to participate in the IMR process may cause the Member to forfeit any statutory right to pursue legal action against the plan regarding the disputed health care service.

Additional information regarding the IMR process may be obtained by calling Health Plan at (805) 685-9525, or outside of Santa Barbara, toll-free at (877) 814-1861, or by writing to Santa Barbara Regional Health Authority, 110 Castilian Drive, Goleta, CA 93117-3028.

7.2.3 Time Limit for Commencing Arbitration

If the Member is dissatisfied with the final resolution upon completion of the grievance process and wishes to pursue the matter further, he or she may file a request for binding arbitration. Except as provided in section 8.1 hereof, requests for arbitration must be made within the statutory time limits prescribed for litigation pursuant to the California Code of Civil Procedure.

SECTION 8 – MEDIATION AND ARBITRATION

8.1 VOLUNTARY MEDIATION

A Member may request non-binding voluntary mediation with the Health Plan prior to submitting a grievance to DMHC or initiating binding arbitration. If the Health Plan agrees to mediation, the expenses for mediation shall be borne equally by both sides. Mediation is administered privately, and not by the DMHC. The time limit for initiating binding arbitration is extended for the duration of the mediation process. The use of mediation services does not preclude Member from the right to submit a grievance to DMHC upon completion of the mediation.

8.2 BINDING ARBITRATION

Binding arbitration is the final process for resolving any disputes between Interested Parties arising from or related to Health Plan membership, 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 rendered were unnecessary or unauthorized or were improperly, negligently or incompetently rendered). "Interested Parties" means Members, the heirs-at-law or personal representative(s) of a Member, an employer group, a Participating Provider and Health Plan, including any agents or employees of an Interested Party. The agreement to elect binding arbitration shall be enforced even if an Interested Party is also involved in another action or proceeding with a third party arising out of the same matter. Interested Parties may be giving up their constitutional right to the extent permissible by law to have their dispute decided in a court of law before a jury, if they accept binding arbitration.

Unless otherwise agreed by the parties to the arbitration, the arbitration shall occur within the Health Plan Service Area in accordance with the applicable rules of the American Arbitration Association (AAA) or such other neutral dispute resolution service as mutually agreed by the parties. If the AAA declines the case and the parties do not agree on an alternative service, either party may petition the court for appointment of a neutral arbitrator under California Code of Civil Procedure § 1281.6.

The parties will equally share the arbitrator's fee, if any, as well as any administrative fee, unless otherwise assessed by the arbitrator. In cases of extreme hardship to a Member, 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 Health Plan.

The arbitrator will establish the procedures which will govern the arbitration, including procedures concerning discovery. The arbitrator will be bound by applicable state and federal law and regulations; and will issue a written opinion setting forth findings of fact, conclusions of law and the basis of the decision. The parties will 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.

SECTION 9 – LIMITATIONS ON REMEDIES

9.1 MEDICAL INJURY COMPENSATION REFORM ACT

In any proceeding involving allegations of professional negligence, the damage limits provided by the California Medical Injury Compensation Reform Act shall apply. The ability to obtain an order for periodic payments under California Code of Civil Procedure § 667.7 shall be available in the same manner as if the dispute or controversy had been tried by a court or jury.

9.2 WAIVER OF PUNITIVE DAMAGES

In the event of any claim or controversy between Interested Parties, all Interested Parties expressly waive their right to recover punitive damages against other Interested Parties.

9.3 MEDICAL MALPRACTICE CLAIMS

Any claim alleging wrongful acts or omissions of Participating Providers shall not include Health Plan and shall include only the Participating Providers subject to the allegation.

SECTION 10 – GENERAL PROVISIONS

10.1 CHANGE IN COVERED SERVICES

Health Plan will not decrease Covered Services except as permitted by law and upon at least thirty (30)days prior written notice by postage-paid mail to Group.

10.2 NOTICE OF PARTICIPATING PROVIDER'S INABILITY TO PERFORM

Health Plan will provide affected Members with written notice within a reasonable time of any termination or breach of contract by, or the inability to perform of, any Participating Provider who is rendering services to said Member.

10.3 ADMINISTRATION OF AGREEMENT

Health Plan may adopt reasonable policies, procedures, rules and interpretations to promote orderly and efficient administration of this Agreement.

10.4 NECESSARY DOCUMENTS

Any Member who fails to submit any documents requested under this Agreement related to services received must pay the charges for such services received.

10.5 I.D. CARDS

Cards issued by Health Plan to Members are for identification only. Possession of a Health Plan identification card confers no right to services or other benefits under this Agreement. To be entitled to such services or benefits, the holder of the card must, in fact, be a Member on whose behalf all applicable charges under this Agreement have actually been paid. If any Member permits the use of his or her Health Plan identification card by any other person, such card may be retained by Health Plan, and all rights of such Member pursuant to this Agreement shall be immediately terminable by Health Plan upon written notice. Any person receiving services or other benefits to which he or she is not then entitled pursuant to the provisions of this Agreement must pay applicable charges.

10.6 SERVICES NON-TRANSFERABLE

No person other than a Member is entitled to receive Covered Services under this Agreement. Such right to Covered Services is not transferable.

10.7 WORKERS' COMPENSATION INSURANCE

This Agreement is not in lieu of and does not affect any requirement of coverage by Workers' Compensation insurance. All benefits paid or payable by Workers' Compensation for Covered Services are payable to Health Plan under Section 11.5 (Third Party Responsibility).

10.8 NO MEMBER LIABILITY FOR HEALTH PLAN'S FAILURE TO PAY PARTICIPATING PROVIDERS

As required by law, every contract between Health Plan and a Participating Provider specifies that in the event Health Plan fails to pay such provider, Member will not be liable to the Participating Provider for any sums owed by Health Plan.

10.9 MEMBER LIABILITY TO NON-PARTICIPATING PROVIDERS

In the event Health Plan fails to pay a non-Participating Provider, Member may be liable to such non-Participating Provider for the cost of such provider's services, unless Prior Authorization has been obtained from Health Plan or the services were for Emergency services.

10.10 HEALTH PLAN LIABILITY FOR CHARGES

Upon termination of a Participating Provider contract, Health Plan will be liable for Covered Services (other than for Copayments) rendered by such Participating Provider for a Member under the care of such Participating Provider at the time of such termination until the Covered Services are completed, unless Health Plan makes reasonable and medically appropriate provisions for the assumption of such Covered Services by another provider.

10.11 NONDISCRIMINATION

Health Plan may not refuse to enter into any contract, cancel or decline to renew or reinstate any contract, nor may Health Plan modify the terms of a contract because of race, color, national origin, ancestry, religion, sex, marital status, sexual orientation, genetic characteristics, handicapped status, or age (except as provided in Section 1, Eligibility) of any contracting party, or person reasonably expected to benefit from such contract.

10.12 RELATIONSHIPS AMONG THE PARTIES

The relationship between Health Plan and Participating Providers is that of independent contractors. Participating Providers are not employees or agents of Health Plan. Neither Health Plan nor any of its employees are, or will be deemed to be employees, agents or representatives of Participating Providers.

Participating Providers maintain the provider-patient relationship with Members and are solely responsible to Members for all of their services. In no event will Health Plan be liable for the negligence, wrongful acts,

or omissions by a Participating Provider's delivery of services regardless of whether they are covered under this Agreement, nor will Health Plan be liable for services or facilities which for any reason beyond its control are unavailable to Member. Neither Group nor any Member is the agent or representative of Health Plan.

10.13 BINDING EFFECT UPON MEMBERS

By executing this Agreement, Group agrees to make Health Plan benefits available to persons who are eligible and duly enrolled under Section 1 (Eligibility). By enrollment or accepting services or benefits under this Agreement, Members legally capable of contracting and legal representatives of all Members incapable of contracting agree to all terms, conditions, and provisions hereof and thereby agree to be bound by this Agreement.

10.14 CHANGE IN AGREEMENT

Health Plan may add, amend, modify, or delete provisions in this Agreement as permitted by law by giving Group thirty (30) days written notice. Otherwise this Agreement may not be changed, amended, or modified except in writing executed by Group and Health Plan. Group's concurrence in such amendments is established by continuation of coverage hereunder after the effective date of the amendment. This Agreement may be amended, modified or terminated in accordance with its terms, without the consent of the Members.

10.15 NONWAIVER

No delay or failure by Health Plan to exercise any right under this Agreement will be deemed a waiver of such right in the future. The provision by Health Plan of extra-contractual benefits to a Member will not create any rights to extra-contractual benefits, either to the same Member in the future or as to any other Member.

10.16 ASSIGNMENT

Neither party shall have the right to assign this Agreement unless such assignment is required by law or the prior written consent of the other party is first obtained. Any purported assignment in violation hereof shall be void and unenforceable. Health Plan may, however, assign its rights and obligations under this Agreement to another licensed health care service plan or nonprofit hospital service plan affiliated with or acting as a successor to Health Plan.

10.17 NOTICES

Unless otherwise specified in this Agreement, Group agrees to disseminate to its Members the EOC and any changes to the EOC, plan summaries or other notices regarding material matters in the next regular communication to such Members, but in no event later than thirty (30) days after receipt thereof from Health Plan. Where Group is obligated to initiate notice, Group shall do so in accordance with the specific contractual terms and time frames contained in this Agreement and in accordance with applicable state and federal law pertaining to the notice.

Notice will be sent by United States mail, first class, postage prepaid, addressed to:

To Health Plan:	Santa Barbara Regional Health Authority 110 Castilian Drive Goleta, CA 93117-3028
To Member:	Member's last address known to Health Plan
To Group:	Group's last address known to Health Plan

10.18 PARAGRAPH HEADINGS

The paragraph headings and captions of this Agreement are for ease of reference and will not limit, amplify or otherwise affect the meaning of any provision of this Agreement.

10.19 GOVERNING LAW

Health Plan is subject to the requirements of the Knox-Keene Act and its regulations (Chapter 2.2 of Division 2 of the California Health & Safety Code and applicable regulations developed by the Director of DMHC as set forth in Chapter 1 of Title 28 of the California Code of Regulations). Any provisions required by either of the above will bind Health Plan whether or not specifically set forth in this Agreement.

10.20 ENTIRE AGREEMENT

This Agreement, addenda and membership applications constitute the entire agreement between the parties as of the Effective Date, and supersedes all other agreements between the parties. No representation by any broker, agent, or marketing representative or any other person will be binding upon Health Plan unless expressly set forth in this Agreement.

SECTION 11 – LIMITATIONS ON BENEFITS

11.1 CIRCUMSTANCES BEYOND HEALTH PLAN'S CONTROL

If, due to circumstances not reasonably within the control of Health Plan, such as complete or partial destruction of facilities, major disaster, epidemic, war, riot, civil insurrection, or similar causes, the rendition of Covered Services is delayed or rendered impractical, then Health Plan will make a good faith effort to provide or arrange for such Covered Services under this Agreement within the limitations of such policies and personnel as are then available. Under such conditions, Members should seek services from the nearest hospital or call the "9-1-1" emergency response system. In the case of labor disputes, the obligation of Health Plan will be to arrange and pay for an alternate method of receiving care.

11.2 NON-DUPLICATION OF BENEFITS

The benefits under this Agreement are not designed to duplicate any benefits for Members who are entitled to receive benefits under Workers' Compensation, employer liability laws, Medicare, CHAMPUS, or any other health plan or insurance policy. All sums paid or payable for Covered Services provided pursuant to this Agreement will be payable to and are deemed assigned to Health Plan. By executing an enrollment application, Member agrees for himself/herself to submit to Health Plan the necessary claim forms, consents, releases, assignments and other documents reasonably requested by Health Plan, including enrollment under Parts A and B of the Medicare Program, in order to assist Health Plan in recovering the reasonable value of Covered Services provided to a Member who receives benefits covered under Medicare, CHAMPUS, Workers' Compensation or any other health plan or insurance policy. Any Member who fails to submit such documents reasonably requested must pay charges for Covered Services received, as determined by Health Plan, and will be subject to termination. When a Member has available benefits with another health plan or insurance policy, Health Plan as a secondary payor, will pay only the remaining allowable charges whether or not a claim is made to the primary payor. The fact that a Member has duplicate coverage in no way reduces Member's obligation to make all required Copayments. The non-duplication provisions of this paragraph apply to the full extent permitted by law.

11.3 REIMBURSEMENT RESPONSIBILITY OF HEALTH PLAN

In the event Health Plan for any reason beyond its control, is unable to provide Covered Services, then Health Plan will be liable for reimbursement of the expenses necessarily incurred by any Member in procuring the services through non-Participating Providers to the extent required by DMHC.

11.4 REFUSAL OF TREATMENT

Members may, for personal reasons, refuse to accept procedures or treatment recommended by Participating Providers. Participating Providers may regard such refusal to accept their recommendations as incompatible with the continuance of the physician-patient relationship and as obstructing the provision of proper medical care. If a Member refuses to accept such a recommended treatment or procedure and the Participating Provider believes that no professionally acceptable alternative exists, Member will be so advised and Member may seek a second opinion from another Participating Provider.

11.5 THIRD PARTY RESPONSIBILITY

In cases of injuries caused by any act or omission of a third party (including, without limitation, motor vehicle accidents and Workers' Compensation cases) and complications incident thereto, Health Plan will furnish Covered Services. However, in the event of any recovery from a third party on account of such injuries, Member will reimburse Health Plan for the reasonable costs actually paid to perfect the claim for reimbursement, as set forth below. By executing an enrollment application, each Member grants Health Plan a lien on any such recovery and agrees to protect the interests of Health Plan when there is a possibility that a third party may be liable for a Member's injuries.

(A) Member's reimbursement to Health Plan or the medical provider under this lien will not exceed the reasonable costs actually paid by Health Plan to perfect the lien. Determining the lien amount, depends on how the Participating Provider was paid and will be determined as permitted by law as follows: (1)For health care services not provided on a capitated basis, the amount actually paid by the licensee, medical group, or independent practice association pursuant to that contract or policy to any treating medical provider; (2) For health care services provided on a capitated basis, the amount equal to 80 percent of the usual and customary charge for the same services by medical providers that provide health care services on a noncapitated basis in the geographic region in which the services were rendered.

(B) Each Member will give prompt notification to Health Plan of the name and location of the third party, if known, the name and address of Member's lawyer if using one, and a description of how the injuries were caused.

(C) Each Member will: (i) complete any paperwork that Health Plan or the medical providers may reasonably require to assist in enforcing the lien; (ii) promptly respond to inquiries about the status of the third party case and any settlement discussions; (iii) notify the Health Plan immediately upon his/her or his/her lawyer receiving any money from the third parties or their insurance companies; and (iv) hold any money that he/she or his/her lawyer receives from the third parties or their insurance companies in trust, and reimburse Health Plan for the amount of the lien as soon as he/she is paid by the third party.

(D) If a Member obtains a final judgment that includes a special finding by a judge, jury or arbitrator that Member was partially at fault, the reimbursement due Health Plan under this section will be reduced by the same percentage of comparative fault by which the Member's recovery was reduced. The reimbursement due Health Plan under this section will also be reduced by a pro rata share of the Member's reasonable attorneys' fees and costs, in accord with the common fund doctrine. Further, the reimbursement due to Health Plan under this section will not exceed one-third (1/3) of Member's recovery if Member engaged an attorney, or one-half (1/2) of Member's recovery if Member did not engage an attorney. (The provisions of this subparagraph (D) do not apply to reimbursement sought through a Workers' Compensation claim.)

(E) The obligation to reimburse Health Plan applies to the full amount of the recovery even though the judgment, award or settlement is less than the total amount of the Member's alleged damages, or does not specify a monetary amount for medical expenses, or specifies that all or part of the recovery is for damages other than medical expenses.

(F) Hospitals and other parties providing medical services to Members may have additional lien rights of their own, which are not created through any agreement with Health Plan, and are separate from the lien rights described in this section.

11.6 COORDINATION OF BENEFITS (COB)

11.6.1 Medicare Eligible Members

For this Group, because there is no coverage for any dependents, the provisions of this subsection 11.6.1 shall most likely cover COB situations for Group Members. However, the provisions of section 11.6.2 are set forth herein to describe all COB situations.

If Group employs twenty or more employees for each working day in each of twenty (20) or more calendar weeks in the current calendar year or the preceding calendar year, and thus is obligated to comply with the Tax Equity and Fiscal Responsibility Act (TEFRA) laws and regulations, as amended, then Members who are employees actively at work (including reemployed retirees or annuitants) and who are age 65 or older will be subject to the same benefits, prepayment fees, and other conditions as other Members and Health Plan will provide primary coverage with respect to such active employees.

11.6.2 General COB Law and Regulation.

Except as otherwise provided in the next paragraph, if Group normally employs at least 100 employees on a typical business day during the previous calendar year, then Members under age 65 who are entitled to Medicare based on disability shall be subject to the same benefits, prepayment fees, and other conditions as other Health Plan Members, and Health Plan will provide primary coverage with respect to such disabled Members.

Irrespective of the number of employees of Group, Members who are under age 65 and who are entitled to Medicare solely on the basis of End Stage Renal Disease shall, for a period of thirty (30) months from inception of Medicare eligibility, or such other period as may be required by law, be subject to the same benefits, prepayment fees and other conditions as other Health Plan Members, and Health Plan will provide primary coverage to such Members for such time period. Notwithstanding any other limitation contained herein, Members who have End Stage Renal Disease (whether or not entitled to Medicare) will also be subject to the same benefits and the same prepayment fees as other Health Plan Members who do not have End Stage Renal Disease, provided that following the 30-month period or such other period as may be required by law, Health Plan will provide secondary coverage with respect to such Members who are Medicare eligible.

Except as otherwise provided above, Members who are or who become Medicare eligible shall enroll in Medicare (Parts A and B) as a condition of continued eligibility for Health Plan benefits. Health Plan will provide with respect to such Members only secondary coverage with Medicare deemed to be primary.

(A) Benefits Subject to This Provision

All the benefits provided under this Plan contract are subject to this section 11.6.

(B) Definitions for Purposes of This Section:

(1) “Plan” means any plan providing benefits or services for or by reason of medical or dental care or treatment which benefits or services are provided by:

(a) Group, blanket, or franchise insurance coverage;

(b) Service plan contracts, group practice, individual practice, and other prepayment coverage;

(c) Any coverage under labor-management trustee plans, union welfare plans, employer organization plans, or employee benefit organization plans; and

(d) Any coverage under governmental programs, and any coverage required or provided by any statute.

The term "Plan" will be construed separately with respect to each policy, contract, or other arrangement for benefits or services and separately with respect to that portion of any policy, contract or other arrangement which reserves the right to take the benefits or services of other Plans into consideration in determining its benefits and that portion which does not.

(2) "This Plan" means that portion of this Agreement which provides the benefits that are subject to this section 11.6.

(3) "Allowable Expense" means any necessary, reasonable, and customary item of expense at least a portion of which is covered under at least one of the Plans covering the person for whom the claim is made. When a Plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered will be deemed to be both an Allowable Expense and a benefit paid.

(4) "Claim Determination Period" means a calendar year.

(C) Effect on Benefits

(1) This Section (C) will apply in determining the benefits as to a person covered under This Plan for any Claim Determination Period if, for the Allowable Expenses incurred as to such person for such period, the sum of:

(a) The value of the benefits that would be provided by This Plan in the absence of this COB provision; and

(b) The benefits that would be payable under all other Plans in the absence therein of provisions of similar purpose to this provision would exceed such Allowable Expenses.

(2) As to any Claim Determination Period to which this COB provision is applicable, the benefits that would be provided under This Plan in the absence of this COB provision for the Allowable Expenses incurred as to such person during such Claim Determination Period will be reduced to the extent necessary so that the sum of such reduced benefits and all the benefits payable for such Allowable Expenses under all other Plans, except as provided in subparagraph (3) of this section (C) will not exceed the total of such Allowable Expenses. Benefits payable under another Plan include the benefits that would have been payable had claim been duly made therefor.

(3) If

(a) Another Plan which is involved in subparagraph (2) of this section (C) and which contains a provision coordinating its benefits with those of This Plan would, according to its rules, determine its benefits after the benefits of This Plan have been determined, and

(b) The rules set forth in subparagraph (4) of this section (C) would require This Plan to determine its benefits before such other Plan, then, the benefits of such other Plan will be ignored for the purposes of determining the benefits under This Plan.

(4) For the purposes of subparagraph (3) of this section (C), the rules establishing the order of benefit determination are:

(a) The benefits of a Plan which covers the person on whose expenses claim is based other than as a family member, will be determined before the benefits of a Plan which covers such person is covered as a family member, except that if the person is also a Medicare beneficiary and as a result of the rules established by Title XVIII of the Social Security Act and implementing regulations, Medicare is:

1. Secondary to the Plan covering the person as a family member; and

2. Primary to the Plan covering the person as other than a family member (a retired employee);

then the benefits of the Plan covering the person as a family member are determined before those of the Plan covering that person as other than a family member.

(b) Except for cases of a person for whom claim is made as a child whose parents are separated or divorced, the benefits of a Plan which covers the person on whose expenses claim is based as a family member of a person whose date of birth, excluding year of birth, occurs earlier in a calendar year, will be determined before the benefits of a Plan which covers such person as a family member of a person whose date of birth, excluding year of birth, occurs later in a calendar year. If either Plan does not have the provisions of this subparagraph which results either in each Plan determining its benefits before the other or in each Plan determining its benefits after the other, the provisions of this subparagraph will not apply, and the rule set forth in the Plan which does not have the provisions of this subparagraph will determine the order of the benefits.

(c) Except as provided in subparagraph (4)(e) of this Section (C), in the case of a person for whom claim is made as a child whose parents are separated or divorced and the parent with custody of the child has not remarried, the benefits of a Plan which covers the child as a family member of the parent with custody of the child will be determined before the benefits of a Plan which covers the child as a dependent of the parent without custody.

(d) Except as provided in subparagraph (4)(e) of this Section (C), in the case of a person for whom claim is made as a dependent child whose parents are divorced and the parent with custody of the child has remarried, the benefits of a Plan which covers the child as a dependent of the parent with custody will be determined before the benefits of a Plan which covers that child as a dependent of the stepparent, and the benefits of a Plan which covers that child as a dependent of the stepparent will be determined before the benefits of a Plan which covers that child as a dependent of the parent without custody.

(e) In the case of a person for whom claim is made as a dependent child whose parents are separated or divorced, where there is a court decree which would otherwise establish financial responsibility for the medical, dental or other health care expenses with respect to the child, then, notwithstanding subparagraphs (4)(c) and (4)(d), the benefit of a Plan which covers the child as a dependent of the parent with such financial responsibility will be determined before the benefits of any other Plan which covers the child as a dependent child.

(f) Except as provided in subparagraph (4)(g) of this section (C), the benefits of a Plan covering the person for whose expenses claim is based as a laid off or retired employee, or family member of such person, will be determined after the benefits

of any other Plan covering such person as an employee, other than a laid off or retired employee or family member of such person.

(g) If either Plan does not have a provision regarding laid off or retired employees, which results in each Plan determining its benefits after the other, then the rule under subparagraph (4)(f) of this section (C) will not apply.

(h) If a person whose coverage is provided under a right of continuation pursuant to federal or state law is also covered under another Plan, the following will be the order of benefit determination:

1. First, the benefits of a Plan covering the person as an employee, member, or Member, or as that person's family member;

2. Second, the benefits under continuation coverage. If the other Plan does not have the rules described above, and if, as a result, the Plans do not agree on the order of benefits, the rule under this subparagraph (4)(h) of section (C) is ignored.

(i) When subparagraphs (4)(a) through (4)(h) of this section (C) do not establish an order of benefit determination, the benefits of a Plan which has covered the person on whose expenses claim is based for the longer period of time will be determined before the benefits of a Plan which has covered such person the shorter period of time.

(5) When this COB provision operates to reduce the total amount of benefits otherwise payable as to a person covered under This Plan during any Claim Determination Period, each benefit that would be payable in the absence of this COB provision will be reduced proportionately, and such reduced amount will be charged against any applicable benefit limit of This Plan.

(D) Right to Receive and Release Necessary Information

For the purpose of determining the applicability of and implementing the terms of this provision of This Plan or any provision of similar purpose of any other Plan, This Plan may release to or obtain from any insurance company or other organization or person any information, with respect to any person, which This Plan deems to be necessary for such purposes. Any person claiming benefits under This Plan will furnish such information as may be necessary to implement this provision.

(E) Facility of Payment

Whenever payments which should have been made under This Plan in accordance with this COB provision have been made under any other Plans, This Plan will have the right, exercisable alone and in its sole discretion, to pay over to any organizations making such other payments any amounts it will determine to be warranted in order to satisfy the intent of this provision, and amounts so paid will be deemed to be benefits paid under This Plan and, to the extent of such payments, This Plan will be fully discharged from liability under This Plan.

(F) Right of Recovery

Whenever payments have been made by This Plan with respect to Allowable Expenses in a total amount, at any time, in excess of the maximum amount of payment necessary at that time to satisfy the intent of this COB provision, This Plan will have the right to recover such payments, to the extent of such excess, from one or more of the following, as This Plan will determine: any persons to or for or with respect to whom such payments were made, any insurers, service plans or any other organizations.

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Summary of Benefits and Covered Services Matrix

NOTE: THIS BENEFIT GRID WAS DELETED IN ITS ENTIRETY. THE BENEFIT GRID AND COPAYMENT AMOUNTS MAY BE FOUND IN ATTACHMENT 2.

NOTE: THIS ENTIRE SECTION WAS DELETED. THE EXCLUSIONS MAY BE FOUND NOW IN ATTACHMENT 2.

SECTION 12 – DEFINITIONS

12.1 **"Approved Drug Usage"** means: (i) use for the labeled indications (FDA-approved indications); or (ii) use by a Physician for treatment of a life-threatening condition; and (iii) use for which the drug has been recognized by the AMA Drug Evaluations, The American Hospital Formulary, the United States Pharmacopoeia, or at least two articles from major peer reviewed medical journals that present data supporting the proposed use as safe and effective unless clear and convincing contradictory evidence appears in a similar journal.

12.2 **"Charges"** means the Participating Providers' contracted rates or the actual charges payable for Covered Services, whichever is less. Actual charges payable to non-Participating Providers shall not exceed usual, customary and reasonable charges. "Usual" charges means the fees usually charged for given services by providers to their private patients (their usual fees). "Customary" charges mean the fees that are within the range of usual charges charged by providers of similar training and experience for the same services within the same geographic area as determined by Health Plan. "Reasonable" charges mean the charges that are usual and customary or are justifiable in consideration of any Medically Necessary special circumstances.

12.3 **"Copayment"** means the amount which a Member is required to pay for certain Benefits, as set forth in Attachment 2 of this Agreement, and as disclosed in the EOC.

12.4 **"Coinsurance"** means a Member's share of the medical benefit cost for certain covered benefits.

12.5 **"Covered Services"** means those Medically Necessary health care services and supplies that a Member is entitled to receive as determined by Health Plan and subject to all of the terms, conditions, exclusions and limitations of this Agreement.

12.6 **"Custodial"** or **"Domiciliary Care"** means care that can be provided by a lay person, that does not require the continuing attention of trained medical or paramedical personnel, and that has no significant relation to treatment of a medical condition. Such services include, but are not limited to, help in walking and getting out of bed, assistance in bathing, dressing, eating, using the toilet, preparation of special diets and supervision of medication which can usually be self-administered.

12.7 **"Dental Services"** means any services or X-ray exams involving one or more teeth, the tissue or structure around them, the alveolar process or the gums. Such services are considered dental even if a condition requiring any of these services involves a part of the body other than the mouth, such as treatment of Temporomandibular Joint Disorders (TMJD) or malocclusion involving joints or muscles by such methods as crowning, wiring or repositioning teeth. Medically Necessary surgical procedures for a condition directly affecting the upper or lower jawbone, or associated bone joints, is not considered a Dental Service.

12.8 **"Diabetes Equipment and Supplies"** means the following items for the treatment of insulin-using diabetes or non-insulin-using diabetes and gestational diabetes as Medically Necessary: (i) blood glucose monitors; (ii) blood glucose testing strips; (iii) blood glucose monitors designed to assist the visually impaired; (iv) insulin pumps and related necessary supplies; (v) ketone urine testing strips; (vi) lancets and lancet puncture devices; (vii) pen delivery systems for the administration of insulin; (viii) podiatric devices to prevent or treat diabetes related complications; (ix) insulin syringes; and (x) visual aids, excluding eyewear to assist the visually impaired with proper dosing of insulin.

12.9 **"Educational Services"** means services or supplies whose primary purpose is to provide any of the following: training in the activities of daily living; instruction in scholastic skills such as reading or writing; preparation for an occupation; or treatment for learning disabilities.

12.10 **"Emergency"** means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

(A) serious jeopardy to the health of the individual or, in the case of a pregnant woman, the health of the woman or her unborn child; or

(B) serious impairment to bodily functions; or

(C) serious dysfunction of any bodily organ or part.

Emergency services include (but are not limited to) the evaluation to determine if a psychiatric emergency medical condition exists and treatment necessary to relieve or eliminate the psychiatric emergency medical condition.

12.12 **"Experimental or Investigational Treatment"** means services, tests, treatments, supplies, devices or drugs that are not generally accepted by informed medical professionals in the United States, at the time the services, tests, treatments, supplies, devices or drugs are rendered, as safe and effective in treating or diagnosing the condition for which their use is proposed, unless approved by:

(A) The Diagnostic and Therapeutic Technology Assessment Project of the American Medical Association;

(B) The Office of Health Technology Assessment of the U.S. Congress;

(C) The National Institute of Health;

(D) The Federal Food and Drug Administration; or

(E) The specialty board and the academy it represents as recognized by the American Board of Medical Specialties (ABMS).

Approved Drug Usage will not be excluded as Experimental or Investigational.

12.13 **"FDA-Approved Drug**" means drugs, medications and biologicals approved by the Food and Drug Administration and listed in the United States Pharmacopoeia, the AMA Drug Evaluations and/or the American Hospital Formulary.

12.14 **"Hospice Care"** means care and services provided in a home or facility by a licensed or certified hospice provider that are: (i) designed to provide palliative and supportive care to individuals who have received a diagnosis of terminal illness (i.e. a medical prognosis that life expectancy is one year or less if the disease follows its natural course); (ii) directed and coordinated by medical professionals; and (iii) authorized by Health Plan.

12.15 **"Hospital**" means either of the following:

(A) a licensed and accredited health facility that is primarily engaged in providing, for compensation from patients, medical, diagnostic surgical facilities and/or rehabilitation services for the care and treatment of sick and injured Members on an Inpatient basis, and which provides such facilities under the supervision of a staff of physicians and 24 hour a day nursing service by registered nurses. A facility that is principally a rest home, nursing home or home for the aged is not included; **or**

(B) a psychiatric hospital licensed as a health facility accredited by the Joint Commission on Accreditation of Health Care Organizations; **or**

(C) a licensed health facility operated primarily for the treatment of alcoholism and/or substance abuse accredited by the Joint Commission on Accreditation of Health Care Organizations; **or**

(D) a "psychiatric health facility" as defined in § 1250.2 of the Health and Safety Code.

12.16 "Inpatient Hospital Services" means those Covered Services which are provided by a Hospital, excluding long term non-acute care, to an individual who has been admitted to a Hospital as a registered bed patient and is receiving services under the direction of a Physician.

12.19 "Peer-reviewed scientific studies published in or accepted for publication by medical journals that meet nationally recognized requirements;

(A) Medical literature that meet the criteria of the National Institutes of Health's National Library of Medicine for indexing in Index Medicus, Excerpta Medicus (EMBASE), Medline, and MEDLARS data base Health Services Technology Assessment Research (HSTAR);

(B) Medical journals recognized by the Secretary of Health and Human Services, under § 1861(t)(2) of the Social Security Act;

(C) The American Hospital Formulary Service-Drug Information, the American Medical Association Drug Evaluation, the American Dental Association Accepted Dental Therapeutics, and the United States Pharmacopoeia-Drug Information;

(D) Findings**,** studies, or research conducted by or under the auspices of federal government agencies and nationally recognized federal research institutes, for the purpose of evaluating the medical value of health services; or

(E) Peer-reviewed abstracts accepted for presentation at major medical association meeting.

12.20 "Medically Necessary" means that the service is:

(A) Rendered for the treatment or diagnosis of an injury or illness; and

(B) Appropriate for the symptoms, consistent with diagnosis, and otherwise in accordance with sufficient scientific evidence, professionally recognized standards and Health Plan medical criteria; and

(C) Not furnished primarily for the convenience of the Member, the attending physician, or other provider of service, and not required solely for custodial, comfort, or maintenance reasons; and

(D) Furnished in the most economically efficient manner that may be provided safely and effectively to the Member, and at a frequency that is accepted by the medical community as medically appropriate.

The fact that a physician may have ordered or prescribed a service does not mean that it is Medically Necessary or a Covered Service under this Agreement.

Whether there is "sufficient scientific evidence" shall be determined by Health Plan based on, but not limited to, Medical or Scientific Literature.

12.21 **"Member"** means a Member who is entitled to receive covered services. For purposes of this Agreement, since there is no dependent coverage available, "subscriber" and "Member" may be used interchangeably. Additionally, when a husband and wife are both employees of the group both are entitled to claim the combined maximum contractual benefits to which an employee is entitled, not to exceed in the aggregate 100% of the charge for the covered expense or Covered Service.

12.22 **"Orthotic Device"** means a rigid or semi-rigid device used as a support or brace affixed to the body externally to support or correct an acutely injured or diseased body part and that is Medically Necessary to the medical recovery of the Member.

12.23 **"Out of Area Coverage"** means coverage while a Member is anywhere outside the Service Area, and shall also include coverage for Urgent Care Services to prevent serious deterioration of a Member's health resulting from unforeseen illness or injury for which treatment cannot be delayed until the Member returns to the Service Area.

12.24 **"Outpatient Hospital Services"** means those Covered Services which are provided by a hospital to Members who are not inpatients at the time such services are rendered.

12.25 **"Participating Hospital"** means a duly licensed Hospital which, at the time care is provided to a Member, has a contract in effect with Health Plan to provide services to Members. The Covered Services which some Participating Hospitals may provide to Members are limited by Health 14.22

12.26 **"Participating Physician"** means a Physician who, at the time care is provided to a Member, has a contract in effect with Health Plan to provide services to Members.

12.27 **"Participating Provider"** means a Participating Physician, Participating Hospital, or other licensed health professional or licensed health facility, including subacute facilities, located within the Service Area who, or which, at the time care is provided to a Member, has a contract in effect with Health Plan to provide Covered Services to Members. Information about Participating Providers may be obtained by telephoning Health Plan at (805) 685-9525 or, outside of Santa Barbara, (800) 421-2560.

12.28 **"Person"** means any person, individual, firm, association, organization, partnership, business trust, foundation, labor organization, corporation, limited liability company, public agency, or political subdivision of the State.

12.29 **Prepayment Fees"** means the amount required to be paid by Group on behalf of Members in order for Members to be entitled to receive Covered Services.

12.30 **"Primary Care Physician"** or **"PCP"** means a general practitioner, board certified or eligible family practitioner, internist, obstetrician/gynecologist, or pediatrician who has contracted with the Plan as a primary care physician to provide primary care to Members and to refer, authorize, supervise and coordinate the provision of all benefits to Members in accordance with Group Health Service Agreement.

12.31 **"Prior Authorization"** means the requirement that a Member's attending physician request approval of coverage from Health Plan prior to the Member obtaining certain Covered Services. Requests for Prior Authorization will be denied if not Medically Necessary. Requests for Prior Authorization of coverage for services by non-Participating Providers will also be denied if Health Plan determines that comparable or more appropriate services are available through Participating Providers. The fact that a Participating Provider may order or refer a Member for a service does not constitute Prior Authorization. Prior Authorization must come directly from Health Plan.

12.32 **"Prosthetic Device"** means a standard artificial device affixed externally to the body to replace a missing body part.

12.33 **"Referral Authorization Form"** or **"RAF"** means the required referral authorization form, or number, evidencing a referral by a PCP, the PCP's designee, or the Medical Director or his/her non-physician designee, to render services. Selected services that do not require RAFs (including but not limited to Emergency services and most Self Referral Services) are set forth in the Operations Manual that is made available to Participating Providers**.**

12.34 **"Self Referral Services"** means the services in addition to Emergency or Urgent Care Services that Members are allowed to access, through a Participating Provider, without authorization. Self-Referral Services include, but are not limited to the following: Family Planning and abortion services; OB/GYN services; AIDS/HIV testing; Sexually transmitted disease testing and treatment; services from a specialist when a standing RAF has been issued by the PCP, Nutrition Education services (first visit) under the diabetes management benefit or for those receiving treatment for phenylketonuria.

12.35 **"Service Area"** means Santa Barbara County, California.

12.36 **"Skilled Nursing Facility"** means a facility that is licensed to operate in accordance with the state and local laws pertaining to institutions identified as such and that is listed by the American Hospital Association and accredited by the Joint Commission on Accreditation of Hospitals and Related Facilities, or that is recognized as a Skilled Nursing Facility by the Secretary of Health and Human Services of the United States pursuant to the Medicare Act.

12.37 **"Subscriber"** means the person whose employment or other status, except for family dependency, is the basis for eligibility, who meets all applicable eligibility requirements of 0 (Eligibility) and who has enrolled in accordance with that section. For purposes of this Agreement, since there is no dependent coverage available, "Subscriber" and "Member" may be used interchangeably.

12.38 **"Surcharge"** means an additional fee which is charged to a Member for a Covered Service but which is not provided for in this Agreement nor in the EOC. A Surcharge by any contracted provider constitutes a breach of contract.

12.39 **"Totally Disabled"** or **"Total Disability"** means that an individual, by reason of injury, illness, birth defect, or other physical condition, which has lasted or can be expected to last for a continuous period of not less than twelve (12) months, is unable to engage in substantially all of those normal activities conducted prior to the occurrence of the disability, including but not limited to, the duties of employment in any gainful employment for which such person is reasonably fitted by training, education, experience or school attendance, including the performance of housework. A Member who is able to work, attend school, or perform household activities on a part-time basis is not Totally Disabled. Determinations regarding the existence of the Total Disability shall be made only on the basis of medical examination by a Participating Physician of the person claiming such disability and concurrence by the Plan based on professionally recognized standards, including but not limited to, Social Security Administration criteria for total disability.

12.40 **"Urgent Care Services"** means services provided in response to the member's need for a prompt diagnostic workup and/or treatment of a medical or mental disorder that could become an emergency if not diagnosed and/or treated in a timely manner and delay is likely to result in prolonged temporary impairment, unwarranted prolongation of treatment increasing the likelihood of more complex or hazardous treatment, development of chronic illness, or inordinate physical or psychological suffering of the member.

12.41 **"Vocational Rehabilitation"** means evaluation, counseling and placement services designed or intended primarily to assist an injured or disabled individual find appropriate employment.

ATTACHMENT 1

RATE SCHEDULE

The following monthly rates are effective January 1, 2005 and will continue through December 31, 2005:

$335 per member per month.

Santa Barbara Regional Health Authority Health Plan

For

IN-HOME SUPPORTIVE SERVICES

Combined Evidence of Coverage and Disclosure Form
And
Member Handbook

Santa Barbara Regional Health Authority
110 Castilian Drive
Goleta, CA 93117
1-877-814-1461

DRAFT FOR EARLY REVIEW BY COUNTY COUNSEL ONLY - NOT FOR GENERAL DISTRIBUTION

This combined evidence of coverage and disclosure form constitutes only a summary of the health plan. The health plan contract must be consulted to determine the exact terms and conditions of coverage.

Welcome to the Santa Barbara Regional Health Authority!

Dear In-Home Supportive Services Health Plan Participant,

Welcome to the Santa Barbara Regional Health Authority! Thank you for choosing us!

The Santa Barbara Regional Health Authority administers the In-Home Supportive Services Health Plan and offers you a wide choice of physicians, hospitals, pharmacies, and other providers to provide you the best possible health care. We look forward to serving your health care needs. We want you to have a provider when you are ill, but we also have many services to keep you well. We encourage you to schedule annual check-ups for recommended vaccines, and other services listed in our Preventive Guidelines for Adults which are included with your New Member Packet.

This Member Handbook is your Combined Evidence of Coverage and Disclosure Form, it will explain how our Health Plan works and what services you can receive from your In-Home Supportive Services Health Plan. You can also find helpful information at our website, www.sbrha.org.

Please call the Santa Barbara Regional Health Authority if you have any questions about your health plan. You have taken an important step to better health by signing up for the In-Home Supportive Services Health Plan. We want to make sure you receive the care needed to stay healthy!

Thank you again for the opportunity to serve you.

Sincerely,

Dave Lamkin
Executive Director
Santa Barbara Regional Health Authority

January 1, 2005 – December 31, 2005

Table of Contents

Section 1: INTRODUCTION

Welcome

Welcome to Santa Barbara Regional Health Authority (SBRHA) and the In-Home Supportive Services (IHSS) Health Plan. It is important for you to understand how SBRHA works for its In-Home Supportive Services Health Plan members.

This Combined Evidence of Coverage (EOC) and Disclosure Form and Member Handbook provides detailed information about your IHSS Health Plan's providers, benefits, terms and conditions of coverage. It provides you with the rules of your IHSS Health Plan and your rights and responsibilities as an IHSS Health Plan "Member". The EOC should be read completely and carefully. Individuals with special health care needs should read thoroughly those sections that apply to them.

A Summary of Benefits is located within this EOC. You have a right to view this document prior to enrollment.

The Group Agreement ("Agreement") between SBRHA ("Health Plan" or "Plan") and the Santa Barbara County IHSS Public Authority ("Group") must be consulted to determine the exact terms and conditions of coverage. A copy of this Agreement is available upon request. If you would like a copy of this Agreement, or if you have any questions about your IHSS Health Plan benefits, please contact SBRHA's Member Services Department at our toll-free number 1-887-814-1861 in Spanish and English. Our offices are located at 110 Castilian Drive, Goleta, California 93117.

How to Use this Evidence of Coverage

Here are some things to do when you get this EOC:

- Turn to the Table of Contents on the previous page to find out what is in this handbook.
- If you have questions about what to do in an emergency, read Section 3.
- If you want to know what services you can receive and if there is a copayment, read the Summary of Benefits in Section 4.
- If you have questions or concerns and need to contact SBRHA, read Section 7 about the Member Services Department.
- Review the Definitions Section at the end of the EOC. This list gives the meaning of certain words in the handbook.

Here are some of the words in this EOC that you should know:

Subscriber - the person who is enrolled and responsible for payment for the health care insurance coverage and is the basis of eligibility for membership in the IHSS Health Plan.

Member – the Subscriber who is enrolled in the IHSS Health Plan in agreement with the eligibility requirements.

Health Plan / Plan – refers to the IHSS Health Plan that is administered by the Santa Barbara Regional Health Authority (SBRHA).

Provider/Practitioner - the doctor/physician, pharmacy, hospital, facility, or other health professional that provides medical services to you.

This EOC has more definitions in Section 9 and will inform you about what health services you can receive and how to get the care you need. Please keep it in a safe place and refer to it when you have a question, or call:

Member Services Department 1-877-814-1861
Telecommunications Device for the Hearing Impaired (TDHI) at 1-805-685-4131.
Monday - Friday 8:00 AM - 5:00 PM

About Your Health Plan

SBRHA is a licensed managed care organization that administers your IHSS Health Plan. SBRHA is not a medical provider. All health care services you will receive under your IHSS Health Plan are provided by independent physicians, clinics, hospitals, facilities, and other Health Plan providers.

All IHSS Health Plan members are asked to select a Primary Care Provider (PCP) from the IHSS Health Plan's Participating Providers. Your PCP will take care of most of your needs, or will coordinate your care with other providers. This includes your routine check ups and preventive care such as immunizations and gynecological examinations for women. Your PCP will refer you to Specialists when necessary.

If your PCP decides that you need to be hospitalized, you will usually be sent to the hospital used by the PCP. IHSS Health Plan contracted hospitals are listed in your provider directory.

Eligibility and Enrollment

In order to be eligible to enroll in the In-Home Supportive Services Health Plan, you must meet the following requirements:

- Work two (2) consecutive months **and** a minimum of seventy (70) hours per month.
- Either live or work in SBRHA's service area (Santa Barbara County);
- Have not been previously terminated by SBRHA for fraud, deception or failing to provide complete information.
- Have submitted the required enrollment information to the Santa Barbara County IHSS Public Authority.

Commencement of Coverage

The Santa Barbara County IHSS Public Authority will notify you when you are eligible to enroll in the In-Home Supportive Services Health Plan. You will receive an enrollment packet that includes information about your benefits and an application for enrollment.

If you choose to enroll in the In-Home Supportive Services Health Plan, you must submit your completed application to the Santa Barbara County IHSS Public Authority by the designated day of the month that they determine in order for your coverage to begin by the first (1st) day of the next month. If you submit a completed application after the designated day of the month in which you are eligible, your coverage will not be effective until the first (1st) of the second month following submission of your application. Please contact the Santa Barbara County IHSS Public Authority for the designated enrollment day.

For example, if the 12th is the designated enrollment day:

- If your completed application is submitted on or before the 12th day of the month of eligibility, your effective date of coverage is the 1st day of the month following submission of your application.
- If your completed application is submitted to the Santa Barbara County IHSS Public Authority after the 12th day of the month of eligibility, your effective date of coverage is the 1st day of the second month following submission of your application.

Interpreter Services

To ensure that all of our members receive quality health care, the IHSS Health Plan offers bilingual interpreting services at no cost to members whose primary language is other than English. These services are available for appointment scheduling, telephone assistance and in-person or face-to-face, for provider visits.

Members have the right not to use family members or friends as interpreters, and to request an interpreter during discussions of medical information, such as diagnoses of medical conditions and proposed treatment options. If you feel your linguistic needs are not being

met, you have the right to file a complaint with the Health Plan. Please see *Section 7, Responding To Your Concerns, Member Grievance System.*

The SBRHA Member Services Department is bilingual in English and Spanish. We can assist members in arranging interpreter services for medical appointments between the hours of 8 a.m. to 5 p.m., Monday through Friday. In addition, SBRHA contracts with the Language Line to provide telephonic interpreter services in 140 different languages. This service is available seven (7) days a week, twenty-four (24) hours a day. The Language Line can be easily accessed by your PCP or other IHSS Health Plan provider.

MEMBER RIGHTS AND RESPONSIBILITIES

As a member of the Santa Barbara Health Regional Authority (SBRHA):

You have the right to:

1. Receive information about SBRHA, your IHSS Health Plan, its Participating Providers, the health services available to you, and information about your rights and responsibilities in the appropriate language as required by Federal Guidelines.
2. Be treated with respect by your health care providers and Health Plan staff.
3. Have your right to privacy and confidentiality of records protected.
4. Receive information about your medical condition in terms you can understand in order to participate in making decisions about your care with your health care provider.
5. Have an open and direct discussion of appropriate treatment options for your condition, regardless of cost and benefit coverage.
6. Make recommendations about the Health Plan's Member Rights and Responsibilities policies.
7. Obtain needed interpreter services at no charge when receiving medical care. You may also file a complaint if your language needs are not met.
8. Voice complaints or concerns about your IHSS Health Plan or the health care provided, and have those concerns investigated.
9. File an appeal if you disagree with your Health Plan's decision to deny coverage for services.

You have a responsibility to:

1. Learn how to use your IHSS Health Plan and to provide information to SBRHA and your provider that is needed to give you the best care possible.
2. Treat your providers and Health Plan staff with courtesy and respect.
3. Understand your health problems and be a part of making a treatment plan with your provider that you both agree on.
4. Follow the instructions and treatment plan you agree on with your health care provider.
5. Be on time for your appointments and inform the provider's office if you must cancel.
6. Follow the recommendations for preventive care, yearly check-ups and a healthy lifestyle.
7. Contact your Primary Care Provider first when seeking care, except in a true emergency.
8. Cooperate with your Health Plan or PCP to supply necessary information to coordinate benefits between health plans or to recover overpayments made on behalf of a Member.

If you have questions about your rights and responsibilities or need assistance, call **SBRHA's Member Services Department at 1-877-814-1861.**

2. Choice of Physicians, Providers, and Facilities

Please read the following information to learn how to use the services provided to you under your Health Plan, and what physician, providers and facilities that you may use for your health care needs.

Independent Physicians and Health Care Providers/Facilities

Santa Barbara Regional Health Authority (SBRHA) administers the IHSS Health Plan. SBRHA is not a medical provider. All of the health care services provided to you under your Health Plan, are provided by physicians, facilities and other health care providers who are independent of SBRHA. These physicians, hospitals, and other health care providers are not employees or agents of SBRHA.

SBRHA publishes a Contracted Provider List that includes all IHSS Health Plan Participating Providers. These providers can provide services to you and include Primary Care Providers (PCPs), specialty physicians, non-physician health care professionals, clinics, skilled nursing facilities, and hospitals. The directory also includes those providers who are not accepting new patients. Before selecting a PCP, you should verify that the PCP is accepting new patients.

Upon request, your IHSS Health Plan will provide you with certain information regarding any physician listed in its Contracted Provider Directory, such as the doctor's professional degree, board certification and any sub-specialty qualification a Specialist may have. You may also find information about a specific physician by calling the Medical Board of California, Consumer Information Unit at (916) 263-2382 or visiting their web site at www.medbd.ca.gov.

Please call SBRHA's Member Services Department at 1-877-814-1861 or Telecommunications Device for the Hearing Impaired (TDHI) 1-805-685-4131 to obtain a Contracted Provider List, or to request specific provider information.

Choice of Providers, Facilities, and Locations You May Use

Specialty providers, pharmacies, facilities and hospitals you may use are listed in your Provider Directory. Your PCP may refer you to other Participating Providers for services. These providers are chosen for their education, experience, and willingness to serve our members. If you wish more information about your provider's degree, board certification and any recognized sub-specialty qualifications, please call our Member Services Department for assistance.

Need more information about your IHSS Health Plan Participating Providers?
Call the Member Services Department for information about office hours, languages spoken, and handicap accessibility.

Important: Some hospitals or providers may not offer one or more of the following covered services or benefits: family planning; contraceptive services including emergency contraception; sterilization, including tubal ligation at the time of labor and delivery; or abortion. Call your PCP to make sure that you can get the health services you need.

Selecting a Primary Care Provider

In-Home Supportive Service (IHSS) Health Plan Members are required to have a Primary Care Provider (PCP). As an IHSS Health Plan Member you are encouraged to select a PCP at the time of enrollment. Your PCP is responsible for providing your medical care and coordinating your medical care needs. Your PCP makes referrals to Specialists and other providers when needed, and obtains authorization from the Health Plan when required. Your PCP will also prescribe medically necessary lab tests, x-rays and other covered

services. If you need to be hospitalized you will be admitted to the hospital where your physician has privileges to admit patients.
To ensure access to services your PCP should be within a thirty (30) minute or fifteen (15) mile radius of your home or work. If you do not select a PCP at the time of enrollment your IHSS Health plan will designate one for you and you will be notified. This designation will remain in effect until you notify your IHSS Health plan of your own selection.

In order to access your benefits you must have a PCP. Call SBRHA's Member Services Department, Monday through Friday during normal business hours, to select a PCP. You may then contact your PCP to make appointments for the care you need. Except for medically necessary urgent or emergency services, your PCP must coordinate and authorize your health care (see definitions of *"Urgent and Emergency Services"*).

You may select a physician who is a general practitioner, family practitioner, internist, obstetrician/gynecologist or pediatrician. Your IHSS Health plan provides open access (no referral needed) to members for obstetrician-gynecologist services. Please see Section 3, OB/GYN Access for more information.

SBRHA Identification Card
After you select your Primary Care Provider (PCP), you will receive an IHSS Health Plan Identification (ID) card. The ID card has the name and phone number of your PCP and other valuable benefit copayment information. Members must present this ID card when getting medical services or prescription drugs.

Changing Your Primary Care Provider

Members may change PCPs at any time by calling the SBRHA Member Services Department. The change is effective the first day of the month following notice of approval by your IHSS Health plan.

Reassignment to a PCP

In order to help your PCP provide you with all medically necessary and appropriate professional services in a manner compatible with your health care needs, it is important that you and your PCP maintain a cooperative physician/patient relationship. If a cooperative relationship cannot be maintained, your IHSS Health plan will assist you in the selection of another PCP.

For example, your PCP may regard your refusal to comply with recommended procedures and treatments as incompatible with fostering a positive physician/patient relationship. He or she may request that you be reassigned to another PCP. In addition, a PCP may refuse to accept you as a patient if you were previously terminated from the physician/patient relationship for cause. In these cases, SBRHA's Member Services Department will assist you in choosing another PCP.

Continuity of Care

In certain circumstances, you may request to continue to receive services from a non-participating or terminated provider until a safe transfer to a Health Plan provider can be made, consistent with good professional practice.

You may be eligible to continue to receive care from a non-participating or terminated physician if:

1. You are a new IHSS Health Plan Member; **OR** you are an IHSS Health Plan Member when your PCP or Specialist physician terminates their contract as an IHSS Health Plan Participating Provider,

   AND

2. You are being treated for any of the following conditions as defined by the DMHC:

   - An acute condition
   - A serious chronic condition
   - Pregnancy

- A terminal illness
- The care of your newborn for the first newborn visit
- A procedure or surgery authorized by the IHSS Health Plan

If you believe you qualify for Continuity of Care, please call the SBRHA's Member Services Department for assistance. A Member Services Representative will assist you in submitting your request for continued care.

Please Note: It is not enough to prefer receiving treatment from a former physician or other non-participating provider; you should not continue care with a non-participating provider without formal approval.

The Health Plan may require the terminated provider whose services are continued beyond the contract termination date to agree in writing to be subject to the same contractual terms and conditions that were imposed upon the provider prior to termination, including, but not limited to, credentialing, hospital privileging, utilization review, peer review, and quality assurance requirements. If the terminated provider does not agree to comply or does not comply with these contractual terms and conditions, the Health Plan may decide to not continue the provider's services beyond the contract termination date.

The Health Plan will notify you if your PCP, Specialist or any other provider who is seeing you regularly terminates his/her contract as an IHSS Health Plan Participating Provider (decides not to offer services to IHSS Health Plan Members). Our Member Services Department will assist you in selecting another PCP or provider. Members will be provided a copy of SBRHA's policy regarding continuity of care upon request.

You may also contact the DMHC for additional information regarding your right to continuity of care. Refer to the "*Complaints to the Department of Managed Health Care (DMHC)"* section of this EOC for more details.

3. How to Use Your Health Plan

Authorization for Services

In this EOC, we use the words, "authorize", "authorization", and "prior authorization". These terms refer to the need to obtain approval from the Health Plan for health care services referred or prescribed by your PCP before such services are provided.

The IHSS Health Plan contracts with PCPs and Health Plan providers who are responsible for providing and coordinating covered services or benefits for its Members. Except in the event of an emergency or if the Health Plan has authorized the services in advance, you must receive all of your care from these contracted providers. Services not received from the Member's PCP require a referral or prior authorization unless such services are eligible to self-refer for such services as defined in the section of this EOC titled *"Self Referral/Access to Services"*. An IHSS Health Plan PCP must initiate referral to Specialists on behalf of the Member. Please note, however, that a referral by your PCP does not guarantee coverage for these services. The eligibility provisions, benefits, exclusions, and limitations described in this EOC will apply, whether or not the services are referred or prescribed by your PCP.

As needed, prior authorization is sent to SBRHA's Utilization Management Department for approval or denial. Members are generally notified of authorizations from the PCP in person or by telephone. Members are notified of denials in writing. Except in an Emergency or Urgent Care situation (refer to the section *"Emergency and Urgently Needed Services"*), if you receive services without a referral or prior authorization or if you receive services outside of the

IHSS provider network, you will be responsible for the charges.

If you believe that the Health Plan has improperly denied a request for treatment or services or you are dissatisfied with any action of your IHSS Health Plan or any provider, you should follow the procedures in the section of this EOC titled *"Member Grievance System"*. In addition, you may also contact the California Department of Managed Health Care. Refer to the *"Complaints to the Department of Managed Health Care (DMHC)"* section of this EOC for more details.

Second Medical Opinions

A second medical opinion is a reevaluation of your condition or health care treatment by an appropriately qualified provider. To ensure you receive appropriate and necessary health care services, your IHSS Health Plan allows you to obtain a second medical opinion through a consultation with an appropriately qualified health care professional.

You have the right to request and receive a second medical opinion. Reasons to request a second opinion include, but are not limited to, the following:

1. If you question the reasonableness or necessity of recommended surgical procedures.

2. If you question a diagnosis or plan of care for a condition that threatens loss of life, loss of limb, loss of bodily function, or substantial impairment, including, but not limited to, a serious chronic condition.

3. If the clinical indications are not clear or are complex and confusing, a diagnosis is in doubt due to conflicting test results, or the treating health professional is unable to diagnose the condition, and you request an additional diagnosis.

4. If the treatment plan in progress is not improving your medical condition within an appropriate period of time given your diagnosis and plan of care, and you request a second opinion regarding the diagnosis or continuance of the treatment.

5. If you have attempted to follow the plan of care or consulted with the initial provider concerning serious concerns about the diagnosis or plan of care.

If you request a second medical opinion about care from your PCP, the second opinion will be provided by an appropriately qualified health care professional of your choice within the IHSS Health Plan's Participating Providers. An appropriately qualified health care professional is a PCP or Specialist who is acting within his or her scope of practice and who possesses a clinical background, including training and expertise, related to the particular illness, disease, condition or conditions associated with the request for the second opinion.

If you or a participating practitioner treating you requests a second opinion, an authorization or denial of the request for a second opinion will be provided to you in an expeditious manner. When your condition is such that you face an imminent and serious threat to your health, including, but not limited to, the potential loss of life, limb, or other major bodily function, or lack of timeliness that would be detrimental to your ability to regain maximum function, the second opinion will be authorized or denied in a timely fashion appropriate for the nature of your condition, not to exceed 72 hours after the Health Plan's receipt of your request, whenever possible.

If the Health Plan approves your request for a second opinion, you will be responsible only for the costs of applicable copayments that the Health Plan requires for similar referrals. If the Health Plan denies your request for a second opinion, it will notify you in writing of the reasons for the denial and will inform you of the right to file a grievance with the Plan.

If an appropriately qualified provider gives a second medical opinion and recommends a particular medical treatment, diagnostic test or service, recommended treatment, tests or services may be subject to Health Plan prior authorization requirements. If you have any questions or if you want a copy of SBRHA's policy regarding second medical opinions, please call SBRHA's Member Services Department at 1-877-814-1861.

Referrals to Specialty Physicians

Your PCP is responsible for determining when it is medically necessary for you to see a specialist. There are a limited number of exceptions to this requirement. These exceptions are explained below in *"Self Referral/Access to Services"*.

If your PCP determines that you need to see a specialist, you will generally be referred to a specialist who is an IHSS Health Plan Participating Provider. In the rare event that covered services are not available through your Health Plan, your PCP will arrange for you to receive services outside the IHSS Health Plan network.

If you receive services without a referral authorization, or if you receive services outside of the IHSS Health Plan network you will responsible for the charges.

Self Referral/Access to Services

You do not need referrals from your IHSS Health Plan PCP to other Participating Providers for the following services:

- All medically necessary urgent care and emergency services (Please see Section 3, *"How to Use Your Health Plan"*, for more information on urgent and emergency services);
- Family planning services;
- Obstetrical/gynecological visits including nurse midwives;
- AIDS/HIV testing;
- Sexually transmitted disease testing and treatment;
- Nutrition Education (1st visit only) for diabetes management and for treatment of phenylketonuria (PKU).

Obstetrician/Gynecologist (OB/GYN) Access

Because of the unique, private, and personal relationship between women patients and their OB/GYN physicians, IHSS Health Plan members may go directly to a OB/GYN Participating Provider, family practitioner, or nurse practitioner without referral, on an unlimited basis. If the OB/GYN physician, family practitioner, or nurse practitioner that you need to obtain services from is not your PCP, those services must be related to an OB/GYN condition. Before making the appointment, you should call SBRHA's Member Services Department at 1-887-814-1861 to confirm that the provider is a IHSS Health Plan Participating Provider. An examination by a Non-participating Provider, unless authorized, is not a covered benefit under your IHSS Health Plan.

By law, each contract between SBRHA and Participating Providers states that in the event SBRHA fails to pay the participating provider, the member shall not be liable to the Participating Provider for any sums owed by SBRHA.

Standing Referral to a Specialist and Extended Referral for Care by a Specialist

A "standing referral" is a referral by your PCP that authorizes more than 1 visit to a Health Plan Specialist. A standing referral may be provided if your PCP, in consultation with the Specialist and you, determine that as part of a treatment plan you need continuing care from the Specialist.

If you have a condition or disease that requires specialized medical care over a prolonged period of time and it is life-threatening, degenerative, or disabling, you may receive an "extended referral" to a Specialist or specialty care center that has expertise in treating the condition or disease. An extended referral is to enable a Specialist to serve as the primary coordinator of your treatment. The Specialist does this in accordance with your treatment plan.

You may request a standing referral or an extended referral from your PCP. Your IHSS Health Plan will make a decision in response to your request for a standing referral within three business days of the date the request and all information necessary to make a decision are received. If approved, the referral to the Specialist will be made within four business days of the date the proposed treatment plan, if any, is submitted to the IHSS Health Plan's Medical Director or designee. A standing or extended referral to a Specialist and treatment plan is only allowed if approved by your PCP, subject to the necessary treatment authorization requirements of your IHSS Health Plan.

The referral will be to an IHSS Health Plan Specialist Participating Provider, unless there is no contracted Specialist that is appropriate to provide your treatment, as determined by your PCP and approved by the Health Plan.

After the referral is made, the Specialist will be authorized to provide health care services and training to you that are within the Specialist's area of expertise. The treatment plan may require the Specialist to provide your PCP with regular reports on your treatment and condition.

For more information or to obtain a copy of SBRHA's policy regarding standing and extended referrals to specialty physicians, please call SBRHA's Member Services Department at 1-877-814-1861.

Urgent and Emergency Services

Emergency Services

IMPORTANT!

IF YOU BELIEVE YOU ARE EXPERIENCING AN EMERGENCY MEDICAL CONDITION, CALL 911 OR GO DIRECTLY TO THE NEAREST HOSPITAL EMERGENCY ROOM OR OTHER FACILITY FOR TREATMENT.

Emergency Services are medically necessary ambulance or ambulance transport services provided through the 911 emergency response system. It is also the medical screening, examination and evaluation by a physician, or other licensed personnel to determine if an emergency medical condition, emergency psychiatric condition, or active labor exists. If either of these conditions exists, emergency services include the care, treatment and/or surgery by a physician necessary to stabilize or eliminate the emergency medical condition or emergency psychiatric condition within the capabilities of the facility.

The state of California defines an emergency medical condition as a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in any of the following:

1) Placing your health in serious jeopardy;

2) Serious impairment to bodily functions;

3) A serious dysfunction of any bodily organ or part.

Active labor is an emergency service if there is inadequate time to effect a safe transfer to another hospital prior to delivery, or a transfer may pose a threat to your health and safety or the health and safety of your unborn child.

If you believe you are experiencing an Emergency Medical Condition call 911 or go directly to the nearest hospital emergency room or other facility for treatment. You do not need to obtain preauthorization to seek treatment or an emergency medical condition that could cause you harm. Ambulance transport service provided through the 911 emergency response system is covered if you reasonably believe that your medical condition requires emergency ambulance transport service.

You or someone else on your behalf, must notify the Health Plan within 24 hours, or as soon as reasonably possible, following your receipt of emergency services

so that your PCP can coordinate your care and schedule any necessary follow-up treatment. When you call, please be prepared to give the name and location of the facility and a description of the emergency services that you received.

The IHSS Health Plan covers all medically necessary emergency services provided to you in order to stabilize an emergency medical condition. Following the stabilization of an emergency medical condition the treating health care provider may believe that you require additional medically necessary hospital services prior to your being safely discharged. In such a situation the medical facility will contact your Health Plan in order to obtain the timely authorization for these post-stabilization services. The IHSS Health Plan reserves the right, in certain circumstances, to transfer you to a participating hospital instead of authorizing post-stabilization services at the treating facility.

Emergency services and medical follow-ups are not covered services if you choose to remain in a non-participating facility after the Health Plan has notified you that it intends to transfer you to a participating provider facility. Please see Section 11 *"Definitions"*, for the definition of *"Emergency"*.

Urgently Needed Services

Urgently Needed Services are medically necessary health care services required to prevent serious deterioration of your health, resulting from an unforeseen illness or injury for which treatment cannot be delayed.

If in need of Urgently Needed Services you should contact your PCP. The telephone number for your PCP is on your SBRHA ID Card. Assistance is available from your PCP 24 hours a day, 7 days a week. If you call after regular business hours and your PCP is not available, ask to have the physician on call paged. Explain your condition and follow provided instructions. If your PCP is unavailable you should seek Urgently Needed Services from any IHSS Participating Provider.

When you are in the geographic area served by the IHSS Health Plan, you should seek Urgently Needed Services from a Participating Provider. Refer to the IHSS Health Plan Contracted Provider List to identify an appropriate provider. If you are outside the area served by your IHSS Health Plan, including travel out of the country, and require Urgently Needed Services, you should, if possible, call your PCP or Health Plan. If you are unable to contact your PCP or Health Plan you may receive services from any licensed medical professional wherever you are located.

You or someone else on your behalf, must notify the Health Plan within 24 hours, or as soon as reasonably possible, following your receipt of Urgently Needed Services so that your PCP can coordinate your care and schedule any necessary follow-up treatment. When you call, please be prepared to give the name and location of the facility and a description of the Urgently Needed Services that you received. Follow-up care to any Urgently Needed Services should be obtained through your PCP. Follow-up care through Non-participating Providers, however, will be covered as long as the care required continues to meet the definition of Urgently Needed Services.

You may need to initially pay for Urgently Needed Services. In this circumstance, pay for the Urgently Needed Services and submit all receipts and copies of relevant medical documentation as explained below.

Reimbursement Provisions for Emergency Services and Urgently Needed Services

If you received Emergency or Urgently Needed Services and expenses were incurred for such services, you must submit a claim form (member billing statement) with the service record for payment to your IHSS Health Plan within 180 days or as soon as possible after receiving Emergency or Urgently Needed Services. If you cannot do so within 180 days, you

must show that it was not reasonably possible to submit your claim within that time limit and that you submitted your claim as soon as was reasonably possible. If the services were not previously authorized, your IHSS Health Plan will review the claim retrospectively to make a decision about coverage.

Payment for Emergency services and care may be denied if the IHSS Health Plan reasonably determines that the Emergency services and care were never performed for you; or that you did not require Emergency services and care and that you reasonably should have known that an Emergency did not exist. The decision as to whether you reasonably believed that the medical condition was an Emergency medical condition that required an Emergency response, will not be based solely upon a retrospective analysis of the level of care eventually provided to you, or your final discharge diagnosis. If you receive non-authorized services in a situation that your IHSS Health Plan determines was not an Emergency, and in which it was not reasonable to believe that the situation was an Emergency, you will be responsible for the costs of those services and you will be notified of that decision. In the event that your IHSS Health Plan determines that Emergency services obtained are covered, your IHSS Health Plan will pay the provider directly or reimburse you if you paid for services.

Claims may be submitted to Santa Barbara Regional Health Authority, Attention Member Billing, 110 Castilian Drive, Goleta, California 93117-3028.

Other Charges: Member Copayments, Copayment Limits and Coinsurance

For non-preventive services, the member is responsible for paying a minimum charge (copayment) to the physician or provider of services at the time services are received. For some benefits a coinsurance charge may also be required at the time of service. Coinsurance is a percentage of your IHSS Health Plan covered charges. Specific copayments and coinsurance amounts are listed in the following *"Summary of Benefits and Covered Services Matrix"*.

There is an annual accrued copayment maximum and a annual benefit maximum. The annual accrued copayment maximum per benefit year is $5,000 per individual per benefit year. Copayments for outpatient prescription medications, durable medical equipment, and any coinsurance charges noted in the *"Health Plan Benefits"* section of this EOC, and/or *"Summary of Benefits and Covered Services Matrix"*, will not count toward this maximum.

You should keep all receipts for any copayments you make to providers. Once the $5,000 copayment maximum is met, your IHSS Health Plan will issue a new identification card to you, which notes that your copayment responsibility has been met for the remainder of the benefit year. In order to receive the new identification card(s), you are required to submit your copayment receipts to your IHSS Health Plan in order to demonstrate that the annual accrued copayment maximum has been met for the benefit year. IHSS Health Plan providers will receive instructions from your IHSS Health Plan on the use of these identification cards and the annual accrued copayment maximum.

You are not financially responsible for the costs of services that are IHSS Health Plan benefits, except for any applicable copayments and coinsurance charges if the services are referred by your PCP and authorization has been obtained.

If you fail to keep a scheduled appointment with your provider and do not call at least 24 hours in advance to cancel your appointment, you may be responsible for the office copayment to the provider.

Services that are IHSS Health Plan benefits, but have not been authorized, will not be covered by your IHSS Health Plan and will be your financial responsibility, unless such services are emergency medical services, as defined by your IHSS Health Plan.

Services that you obtain that are not benefits under your IHSS Health Plan are your financial responsibility, even if such services are referred by your PCP.

If you have any questions or need further information regarding copayments, coinsurance, or your financial responsibilities, please contact SBRHA's Member Services Department at the toll free number at 1-877-814-1861.

Summary of Benefits and Covered Services Matrix

THIS BENEFIT SUMMARY IS INTENDED TO HELP YOU COMPARE COVERAGE BENEFITS AND IS A SUMMARY ONLY. FOR A MORE DETAILED DESCRIPTION OF COVERAGE, BENEFITS, AND LIMITATIONS, PLEASE CONTACT THE HEALTH CARE SERVICE PLAN OR HEALTH INSURER. THE COMPARATIVE BENEFIT SUMMARY IS UPDATED ANNUALLY, OR MORE OFTEN IF NECESSARY TO BE ACCURATE. THE MOST CURRENT VERSION OF THIS COMPARATIVE BENEFIT SUMMARY IS AVAILABLE ON WWW.SBRHA.ORG.

Annual Maximum Benefit - $750,000 per benefit year.

Copayments marked by "" apply to the annual out-of-pocket copayment maximum of $5,000 per benefit year.**

Benefit	Description/Limitations	Copayment
Preventive Health Services	• Scheduled routine physical examinations. • Annual breast and pelvic exams and Pap tests. • Immunizations. • Venereal disease testing including confidential HIV/AIDS counseling and testing. • Cancer screening including mammography. • Vision and Hearing screening by Member's primary care provider to determine the need for vision correction and to determine the need for an audiogram for hearing correction.	• No copayment • No copayment • No copayment • No copayment • No copayment • No copayment
Diabetes Management & Treatment	• Outpatient care and laboratory testing. • Diabetes self-management**,** education, and medical nutrition services. • Durable medical equipment (DME) used in the management and treatment of diabetes. • Applicable medications and supplies covered under the • Plan's prescription drug benefit.	• No copayment • No copayment • DME coinsurance • Pharmacy copayment
Maternity Care	• Prenatal care physician visits, laboratory testing, including genetic and alpha-fetoprotein testing, and radiology services for complete prenatal and post-partum outpatient maternity care. • One (1) well-baby care physician visit to hospital after birth of newborn, including newborn evaluation services.	• No copayment • No copayment
Physician and Professional Services	• Physician office visits, including specialty visits, consultations and examinations, and second opinions. • Physician home visits. • Allergy testing and treatment. • Physician services in a hospital, skilled nursing and rehabilitation facilities.	• $20 per visit ** • $20 per visit ** • $20 per visit ** • No copayment

Family Planning Services	• Voluntary family planning counseling. • Surgical procedures for sterilization, including but not limited to, tubal ligation and vasectomy. • Pregnancy test (by physician). • Abortion. • Contraceptive drugs and devices pursuant to the Plan's prescription drug benefit.	• No copayment • No copayment • No copayment • No copayment • Applicable Pharmacy copayment (refer below to *"Prescription Drug Coverage")*
Outpatient Hospital and Other Outpatient Facilities Outpatient Services	• Services and supplies for treatment or surgery in an outpatient hospital setting or ambulatory surgery center. • Diagnostic services including X-ray, mammography, CT scan, MRI, nuclear medicine, and laboratory services. • Physical, occupational, and speech therapy may be provided in a medical office, in the home, or other appropriate outpatient setting when ordered by the Member's PCP.	• 20% Coinsurance • $15 Copayment **
Emergency and Urgent Health Care Services	• Emergency room services for emergency conditions. • Urgent Care services for urgent conditions.	• $75 Per visit ** • $30 Per visit **
Inpatient Hospital Services	• Inpatient acute care hospital room and board, general nursing care, ancillary services, including operating room, intensive care unit, prescribed drugs, laboratory and radiology, physical, occupational, and speech therapy, pain control, and symptom management.	• $500 Per stay **
Inpatient Rehabilitation Services	• Inpatient rehabilitation facility room and board, general nursing care, ancillary services, and appropriate physical, occupational, and speech therapy.	• $500 Per stay **
Medical Transportation	• Emergency medical transportation for transport to the nearest hospital which can provide such emergency care. • Non-Emergency medical transportation to transfer the Member from a non-participating hospital to a Plan hospital for admission. • Non-emergency medical transportation to transfer the Member from a hospital or other medical facility to the Member's residence only when the member requires transport in a prone or supine position or requires specialized safety equipment, for medical reasons. • Air ambulance only in emergencies where ground transport is contraindicated due to distance and/or member's medical condition.	• $50 Per ride ** • No copayment • $50 Per ride ** • $50 Per ride **

Prescription Drug Coverage	• Generic formulary: 30 day or 1 month supply based on package size • Brand formulary: 30 day or 1 month supply based on package size • Non-formulary: 30 day or 1 month supply based on package size	• $15 Copayment • $25 Copayment • $50 Copayment
	• 90 day supply of maintenance drugs by Mail Order	• $20 generic • $50 brand formulary • $150 non-formulary
	Contraceptive Drugs • 90 day supply of oral contraceptive drugs by Mail Order • Contraceptive devices • Emergency contraceptives • One cycle of tobacco cessation drugs per benefit year in conjunction with enrollment in tobacco cessation classes or program. o Generic formulary o Brand formulary o Non-formulary	 • 2 X applicable 30 day copayment • $25 Copayment • $25 Copayment • $15 Copayment • $25 Copayment • $50 Copayment
	• Formula and special food products for the treatment of phenylketonuria (PKU). o Generic formulary o Brand formulary o Non-formulary	 • $15 Copayment • $25 Copayment • $50 Copayment
	• Inpatient drugs to member in an inpatient setting, or administered in the doctor's office, or in an outpatient facility setting during the member's stay at the facility.	• No copayment
Durable Medical Equipment	• Durable medical equipment (DME) as prescribed, includes but is not limited to, the purchase or rental of equipment such as: ambulatory items, wheelchairs, oxygen and related respiratory equipment, hospital beds and accessories, bathroom safety equipment, home monitoring equipment for diabetes, asthma and high blood pressure management. • Medically necessary repairs and replacement of DME as authorized unless necessitated by misuse or loss.	• 40% Coinsurance • 50% Coinsurance
Medical Supplies	• Medical supplies as prescribed to include, but are not limited to, wound care dressings, urological supplies, ostomy supplies and diabetic supplies.	• 40% Coinsurance
Orthotic / Prosthetic Appliances	• Orthotic and prosthetic (O&P) appliances when prescribed as necessary for the restoration of function or replacement of body parts, as prescribed. O & P items include, but are not limited to custom footwear required for foot disfigurement from disease or accident and for insulin dependent diabetics, devices used to restore a method of speaking following laryngectomy, and devices to restore and achieve symmetry incident to mastectomy.	• 40% Coinsurance

Hearing Aid Services	• Audiological evaluation to measure the extent of hearing loss and hearing aid evaluation to determine the most appropriate make and model of hearing aid. • Hearing Aids, monaural or binaural, including ear mold(s), hearing aid instrument, the initial battery, cords and other ancillary equipment. • Visits for fitting, counseling, adjustments, and repairs. • Surgically implanted FDA-approved hearing devices, including implantable cochlear devices for bilateral, profoundly hearing impaired individuals who are not benefited from conventional amplification (hearing aids).	• No copayment • Maximum benefit of $1,000 every 36 months for the hearing aid instrument and ancillary equipment. Does not apply to implantable cochlear devices and surgical services and procedures to implant a hearing device.
Mental Health Services Inpatient	• Mental health care coverage during confinement limited to ten (10) days inpatient stay for mental health conditions other than Severe Mental Illness (SMI) or Serious Emotional Disturbances (SED). • Severe Mental Illness (SMI) - no inpatient stay limit. • Serious Emotional Disturbances (SED) – no inpatient stay limit.	• $250 Copayment & 20% Coinsurance per stay • Maximum of $500 per stay for SMI or SED conditions.
Mental Health Services Outpatient	• Mental health care coverage limited to ten (10) outpatient visits for mental health conditions other than Severe Mental Illness (SMI) or Serious Emotional Disturbances (SED). • Severe Mental Illness (SMI) – no visit limits. • Serious Emotional Disturbances (SED) - no visit limits.	• $20 Per Visit ** • $20 Per Visit ** • $20 Per Visit **
Skilled Nursing Facility Services	• Inpatient care limited to 100 days per benefit year. • Physical, occupational and speech language pathology services as medically necessary while inpatient at a Skilled Nursing Facility.	• $50 Per day ** • No copayment
Hospice	• Hospice services in an approved hospice program to include nursing care, home health aid, counseling and medications. Hospice care is limited to those individuals who are diagnosed with a terminal illness with a life expectancy of twelve (12) months or less.	• No copayment
Home Health Services	• Home Health Care Services when the Member is required to be at home for medically necessary purposes at the direction of the Member's primary care physician or other appropriate authority designated by Plan. • Medical supplies given to recipients by home health agency personnel	• $20 Per visit ** • DME & Prescription Copayments apply
Organ Transplants	• Medically necessary major organ transplants, which are not experimental or investigational in nature by current standards of medical care, and are performed at an approved transplant facility.	• Inpatient / Outpatient, Professional and Prescription Copayments apply **
Reconstructive Surgery	• Reconstructive surgical services to correct a disfigurement or physical function disorder caused by	• Inpatient / Outpatient, Professional and

	injury, disease, congenital abnormality or medically necessary surgery. • Following medically necessary mastectomy surgery.	Prescription Copayments apply ****

Blood and Blood Products	• Processing, storing, administering of blood and blood products including collecting and storing of autologous blood when medically necessary.	• No copayment
Routine Care for Patients in Cancer Clinical Trials	To participate in clinical trials: • Member must be diagnosed with cancer; • Treating physician must have recommended participation in the clinical trial as potential benefit to Member's health; and • Member must then be accepted into the clinical trial.	• $20 Per visit, Inpatient / Outpatient copayments apply
Chiropractic Care Services	• Chiropractic services for an injury or illness when referred to a Plan chiropractor by member's PCP; including visits, examinations and procedures performed in the chiropractic office.	• $20 Per visit ****
Acupuncture Care Services	• Acupuncture services after an illness or injury when referred by Member's PCP.	• $20 Per visit ****
Health Education	• Health education is offered if associated with disease management programs provided by the Plan, or by providers affiliated with the Plan. • Nutritional counseling is offered through the Plan's contracted Registered Dieticians, Certified Diabetes Educators, and other designated providers. • Personalized health education, is offered by Plan PCPs.	• No copayment

The California Department of Managed Health Care (DMHC) is responsible for regulating health care service plans. The California DMHC 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 is http://www.hmohelp.ca.gov.

4. Health Plan Benefits

Your IHSS Health Plan covers the benefits described in this section and listed in your Evidence of Coverage and Disclosure Form and Member Handbook, provided that services are obtained as described in Section 3 of this EOC, *"How to Use Your Health Plan, Authorization for Services"*. Please consult the *"Summary of Benefits and Covered Services Matrix"* for your benefit schedule and copayment and coinsurance amounts.

Important Information: Services are covered as Health Plan benefits only if they are medically necessary and provided to you while you are a member of SBRHA's IHSS Health Plan. A service is medically necessary if it is recommended by a qualified medical professional, has been established as safe and effective, and is furnished in accordance with generally accepted professional standards to treat an illness or injury. In addition, such service must be consistent with the symptoms or diagnosis, not furnished primarily for the convenience of the member, the attending physician or other provider, and must be furnished at the most appropriate level at which the service can be provided safely and effectively to you.

Services or procedures that require prior authorization for coverage are reviewed by SBRHA's Utilization Management staff, consistent with generally accepted medical standards, and decisions to deny coverage are subject to appeal in accordance with the procedures outlined *in Section 7, "Member Grievance System"*.

Schedule of Benefits

Subject to referral by your PCP, authorization, and applicable copayments or coinsurance, and all other terms, conditions, limitations and exclusions of this EOC, including those listed in *"Exclusions and Limitations"* the following IHSS services are covered by your IHSS Health Plan when medically necessary:

Preventive Health Services

Scheduled routine physical examinations as follows:

- Periodic health exams, including all routine diagnostic testing and laboratory services appropriate for such examinations and based on age and other risk factors. The frequency of such examinations shall not be increased for reasons that are unrelated to your medical needs, including your desire for physical examinations, or reports or related services for employment, licenses, insurance, or school sports clearance.
- Immunizations consistent with the most current recommendations of the Centers for Disease Control and Prevention.
- Testing for venereal disease and confidential HIV/AIDS testing and counseling.
- Cancer screening exams for breast, cervical and prostate cancer to include mammography, PAP tests, and the option of any other cervical and prostate screening test approved by the Food and Drug Administration (FDA) upon referral by the member's health care provider and consistent with generally accepted medical practice and scientific evidence.
- Hearing tests and eye examinations by the PCP to determine the need for vision correction and to determine the need for an audiogram for hearing correction.

Exclusions/Limitations

- ***Exclusion*** **-** Preventative services related to travel, and routine physical examinations required for licensure, employment, insurance, recreational or organizational activities are not covered, unless the examination corresponds to the schedule of routine physical examinations provided in the Schedule of Benefits.

- ***Exclusion*** **-** Examinations, immunizations and treatment precedent to engaging in travel, or for pre-marital or pre-adoption purposes, and for any other purposes unrelated to screening for disease or prevention of disease.

- ***Exclusion*** **-** Eyeglasses and contact lenses other than those prescribed as necessary following cataract surgery.

- ***Limitation*** **-** Vision and hearing screening services limited to one (1) visit per year.

- ***Limitation*** **-** Routine Screening Mammography limited to once per benefit year or consistent with generally accepted medical practice and scientific evidence, upon referral by the Member's PCP or other appropriate provider. Diagnostic mammograms are covered under the outpatient benefit described in the section of this EOC titled *"Outpatient Hospital Services and Other Outpatient Facilities*".

Diabetes Management and Treatment

Diabetes outpatient care, services, and laboratory testing consistent with the American Diabetes Association practice recommendations. Diabetes self management, education, and medical nutrition services upon referral by the PCP. Applicable supplies and equipment used in the management and treatment of insulin dependent, non-insulin dependent and gestational diabetes, as medically necessary. Please also refer to the *"Prescription Drug Benefit"* and the *"Durable Medical Equipment"* sections of this EOC for further information.

- Blood glucose monitors and blood glucose testing strips.
- Insulin pumps and necessary supplies.
- Ketone urine testing strips.
- Lancets and lancet puncture devices.
- Pen delivery systems for the administration of insulin.
- Insulin syringes.
- Visual aids, excluding eyewear, to assist the visually impaired with proper dosing of insulin.
- Insulin.
- Prescriptive medications for the treatment of diabetes.
- Podiatric services and devices to prevent or treat diabetes complications.
- Outpatient self-management training, education and medical nutrition therapy necessary to enable you to properly use the equipment, supplies and medications as prescribed by your provider.

Pregnancy and Maternity Care

Prenatal and Postnatal Physician Office Visits and Delivery

- Prenatal physician office visits, laboratory testing including genetic and alpha-fetoprotein testing, and radiology services for complete prenatal and post-partum outpatient maternity care.
- Inpatient hospital services for the purposes of a normal delivery, cesarean section, complications or medical conditions arising from pregnancy or resulting childbirth. The length of inpatient hospital stay is based upon the unique characteristics of each mother. Your IHSS Health Plan will not restrict inpatient hospital care to less than forty-eight (48) hours following a normal vaginal delivery, and not less than ninety-six (96) hours following a cesarean section delivery. However, coverage of inpatient hospital care may be for a time period less than forty-eight (48) to ninety-six (96) hours if the following two (2) conditions are met:
  1) The discharge decision is made by the treating physician, in consultation with the mother; and;
  2) The treating physician schedules a follow-up visit for the mother and newborn within forty-eight (48) hours of discharge.

- One (1) well-baby care physician visit to the hospital after the birth of newborn which includes newborn evaluation services as recommended by the American Academy of Pediatrics.

Nurse midwife services are available to you if you are seeking obstetrical care. The chosen nurse midwife must be associated with a Participating Provider. Participating Providers who offer nurse midwives are listed in the Contracted Provider List.

Exclusions/Limitations

- ***Limitation*** - No dependent (inpatient/outpatient) benefit coverage for newborn with the exception of the one (1) well-baby care physician visit to hospital after birth of newborn, including newborn evaluation services as recommended by the American Academy of Pediatrics.
- ***Exclusion –*** Ultrasound, amniocentesis, or any other procedure for the purpose of determining sex of fetus.

Physician and Professional Services

- Physician office visits for examination, diagnosis, and treatment of a medical condition, disease, or injury, including referral Specialist office visits, second opinions and consultations.
- Physician home visits when medically necessary.
- Medical and surgical physician services for examination, diagnosis, treatment, and consultation (including assistant surgeon, anesthesiologist, pathologist and radiologist) while you are an inpatient at a hospital, skilled nursing facility, or rehabilitation facility for the following.
- Office visits for the purpose of allergy testing and treatment, including allergy injections and serum.

Exclusions/Limitations

- ***Exclusion*** - Infertility reversal for and incident to the reversal of a vasectomy or tubal ligation.
- ***Exclusion*** - Repeat vasectomy or tubal ligation.
- ***Exclusion*** - Infertility services for and incident to sexual dysfunction or sexual inadequacies (except as provided for treatment for organically based conditions), ovum transplants, artificial insemination, in vitro fertilization, including GIFT and ZIFT procedures or any other form of induced fertilization or services incident to or resulting from procedures for a surrogate mother who otherwise is not eligible for covered pregnancy and maternity care under the Plan's health care benefits.
- ***Exclusion*** - Experimental and investigational treatments unless required by an external, independent review panel pursuant to California Health and Safety Code Section 1370.4. Unless otherwise dictated by federal or state law, decisions as to whether a particular treatment is experimental or investigational, are determined by the IHSS Health Plan's Medical Director or his or her designee based upon criteria reflecting current standards of medical care, including but not limited to, published authoritative medical or scientific literature, established medical protocols, opinions of other medical agencies or professional review organizations, expert medical opinion, and regulations and other official actions and publications issued by the Food and Drug Administration (FDA) or Department of Health and Human Services (DHHS).

  If your IHSS Health Plan denies or delays a requested service on the basis that it is experimental or investigational, you may request an Independent Medical Review (IMR) by the DMHC. The process for requesting an IMR is described in Section 7 of this EOC, *"Member Grievance System"*.

- ***Exclusion*** **-** Routine foot care, including, but not limited to, removal or reduction of corns and calluses, clipping of toenails, treatment of flat feet, fallen arches, and chronic foot strain, except if you have diabetes and as required for foot disfigurement from disease or accident. Specialized footwear, including foot orthotics, custom made standard orthopedic shoes, or customized footwear, which is not permanently attached to an orthopedic brace.
- ***Exclusion*** **-** Specialty pain management services (services provided by a pain management Specialist or in a pain management center or clinic) to treat or cure chronic pain, except as may be provided through a participating hospice agency under the hospice benefit.
- ***Exclusion*** **-** Workers' compensation and work-related injury for or incident to any injury or disease arising out of, or in the course of any employment for salary, wage or profit if such injury or disease is covered by any workers' compensation law, occupational disease law or similar legislation.
- ***Limitation*** **-** Allergy testing and treatment: maximum of eight (8) allergy injections within a 120 day period without prior authorization from the Plan.
- ***Limitation*** **-** Inpatient professional services, including hospital, skilled nursing or rehabilitation facility services, are covered only if you are referred by your PCP.
- ***Exclusion*** **-** Spinal manipulation or adjustments other than those provided under the Plan's Chiropractic benefit.
- ***Exclusion*** **-** Surgery for morbid obesity, including gastric bypass, gastric stapling, prescription medications, and other procedures for the treatment of obesity, except when medically necessary.

Family Planning

- Family planning counseling.
- Counseling, professional services, and surgical procedures for sterilization as permitted by state and federal law, including but not limited to tubal ligation and vasectomy.
- Pregnancy test performed by a physician
- Contraceptive drugs and devices pursuant to the Plan's prescription drug benefit, including insertion or removal of an Intrauterine device (IUD). Please refer to the Prescription Drug Benefit in this section for more information.
- Therapeutic and elective abortion

Exclusions/Limitations

- ***Limitation*** **-** Family planning counseling limited to 15 visits per year.
- ***Exclusion*** **-** Infertility services and treatment, including artificial insemination and sperm storage.
- ***Exclusion*** **-** Over-the-counter condoms and spermicides (creams and gels).

Outpatient Hospital Services and Other Outpatient Facilities

- Services and supplies for treatment, therapeutic services (including radiation and chemotherapy) or surgery in an outpatient hospital setting or ambulatory surgery center.
- Diagnostic services including X-ray, mammography, CT scan, MRI, nuclear medicine, and laboratory services.
- Physical, occupational, and speech therapy may be provided in a medical office, in the home or other appropriate outpatient setting when ordered by your PCP.

- General anesthesia and associated facility charges are covered for dental procedures rendered in a hospital or surgery center setting, when the clinical status or underlying medical condition of the patient requires dental procedures that ordinarily would not require general anesthesia to be rendered in a hospital or surgery center setting. Prior authorization for general anesthesia required for dental care procedures may be required in the same manner that prior authorization is required for other covered diseases or conditions.

- General anesthesia and associated facility charges are covered only if you are less than seven years of age; developmentally disabled, regardless of age; or if your health is compromised and general anesthesia is medically necessary, regardless of age.

- Cataract spectacles, cataract contact lenses, or intraocular lenses that replace the natural lens of the eye after cataract surgery.

Exclusions/Limitations

- ***Exclusion*** **-** Dental procedures, including but not limited to the professional fee of the dentist.
- ***Exclusion*** **-** Unauthorized non-urgent or non-emergency services.
- ***Limitation*** - Physical, occupational, and speech therapy visits limited to 36 visits per benefit year. Additional visits may be authorized as medically necessary, with evidence of continued significant improvement, as part of an approved treatment plan.

Emergency Health Care Services

You are encouraged to appropriately use the "911" emergency response system when you have an emergency medical condition. Please notify your IHSS Health Plan within twenty-four (24) hours or as soon as possible.

An "emergency medical condition" is defined as a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in any of the following:

- Placing the patient's health in serious jeopardy.

- Serious impairment to bodily functions.

- Serious dysfunction of any bodily organ or part.

Payment for emergency services and care may be denied only if the IHSS Health Plan reasonably determines that the emergency services and care were never performed; or when the Plan enrollee did not require emergency services and care and the enrollee reasonably should have known that an emergency did not exist. The determination as to whether you reasonably believed that the medical condition was an emergency medical condition that required an emergency response will not be based solely upon a retrospective analysis of the level of care eventually provided to you, or your final discharge diagnosis. If you receive non-authorized services in a situation that your IHSS health plan determines was not an emergency, and in which it was not reasonable to believe that the situation was an emergency, you will be responsible for the costs of those services.

If you are outside the service area and have an emergency you may receive services from a non-contracted provider. Please notify your IHSS Health Plan within twenty-four (24) hours, or as soon as your condition permits. Your IHSS Health Plan will provide care in a non-contracted hospital for as long as the medical condition prevents a safe transfer to a Participating Provider.

Continuing or Follow-up Treatment: Your IHSS Health Plan will provide care in a non-contracted hospital only for as long as your medical condition prevents transfer to a hospital in the service area, as approved by your IHSS Health Plan. Continuing or follow-up care after the initial emergency has been treated in a Non-participating Provider hospital is not a covered service unless authorized.

Urgent Services

For urgent services within your IHSS Health Plan's service area, you should call your PCP's twenty-four (24) hour phone number for guidance before seeking care. Your condition may require immediate emergency care rather than urgent care. If you are outside the service area and require urgent services, you may receive services from a non-contracted provider. Please notify your IHSS Health Plan within twenty-four (24) hours, or as soon as your condition permits.

Inpatient Hospital Services

The following hospital services are IHSS Health Plan benefits when provided at a Participating Provider hospital as referred by your PCP and authorized in accordance with IHSS Health Plan rules. Emergency care and urgent care services do not need to be authorized or referred. Hospital benefits are not covered if you refuse to be under the direct care and treatment of a Participating Provider, or if services are received through a physician whose services have not been authorized.

- Semi-private room and board, unless a private room is medically necessary and authorized. If a private room is used without authorization, you will be responsible for the difference between the IHSS Health Plan's rate for a semi-private room and the hospital's rate for a private room.
- General nursing care and special duty nursing when medically necessary and authorized.
- Intensive care services.
- Delivery room and newborn nursery.
- Hospital ancillary services including operating room, diagnostic laboratory, radiology, physical, occupational and speech language therapy services, pain control and symptom management.
- Prescribed drugs, medications, IV fluids, biologicals, and oxygen administered in the hospital. Up to three (3) days supply of drugs as prescribed upon discharge by a Participating Provider to cover transition from the hospital to home.
- Surgical and anesthetic supplies, dressings and cast materials, surgically implanted devices and prostheses (not including surgically implanted hearing aids), other medical supplies, medical appliances, and equipment administered in the hospital, and prosthetic devices to restore and achieve symmetry after mastectomy or to restore speech after laryngectomy.
- Administration of blood and blood products.
- Radiation therapy, chemotherapy, and renal dialysis.

Exclusions/Limitations

- ***Exclusion*** **-** Personal comfort and convenience items such as telephones, televisions, guest trays, and personal hygiene items and private rooms.

Inpatient Rehabilitation Services

The following hospital services are IHSS Health Plan benefits when provided at a hospital that is a Participating Provider if referred by your PCP and authorized in accordance with IHSS Health Plan requirements.

Rehabilitation facility room and board, general nursing care, ancillary services and appropriate physical, occupational, and speech therapy services.

Exclusions/Limitations

- ***Limitation*** - Coverage is limited to a maximum 30 days per benefit year. Additional days may be authorized as medically necessary, with evidence of continued significant improvement.
- ***Exclusion*** **-** Vocational rehabilitation services (therapy services for the purpose or goal of gaining or maintaining employment).

Medical Transportation Services

Emergency Transportation Services

Ambulance transportation to the nearest hospital is covered if the transportation:

- Was for an Emergency Medical Condition and ambulance transport services were required, OR
- You reasonably believed your medical condition was an Emergency Medical Condition and reasonably believed that the condition required ambulance transport services.

This includes ambulance transportation services provided through the "911" emergency response system.

Air ambulance is covered only in emergencies when ground transport is contraindicated due to distance and/or your medical condition.

Non-Emergency Transportation Services

- Ambulance transportation for non-emergency medical transportation to transfer you from a Non-participating Provider hospital to a Participating Provider hospital for admission.
- Non-emergency medical transportation to transfer you from a hospital or other medical facility to your residence only when you require transport in a prone or supine position or require specialized safety equipment, for medical reasons.

Exclusions/Limitations

Exclusions **-** Transportation services other than those specifically provided for in the in this section of the EOC, *"Medical Transportation Services"*, or in the *"Summary of Benefits and Covered Services Matrix*", including but not limited to airplane, passenger car, taxi, or other form of public or private conveyance.

Prescription Drugs

Benefits are provided for outpatient prescription drugs which meet all of the requirements specified in this section, are prescribed by a physician or other licensed health care provider within the scope of his or her license as long as the prescriber is a Participating Provider, are obtained from a participating pharmacy, and are listed on the Drug Formulary. Drug coverage is based on the use of the Santa Barbara Regional Health Authority Choice Formulary and is administered in cooperation with MedImpact. The Drug Formulary is updated on an ongoing basis by MedImpact's Pharmacy and Therapeutics Committee and reviewed by the SBRHA Pharmacy and Therapeutics Committee. Non-formulary drugs may be covered subject to higher copayments. Selected drugs and drug dosages may require prior authorization by your IHSS Health Plan for medical necessity and appropriateness of therapy. Non-formulary drugs, which are medically necessary, are covered if your physician obtains prior authorization by sending an authorization request form to the IHSS Health Plan. Off label use of drugs is not precluded by this formulary.

Outpatient Prescription Drug Formulary

The Drug Formulary applies only to outpatient drugs provided to you, and does not apply to medications used in inpatient settings. Medications are selected for inclusion in your IHSS Health Plan Choice Formulary based on safety, efficacy, FDA bioequivalence data, and cost. New drugs and clinical data are reviewed regularly to update the Formulary. Drugs considered for inclusion or exclusion from the Formulary are reviewed by the SBRHA Pharmacy and Therapeutics Committee.

You may call the SBRHA Member Services Department at the number listed on your ID Card or MedImpact at 1-800-788-2949 to inquire if a specific drug is included in the Formulary. Member Services can also provide members with a printed copy of the Formulary. You may also access the Formulary through the SBRHA Website at http://www.sbrha.org.

Obtaining Outpatient Prescription Drugs at a Participating Pharmacy

To obtain drugs at a participating pharmacy, you must present your Plan ID card. Note that, except for covered emergencies, claims or billing requests for payment for drugs you obtained without using your Plan ID card will be denied.

Generic substitution

- When available, FDA approved generic drugs are to be used in all situations, regardless of the brand name indicated (except as noted below). The generic names are **bolded** in the formulary listing whenever an FDA approved generic drug product is available. This policy is not meant to replace any state statutes that may exist. All drugs that are or become available generically are subject to review by the Plan's Pharmacy and Therapeutics Committee in cooperation with MedImpact's Pharmacy and Therapeutics Committee.

- You are responsible for paying the applicable copayment for each covered new and refill prescription drug. The pharmacist will collect the applicable copayment from you at the time the drugs are obtained.

    - $15 generic

    - $25 Formulary brand name

    - $50 non-Formulary brand name per prescription for the amount prescribed not to exceed a 30-day supply.

  Note: For diabetic supplies (including needles and syringes) the Formulary brand name copayment applies.

- If you request a Formulary brand name drug when a Formulary generic drug equivalent is available, you are responsible for paying the difference in cost in addition to the applicable Formulary brand name drug copayment.

- If a prescription specifies a Formulary brand name drug and the prescribing provider had written "Dispense as Written" or "Do not Substitute" on the prescription, or if a Formulary generic drug equivalent drug is not available, you are responsible for paying the applicable Formulary brand name drug copayment or the non-Formulary brand name drug copayment.

  Note: Certain drug products will not be subject to substitution: These products are:

    - Dilantin (except suspension)

    - Neoral Oral Solution

    - Lanoxin

- Drugs obtained at a non-participating pharmacy are not covered, unless medically necessary for a covered emergency, including drugs for emergency contraception. If you must obtain drugs from a non-participating pharmacy due to an emergency, the submission of a Prescription Drug Claim Form is required. Claim forms are available by contacting the Member Services Department's toll-free number 1-877-814-1861. Claim forms must be received within 180 days (6 months) from the date of service to be considered for payment. Reimbursement for covered emergency claims will be based upon the purchase price of covered prescription drug(s) less any applicable copayment(s).

Obtaining Outpatient Prescription Drugs – Mail Order Program

For your convenience, when drugs have been prescribed for a chronic condition and your medication dosage has been stabilized, you may obtain the drug through the Plan's Mail Order Prescription Program. This program is available from MedImpact's Mail Order Pharmacy.

- Prior to using this Mail Order Program, you must have received the same medication and dosage through the Plan's pharmacy network for at least two (2) months. The Plan will

provide mail order forms and information at the time of enrollment. You should submit the applicable copayment, an order form with your Plan ID number and include your return address on the mail order envelope.

Be sure to send in the refill request approximately three (3) weeks before your supply runs out. You should allow fourteen (14) days to receive the drug. Your provider must indicate a prescription quantity which is equal to the amount to be dispensed.

- You are responsible for paying the applicable copayment for each covered new and refill drug. Copayments will be tracked for you.

Copayments for a 90 day supply are as follows:

- $20 generic
- $50 Formulary brand name
- $150 non-formulary brand name per prescription not to exceed a 90-day supply.

If your provider indicates a prescription quantity of less than a 90-day supply, that amount will be dispensed, and refill authorizations cannot be combined to reach a 90-day supply.

Note: For diabetic supplies (including needles and syringes) the Formulary brand name copayment applies.

- If you request a mail order Formulary brand name drug when a mail order Formulary generic is available, you are responsible for the difference between the cost of the mail order Formulary brand name drug and its mail order generic equivalent, as well as three (3) applicable Formulary brand name copayments.
- If the prescription specifies a mail order Formulary brand name drug and the prescribing provider has written "Dispense as Written" or "Do Not Substitute" on the prescription, or if a mail order generic drug equivalent is not available, you are responsible for paying the applicable mail order Formulary brand name drug copayment or mail order non-Formulary copayment.

  Note: Certain drug products will not be subject to substitution: These products are:

  - Dilantin (except suspension)
  - Neoral Oral Solution
  - Lanoxin

For information about the Mail Order Prescription Drug Program, you may refer to the mail service program brochure for the phone number and a more detailed explanation or call SBRHA's Member Services Department's toll-free number at 1-877-814-1861.

Prescription Drug Benefit Coverage and Limitations

The Formulary does not provide information regarding specific coverage and limitations an individual IHSS Health Plan Member may have. Many Health Plan Members have specific inclusions, exclusions, copayments, or a lack of coverage, which are not reflected in the Formulary.

The Formulary applies only to outpatient drugs provided to you, and does not apply to medications used in inpatient settings (such as hospital, rehabilitation facilities, and nursing homes). Drugs administered to you while you are an inpatient, are covered under the IHSS inpatient benefit as described in the *"Inpatient Hospital Services"* section of this EOC. If you have specific questions regarding your coverage you may contact SBRHA's Member Services Department's toll-free number at 1-877-814-1861 or MedImpact at 1-800-788-2949.

Exclusions/Limitations

- ***Limitation* –** Some drugs may be subject to specific quantity limits. Some prescription drugs may be subject to specific quantity limits as dictated by the medical necessity to adequately

treat the condition. Drugs exceeding quantity limits which are medically necessary are covered if your physician obtains prior authorization by sending an authorization request form to the IHSS Health Plan.

- ***Exclusion*** **-** Drugs obtained from a non-participating pharmacy, except for a covered emergency.
- ***Exclusion*** - Over the Counter (OTC) medications or their equivalents, unless otherwise specified in the Formulary listing.
- ***Exclusion*** - Drugs listed as not covered.
- ***Exclusion*** **-** Any drug products used for cosmetic purposes. Some drugs used for cosmetic purposes may be covered with a doctor's prescription for a medically necessary condition.
- ***Exclusion*** **-** Experimental drug products or any drug product used in an experimental manner. If your IHSS Health Plan denies a requested service on the basis that it is experimental or investigational, you may request an Independent Medical Review (IMR) by the DMHC. The process for requesting an IMR is described in Section 7 of this EOC, *"Member Grievance System"*.
- ***Exclusion*** - Replacement of lost or stolen medication.
- ***Exclusion*** **–** Non-self-administered injectable drug products, unless otherwise noted. Injectables administered by a Participating Provider are covered under the IHSS Health Plan's medical benefit.
- ***Exclusion*** **-** Drugs not approved by the United States Food and Drug Administration.
- ***Exclusion*** - Take home drugs received from a hospital, convalescent home, skilled nursing facility, or similar facility.
- ***Exclusion*** - Dietary or nutritional products except for medical formulas or special food products required for treatment of PKU.
- ***Exclusion*** - Medical devices or supplies, except as specifically listed as covered.
- ***Exclusion*** - Appetite suppressants and other weight loss medications, unless specifically listed as covered or as medically necessary for the treatment of morbid obesity.
- ***Exclusion*** - Compounded medications with Formulary alternatives or those with no FDA approved indications.

For questions regarding the IHSS Formulary or to obtain a copy of the Formulary, contact the Member Services Department's toll-free number at 1-877-814-1861.

Durable Medical Equipment

Durable medical equipment (DME) is covered when prescribed in writing by your PCP or other Participating Provider. DME includes, but is not limited to, the purchase or rental of equipment such as:

- Ambulatory items; need to clarify
- Wheelchairs;
- Oxygen and related respiratory equipment, hospital beds and accessories;
- Bathroom safety equipment; and
- Home monitoring equipment for diabetes asthma and high blood pressure management.

Rental charges for DME are covered up to the purchase price.

- Medically necessary repairs and replacement of DME are covered as authorized unless necessitated by misuse or loss.

Exclusions/Limitations

- ***Exclusion*** **-** Home monitoring equipment except for those provided under the diabetes management program, asthma and high blood pressure benefit.

- ***Exclusions*** **-** DME provided by a non-participating provider; customization of living environment or motor vehicles; experimental equipment; items that duplicate the function of other equipment; and other convenience items not generally used primarily for medical care. Examples include, but are not limited to, exercise equipment, air conditioners or heaters, lighting devices, orthopedic mattresses, recliners, seat lift chairs, elevators, waterbeds, household and furniture items.

- ***Limitation*** – Certification by a licensed Occupational or Physical Therapist or certified Rehabilitation Technician is required for custom made manual wheelchairs and power operated wheelchairs/scooters.

Medical Supplies

- Medical supplies are covered as prescribed in writing by your PCP or other Participating Provider. Medical supplies include, but are not limited to:
  - Wound care dressings
  - Urological supplies
  - Ostomy supplies
  - Diabetic supplies

Exclusion/ Limitations

- ***Exclusion*** **-** Therapeutic devices or apparatuses, regardless of therapeutic effect (e.g. hypodermic needles and syringes, except as needed for insulin and covered injectable medications), support garments and similar items.

- ***Exclusion*** **-** Incontinence supplies.

- ***Exclusion*** **-** Over-the-counter medical supplies. Examples of over-the counter medical supplies include, but are not limited to, incontinence supplies, wipes / towelettes, thermometers, band-aids, elastic wraps, tape, and batteries.

Orthotic and Prosthetic Appliances

Orthotic and Prosthetic (O&P) appliances are covered when such appliances are necessary for the restoration of function or replacement of body parts, as prescribed in writing by a Participating Provider.

O&P services will be covered only when medically necessary to restore bodily functions essential to activities of daily living, prevent significant physical disability or serious deterioration of health or to alleviate severe pain.

O&P items include, but are not limited to:

- Custom footwear required for foot disfigurement from disease or accident and for insulin dependent diabetics.

- Devices to restore and achieve symmetry incident to mastectomy.

- Devices to restore a method of speaking following laryngectomy

In the event that more than one type of prosthetic device or corrective appliance is available, benefits will be provided only for the device or appliance which is medically and reasonably indicated in accordance with accepted medical practice.

Exclusions/Limitations

- ***Exclusion*** - Miscellaneous equipment for orthopedic shoes, except for therapeutic footwear for diabetes, and except as provided under the Diabetes Management and Treatment benefit.

- ***Exclusion*** - Appliances provided by Non-participating Providers. Over-the-counter items including but not limited to: shoe inserts; arch supports; elastic stockings; and items used for fitness or athletic activities.

Hearing Aid Services

- Audiological evaluation to measure the extent of hearing loss, and a hearing aid evaluation to determine the most appropriate make and model of hearing aid are covered.
- Hearing Aid - monaural or binaural hearing aids, including ear molds(s), the hearing aid instrument, the initial battery, cords and other ancillary equipment.
- Visits for fitting, counseling, adjustments, repairs, etc., at no charge for one (1) year following the provision of a covered hearing aid.
- Surgically implanted FDA-approved hearing devices, including implantable cochlear devices for bilateral, profoundly hearing impaired individuals who are not benefited from conventional amplification (hearing aids).

Exclusions/Limitations

- ***Limitation*** - no charge for visits for a 1-year period following the provision of a covered hearing aid.
- ***Limitation*** - Up to a maximum benefit of $1,000 every 36 months for the hearing aid instrument and ancillary equipment. Does not apply to implantable cochlear devices and surgical services and procedures to implant a hearing device.
- ***Exclusion*** - Batteries or other ancillary equipment, except those covered under the terms of the initial hearing aid purchase. Charges for a hearing aid which exceeds specifications prescribed for correction of a hearing loss. Replacement parts for hearing aids, repair of hearing aid after the covered 1-year warranty period and replacement of a hearing aid more than once in any period of 36 months.

Mental Health Care

Your IHSS Health Plan provides for mental health coverage including the diagnosis and medically necessary treatment of Serious Mental Illness (SMI) and Serious Emotional Disturbances (SED). Benefits include outpatient and inpatient hospital services and partial hospital services. Your IHSS Health Plan provides limited coverage for mental health conditions other than SMI or SED. See Definitions Section 11.

Inpatient Mental Health Services

Mental health care in an IHSS Health Plan hospital when ordered and performed by a mental health Participating Provider for the treatment of a mental health condition. Except for the treatment of SMI and SED, inpatient mental health services are limited to ten (10) days in a calendar year.

With your agreement, or the agreement of another adult who is legally empowered to make treatment decisions on your behalf, each day of inpatient hospitalization may be substituted for two (2) outpatient visits.

Exclusions/Limitations (Inpatient)

- ***Limitation*** - benefit limited to ten (10) days inpatient stay per benefit year for non-SMI or non-SED conditions.
- ***Limitation*** - Maximum benefit per year is limited to $10,000 for non-SMI or non-SED conditions.

Outpatient Mental Health Services

Mental health care when ordered and performed by a Health Plan mental health professional. Except for the treatment of SMI and SED, outpatient services for evaluation and care are limited to ten (10) visits in a calendar year. This outpatient benefit is in

addition to any outpatient visits substituted for inpatient days.

Outpatient Mental Health Services for the treatment of SMI and SED are provided with no visit limitations.

Exclusions/Limitations (Outpatient)

- ***Limitation*** **-** benefit limited to ten (10) outpatient visits per benefit year for non-SMI or non-SED conditions.

Skilled Nursing Facility Services

Skilled nursing care is covered in a nursing facility licensed by the State of California. A skilled nursing facility may be a distinct part of a hospital, and use of such a distinct part is counted towards the maximum number of days described below.

This benefit is limited to one hundred (100) days during any benefit year. Subject to this limitation, the following skilled nursing facility benefits are provided when medically necessary and authorized, and are not for custodial, convalescent or domiciliary care:

- Semi-private room and board, unless a private room is medically necessary and authorized. If a private room is used without authorization, you will be responsible for the difference between the skilled nursing facility's customary charge for a two (2) bed room and the private room;
- General nursing care and special duty nursing when authorized;
- Physical, occupational, and speech language pathology while inpatient under the SNF benefit of 100 days.
- Durable medical equipment utilized by you during an authorized stay in the skilled nursing facility.

Exclusions/Limitations

- ***Limitation*** – 100 days per benefit year
- ***Limitation –*** If private room requested, you must pay the difference between the private and semi-private room charges.
- ***Limitation*** - Physical, occupational, and speech language pathology services only while inpatient under the IHSS Health Plan benefit.
- ***Exclusion*** **-** Any services or supplies furnished by a non-eligible institution, which is defined as other than a legally operated hospital or Medicare-approved skilled nursing facility, or which is primarily a place of rest, a place for the aged, a nursing home, or any similar institution, regardless of how denominated.
- ***Exclusion –***Long term, maintenance, or chronic level rehabilitation services including physical, occupational, and speech therapy provided on an inpatient or outpatient basis, except for the restricted and limited rehabilitation services provided in the Summary of Benefits.
- ***Exclusion*** **-** Skilled nursing care, skilled nursing facility room and board and ancillary charges incurred beyond the 100 days per benefit year.

Hospice Care

Hospice services are provided upon formal admission to an approved hospice program, through a hospice agency that is a Participating Provider. The IHSS Health Plan will provide hospice care for you if you are terminally ill and if you elect palliative care instead of other benefits for terminal illness that are provided by the IHSS Health Plan. Terminal illness is defined as a medical condition resulting in a prognosis for life expectancy of twelve (12) months or less, if the disease follows its natural course. Hospice care is a specialized form of interdisciplinary health care that is designed to provide medical management for pain and other symptoms associated with a terminal illness and its related conditions, but does not provide efforts to cure the disease.

You may change your decision to receive hospice care at any time, and request other services offered as benefits of your IHSS Health Plan.

When ordered by a Participating Provider, hospice benefits include:

- Skilled nursing services, certified health aide services, and homemaker services under the supervision of a qualified registered nurse;
- Bereavement services;
- Social services, counseling services with medical social services provided by a qualified social worker;
- Dietary counseling by a qualified provider when needed;
- Medical direction with the hospice facility's medical director being also responsible for meeting your general medical needs for the terminal illness, to the extent that these needs are not met by a personal physician;
- Volunteer services;
- Short-term inpatient care arrangements related to the hospice terminal illness;
- Pharmaceuticals, medical equipment and supplies that are reasonable and necessary for the management of the terminal illness and related conditions;
- Physical, occupational, and speech language pathology services, for the purpose of symptom control, or to enable you to maintain activities of daily living and basic functional skills;
- Nursing care services covered on a continuous basis for as much as twenty four (24) hours a day during periods of crisis as necessary to keep you at home; and
- Respite care services for up to five (5) consecutive inpatient days to provide relief to families.

Exclusions/Limitations

- ***Limitation*** - Hospice care is limited to those individuals who are diagnosed with a terminal illness with a life expectancy of twelve (12) months or less.

Home Health Care Services

Home health care services are covered when you are required to be at home for medically necessary purposes at the direction of your PCP or other appropriate authority designated by the Health Plan. This benefit provides skilled medical services to you if you are homebound to transition you from institutionalization or to prevent institutionalization.

Home health care services are provided pursuant to an authorized home health treatment plan and only when medically necessary and authorized.

Home visits to provide skilled services by any of the following professional providers are covered:

- Registered nurse;
- Licensed vocational nurse;
- Certified home health aid in conjunction with the service of a registered nurse or licensed vocational nurse;
- Physical therapist, occupational therapist, speech therapist or respiratory therapist;
- Medical social worker; and
- Medical supplies given to you by the home health agency's personnel if they are provided in accordance with your written treatment plan.

Exclusions/Limitations

- ***Exclusion*** - Custodial maintenance or domiciliary care, except as provided under the Hospice benefit.
- ***Exclusion*** - Services performed by a Non-Participating Provider.

Other Benefits

Organ Transplant Benefits

- Medically necessary major organ transplants which are not experimental or investigational by current standards of care. If your IHSS Health Plan denies a requested service on the basis that

it is experimental or investigational, you may request an Independent Medical Review (IMR) by the DMHC. The process for requesting an IMR is described in Section 7 of this EOC, *"Member Grievance System"*.

Hospital and professional services are covered for certain major organ transplants only if:

1) Performed at a Medicare approved transplant center. A "transplant center" is a medical institution that operates an organ transplant program;
2) Prior authorization is obtained, in writing, from the Health Plan; and
3) You are the recipient of the transplanted organ and you meet all other IHSS Health Plan eligibility requirements.

The medical and hospital expenses incident to obtaining the human organ transplant material from a living donor are covered benefits, subject to your annual benefit maximum dollars.

Exclusions/Limitations

- ***Limitation –*** Preoperative evaluation, surgery, and follow-up care will be provided at centers that have been designated by your IHSS Health Plan as an approved transplant centers. Non-acute/non-emergency evaluations, transplantations and follow-ups at facilities that have not been designated by your IHSS Health Plan will not be approved.
- ***Limitation –*** The patient-selection committee of the approved transplant center will select recipients. If a Participating Provider or the referral facility determines that you do not satisfy the patient selection criteria for the transplant, tissue and organ transplant procedures and services will be excluded. Your IHSS Health Plan will pay only for the services you received before that decision is made.
- ***Exclusion -*** Organ transplants, anti-rejection drugs, biologicals and procedures that are considered experimental or investigational in nature by current standards of medical care and/or non-human or artificial organs and their implantation.
- ***Exclusion –*** Recipient or donor lodging, meals, and transportation costs to and from the transplant center.
- ***Exclusion –*** Charges associated with the procurement of donor organ or tissue.

Reconstructive Surgery

Reconstructive surgery is limited to those surgical services that:

- Are performed to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors or disease, and are likely to improve physical function or create a normal appearance, to the extent possible; or
- Follows medically necessary mastectomy surgery (including implants) which resulted from disease, illness, or injury

Exclusions/Limitations

- ***Exclusion -*** Surgical procedures that are defined as cosmetic and implants that are experimental or investigational.
- ***Exclusion -*** Cosmetic surgery or any resulting complications, except medically necessary services to treat complications of cosmetic surgery (e.g. infections or hemorrhages), but only upon review and approval by the Plan's Medical Director or designee. When services are determined to be cosmetic, all services to be provided as part of the cosmetic treatment plan are also excluded, including hospital, physician, medical supplies, or medications.
- ***Exclusion -*** Penile implant devices and surgery, and any related services, except for any resulting complications and medically necessary services as provided under covered reconstructive surgery benefits.
- ***Exclusion -*** Reconstructive surgery and procedures: (a) where there is another more

appropriate surgical procedure that is approved by Plan's Medical Director or physician consultant; or (b) when the surgery or procedure offers only a minimal improvement in your function or appearance.

- ***Exclusion*** **-** Sex transformations and related procedures, services, medications, and supplies.

Blood and Blood Products

- The processing, storage, and administration of blood and blood products are covered in inpatient and outpatient settings, including the collection and storage of autologous blood when medically indicated. (See Definition Section 11)

Phenylketonuria (PKU)

Benefits are provided for testing for PKU and for providing enteral formulas, special food products, and other treatments consistent with the recommendations and best practices of qualified health professionals with expertise in the treatment and care of, phenylketonuria (PKU), and that are medically necessary to avert the development of serious physical or mental disabilities or to promote normal development or function as a consequence of phenylketonuria (PKU). "Special food product" is defined as a food product that is:

- Specially formulated to have less than one gram of protein per serving, but does not include food that is naturally low in protein; and
- Used in place of normal food products, such as foods found in retail food stores and used by the general population.

Cancer Clinical Trials

Your IHSS Health Plan covers routine patient care costs that would otherwise be benefits when related to your participation in a cancer clinical trial. In order to participate in a clinical trial you must be diagnosed with cancer, your treating physician must have recommended the participation in the clinical trial based upon the potential benefit to your health, and you must be accepted into the clinical trial. Coverage includes costs for benefits described in this EOC.

Exclusions/Limitations

- ***Exclusion*** - Drugs or devices that have not been approved by the Food and Drug Administration (FDA) and which are not associated with a cancer clinical trial.

- ***Exclusion*** **-** Travel or housing expenses, companion expenses and other non-clinical expenses that may be incurred as a result of participation in a clinical trial.

- ***Exclusion*** **-** Any item or service provided solely for the purpose of data collection and that is not used in the clinical management of the patient.

- ***Exclusion*** **-** Services that are specifically excluded from coverage under this plan.

- ***Exclusion*** **-** Services customarily provided by the research sponsors free of charge to participants of a clinical trial.

Chiropractic Care

- Chiropractic services **are covered** for an injury or illness when referred **by** your **PCP to a** Participating Provider that is a chiropractor**;** including visits, examinations and procedures performed in the chiropractor's office.

***Limitations* –** Maximum of 20 visits per benefit year

Acupuncture

Acupuncture services are covered following an illness or injury when referred by your PCP to a Participating Provider that is an acupuncturist.

- Acupuncture is performed to prevent, modify or alleviate the perception of severe, persistent, or chronic pain resulting from a generally recognized medical condition, with or without electric stimulation of the needles.

Limitations – Maximum of 20 visits per benefit year.

Health Education

Health education is offered through routine materials provided by the IHSS Health Plan, if associated with disease management programs provided by the Plan, or by providers affiliated with the plan. The Plan encourages your participation in its disease management programs. For information on available programs call the Plan's Member Services Department at 1-877-814-1861.

Nutritional counseling is offered through the Plan's contracted Registered Dieticians, Certified Diabetes Educators, and other designated providers. Refer to the Plan's Contracted Provider Directory for participating providers. For personalized health education, consult with your PCP.

Exclusions/Limitations

- ***Limitation –*** Health education benefits are limited to $1,000 per benefit year.
- ***Limitation-*** Health education is limited to programs provided by the Plan and providers contracted with the Plan.

5. Medical Exclusions and Limitations

General Exclusions and Limitations

Only those services that are specifically described as benefits in this Evidence of Coverage and Disclosure Form and Handbook (EOC) are covered benefits of this Health Plan. You should read all such descriptions to get the full details of your coverage and non-coverage and/or limitations under Santa Barbara Regional Health Authority's IHSS Health Plan. Such services are covered benefits only if obtained in accordance with the procedures described in this document, including applicable authorization and referral requirements, and eligibility requirements for IHSS Health Plan membership.

BENEFITS ***NOT*** COVERED BY THE SBRHA IHSS HEALTH PLAN

1. **Alcohol and Substance Abuse Treatment (except inpatient emergency treatment for acute detoxification as medically necessary)**
2. **Dental Care (except as otherwise noted)**
3. **Vision Care (except as otherwise noted)**
4. **Services that are rendered without authorization from your IHSS Health Plan are not covered, except for Emergency Services, Urgently Needed Services, and obstetrical and gynecological services that can be accessed without referral, as described in this EOC.**
5. **Services, procedures, drugs, or any other IHSS Health Plan benefits for which charges are less than or equal to the applicable copayment.**
6. **Services, procedures, drugs, or any other IHSS Health Plan benefits for which you are not legally obligated to pay, or for which no charge is made.**

6. Coordination of Benefits and Third Party Liability

Coordination of Benefits

Your IHSS Health Plan will coordinate benefits for you if you are covered under two or more health plans. When there is Coordination of Benefits (COB) the health plans share costs of the authorized services under the IHSS Health Plan. You may be able to receive up to 100% coverage. To obtain the

maximum benefits available, you should submit claims to your IHSS Health Plan for all covered services.

Please notify your IHSS Health Plan if you are covered under another health plan, including government health care programs such as the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) and Medicare or workers' compensation or any other arrangement whereby you may be entitled to payment or reimbursement for hospital or medical expenses.Your IHSS Health Plan will not cover benefits if your IHSS Health Plan benefits duplicate other plan benefits to which you are entitled.

SBRHA has the right to recover any overpayments made under this IHSS Health Plan. In certain circumstances, you may be required to assist SBRHA with necessary documentation so payment can be made to SBRHA or to SBRHA's providers. If the other health plan or payment or reimbursement arrangement does not have a coordination of benefits provision, it must provide its benefits first, or you must first obtain benefits from the other health plan.

Third Party Liability

It is your responsibility to inform SBRHA at our toll-free telephone number at 1-877-814-1861 or your provider when services performed are covered through workers' compensation laws, automobile, accident or other liability coverage. The IHSS Health Plan will not duplicate coverage for such services. The IHSS Health Plan and/or its Participating Providers will seek reimbursement for up to the amount your IHSS Health Plan paid for any services rendered which duplicate such coverage. In the case of a monetary award, SBRHA or its Participating Providers must be reimbursed immediately after the award is received. SBRHA also has the option to be subrogated to your right to the extent of the cost of benefits provided by the Health Plan.

If you wish to release a third party form liability or settle a claim against a third party for which you receive compensation for medical care provided through this Health Plan, you must obtain prior written consent from SBRHA if such acts would limit SBRHA's right to reimbursement.

You are required to give prompt notification to SBRHA of the name and location of the third party, if known, the name and address of your lawyer if any, and a description of how the injuries were caused.

You may be required to:

- Complete any paperwork that SBRHA or the medical providers may reasonably require to assist in enforcing the lien;
- Promptly respond to inquiries about the status of the third party case and any settlement discussions;
- Notify SBRHA immediately upon receiving any money or his/her lawyer receiving any money from the third parties or their insurance companies.

7. Member Grievance System

How the Member Grievance Process Works

If for any reason you are unhappy with the services you receive from your provider, we encourage you to speak with your doctor as soon as possible. If you do not feel comfortable discussing the issue with your doctor, please contact SBRHA at our toll-free telephone number at 1-877-814-1861. You will not be treated differently because you filed a complaint or appeal.

How to File a Complaint or Appeal with your IHSS Health Plan

You may report a grievance in person, by mail, fax, telephone or through SBRHA's website. If you would like help with a problem, or you would like to file a complaint or appeal, please contact the Member Services Department:

By Telephone:	877-814-1861
By Fax:	805-685-2767
By TDHI	805-685-4131
In Person/By Mail:	SBRHA Member Services 110 Castilian Drive Goleta, CA 93117-3028

Through the SBRHA Website: www.SBRHA.org

A Complaint Form can be obtained by calling the Member Services Department. Additionally, Complaint Forms are available and may be filed at any Participating Provider office. The Grievance Coordinator or a Member Services Representative is available to assist you in completing the Complaint Form. You do not have to use a Complaint Form to file a complaint or appeal. You can also submit a complaint by completing the online grievance form at the Plan's website: www.SBRHA.org. .

Member Grievance System Response

When you file a complaint or appeal, your IHSS Health Plan will send you a letter within five (5) calendar days, letting you know that we have received your concerns. You will then receive a written response from your IHSS Health Plan regarding the resolution of the grievance within 30 (thirty) calendar days after receiving your complaint/appeal.

Complaints indicating a serious threat to your health are considered urgent. Urgent complaints/appeals refer to cases involving an imminent and serious threat to your health, including but not limited to severe pain, potential loss of life, limb, or major bodily function. In the case of an urgent complaint or appeal, you have the right to immediately contact the DMHC if you feel the Plan is not responding to your concerns. You are not required to participate in your IHSS Health Plan's grievance system process prior to applying to the DMHC for review of the urgent complaint or appeal.

Your IHSS Health Plan has three (3) calendar days to resolve urgent complaints or appeals. Your IHSS Health Plan will send you a written statement on the resolution or pending status of the urgent complaint/appeal within three (3) days after receipt of the complaint/appeal.

Your Rights

- Your complaint/appeal will be investigated and you will be notified of the resolution within thirty (30) days.
- If your complaint/appeal is urgent due to a condition that threatens your health, IHSS Health Plan staff will review and resolve your case within three (3) days.
- You have the right to ask a relative or another designated representative to help file your complaint/appeal. If you are a minor, a complaint may be registered for you by the parent, guardian, conservator, relative, or your other designee, as appropriate.

Complaints to the Department of Managed Health Care (DMHC)

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 by calling 1-877-814-1861or our TDD line 1-805-685-4131 for the hearing and speech impaired 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 unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number (1-888-HMO-2219) and a TDD line (1-877-688-9891) for the hearing and speech impaired. The department's Internet Web site http://www.hmohelp.ca.gov has complaint forms, IMR application forms and instructions online.

Your IHSS Health Plan's grievance process and the DMHC complaint review process are in addition to any other dispute resolution procedures that may be available to you. Your failure to use these processes does not preclude your use of any other remedy provided by law.

Independent Medical Review

You may request an independent medical review (IMR) from the DMHC if you believe that health care services have been improperly denied, modified, or delayed by your IHSS Health Plan or one of its Participating Providers, or where your IHSS Health Plan denied coverage for an experimental or investigational therapy.

The IMR process is in addition to any other procedures or remedies that may be available to you. You pay no application or processing fees for any kind of IMR. You have the right to provide information in support of the request for an IMR. Your IHSS Health Plan must provide you with an IMR application form with any complaint disposition letter that denies, modifies, or delays health care services. A decision not to participate in the IMR process may cause you to forfeit any statutory right to pursue legal action against the plan regarding the disputed health care service

IMR for a disputed health care service

You may request an IMR of disputed health care services from the DMHC if you believe that the health care services have been improperly denied, modified, or delayed by your IHSS Health Plan or one of its participating providers.

A "disputed health care service" is any health care service eligible for coverage and payment under your subscriber contract that has been denied, modified, or delayed by your IHSS Health Plan or one of its Participating Providers, in whole or in part, because the service is not medically necessary.

Your application for an IMR of a disputed health care service will be reviewed by the DMHC to confirm that:

- Your provider has recommended a health care service as medically necessary, or
- You have received urgent care or emergency services that a provider determined was medically necessary, or
- You have been seen by a Plan provider for the diagnosis or treatment of the medical condition for which you seek independent review.
- The disputed health care service has been denied, modified, or delayed by your IHSS Health Plan or one of its Participating Providers, based in whole or in part on a decision that the health care service is not medically necessary; and
- You have filed a grievance with your IHSS Health Plan or one of its Participating Providers and the disputed decision is upheld or the grievance remains unresolved after thirty (30) days. If your grievance requires expedited review you may bring it immediately to the DMHC's attention. The DMHC may waive the requirement that you follow the IHSS Health Plan's grievance process in extraordinary and compelling cases.

If your case is eligible for an IMR, the dispute will be submitted to a medical Specialist who will make an independent decision of whether or not the care

is medically necessary. You will receive a copy of the assessment made in your case. If the IMR determines the service is medically necessary, your IHSS Health Plan will provide the health care service.

For non-urgent cases, the IMR organization must provide its decision within thirty (30) calendar days of receiving your application and supporting documents. For urgent cases involving imminent and serious threat to your health, including, but not limited to, serious pain, the potential loss of life, limb, or major bodily function, or the immediate and serious deterioration of your health, the IMR organization must provide its determination within three (3) business days.

IMR regarding Experimental or Investigational therapies

You may also request an IMR if you have been denied coverage based on the IHSS Health Plan's determination that a drug, device, procedure, or other therapy proposed for you is experimental or investigational in nature. Your IHSS Health Plan will notify you of your right to request an external independent review within five (5) business days of its decision to deny coverage. You may have the legal right to have the IHSS Health Plan's denial reviewed if the following criteria are met:

- You have a life threatening or seriously debilitating condition.
- Your physician has also certified that standard therapies have not been effective in improving your condition, that standard therapies would not be medically appropriate for you, or that there is not a more beneficial therapy covered by the IHSS Health Plan than the therapy being proposed.
- Either 1) your PCP has recommended a drug, device, procedure or other therapy that the PCP certifies in writing is likely to be more beneficial to you than any available standard therapies, or 2) your physician who is licensed, board-certified or board eligible to practice in the area of practice appropriate to treatment for your condition for which therapy is being proposed has requested a therapy that is likely to be more beneficial to you than any available standard therapies, and has provided appropriate medical and scientific evidence to support his/her request.
- You have been denied coverage by your IHSS Health Plan for the drug, device, procedure and/or other therapy for which independent review is now being sought because the IHSS Health Plan determined that it is experimental or investigational treatment.
- The specific drug, device, procedure, or other therapy recommended would be a covered service, except for the IHSS Health Plan's determination that the therapy is experimental or investigational.

If you meet the conditions listed above, you may request an IMR from the DMHC. The DMHC will review your request when you return the application. You can also provide information to the DMHC in support of your request. This review is free of charge to you. The DMHC does not require that you participate in SBRHA's grievance process prior to seeking an IMR of the Plan's decision to deny a requested service on the basis that was experimental or investigational in nature. For information about the IMR process, or to obtain an application call the DMHC toll-free at 1-888-HMO-2219 or log on to the DMHC's Internet website at **http://www.hmohelp.ca.gov**.

The analysis and recommendations of the experts on the IMR panel shall be in written form and state the reasons the requested therapy is or is not likely to be more beneficial for you than any available standard therapy, and the reasons the experts recommend that the therapy should or should not be provided by the IHSS Health Plan. The written response will be provided in writing to you, your Participating Provider, and the IHSS Health Plan within thirty (30) days of the receipt of your request for review. If your participating provider determines that the proposed therapy would be significantly less effective if not promptly initiated, the analysis and recommendations shall be rendered within seven (7) days of the request. The IMR panel experts may extend the deadline by up to

three (3) days for any delay in providing the documents necessary for review.

If the DMHC approves your request for an IMR, the IHSS Health Plan will send a copy of all your medical records and other relevant documents requested by the DMHC. After reviewing your case, the IMR panel will notify you, your provider, and the IHSS Health Plan of its decision. For more information regarding the IMR process, or to request an application form, call the DMHC toll-free at 1-888-HMO-2219 or log on to the DMHC's Internet website at **http://www.hmohelp.ca.gov** Please note, however, that your case is not eligible for independent review if the care requested is not a covered benefit.

Member Satisfaction

Your IHSS Health Plan may request information from you on your experience and satisfaction with the quality, availability, and accessibility of care received as a Member of your SBRHA IHSS Health Plan. The results of these surveys will be reported to the appropriate SBRHA professional committees, our physicians and other participating providers. No Member who gives information will be identified by name or any other means. These surveys will be used regularly by SBRHA to identify and investigate sources of Member dissatisfaction with SBRHA and/or the IHSS Health Plan, to identify opportunities to improve patient care and outcomes, and to identify satisfactory performance on the part of a Participating Provider, staff, a hospital, or SBRHA.

8. Term, Cancellation, and Termination

Term / Renewal Provisions

The initial term of the Agreement between SBRHA and the Santa Barbara County IHSS Public Authority is effective January 1, 2005 and will continue until December 31, 2005, unless terminated earlier as described in the Agreement. The Agreement will renew automatically from year to year on the anniversary date subject to any changes in prepayment fees, other charges, benefits, coverage and termination provisions described in this section.

Prepayment of Fees

The Santa Barbara Regional Health Authority charges a monthly premium for an eligible IHSS employee (determined by Public Authority) that is enrolled in the Santa Barbara County IHSS Public Authority's Health Plan. These premium and contribution amounts are subject to changes as a result of collective bargaining agreements or legislative action. Any such change will be accomplished by the Santa Barbara County IHSS Public Authority without any action on your part.

Should your health benefit plan premium or benefit change as a result of either collective bargaining agreements, legislative action or by SBHRA, you will be notified of this change in writing (30) thirty days prior to the effective date of such change.

For current contribution information, contact the Santa Barbara County IHSS Public Authority health benefits representative. The rates shown below are effective January 1, 2005, and will be reduced by the amount the Santa Barbara County IHSS Public Authority contributes toward the cost of your health benefit plan

Rates for IHSS Health Benefit Plan

Type of Enrollment	Monthly Rate
IHSS worker	$ 335.00

Effect of Cancellation

Upon cancellation or expiration of the term, this Agreement and/or your coverage and rights under this Agreement (referred to as "coverage") are terminated subject to any applicable provisions for reinstatement, conversion to individual Membership, temporary continuation of benefits, continuation coverage or extension of benefits. Cancellation of this Agreement cancels coverage for all Subscribers of the Group.

Cancellation of Entire Agreement

Termination of Benefits for Non-Payment

If the Santa Barbara County IHSS Public Authority fails to pay any amount due SBRHA on the agreed upon due date, then SBRHA may cancel the Agreement. SBRHA will promptly mail to each Member a legible, true copy of the notice of termination. All rights to benefits terminate no less that (15) fifteen days before the end of the period for which prepayment fees have been paid for all Members, including those who are hospitalized or undergoing treatment for an ongoing condition (unless you may be covered under Extension of Benefits due to Total Disability). An example of this timeline would be if you were to receive a notification of termination letter for employer non-payment of premium on April 28th, your coverage will end midnight May 31st.

These rights may be reinstated only by payment of the amounts due in accordance with the Reinstatement provisions stated in the Group Agreement.

Cancellation by Group

The Santa Barbara County IHSS Public Authority may terminate the Agreement by giving thirty (30) days prior written notice to SBRHA.

Reinstatement

Receipt by SBRHA of the proper monthly prepayment fees subsequent to SBRHA's issuance

of cancellation to the Santa Barbara County IHSS Public Authority for non-payment of prepayment fees will reinstate the Santa Barbara County IHSS Public Authority as though there never was a cancellation, if such payment is received on or before the due date for the succeeding monthly prepayment fees, unless: 1) in the notice of termination, SBRHA notifies the Santa Barbara County IHSS Public Authority that if payment is not received within fifteen (15) days, a new application is required and the conditions on which a new contract will be issued or the original contract reinstated; 2) such payment is received more than fifteen (15) days after issuance of the notice of termination, and SBRHA refunds such payment within twenty (20) business days; or three 3) such payment is received more than fifteen (15) days after issuance of the notice of termination, and SBRHA issues to the Santa Barbara County IHSS Public Authority within twenty (20) business days of receipt of such payment, a new contract accompanied by written notice stating clearly those aspects in which the new contract differs from the canceled contract in benefits, coverage or otherwise.

Cancellation of Individual Members

Loss of Eligibility

If you cease to meet the eligibility requirements as defined in this EOC, then (subject to any applicable provisions for continuation or conversion of benefits) your coverage terminates at midnight on the last day of the month in which loss of eligibility occurs. The Santa Barbara County IHSS Public Authority agrees to notify SBRHA immediately if you cease to meet the eligibility requirements. Except in the event of fraud or deception as described below, SBRHA will provide written notice to you at least fifteen (15) days prior to the termination of coverage.

Disenrollment by Member

If you elect coverage under an alternative health benefits plan offered by the Santa Barbara County IHSS Public Authority as an option in lieu of coverage under this Agreement, then your coverage terminates automatically at the time and date the alternate coverage becomes effective. In such event, the Santa Barbara County IHSS Public Authority agrees to notify SBRHA immediately, that you have elected coverage elsewhere.

Cancellation of Members for Good Cause

Failure to Furnish Correct or Complete Information.

If you knowingly fail to furnish information required, or furnish materially incorrect or misleading enrollment or required updated information, then SBRHA may cancel your coverage effective fifteen (15) days after your receipt of written notice of termination from SBRHA, unless you furnish SBRHA or the Santa Barbara County IHSS Public Authority with the required information within such fifteen (15) day period.

Fraud or Deception

If you engage in fraud or deception in the use of the services or facilities of the IHSS Health Plan or permit such fraud or deception by another, including but not limited to the unauthorized use of an SBRHA identification card or making a material misrepresentation on an IHSS Health Plan enrollment document, then SBRHA may cancel your coverage effective on the date SBRHA mails notice of cancellation to you.

Member's Right to Review of Certain Cancellations

If you believe that your coverage, subscription or enrollment has been canceled or not renewed because of your health status or requirements for health care services, you may request a review by the California Director of the Department of Managed Health Care.

Extension of Benefits upon Termination

If, when the Agreement between the Plan and the Group is terminated as to the entire group, you are receiving treatment for a condition for which benefits are available under the Agreement and which condition has caused Total Disability as determined by an IHSS Health Plan Participating Provider, then you will be covered, subject to all limitations and restrictions of the Agreement, including payment of copayments and the monthly prepayment fees, for covered services directly relating to the condition causing Total Disability. This extension of benefits terminates upon the earlier of (1) the end of the twelfth month after termination of this Agreement, or (2) the date you are no longer Totally Disabled as determined by an IHSS Health Plan Participating Provider, or (3) the date your coverage becomes effective under any replacement contract or policy without limitation as to the disabling condition. A person is Totally Disabled if he or she satisfies the definition of Totally Disabled in this Agreement.

Determinations regarding the existence of a Total Disability will be made by a Participating Provider and approved by SBRHA's Medical Director. A medical examination performed by a physician specified by Health Plan may be required to determine the existence of a Total Disability. Proof of continuing Total Disability shall be provided to SBRHA at no less than thirty-one (31) day intervals during the period that extended benefits are available, along with appropriate certification from a participating provider.

9. Individual Conversion Coverage; Group Continuation Coverage (COBRA or Cal-COBRA)

Conversion to Individual Non-Group Membership

In the event your coverage ends under the IHSS Health Plan, you may convert your Membership to individual non-group Membership for yourself without regard to health status or requirements for health care services. However, conversion is not available if:

- The Group Agreement has been terminated, and is replaced by similar coverage under another group contract within fifteen (15) days of the date of termination of the Group Agreement.
- The Program has been canceled or is being canceled by SBRHA.
- You fail to pay amounts due to SBRHA.
- You are terminated by SBRHA for cause.
- You are eligible for benefits under Medicare or any other Federal or State law.
- You are eligible for health benefits under any form of group coverage, or are covered for health benefits under an individual policy or contract.
- You have not been continuously covered during the three-month period immediately preceding the date of termination of group coverage.

Notwithstanding any other provision to the contrary, no Member is eligible to convert to individual non-group coverage where the Member's group coverage was terminated for cause.

You may convert to non-group membership by submitting a written application and the first premium payment no later than sixty-three (63) days after termination from the group, after which SBRHA will issue a conversion contract effective on the day following the termination of coverage under the Group Agreement.

Federal Continuation Coverage (COBRA)

In accordance with the Consolidated Omnibus Budget Reconciliation Act (COBRA), Group Continuation Coverage is available, under certain conditions, to employees of most employers. If membership in SBRHA is sponsored by an Employer, you may be eligible for Group Continuation of Coverage. Contact SBRHA's Member Services Department toll-free at 1-877-814-1861.

State Continuation Coverage (Cal-COBRA)

If membership in SBRHA is sponsored by an Employer, and you are eligible for and covered by Group Continuation Coverage, you may further continue coverage under SBRHA through State Continuation of Benefits Coverage. Contact the Member Services Department toll-free at 1-887-814-1861.

If you have exhausted federal COBRA coverage and have had less than thirty-six (36) months of COBRA coverage, you have the opportunity to continue coverage through Cal-COBRA for up to thirty-six (36) months from the date that federal COBRA coverage began.

Your Rights Under HIPAA If You Lose Group Coverage

Federal law known as the Health Insurance Portability and Accountability Act of 1996 (HIPAA) protects health insurance coverage for workers when they change or lose their jobs. California law provides similar and additional protections.

If you lose group health insurance coverage and meet certain criteria, you are entitled to purchase individual health coverage (non-group) from any health plan that sells individual coverage for hospital, medical or surgical benefits. Every health plan that sells individual health coverage for these benefits must offer individual coverage to an eligible person under HIPAA. The health plan cannot reject your application if: 1) your are an eligible person under HIPAA; 2) you agree to pay the required premiums; and 3) you live or work inside the plan's service area.

To be considered an eligible person under HIPAA you must meet the following requirements:

- You have 18 or more months of creditable coverage without a break of 63 days or more between any of the periods of creditable coverage or since your most recent coverage was terminated.
- Your most recent creditable coverage was a group, government or church plan that provided hospital, medical or surgical benefits. (Cobra and Cal-COBRA are considered group coverage).
- You were not terminated from your most recent creditable coverage due to nonpayment of premiums or fraud.
- You are not eligible for coverage under a group health plan, Medicare or Medi-Cal.
- You have no other health insurance coverage.
- You have elected and exhausted any continuation coverage you were offered under COBRA or Cal-COBRA.

There are important choices you need to make in a very short time frame regarding the options available to you following termination of your group health care coverage. You should read carefully all available information regarding HIPAA coverage so you can understand fully the special protections of HIPAA coverage and make an informed comparison and choice regarding available coverage.

Contact the Member Services Department toll-free at 1-887-814-1861.

If you believe your HIPAA rights have been violated, you should contact the DMHC at 1-888-HMO-2219 or visit the Department's website at www.hmohelp.ca.gov.

10. Other Provisions

Community Advisory Board

SBRHA is a publicly sponsored managed care organization. Meetings of its Governing Board of Directors are open to the public. The Community Advisory Board, whose membership is composed of several SBRHA health plan Members, makes recommendations to the Board of Directors regarding various topics including benefits, appropriate advisory groups, collaborative committees and public policy. This is a standing committee of the Santa Barbara Regional Health Authority. If you are interested in membership on this Committee, please contact the Member Services Department.

Right of Health Plan to Change Benefits and Charges

SBRHA reserves the right to change the benefits, exclusions and limitations of the IHSS Health Plan, following at least thirty (30) days written notice by SBRHA to you.

Non-Assignability

Benefits of the IHSS Health Plan are not assignable without the written consent of SBRHA.

Independent Contractors

IHSS Health Plan Participating Providers are neither agents nor employees of SBRHA but are independent contractors. SBRHA regularly credentials the physicians who provide services you. However, in no instance shall SBRHA be liable for negligence or wrongful acts or omissions by any person who provides services to you, including any physician, hospital, or other provider or their employees.

Payment of Providers

SBRHA contracts with a network of local physicians and medical groups, as well as pharmacies, hospitals, and ancillary providers to provide services to you. For tertiary care, SBRHA contracts with tertiary care facilities. Contracts are based upon specific reimbursement agreements.

PCPs are reimbursed on a fee-for-service basis. Specialist or referral physicians and ancillary providers are also reimbursed on a fee-for-service basis.

Participating hospitals are reimbursed for services based on a per diem rate. Hospitals outside SBRHA's service area that perform emergency or tertiary services are reimbursed at a rate negotiated between the hospital and SBRHA.

A full disclosure of reimbursement methodology is available to you if you would like more information. Information can be obtained at SBRHA's office at 110 Castilian Drive, Goleta, CA. 93117-3028.

Confidentiality - Privacy

Notice of Information Practices

The Insurance Information and Privacy Protection Act provides that SBRHA may collect personal information from persons other than the individual or individuals applying for insurance coverage. SBRHA will not disclose any personal or privileged information about an individual that SBRHA may have collected or received in connection with an insurance transaction unless the disclosure is with the written authorization of the individual or individuals. Individuals who have applied for insurance coverage through SBRHA have a right of access to and collection of personal information that may have been collected in connection with the application for insurance coverage. All IHSS Health Plan members receive a copy of SBRHA's Privacy Notice with their Evidence of Coverage and new member ID card.
SBRHA POLICIES AND PROCEDURES FOR PRESERVING THE CONFIDENTIALITY OF MEDICAL RECORDS ARE AVAILABLE AND WILL BE FURNISHED UPON REQUEST.

Governing Law

The IHSS Health Plan is subject to the requirements of the California Knox-Keene Act, Chapter 2.2 of Division 2 of the California Health and Safety Code, and the regulations set forth in Title 28 of the California Administrative Code. Any provision required to be in this benefit program by either the Knox-Keene Act or the regulations shall be binding on the IHSS Health Plan, even if it is not included in this EOC or IHSS Health Plan contract.

Natural Disasters, Interruptions, and Limitations

Circumstances beyond SBRHA's control, for example, natural disaster, war, riot, civil insurrection, epidemic, and complete or partial destruction of facilities may result in your not being able to obtain the medically necessary covered services of this Plan. In such an event, SBRHA will make a good faith effort to provide or arrange for the services that you need. Under these conditions, go to the nearest doctor or hospital for emergency services.

Disability Access

Physical Access
SBRHA has made every effort to ensure that our offices and the offices and facilities of our providers are accessible to the disabled. If you are not able to locate an accessible provider, please contact SBRHA's Member Services Department toll-free at

1-877-814-1861 and a Member Services representative will help you find an alternate provider.

Access for the Hearing Impaired
The hearing impaired may contact a Member Services representative through the California Relay Service at 1-805-685-4131.

Access for the Vision Impaired
For assistance in reading this EOC and other materials, please contact our Member Services Department at 1-877-814-1861.

Disability Access Grievances
If you believe your IHSS Health Plan or its Participating Providers have failed to respond to your disability access needs, you may file a complaint with the Plan. If your disability access complaint remains unresolved, you may contact the ADA Coordinator at the California Managed Risk Medical Insurance Board in Sacramento. See the Americans with Disabilities Act Compliance Statement below for how to contact the Board.

The Americans with Disabilities Act of 1990
Section 504 of the Rehabilitation Act of 1973 states that no qualified disabled person shall, on the basis of disability, be excluded from participation in, be denied the benefits of, or otherwise be subjected to discrimination under any program or activity which receives or benefits from federal financial assistance.

California Government Code Section 11135 prohibits discrimination in a program or activity funded directly by the state or that receives financial assistance from the state on the basis of ethnic group identification, religion, age, sex, color, or disability.

ADA Coordinator
Managed Risk Medical Insurance Board
P.O. Box 2769
Sacramento, CA 95812-2769
(916) 324-4695 (voice)
(800) 735-2929 (California Relay Service for the hearing impaired)

11. Definitions

Acute condition: A medical condition that involves a sudden onset of symptoms due to an illness, injury, or other medical problem that may require prompt medical attention and that has a limited duration.

Authorization, Authorize, or Prior Authorization: The requirement that certain services be approved by your IHSS Health Plan. *See Section 3, "How to Use Your Health Plan, Authorization for Services"*.

Appeal: A request for your IHSS Health Plan to reconsider a denial of a claim, or services prescribed by the Member's PCP, that the Member believes should be provided.

Autologous Blood Donation: The act of donating your own blood for storage and future use for a planned surgery that may require a blood transfusion.

Benefits Those covered services or supplies that are medically necessary and are provided, prescribed or authorized by an IHSS Health Plan Participating Provider, and if necessary, approved by the IHSS Health Plan.

Brand Name Drugs: FDA approved drugs under patent to the original manufacturer and only under the original manufacturer's name.

Coinsurance: A member's share of the medical benefit cost for certain covered benefits.

Complaint: A statement of dissatisfaction the subscriber makes in writing or by calling the Plan's Member Services Department. The complaint or concern can be about the provider or the Plan.

Contracted Provider: A Participating Provider that enters into a written agreement with SBRHA to provide Benefits to IHSS Health Plan Members. *See "Participating Provider"*.

Copayment: The amount a Member is required to pay for certain benefits.

Covered Services/Covered Benefits: *see "Benefits".*

Custodial or Maintenance Care: Care furnished primarily to provide room and board or meet the activities of daily living.

Dental Care and Services (Non Benefit): Any services or x-ray exams involving one or more teeth, the tissue or structure around them, the alveolar process, or the gums. Such services are considered dental even if a condition requiring any of these services involves a part of the body other than the mouth, such as treatment of temporomandibular joint disorders or malocclusion involving joints or muscles, by such methods as crowning, wiring or repositioning teeth. Medically necessary surgical procedures for a condition directly affecting the upper or lower jawbone, or associated bone joints, is not considered a dental service.

Domiciliary Care: Care provided in a hospital or other licensed facility because care in the Member's home is not available or is unsuitable.

Durable Medical Equipment: Medical equipment appropriate for use in the home which is able to withstand repeated use, serves a medical purpose, and is not useful to a person in the absence of illness, injury or congenital anomaly.

Emergency: A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain), such that the absence of immediate medical attention could reasonably be expected to result in: 1) placing the patient's health in serious jeopardy; or 2) serious impairment to bodily functions; or 3) serious dysfunction of any bodily organ or part.

Emergency services include, but are not limited to, the evaluation to determine if an emergency psychiatric condition exists, and treatment necessary to relieve or eliminate the emergency psychiatric condition.

Evidence of Coverage or EOC: Any certificate, agreement, contract, handbook, brochure, or letter of entitlement issued to a Member setting forth the coverage to which the Member is entitled.

Exclusions: Items or services that are not covered by the Plan.

Experimental or Investigational Treatment: Services, tests, treatments, supplies, devices or drugs that SBRHA determines are not generally accepted by informed medical professionals in the United States, at the time the services, tests, treatments, supplies, devices or drugs are rendered, as safe and effective in treating or diagnosing the condition for which their use is proposed, unless approved by: 1) The Diagnostic and Therapeutic Technology Assessment Project of the American Medical Association; 2) The Office of Health Technology Assessment of the U.S. Congress; 3) The National Institutes of Health; 4) The Federal Food and Drug Administration; or 5) The specialty board and the academy it represents as recognized by the American Board of Medical Specialties (ABMS). Approved drug usage will not be excluded as experimental or investigational.

Formulary: A selected list of drugs maintained by Santa Barbara Regional Health Authority's Pharmacy and Therapeutics Committee in cooperation with MedImpact's Pharmacy and Therapeutics Committee for use under the Health Plan's Prescription Drug Benefit Program, which is designated to assist physicians in prescribing drugs that are medically necessary and cost effective. The Formulary is updated on a regular schedule. If not otherwise excluded, the Formulary includes all generic drugs.

Generic Drugs: Drugs that 1) are approved by the FDA as safe and effective 2) are produced and sold under the chemical name after the original patent expired, and 3) cost less than the Formulary brand name drug equivalent.

Health Plan/ Plan Your benefit plan as described in this Combined Evidence of Coverage and Disclosure Form and Member Handbook, and supplemental benefit materials.

Hospital: A health care facility licensed by the State of California, and accredited by the Joint Commission on Accreditation of Health Care Organizations, as either: 1) an acute care hospital; 2) a psychiatric hospital; or 3) a hospital operated primarily for the treatment of alcoholism and/or substance abuse. Facilities are not included if principally a rest home, nursing home or home for the aged, or a licensed Distinct Part/Nursing Facility within a general acute care hospital.

Inpatient: An individual who has been admitted to a hospital as a registered bed patient and is receiving services under the direction of a physician.

Life-threatening: Defined as: 1) diseases or conditions where the likelihood of death is high unless the course of the disease is interrupted; and/or 2) diseases or conditions with potentially fatal outcomes, where the end point of clinical intervention is survival.

Maintenance Drug: Drugs that are prescribed for sixty (60) days or longer and are usually prescribed for chronic conditions such as arthritis, heart disease, diabetes, or hypertension.

Medical Director is a licensed physician who is an employee of the Plan and is responsible for monitoring the quality of care to our Members.

Medically Necessary or Medical Necessity: Services that are: 1) rendered for the treatment or diagnosis of an injury or illness; 2) appropriate for the symptoms and consistent with the diagnosis; are otherwise in accordance with sufficient scientific evidence, professionally recognized standards and the Plan medical criteria; 3) not furnished primarily for the convenience of the Member, the attending physician, or other provider of service, and not required solely for custodial, comfort, or maintenance reasons; and 4) furnished in the most economically efficient manner that may be provided safely and effectively to the Member, and at a frequency that is accepted by the medical community as medically appropriate.

The fact that a physician may have ordered or prescribed a service does not mean that it is medically necessary or a covered service.

Whether there is "sufficient scientific evidence" shall be determined by the Plan based on, but not limited to, medical or scientific literature.

Medical Transportation: Emergency ambulance transportation in connection with life threatening emergency services to the first hospital or urgent care center that accepts the Member for emergency care. Non-emergency transportation for the transfer of a Member from a hospital to another hospital or facility or facility to home when: 1) medically necessary; 2) requested by the Plan's providers; and 3) authorized in advance by the Plan.

Member: An enrollee who is entitled to receive covered services.

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

Non-participating Provider is a hospital or other health care entity, a Physician or other heath care professional, or a health care vendor that has not entered into a written agreement to provide Covered Services to IHSS Health Plan Members.

Non-formulary Drugs: Drugs determined by the Plan's Pharmacy and Therapeutics Committee as being duplicated or as having preferred Formulary drugs available. Benefits may be provided for non-

Formulary drugs and are always subject to the non-Formulary copayment.

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

Orthotic: A rigid or semi-rigid device used as a support or brace affixed to the body externally to support or correct an acutely injured or diseased body part.

Outpatient: An individual receiving services under the direction of a physician but not incurring overnight charges at the facility where services are provided.

Participating Pharmacy: A pharmacy that has entered into a written agreement with SBRHA or an SBRHA subcontractor to provide Covered Services to IHSS Health Plan Members.

Participating Provider: A hospital or other health care entity, a Physician or other heath care professional, or a health care vendor that has entered into a written agreement to provide Covered Services to IHSS Health Plan Members. A Participating Provider may contract directly with your IHSS Health Plan, with a Participating Medical Group or with another Participating Provider.

Physical Therapy: Treatment under the direction of a physician and provided by a registered physical therapist, utilizing specific modalities and training, to improve a Member's musculoskeletal, neuromuscular, and respiratory systems.

Physician: An individual licensed and authorized to engage in the practice of medicine or osteopathic medicine.

Pre-payment Fees/Premium: The monthly subscriber contribution that is made on behalf of each Member by the Santa Barbara County IHSS Public Authority.

Prescription Drug Formulary: A list of drugs that are provided by the Health Plan.

Prescription Drug Benefit:

1. Drugs which are approved by the Food and Drug Administration (FDA), requiring a prescription either by federal or California Law,
2. Compounded medications containing at least one prescription drug, requiring a prescription by federal or California Law,
3. Insulin, glucagons, and disposable hypodermic needles and syringes needed for these medications,
4. Bee sting kits and injectors,
5. Pen delivery systems for the administration of insulin as determined by the Health Plan to be medically necessary,
6. Diabetic testing supplies (including lancets, lancet puncture devices, and blood and ketone urine testing strips and test tablets in medically appropriate quantities for the monitoring and treatment of insulin-dependent, non-insulin dependent, and gestational diabetes), and
7. Oral contraceptives.

Note: No prescription is necessary to purchase items shown in (5) and (6); however, in order for it to be covered by your prescription drug benefit under the Plan's Benefit plan requires these items to be prescribed by your provider.

Primary Care Provider (PCP): A general practitioner, family practitioner, internist, obstetrician/gynecologist, or pediatrician who has contracted with the Health Plan a primary care provider to provide primary care to Members and to refer, authorize, supervise and coordinate the provision of all benefits to Members. Nurse practitioners and physician assistants associated

with a contracted PCP are available to Members seeking primary care.

Prior Authorization: The requirement that a Member's attending physician requests approval of coverage from the Plan prior to the Member obtaining certain covered services. Requests for prior authorizations will be denied if not medically necessary. Requests for prior authorization of coverage for services by non-participating providers will also be denied if the Plan determines that comparable or more appropriate services are available through participating providers. The fact that a participating provider may order or refer a Member for a service does not constitute prior authorization. Prior authorization must come directly from the Plan.

Provider: Any participating physician, participating hospital, or other licensed health care professional or licensed health facility, including subacute facilities, located within the service area who, or which, at the time care is provided to a Member, has a contract in effect with the Health Plan to provide covered services to Members.

Prosthesis: An artificial part, appliance or device used to replace a missing part of the body.

Reconstructive: Services to restore and achieve symmetry and surgery performed to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors or disease that accomplish either of the following: 1) improve function; 2) create a normal appearance to the extent possible; and 3) includes reconstructive surgery to restore and achieve symmetry incident to mastectomy.

SBRHA: Santa Barbara Regional Health Authority. SBRHA is a licensed managed care organization that administers your IHSS Health Plan. SBRHA is not a medical provider.

SBRHA Hospital: A hospital licensed under applicable state law, contracting specifically with SBRHA to provide benefits to Members enrolled in the IHSS Health Plan.

SBRHA Provider: A physician, individual health care provider, hospital, or facility credentialed, trained and licensed to provide covered services and who, or which, at the time care is rendered to a Member, has a contract in effect with SBRHA to furnish covered services to Members. The names of the Plan providers are set forth in the Plan's Contracted Provider Directory. SBRHA does not and cannot guarantee availability of any provider.

SBRHA Specialist or Specialist Physician: A physician other than a primary care provider who has an agreement with the SBRHA to provide services to Members on referral by a Participating Provider who is a PCP.

Serious Chronic Condition: A medical condition due to a disease, illness, or other medical problem or medical disorder that is serious in nature, and that does either of the following: 1) persists without full cure or worsens over an extended period; or 2) requires ongoing treatment to maintain remission or prevent deterioration.

Serious Emotional Disturbances (SED): A child suffering from SED shall be defined as a child under the age of 18 who (1) has one or more mental disorders as identified in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, other than a primary substance use disorder or development disorder, that result in behavior inappropriate to the child's age according to expected developmental norms, and (2) who meets the criteria in paragraph (2) of subdivision (a) of Section 5600.3 of the Welfare & Institutions Code.

Serious Mental Illness (SMI): SMI refers to the presence of a severe psychiatric disorder (including conditions including schizophrenia, schizoaffective disorder, bipolar disorder (manic-depressive illness), major depressive disorders, panic disorder, obsessive-compulsive disorder, pervasive developmental disorder or autism, anorexia nervosa,

or bulimia nervosa) accompanied by significant functional impairment, disruption of normal life tasks, periods of hospitalization, and psychotropic medication.

Seriously Debilitating Illness: Diseases or conditions that cause major irreversible morbidity.

Service Area: That geographic area served by the IHSS Health Plan: Santa Barbara County.

Services: Includes medically necessary health care services and medically necessary supplies furnished incident to those services.

Skilled Nursing Facility: A facility licensed by the California State Department of Health as a "Skilled Nursing Facility." A skilled nursing facility may be a licensed distinct-part skilled nursing facility portion of a hospital.

Specialist or Specialty Physician: A physician other than a Personal Physician, psychologist, licensed clinical social worker, or licensed marriage and family therapist who has an agreement with SBRHA to provide services to Members either according to an authorized referral by a Personal Physician.

Speech Therapy: Treatment under the direction of a physician and provided by a licensed speech pathologist or speech therapist, to treat speech impairments of specific organic origin.

Terminated Provider is any type of provider, (Primary Care Physician, Specialist, physician, hospital or any other provider) that has decided not to renew their contract with the Health Plan or the Health Plan decided not to renew its contract with the provider which results in a termination of relationship between the provider and Health Plan.

Total Disability

1. A disability that prevents a Member from working (in excess of the sick leave permitted such individual) with reasonable continuity in the individual's customary employment or in any other employment in which the individual reasonably might be expected to engage, in view of the individual's station in life and physical and mental capacity.

2. In the case of a Member who is not employed, a disability that prevents the individual from engaging with normal or reasonable continuity in the individual's customary activities or in those in which the individual otherwise reasonably might be expected to engage, in view of the individual's station in life and physical and mental capacity.

Urgently Needed Services: Medically necessary health care services required to prevent serious deterioration of your health, resulting from an unforeseen illness or injury for which treatment cannot be delayed. Examples of Urgently Needed Services include broken bones (e.g., arm or leg), strep throat, migraines and non-life-threatening cuts that require stitches or acute illnesses.

Utilization Management: The process used by the Santa Barbara Regional Health Authority to determine if the services recommended by providers are appropriate for the Member