MemorialCare
Select Health Plan

Combined Evidence of Coverage & Disclosure Form

MemorialCare Select Health Plan

Effective January 1, 2020

MemorialCare Select Health Plan is a health care service plan licensed by the Department of Managed Health Care. We are a managed care system that combines comprehensive medical and preventive care in one plan. You receive preventive care and health care services from a network of providers who are focused on keeping you healthy.

This COMBINED EVIDENCE OF COVERAGE AND DISCLOSURE FORM (EOC) constitutes only a summary of the Plan. The Group Subscriber Agreement between the plan and your employer must be consulted to determine the exact terms and conditions of coverage. A specimen copy of the Group Services Agreement will be furnished to you by the plan or your employer upon request.

The member handbook provides information on how to obtain and understand your health plan benefits, with important information to help you become a knowledgeable and active partner in your healthcare.

Questions? MemorialCare Select Health Plan is ready to take your call and will get you to the right individuals to answer your questions.

Member Services
17360 Brookhurst St.
Fountain Valley, CA 92708

Email: **MCSelectMemberServices@memorialcare.org**

1-844-805-8700 (TTY: 711)
8 a.m. to 5 p.m., Monday to Friday

memorialcareselecthealthplan.org

The meaning of words underlined throughout this Member Handbook can be found in the GLOSSARY section, at the end of the document.

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WELCOME TO MEMORIALCARE SELECT HEALTH PLAN

Thank you for selecting MemorialCare Select Health Plan for your health plan benefits.

MemorialCare Select Health Plan focuses on providing individuals and families with coverage and access to quality, evidence-based medicine, exceptional service and a network of physicians, hospitals, medical groups, imaging centers and other providers.

MemorialCare Select Health Plan is part of MemorialCare Health System, a not-for-profit integrated delivery system which includes four hospitals, Long Beach Memorial Medical Center, Miller Children's & Women's Hospital Long Beach, Orange Coast Memorial Medical Center, Saddleback Memorial Medical Center in Laguna Hills and San Clemente; MemorialCare Medical Group, Greater Newport Physicians and numerous ambulatory surgery centers, imaging facilities and urgent care centers throughout the Southland.

As a member of MemorialCare Select Health Plan, you have access to physicians and a support team of healthcare professionals all who's primary goal is to take care of you.

Please take a moment to read through the following pages, it contains important information to help you understand your benefits and coverage.

Member Services

If you have questions or concerns about your healthcare, MemorialCare Select Health Plan wants to help.

MemorialCare Select Health Plan's Member Service Representatives are available to:

- Answer questions about your plan and covered services,
- Help you choose or change your Primary Care Provider (PCP),
- Tell you where to get the care you need,
- Arrange interpreter services if you do not speak English,
- Provide information in other language and formats if you do not speak English.

Contact Member Services at **1-844-805-8700**, Monday through Friday from 8 a.m. to 5 p.m. You can also visit us online any time at **memorialcareselecthealthplan.org**.

Provider Directory

The provider directory contains a listing of physicians, hospitals and other providers in your plan network. The directory is very important because it lists the participating providers from whom you obtain covered services. The provider directory is available online at **memorialcareselecthealthplan.org**. You can also request a provider directory by calling MemorialCare Select Health Plan's Member Services Department at **1-844-805-8700.**

MyChart, your member portal

Manage your plan by using our member portal, MyChart. Create an account to securely access your complete health plan information and much more, like:

- See details of your coverage,
- Check your benefits, eligibility and costs,
- Choose and change your PCP,
- Update your contact information,
- View, print or request your member ID card,
- Access test results,
- Communicate with your doctor,
- Download member forms, or
- File a complaint

After-Hour Nurse Advice Line

Telephone Advice Nurses are available 24h-hours a day, 7 days a week to assist you. You can speak with a Telephone Advice Nurse, anytime day or night. To access the Telephone Nurse Advice Line, call your PCPs office and select the Telephone Advice Nurse option from the menu.

The Advice Nurse will assess your symptoms, provide advice based on medical protocol and coordinate with your doctor's help to determine the medical care you need.

In the event of a serious life-threatening emergency, call 911 immediately.

How to Participate in Plan Policy

Our Member Advisory committee (called the Public Policy Advisory Committee) allows members to provide input on MemorialCare Select Health Plan policies . Take a more active role in your plan. You can be part of the important decisions that affect you, your family and your community. Call Member Services at **1-844-804-8700** if you would like to join.

Access for the Vision Impaired

This member handbook and other important plan materials are available in alternate formats for the vision impaired, such as large print. For information about alternative formats or the direct help in reading the member handbook or other materials, call Member Services.

Language Assistance Services

MemorialCare Select Health Plan provides free interpreter and language assistance services to all members. If you need language assistance or interpreter services to help you talk to your doctor or plan, or to assist you in obtaining care call Member Services. MemorialCare Select Health Plan has access to interpreting services in over 100 languages. If you need someone to explain medical information while you are at your doctor's office, ask them to call us. You will also have access to certain member materials in your language. For free language assistance call Member Services

HOW TO GET CARE

PLEASE READ THE FOLLOWING INFORMATION SO YOU WILL KNOW FROM WHOM OR WHICH GROUP OF PROVIDERS HEALTH CARE MAY BE OBTAINED. ALL REFERENCES TO NETWORK PROVIDERS, PARTICIPATING MEDICAL GROUPS, PARTICIPATING HOSPITALS AND PARTICIPATING PHYSICIANS IN THIS MEMBER HANDBOOK REFER TO PROVIDERS AND FACILTIES IN YOUR PLAN NETWORK, AS IDENTIFIED ON YOUR MEMBER IDENTIFICATION CARD.

Please read this member handbook carefully to understand how to maximize your benefits. After you have read the member handbook, we encourage you to call MemorialCare Select Health Plan's Member Services Department if you have any questions.

Choice of Physicians and Providers

The provider directory lists the addresses and phone numbers of the participating providers, including PCP's, medical groups, hospitals and other facilities that MemorialCare Select Health Plan uses to deliver your covered medical services. Except for emergency care or out-of-area urgent services you must receive all covered medical services from your assigned PCP, including referrals to a specialist. Under certain circumstances when authorized by MemorialCare Select Health Plan, standing referrals, second opinions and continuity of care from a terminated or non-participating provider will be covered.

- You select any PCP within MemorialCare Select Health Plan's service area where you live or work, for yourself and one for each of your dependent (s). Look in the provider directory to find your current doctor or select a new one if your doctor is not a participating provider with MemorialCare Select Health Plan. Family members may select different PCPs and medical groups to meet their individual needs. If you need help selecting a PCP, please call Member Services. If you are unable to select a doctor at the time of enrollment, we will select one for you so that you have immediate access to care. If you would like to change your PCP, call Member Services.
- All members have direct and unlimited access to OB/GYN physicians as well as PCPs (Family practice, Internal medicine, etc.) in their medical group for obstetric and gynecological services.
- MemorialCare Select Health Plan contracts with non-physician providers at some locations. These include physician assistants (PAs), nurse practitioners (NPs), physical therapist and certified nurse midwives. They are trained and qualified professions who work together with your PCP. Both PAs and NPs are under the supervisor of your PCP and have received accreditation and licensure from the State. If your PCP is unavailable and you prefer, you have the option to see a PA or NP as another member of your care team. You may obtain a list of these providers by contacting your PCPs office.
- You may be liable for payment if you receive services from a contracted provider without required preauthorization from your PCP or MemorialCare Select Health Plan or when services are received from a non-contracted provider, except for medically necessary urgent or emergent services.

- We recognize that the choice of doctor is a personal one and encourage you to choose a PCP who best meets your needs.

Some hospitals and other providers do not provide one or more of the following services that you and your family might need: Family Planning: contraceptive services, including emergency contraception; sterilization, including tubal ligation at the time of labor and delivery; Infertility treatment; or abortion. You should obtain more information before you enroll. Call your prospective doctor, Medical Group or Member Services to ensure you can obtain health care services that you need.

Changing Your PCP

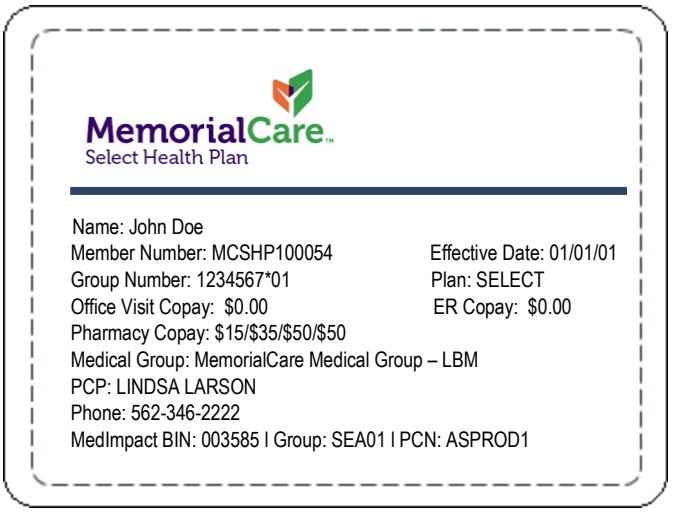
It is a good idea to stay with your PCP so your doctor can get to know your health care needs and medical history. However, you can change to a different PCP for any reason if you choose. If you want to change your PCP, call Member Services, a Member Services Representative will help you choose a new doctor. In general, the change will be effective on the first day of the month following your request. A new member ID card showing the name of the new PCP you have chosen will be sent to you in the mail.

Member Identification (ID) Card

MemorialCare Select Health Plan will send you and each of your dependent (s) a Member ID card that shows your Member ID number, benefits information, certain copayments, your assigned medical group, and your assigned PCP's name and telephone number and information on how to obtain emergency services.

Present this card whenever you need medical care and identify yourself as a MemorialCare Select Health Plan member. Your member ID card can only be used to obtain care for yourself. If you allow someone else to use your member ID card, MemorialCare Select Health Plan may terminate your coverage. If your card becomes, lost, damaged or stolen, contact Member Services to obtain a replacement.

You can also print a temporary ID card online at **memorialcareselecthealthplan.org** by accessing your account on myChart, MemorialCare Select Health Plan's member portal.


MemorialCare
Select Health Plan

Name: John Doe
Member Number: MCSHP100054 Effective Date: 01/01/01
Group Number: 1234567*01 Plan: SELECT
Office Visit Copay: $0.00 ER Copay: $0.00
Pharmacy Copay: $15/$35/$50/$50
Medical Group: MemorialCare Medical Group – LBM
PCP: LINDSA LARSON
Phone: 562-346-2222
MedImpact BIN: 003585 I Group: SEA01 I PCN: ASPROD1


THIS CARD IS FOR IDENTIFICATION ONLY AND DOES NOT PROVE ELIGIBILITY FOR SERVICES.

IF AN EMERGENCY ARISES – **If your situation is an emergency:** Call **911** or go to the nearest Hospital or emergency facility. If you are ill but unsure of the seriousness of your condition, call your Medical Group. In all cases, contact your Primary Care Physician/Medical Group as soon as possible to inform them about your condition.

MemorialCare Select Health Plan Member Services:	**844-805-8700**
ASH Chiropractic and Acupuncture Coverage:	**800-678-9133**
Windstone Behavioral Health:	**800-577-4701**
MedImpact Pharmacy Services:	**844-513-6001**

MemorialCare Select Health Plan Claims:
P.O. Box 20900, Fountain Valley, CA 92728
www.memorialcareselecthealthplan.org

Timely Access to Care

You are entitled to timely access to services consistent with the following standards.

Appointment wait Times

Urgent Appointments	Maximum Wait Times
PCP, no preauthorization is required	48 hours
Preauthorization required	96 hours
Non-Urgent Appointments	**Maximum Wait Times**
PCP (Excludes preventive care appointments)	10 business days
Non-Physician mental health care Provider (e.g. psychologist or therapist)	10 business days
Specialist (Excludes routine follow-up appointments)	15 business days
Ancillary services (e.g. X-rays, lab tests, etc. for the diagnosis and treatment of injury, illness, or other health conditions)	15 business days
Telephone wait times during normal business hours	10 minutes
Triage – 27/7 services	24/7 services – no more than 30 minutes

Exceptions to appointment wait times

Your wait time for an appointment may be extended if your health care provider has determined and noted in your record that the longer time wait will not be detrimental to your health.

Your appointments for preventive and periodic follow up care services (e.g. standing referrals to specialists for chronic conditions, periodic visits to monitor and treat pregnancy, cardiac, or mental health conditions, and laboratory and radiological monitoring for recurrence of disease) may be scheduled in advance, consistent with professionally recognized standards of practice, and exceed the listed wait times.

Referrals to Non-Plan Providers

MemorialCare Select Health Plan has an extensive network of high-quality providers throughout the service area. Occasionally, however, some providers may not be able to provide the services you need that are covered by the plan. If this occurs, your PCP will refer you to a provider where the services you need are available. You should make sure that these services are authorized in advance. If the services are authorized, you pay only the copayments you would pay if the services were provided by a plan provider.

Standing Referral

If you have a condition or disease that requires specialized medical care for a prolonged period and is a life-threatening, degenerative, or disabling condition you may receive a referral to a specialist or specialty care center with expertise to treat the disease or condition, if your PCP and specialist, and MemorialCare Select Health Plan's medical director, determine it is medically necessary.

- MemorialCare Select Health Plan will provide preauthorization to a specialist within the plan's network unless there is not a specialist within the plans network that is appropriate to provide treatment for your.
- Some treatment plans may limit the number of visits to the specialist, limit the period of time the visits are authorized, or require that the specialist provide your PCP with regular reports on the health care being provided.
- MemorialCare Select Health Plan will make a decision to authorize, modify or deny a request within three (3) business days of the date a request for a standing

referral is made and all appropriate information necessary to make the determination is provided.

- When approved, the referral will be provided within four (4) business days of the date the preauthorization request is submitted to MemorialCare Select Health Plan.
- Preauthorization for services that are medically necessary shall be provided for the proposed treatment, of a duration not to exceed one year at a time, utilizing established criteria.
- For the purpose of the diagnosis or treatment of a condition requiring care with a specialized knowledge of HIV medicine, MemorialCare Select Health Plan will provide preauthorization to an HIV/Aids specialist.
- If MemorialCare Select Health Plan denies or modifies your request for a standing referral, you will be notified in writing of the reasons for the denial and your right to file a grievance with the plan.

Obtaining Required Preauthorization for Health Care Services

Except for PCP services, outpatient mental health or chemical dependency office visits, emergency services and obstetric and gynecologic services, you are responsible for obtaining valid preauthorization before you receive benefits. To obtain a valid preauthorization:

- Prior to receiving care, contact your PCP or other approved provider to discuss your treatment plan;
- Request preauthorization for the benefits that have been ordered by your doctor Your PCP or other participating provider is responsible for requesting preauthorization from MemorialCare Select Health Plan or your medical group.
- If preauthorization is approved, obtain the expiration date for the preauthorization. You must access care before the expiration date with the participating provider identified in the approved preauthorization.

A decision will be made on the preauthorization request in a timely fashion based on the nature of your medical condition, but no later than five business days. A letter will be sent to you within two business days of the decision.

If waiting five days would seriously jeopardize your life or health or your ability to regain maximum function or, in your doctor's opinion, it would subject you to severe pain that cannot be adequately managed without the care or treatment that is being requested, you will receive a decision no later than 72 hours after receipt of the preauthorization request.

If we do not receive enough information to decide regarding the preauthorization request, we will send you a letter within five days to let you know what additional information is needed. We will give you and your provider at least 45 days to provide the additional information. (For urgent preauthorization requests, we will notify you and your provider by phone within 24 hours and give you or your_provider at least 48 hours to provide the additional information.)

If you receive preauthorization for an ongoing course of treatment, we will not reduce or stop the previously authorized treatment before providing you with an opportunity to appeal the decision to reduce or stop treatment.

The plan uses evidence-based guidelines for preauthorization, modification or denial of services as well as utilization management, prospective, concurrent and retrospective review. Plan specific guidelines are developed and reviewed on an ongoing basis by MemorialCare Select Health Plan's Chief Medical Officer, Utilization Management Committee and other physicians. A description of the medical review process or the guidelines used in the process will be provided upon request.

If services requiring preauthorization are obtained without the necessary preauthorization, you may be responsible for the entire cost.

Emergency Services and Care

What to do in case of an emergency

If you have an emergency medical condition, all 911 or go to the nearest hospital emergency room. It is not necessary to contact your PCP before calling 911 or going to the hospital if you believe you have an emergency medical condition.

If you are unsure whether your condition requires emergency services, call your PCP (even after normal office hours). Your PCP can help decide the best way to get treatment and can arrange for prompt emergency care. However, do not delay getting care if your PCP is not immediately available.

Emergency Medical Condition

Emergency service means those covered services including emergency services and care, provided inside and outside the plan's service area that are required on an immediate basis for treatment of a emergency medical condition. An emergency medical condition is an illness, injury, symptom (including severe pain), or condition and including active labor, severe enough to risk serious danger to your health if you don't get medical attention right away. If you didn't get immediate medical attention you could reasonably expect one of the following:

- Your health could be put in serious danger,
- You would have serious problems with your bodily functions, or
- You would have serious danger to any part or organ of your body

Emergency services are not a substitute for seeing your PCP, they are intended to provide emergency needed care in a timely manner when needed. Members are encouraged to use the 911 emergency response system appropriately when they have an emergency condition that requires an emergency response.

Emergency Care

Medical screening, examination and evaluation by a physician or to the extent permitted by applicable law, by other appropriate personnel under the supervision of a physician to determine if an emergency medical condition, psychiatric medical condition or active labor exists and, if it does, the care, treatment and surgery by a physician necessary to relieve or eliminate the emergency medical condition within the capability of the facility.

Psychiatric emergency services may include transfer of a member to a psychiatric unit within a general acute hospital or an acute psychiatric hospital to relieve a psychiatric emergency medical condition if, in the opinion of the treating provider, the transfer would not result in a material deterioration of the patient's condition.

Ambulance services are covered when provided in conjunction with emergency services.

Post-Stabilization and Follow-up Care after an Emergency

Once your emergency medical condition is stabilized your treating provider may believe that you require additional medically necessary services prior to your being safely discharged. If the hospital is not a participating provider, your PCP and the plan may arrange for your transfer to a network hospital if your medical condition is sufficiently stable for you to be transferred. If the plan determines that you may be safely transferred to a plan contracted hospital, and you refuse to consent to the transfer, the hospital must provide you written notice that you will be financially responsible for 100% of the cost for services provided to you once your emergency condition is stable.

If you need follow-up care after you receive emergency services, call your PCP to make an appointment or for a referral to a specialist. Do not go back to the hospital emergency room for follow-up care, unless you are experiencing an emergency medical condition.

IF YOU FEEL THAT YOU WERE IMPROPERLY BILLED FOR SERVICES THAT YOU RECEIVED FROM A NON-CONTRACTED PROVIDER, PLEASE CONTACT MEMBER SERVICES.

Urgent Care Services

Urgent care for an illness, injury, or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room care. Urgent conditions are not emergencies but may need prompt medical attention. Urgent care services are not a substitute for seeing your PCP. They are intended to provide urgently needed care in a timely manner when your PCP has determined that you require these services, or you are outside the plan's service area and require urgent care services.

If you need urgent care services and are in the plan's service area, you must call your PCP first to get preauthorization to receive care from an out-of-area provider.

Out-of-area urgent care services are considered emergency services and do not require preauthorization from your PCP. If you are outside the plan's service area and need urgent care services, you should still call your PCP. Your PCP may want to see you when you return to follow up with your care.

If for any reason, you are unable to reach your PCP, please call Member Services. You have access to a nurse evenings and weekends for immediate medical advice.

Second Opinions

You or your doctor may request a second opinion when:

- You question the reasonableness or necessity of recommended surgical procedures,
- You have questions about 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,
- If the clinical indications are not clear or are complex and confusing, a diagnosis is in doubt due to conflicting test results,
- If the treatment plan in progress is not improving your medical condition within an appropriate period of time given the diagnosis and plan of care,
- If you have attempted to follow the plan of care or consulted with the initial provider or have serious concerns about the diagnosis or plan of care.

How to Request a Second Opinion

- You must get approval from your PCP to get a second opinion.
- You can also request a second opinion from another participating provider in your doctor's medical group or from any specialist contracted with the plan.
- You may also request a second opinion from MemorialCare Select Health Plan for Mental Health, Behavioral Health and Substance Use Disorder Treatment Services.
- When authorized, you are only responsible to pay your copayment including preauthorization for out-of-area providers.
- If you are requesting a second opinion about care from your PCP the second opinion shall be provided by an appropriately qualified health care professional within your medical group.
- If you are requesting a second opinion about care from a specialist, the second opinion shall be provided by any provider within the plan's network of the same or equivalent specialty.
- If there is no qualified participating providers within the network, the plan will authorize a second opinion by an appropriately qualified non-participating provider.
- If MemorialCare Select Health Plan denies or modifies your request for a second opinion, you will be notified in writing of the reasons for the denial and your right to file a grievance.

Timeframe for preauthorization

MemorialCare Select Health Plan makes decisions to authorize, deny, delay or modify requests for covered health care services, based on medical necessity, within the following timeframes as required by California state law:

- Decisions based on medical necessity will be made in a timely manner appropriate for the nature of your condition, not to exceed five (5) business days from the receipt of information reasonably necessary to make the decision.
- If your condition poses an imminent and serious threat to your health, including, but not limited to, severe pain, potential loss of life, limb, or other major bodily functions, or lack of timeliness would be detrimental in regaining maximum functions, the decision would be rendered in a timely manner appropriate for the nature of your condition, not to exceed seventy- two (72) hours after receipt of the information reasonably necessary to make the determination.

Continuity of Care

Continuity of care means continued services, under certain conditions, with your current health care provider until your care provider completes your care.

A ***newly enrolled member*** may receive continuity of care services when:

- You are receiving care from a non-MemorialCare Select Health Plan provider; or
- Your previous coverage terminated due to your plan either withdrawing from the market in your service area or ceasing to offer the applicable health benefit plan in your service area.

As a ***current member***, you may also obtain continuity of care when:

- There is a change in your MemorialCare Select Health Plan network provider; or
- Your MemorialCare Select Health Plan medical group, hospital, or health care provider is no longer contracted with the plan.
- Continuity of care may be provided for the completion of care when you or your dependent (s) is in an active course of treatment for the following conditions:

Important Information About Continuity of Care
If you have been receiving care from a health care provider, you may have a right to keep your provider for a designated time period. Please contact your health plan's customer service department, and if you have further questions, you are encouraged to contact the Department of Managed Health Care, which protects consumers, by telephone at its toll-free number, 1-888-466-2219, or at a TDD number for the hearing and speech impaired at 1-877-688-9891, or online at www.dmhc.ca.gov.

Condition	Definition	Length of Time for Continuity of Care
Acute Condition	A medical condition that involves a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention and that has a limited duration.	Duration of the acute condition
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 persists without full cure or worsens over an extended period or requires ongoing treatment to maintain remission or prevent deterioration. Completion of covered services shall be provided for a period necessary to complete a course of treatment and to arrange for a safe transfer to another provider, as determined by the plan in consultation with the enrollee and the terminated provider and consistent with good professional practice.	No more than 12 months
Pregnancy	Three trimesters of pregnancy and immediate post-partum period.	Duration of the pregnancy
Maternal Mental Health	A condition that can impact a woman during pregnancy, peri or postpartum, or that arises during pregnancy, in the peri or postpartum period, up to one year after delivery.	No more than 12 months from the diagnosis or from the end of pregnancy, whichever occurs later.
Terminal Illness	An incurable or irreversible condition that has a high probability of causing death within one year or less.	Duration of the terminal illness which may exceed 12 months from the contract termination date.
Surgery or other procedure	that is authorized by the plan as part of a documented course of treatment and has been recommended and documented by the provider	Must be scheduled within 180 days of health care provider's contract termination.
Newborn	Care of newborn child between birth and age 36 months	No more than 12 months

Your requested health care provider must agree to provide continued services to you, subject to the same contract terms and conditions and similar payment rates to other similar health care providers contracted with MemorialCare Select Health Plan. If your health care provider does not agree, MemorialCare Select Health Plan cannot provide continuity of care.You are required to pay the same copayments, or other cost-sharing during the period of completion of covered serviced with a terminated provider or non-participating provider as you would have paid if receiving care from a provider currently contracted with MemorialCare Select Health Plan.

You are not eligible for continuity of care coverage in the following situations:

- You are a newly enrolled member and had the opportunity to enroll in a plan with out-of-network option.
- You had the option to continue with your previous plan, but instead voluntarily chose to change plans.
- You have an Individual, Medicare, CalChoice, or CCSB (Covered California for Small Business) policy and had the ability to choose a plan that allowed you to stay with your health care provider.

Contact Member Services for more information and how to request continuity of care. You may also request a copy of MemorialCare Select Health Plan's medical policy on continuity of care.

WHAT YOU PAY

Premiums

Your employer pays premiums to the plan each month for you and your dependent (s). Your employer will notify you if you need to make any contribution to the premium or if the premium changes. Often, your share of the cost will be deducted from your salary. Premiums may change at renewal, if your employer changes the benefit plan, or at certain ages. Notice of change of premium relate of coverage will be provided at least 60 days prior to the effective date of the change.

Copayments

A copayment (sometimes referred to as "copay") is the amount that you pay each time to use a doctor. You must pay a copayment for each covered benefit you receive, and you must pay the copayment at the time you receive the services. Different kinds of benefits may have different copayment amounts. For example, doctor visits, emergency room visits, and hospital stays all have different copayment amounts. The copayment are listed in the summary of benefits brochure.

Annual out-of-pocket Maximum

The "annual (yearly) out-of-pocket maximum" is the total you must pay each year for most of your benefits. Each family member has an annual out-of-pocket maximum. If you are a member in a family of two or more members, you reach the annual out-of-pocket maximum either when you meet the maximum for any one member, or when your family reaches the family maximum.

The out-of-pocket maximum for one member is $2,000 and the family maximum is $4,000. For example, suppose you have reached the $2,000 maximum., for benefits subject to the maximum, you will not pay any more cost sharing during the rest of the calendar year, but every other member in your family must continue to pay cost sharing during the calendar year until your family reaches the $4,000 maximum.

When you pay a cost sharing amount that applies toward the annual out-of-pocket maximum, ask for and keep the receipt. When the receipts add up to the annual out-of-pocket maximum, call Member Services to turn in your receipts. When you turn them in, we will give you a document stating that you don't have to pay any more cost sharing for benefits subject to the annual out-of-pocket maximum through the end of the calendar year

MemorialCare Select Health Plan complies with state and federal laws that establish "parity" and cost-share coordination requirements for mental health, behavioral health and substance use disorder services. (cost share coordination" means accounting for the member's share of cost paid for both mental health and non-mental health services when calculating amounts paid towards out of pocket maximums.) If you have any concerns regarding copayments, or out of pocket maximum amounts in connection with mental health, behavioral health and substance use disorder services treatment provided to you, call Member Services.

Coordination of Benefits (If You Have More Than One Health Plan)

Coordination of benefits (COB) is a process used by MemorialCare Select Health Plan and other plans, employer benefit plans, union welfare plans, HMOs, insurance companies, government programs and other types of payors ("Insurers") to make sure that duplicate payments are not made for the same service when more than one Insurer covers a member. MemorialCare Select Health Plan and other insurers must follow state and federal law and regulations when determining the order of payment of claims while providing that the member does not receive more than one hundred percent (100%) coverage from all insurers combined. Contact Member Services for information regarding the coordination of your benefits, or if you would like a copy of MemorialCare Select Health Plan's COB policy. All the benefits provided under this member handbook are subject to COB. You are required to cooperate and assist with MemorialCare Select Health Plan's coordination of benefits by telling all your health care providers if you or your dependent (s) have any other coverage. You are also required to give MemorialCare Select Health Plan your social security number and/or Medicare identification number to facilitate coordination of benefits.

Third Party Responsibility (If Someone else is responsible)

In the event a member suffers injury, illness or death due to the act or omission of a third party (including but not limited to vehicle accidents, slip and falls, dog bites, work injuries, etc.) and complications incident thereto, MemorialCare Select Health Plan will furnish benefits. In the event any recovery is obtained by the member or his or her Representative due to such injury, illness or death, the member and his or her Representative must reimburse MemorialCare Select Health Plan for the value of benefits as set forth below. By executing an enrollment application or otherwise enrolling with MemorialCare Select Health Plan, each member grants MemorialCare Select Health Plan, a lien on any such recovery and agrees to protect the interests of MemorialCare Select Health Plan when there is any possibility that a recovery may be received. Each member also specifically agrees as follows:

- Promptly following the initiation of any injury, illness or death claim, the member or his or her Representative shall provide the following information to MemorialCare Select Health Plan in writing: the name and address of the third party; the name of any involved attorneys; a description of any potentially applicable insurance policies; the name and telephone number of any adjusters; the circumstances which caused the injury, illness or death; and copies of any pertinent reports or related documents;
- Each member or Representative shall execute and deliver to MemorialCare Select Health Plan any and all lien authorizations, assignments, releases or other documents requested which may be needed to fully and completely protect the legal rights of MemorialCare Select Health Plan;
- Immediately upon receiving any recovery, the member or Representative shall notify MemorialCare Select Health Plan and shall reimburse MemorialCare Select Health Plan for the value of the benefits provided, as set forth below. Any such recovery by or on behalf of the member and/or Representative will be held in trust for the benefit of MemorialCare Select Health Plan and will not be used or disbursed for any other purpose without MemorialCare Select Health Plan's express prior written consent. If the member and/or Representative receives any recovery which does not specifically include an award for medical costs, MemorialCare Select Health Plan will nevertheless have a lien against such recovery; and
- Any recovery received by the member or Representative shall first be applied to reimburse MemorialCare Select Health Plan for benefits provided and/or paid, regardless of whether the total amount of recovery is less than the actual losses and damages incurred by the member and/or Representative.

"Recovery" means any compensation received from a judgment, decision, award, insurance payment or settlement in connection with a civil, criminal or administrative claim, complaint, lawsuit, arbitration, mediation, grievance or proceeding which arises from the act or omission of a third party, including uninsured and underinsured motorist claims.

"Representative" means any person pursuing a Recovery due to the injury, illness or death of a member, including but not limited to the member's estate, representative, family, appointee, heir or legal guardian.

The following section is not applicable to workers' compensation liens, may not apply to certain ERISA Plans, Hospital liens, and Medicare Plans and certain other Plans, and may be modified by written agreement. *

The amount MemorialCare Select Health Plan is entitled to recover for capitated and/or non-capitated benefits pursuant to its reimbursement rights described in this member handbook is determined in accordance with California Civil Code Section 3040. Normally, this amount will not exceed one third (1/3) of the recovery if the member or Representative engages and pays an attorney or one half (1/2) of the recovery if no attorney is engaged and paid. MemorialCare Select Health Plan's lien is subject to reduction if any final judgment includes a special finding by a judge, jury or arbitrator that the member was partially at fault for the incident. In that case, the lien will be reduced commensurate with the member's percentage of fault as determined by the final judgment. This reduction will be calculated using the total value of the lien, and prior to any other reductions.

** Reimbursement related to worker's compensation benefits, ERISA Plans, Hospital liens, Medicare and other programs not covered by Civil Code Section 3040 will be determined in accordance with the provisions of this Member Handbook and applicable law.*

What to do if You get a Bill

You are only responsible for paying your contribution of the monthly premiums or copayments for the benefits you receive. Contracts between MemorialCare Select Health Plan and its participating providers state that you will not be liable to for sums owed to them by the plan. You should not receive a medical bill from a participating provider. If you receive a bill in error, call the provider who sent the bill tell them you are a member of MemorialCare Select Health Plan, and ask that to bill the plan. If you still receive a bill, contact Member Services as soon as possible for assistance.

Some doctors and hospitals that are not contracted with MemorialCare Select Health Plan (for example, emergency departments outside MemorialCare Select Health Plan's service area) may require you to pay at the time you receive care. In some cases, a non-participating provider may provide benefits at a contracted facility where we have authorized you to receive care. You are not responsible for any amounts beyond your cost share for the benefits you receive at contracted facilities where we have authorized you to receive care.

If you pay for benefits, you can request reimbursement from MemorialCare Select Health Plan.

How to File a Claim for Reimbursement

To file a claim for payment or reimbursement, this is what you need to do:

If you have paid for the services, you must send us a completed claim form for reimbursement. Claim forms are available at **memorialcareselecthealthplan.org** or may be requested by calling Member Services.

- Attach any bills or receipts from the non-participating provider;
- You must complete and return to us any information that we request to process your claim, such as claim forms, consents for the release of medical records, assignments, and claims for any other benefits to which you may be entitled;
- The completed request and information must be mailed to the following address as soon as possible after receiving the care and no later than 180 days after receiving the care. Any additional information we request should also be mailed to this address:

  MemorialCare Select Health Plan

  Attn: Claims Department

  17360 Brookhurst Street
  Fountain Valley, CA 92708

If coverage under this member handbook is subject to the Employee Retirement Income Security Act (ERISA) claims procedure regulation (29 CFR § 2560.503-1), we will send our written decision within 30 calendar days after we receive the claim unless we request additional information from you or the non-participating provider. If we request additional information, we will send our written decision no later than 15 calendar days after the date we receive the additional information. If we do not receive the necessary information within the timeframe specified in the letter, we will make our decision based on the information we have

If coverage under this member handbook is not subject to the ERISA claims procedure regulation, we will send our written decision within 45 business days after we receive the claim unless we request additional information from you or the non-participating provider. If we request additional information, we will send our written decision no later than 45 business days after the date we receive the additional information. If we do not receive the necessary information within the timeframe specified in the letter, we will make our decision based on the information we have.

If our decision is not fully in your favor, we will tell you the reasons and how to file a grievance as described under the "Reporting and Solving Problems" section of the member handbook.

HOW TO ENROLL

How to Enroll

If you are an employee, you may enroll during your initial enrollment period or during your employer's open enrollment period, provided you meet certain eligibility requirements and complete the required enrollment process. Your initial enrollment period begins the day you become an eligible and ends 31 days after it begins. **If you do not enroll within 31 calendar days of first becoming eligible, you may enroll only during an annual open enrollment period established by your employer.**

As an employee, you are eligible to enroll if you work a normal workweek of at least the number of hours required by your employer.

Eligible employees do not include part-time, temporary, substitute or contracted, unless agreed to by the plan and your employer. If an employee is not actively at work on the date coverage would otherwise become effective (excluding medical leave status), coverage will be deferred until the date the employee returns to an active work status.

Employees must live or work within MemorialCare Select Health Plan's service area for at least nine out of every twelve consecutive months. A member who resides outside the service area must select a PCP within the service area and must obtain all benefits from plan providers inside the service area, except for out-of-area emergency services or urgent care services.

Dependent Eligibility

Dependent (s) (spouse, domestic partner and children) become eligible when the employee is determined to be eligible. Dependent (s) may enroll during the employee's initial enrollment period or open enrollment period. Dependent (s) may only enroll if the employee is also enrolled or enrolls with the dependent (s) and are only eligible for the same plan in which the employee is enrolled.

Eligible dependent (s) include:

- The naturally born child (ren), legally adopted child (ren) or stepchildren of the employee.
- Child (ren) for whom the employee has been appointed a legal guardian by a court.
- Child (ren) for whom the employee is required to provide health coverage pursuant to a qualified medical support order.
- Child (ren), not including foster children, for whom the employee has assumed a parent-child relationship, as indicated by intentional assumption of parental status, or assumption of parental duties, and as certified by the employee at the time of enrollment and annually thereafter.
- A grandchild of the employee is not eligible for enrollment, unless the employee has been appointed legal guardian of the grandchild (ren) or the has assumed a parent-child relationship as described above.

Dependent child (ren) remain eligible up to age 26, regardless of student, marital or financial status. A dependent who reaches age 26 during a benefit year may remain enrolled until the end of that benefit year. Coverage shall end on the last day of the benefit year during which the dependent becomes ineligible.

If you have a new dependent (s) as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependent (s) outside of your employer's open enrollment period. However, you must request enrollment within 30 calendar days after the marriage, birth, adoption or placement for adoption. Your employer is responsible for notifying the plan to enroll or disenroll your eligible dependent (s). If notification of the status change is not received by your employer within the 30-day period, your dependent (s) will not be covered, and you will be responsible for payment of any services received. To add a new spouse to your coverage, you must complete and submit an enrollment change form to your employer within the 30-day period following your marriage.

A dependent (s) who is totally disabled at the time of attaining the maximum age of 26 may remain enrolled as a until the disability ends. For purposes of this provision, a child is considered totally disabled and continues to meet both of the following criteria:

- Incapable of self-sustaining employment by reason of a physically or mentally disabling injury, illness or condition; and
- Chiefly dependent upon the employee for support and maintenance.

Dependent (s) are not required to live with the employee. However, dependent (s) must maintain their primary residence or work within MemorialCare Select Health Plan's licensed service area unless enrolled as a full-time student at an accredited institution or unless coverage is provided under a medical support order. A member who resides outside the service area must select a PCP within the service area and must obtain all benefits from plan providers inside the service area, except for out-of-area emergency services or urgent care.

Newborn Coverage

The newborn of an employee, an employee's spouse or domestic partner is automatically covered for the first 30 calendar days from the date of the newborn's birth.

An adopted child of an employee, an employee spouse or a domestic partner is covered for 30 days from the date you are legally entitled to control the health care of the adopted child.

If you wish to continue coverage for your newborn or adopted child beyond the initial 30-day period, you must submit an enrollment change form to your employer within the 30-day period following the birth or legal adoption. A birth or adoption certificate may be required as proof of dependent (s) status. You must submit an enrollment application to your employer for a newborn or adopted child, even if you currently have dependent coverage.

Grandchildren are not eligible for enrollment, unless you have been appointed legal guardian of the grandchild(ren).

Premium for a newborn or adopted child will be due at the beginning of the month following the month of birth or adoption.

Enrollment Outside of Your Initial or Open Enrollment Period

If you decline enrollment for yourself or your eligible dependent (s) because of other group medical coverage, you may be able to enroll yourself and your eligible dependent (s) in MemorialCare Select Health Plan if you involuntarily lose eligibility for that other coverage. However, you must request enrollment within 30 days after your other coverage ends and will be required to submit documentation indicating the coverage termination date.

Updating Your Enrollment Information

Please notify your employer of any changes to your enrollment application within 30 calendar days of the change. This includes changes to your name, address, telephone number, marital status or the status of any enrolled dependent(s). Your employer will notify MemorialCare Select Health Plan of the change. If you wish to change your PCP, or medical group, please contact Member Services.

MEMBER RIGHTS AND RESPONSIBILITIES

You Have the Right to:

- Timely access to health care services when you need it.
- Continuity of care if your doctor or medical group stops working with MemorialCare Select Health Plan.
- Receive treatment for certain mental health conditions.
- Obtain a second doctor's opinion.
- Know why MemorialCare Select Health Plan denies a service or treatment.
- Understand your health problems and treatments.
- See a written diagnosis (description of your health problem).
- Give informed consent when you have a treatment.
- Service and information in your language. You have the right to ask for a provider or an interpreter who speaks your language when you receive health care services
- Receive written information in your language or preferred format (such as audio, large print or Braille).
- Request copies of your medical records.
- Add your own notes to your medical records.
- Keep your medical information private.
- Disability Access Rights.
- Have an Advance Directive.
- Purchase health insurance or determine Medi-Cal eligibility through the California Health Benefit Exchange, Covered California.
- Stay on a parent's health plan until age 26.
- Receive many preventive care services without a co-pay, co-insurance or deductible.
- Have no annual or lifetime dollar limits on basic health care services.

You Have the Responsibility to:

- Understand your health problems and participate in developing mutually agreed-upon treatment goals, to the degree possible.
- Ask questions if you do not understand explanations and instructions.
- Respect provider office policies and ask questions if you do not understand them.
- Follow advice and instructions agreed-upon with your provider.
- Report any changes in your health.
- Keep all appointments and arrive on time. If you are unable to keep an appointment, cancel 24 hours in advance, if possible.
- Notify MemorialCare Select Health Plan of any changes in your address or telephone number.
- Let your health care provider or MemorialCare Select Health Plan know if you have suggestions, compliments or complaints.
- Notify MemorialCare Select Health Plan of any changes that affect your eligibility, including no longer working or residing in the Plan's Service Area.
- Use the Emergency Room only in an emergency

HELP WHEN YOU NEED IT

If you experience a problem with a participating provider or your plan, give us an opportunity to help. MemorialCare Select Health Plan can assist in working out any issues. If you ever have a question or concern, we suggest that you call Member Services. A Member Service Representative will make every effort to assist you.

How to File a Complaint

You may file a grievance (also called a "complaint") with MemorialCare Select Health Plan up to 180 calendar days following any incident that is subject to your dissatisfaction.

You can request a copy of the grievance policy and procedure by calling Member Services. To file a complaint, you or your authorized representative can call, write, fax or go online at:

MemorialCare Select Health Plan
Attn: Member Services Department
17360 Brookhurst Street
Fountain Valley, CA 92708
Toll-free: 1-844-805-8700
Fax: (562) 424-1486
www.memorialcareselecthealthplan.org

You can send a detailed letter describing your concern or complete a grievance form by calling Member Services. You can also complete the online grievance form on the plan's website, **memorialcareselecthealthplan.org** Please include any information you think is important. Please call Member Services if you need help in completing the form.

There are separate processes for clinical and administrative grievance. Clinical cases are those that require a clinical body of knowledge to render a decision. Only a physician or committee of physicians can render a decision about a clinical grievance. The person who reviews and decides your case will not be the same person who made the initial decision or that person's subordinate.

Except for an complaint of a denial of coverage for a non-formulary drug, which follows the timeframes described below, we will acknowledge receipt of your complaint within 5 calendar days and will send you a written decision within 30 calendar days.

If the complaint involves an imminent and serious threat to your health, including, but not limited to, severe pain, potential loss of life, limb or major bodily function, we will provide you with a decision within 72 hours.

If your complaint involves a request for coverage of a non-formulary drug (referred to as a non-formulary exception request), we will provide you with a decision within 72 hours.

A request may be expedited if urgent, in which case we will provide you with a decision within 24 hours. A non-formulary exception request is considered urgent when a member is suffering from a health condition that may seriously jeopardize life, health, or ability to regain maximum function or when undergoing a current course of treatment using the non-formulary drug.

Non-Formulary Prescription Drug Exception Requests

If we deny a request for coverage of a non-formulary drug, you, your authorized representative or your doctor may request that the original exception request and subsequent denial of such request be reviewed by an Independent Review Organization (IRO). You, your authorized representative or your doctor may submit a request for IRO review up to 180 calendar days following the non-formulary drug exception request denial by:

- Calling 1-844-513-6001
- Mailing a written request to:
  CVS Caremark
  Attn: Prescription Claim Appeal MC 109
  P.O. Box 52084
  Phoenix, AZ 85072-2084
- Faxing 1-866-443-1172
- Completing the member grievance online at **memorialcareselecthealthplan.org.**

You will be notified of the IRO's decision within 72 hours for standard requests or 24 hours for expedited requests.

The IRO review process described above is in addition to your rights to file a grievance with MemorialCare Select Health Plan or request an Independent Medical Review (IMR) with the Department of Managed Health Care (DMHC).

Binding Arbitration – Voluntary

If you have exhausted the plan's grievance process and are still not satisfied, you have a right to use voluntary binding arbitration, which is the final step for resolving complaints.

Any complaint which may arise, except for medical malpractice, may be resolved through binding arbitration rather than a lawsuit. Binding arbitration means that you agree to waive your rights to a jury trial. Medical malpractice issues are not subject to the arbitration process.

You may begin the arbitration process by submitting a demand for arbitration to MemorialCare Select Health Plan. MemorialCare Select Health Plan will utilize a neutral arbiter from an appropriate entity. Arbitration will be conducted in accordance with the rules and regulations of the arbitration entity.

Upon receipt of your request, we will forward to you a complete copy of the Arbitration Rules from the arbitration entity and a confirmation that we have submitted a request to the arbitration entity for a list of arbitrators.

If MemorialCare Select Health Plan determines that the request for arbitration is applicable under the Employee Retirement Income Security Act (ERISA) rules, then the cost of arbitration expenses will be borne by the plan. If we determine the request for arbitration is not applicable under ERISA rules, then the cost of arbitration expenses will be mutually shared between you and MemorialCare Select Health Plan. In cases of extreme hardship, MemorialCare Select Health Plan may assume all or a portion of your arbitration fees. The existence of extreme hardship will be determined by the arbitration entity. Please contact Member Services for more information on qualifying for extreme hardship.

If you do not initiate the arbitration process outlined above, you may have the right to bring a civil action under Section 502(a) of the ERISA if your appeal has not been approved.

Additional Resources

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan toll-free at 1-844-805-8700 and use your health plan's grievance process before contacting the Department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the Department for assistance. You may also be eligible for an Independent Medical Review

(IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The Department also has a toll-free telephone number 1-888-466-2219 and a **TDD line (1-877-688-9891)** for the hearing and speech impaired. The Department's internet website www.dmhc.ca.gov has complaint forms, IMR application forms, and instructions online.

If your case is determined by the Department of Managed Health Care to involve an imminent and serious threat to your health, including but not limited to severe pain, the potential loss of life, limb or major bodily function, or if for any other reason the department determines that an earlier review is warranted, you will not be required to participate in the plan's grievance process for 30 calendar days before submitting your grievance to the department for review.

If you believe that your or your dependent (s) coverage was terminated or not renewed because of health status or requirements for benefits, you may request a review of the termination by the Director of the Department of Managed Health Care, pursuant to Section 1365(b) of the California Health and Safety Code, at the telephone numbers and website listed above.

Mediation

You may request voluntary mediation with the plan prior to exercising your right to submit a grievance to the Department of Managed Health Care. In order to initiate mediation, you and MemorialCare Select Health Plan must both voluntarily agree to mediation. The use of mediation services does not exclude you from the right to submit a grievance to the DHMC upon completion of mediation. Expenses for mediation are shared equally between you and the plan.

Independent Medical Review (IMR)

If care that is requested for you is denied, delayed or modified by MemorialCare Select Health Plan or a plan's medical group, you may be eligible for an Independent Medical Review (IMR). If your case is eligible as described below, and you submit a request for IMR to the California Department of Managed Health Care (DMHC), information about your case will be submitted to a medical specialist who will make an independent determination on your case. You will receive a copy of the determination. If the IMR specialist so determines, the plan will provide coverage for the health care service.

The IMR process is in addition to any other procedures or remedies that may be available to you. 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 care that was requested. You pay no application or processing fees of any kind for IMR. You have the right to provide information in support of the request for IMR. For cases that are not urgent, the IMR organization designated by the DMHC will provide its determination within 30 calendar days of receipt of your application and supporting documents. For urgent cases involving an 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 will provide its determination within three business days. At the request of the experts, the deadline can be extended by up to three days if there is a delay in obtaining all necessary documentation. IMR is available in the situations described below.

Experimental or Investigational Treatment for Life-Threatening or Seriously Debilitating Conditions

If a service is denied by MemorialCare Select Health Plan or a plan's medical group because it is deemed to be an investigational or experimental therapy, you may be entitled to request an IMR of that decision. To be eligible for an IMR under this section all of the following conditions must be true:

- You must have a life-threatening or seriously debilitating condition. "Life-threatening" means either or both of the following: (a) diseases or conditions where the likelihood of death is high unless the course of the disease is interrupted, or (b) diseases or conditions with potentially fatal outcomes, where the end point of clinical intervention is survival. "Seriously debilitating" means diseases or conditions that cause major irreversible morbidity.
- Your plan physician must certify that you have a condition, as described above, for which standard therapies have not been effective, or for which standard therapies would not be medically appropriate, or for which there is no more beneficial standard therapy covered by the plan than the proposed therapy.
- Either (a) your plan physician has recommended a drug, device, procedure or other therapy that he/she certifies in writing is likely to be more beneficial to you than any available standard therapies, or (b) you or your plan physician (board eligible or board certified) has requested a therapy that, based on documentation from the medical and scientific evidence, is likely to be more beneficial than any available standard therapy.
- You have been denied coverage by the plan for a drug, device, procedure or other therapy recommended or requested as described in paragraph above.
- The specific drug, device, procedure or other therapy recommended would be a covered benefit, except for the plan's determination that the therapy is experimental or investigational.

If there is potential that you would qualify for an IMR under this section, the plan will send you an application within five days of the date services were denied. If you would like to request an Independent Medical Review (IMR), return your application to the DMHC. Your physician will be asked to submit the documentation that is described in in this section.

An expedited review process will occur if your physician determines that the proposed therapy would be significantly less effective if not promptly initiated. In such cases the analyses and recommendations of the experts on the panel shall be rendered within seven days of the request for independent review.

Denial of a Health Care Service as Not Medically Necessary

You may request an Independent Medical Review (IMR) of disputed health care services from the DMHC if you believe that health care services have been improperly denied, modified or delayed by MemorialCare Select Health Plan or a plan medical group. A "disputed health care service" is any health care service eligible for coverage and payment under your group subscriber agreement that has been denied, modified or delayed, in whole or in part, because the service is not medically necessary.

The plan will provide you with an IMR application form with any appeal findings letter that denies, modifies or delays health care services because the service is not medically necessary. If you would like to request an IMR, return your application to the DMHC. Your application for IMR must be submitted to the DMHC within six months and meet all of the following conditions:

1. (a) Your plan provider has recommended a health care service as medically necessary; (b) You have received an urgent care or emergency service that a provider determined was medically necessary, or (c) You have been seen by a plan provider for the diagnosis or treatment of the medical condition for which you seek IMR;
2. The disputed health care service has been denied, modified or delayed by the plan or plan's medical group, based in whole or in part on a decision that the health care service is not medically necessary; and
3. You have filed an grievance with the plan and the plan's decision was upheld or your grievance remains unresolved after 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 plan's grievance process in extraordinary and compelling cases.

For more information regarding the IMR process or to request an application form, please call or email Member Services.

WHAT'S COVERED

As a member, you are entitled to receive benefits subject to all the terms, conditions, exclusions and limitations described in this member handbook as described below and must be:

- Medically necessary;
- Specifically described in this member handbook;
- Provided by participating providers;
- Prescribed by a contracted physician and, if required, authorized in advance by your PCP, your medical group or MemorialCare Select Health Plan; and
- Part of a treatment plan or required to treat medical conditions which are direct and predictable complications or consequences of covered benefits.

The Member's summary of benefits details applicable copayments that the member pays for benefits, and also includes the annual out-of-pocket maximum.

Important exclusions and limitations are described in the section of this member handbook entitled, "WHAT'S NOT COVERED"

These exclusions and limitations do not apply to medically necessary services to treat Severe Mental Illness (SMI) or Severe Emotional Disturbance of a Child (SED)

Acupuncture Services

Your benefit plan includes chiropractic and acupuncture benefits administered by American Specialty Health Plans of California Inc., ("ASH Plans").

- $15 copayment per visit
- 30 visit annual maximum

How to access services

To access services please call ASH's Customer Service Department at **1-800-678-9133** or online at **www.ashlink.com.**

- You must get your health care from practitioners who are in the ASH network. Information on ASH participating providers, including their location and description of the services provided may be obtained by asking for an AHP Provider Directory. To request an ASH provider directory, call **1-800-678-9133.**
- If you see a non-participating provider, you will have to pay of the cost, unless you received emergency services, urgent care services or preauthorization from ASH Plans.

Ambulance

Services from a licensed ambulance provided in connection with the following are covered without a copay:

- Emergency services,
- When ordered by your PCP,
- Emergency services rendered through the 911 emergency response system, and
- Air ambulance, if ground ambulance service cannot provide the service needed, to the nearest hospital that can provide the needed care.

Chemotherapy

Chemotherapy is covered. Outpatient chemotherapy is covered without additional copayment as part of a comprehensive treatment plan.

Circumcision

Routine circumcision is a covered benefit and does not require a copayment when the procedure is performed in the contracted provider's office, outpatient facility or prior to discharge during neonatal period. The neonatal period is defined as the period immediately following birth and continuing through the first 28 days of life. For a premature infant, requiring inpatient care due to a medical condition, routine circumcision is covered during the duration of the inpatient stay, and for three months post-hospital discharge.

Non-routine circumcision performed as treatment for a medically necessary indication is covered at any age.

Clinical Trials

Routine health care services associated with a member's participation in an eligible clinical trial are covered without a copayment. To be eligible for coverage, the member must meet the following requirements:

- The member is eligible to participate in an approved clinical trial according to the trial protocol with respect to treatment of cancer or other life-threatening disease or condition. The term "life-threatening condition" means any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.
- Either (1) the referring health care professional is a participating provider and has concluded that the member's participation in such trial would be appropriate based upon the member meeting the conditions of the clinical trial; or (2) the member provides medical and scientific information establishing that the member's participation in the clinical trial would be appropriate based upon the member meeting the conditions of the clinical trial.

The clinical trial must be a Phase I, Phase II, Phase III, or Phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition, and:

1. The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:
   a. The National Institutes of Health:
   b. The Centers for Disease Control and Prevention,
   c. The Agency for Health Care Research and Quality,
   d. The Centers for Medicare & Medicaid Services,
   e. A cooperative group or center of any of the above entities or of the Department of Defense or the Department of Veterans Affairs,
   f. A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants, or
   g. The Department of Veterans Affairs or the Department of Defense or the Department of Energy, but only if the study or investigation has been reviewed and approved through a system of peer review that the U.S. Secretary of Health and Human Services determines meets all of the following requirements: (1) it is comparable to the National Institutes of Health system of peer review of studies and investigations and (2) it assures unbiased review of the highest scientific standards by qualified people who have no interest in the outcome of the review.
4. The study or investigation is conducted under an investigational new drug application reviewed by the Food and Drug Administration.
5. The study or investigation is a drug trial that is exempt from having such an investigational new drug application.

Benefits for clinical trials include the following:

- Health care services typically provided absent a clinical trial,
- Health care services required for the provision of and clinically appropriate monitoring of the investigational drug, item, device, or service,
- Services provided for the prevention of complications arising from the provision of the investigational drug, item, device, or service,
- Reasonable and necessary care arising from the provision of the investigational drug, item, device, or service.

If any contracted providers participate in the clinical trial and will accept the member as a participant in the clinical trial, the member must participate in the clinical trial through a participating provider unless the clinical trial is outside the state where the member lives.

Dental Care

Inpatient hospital services for dental care is covered without a copayment and is limited to 3 days when the stay is:

- Needed for dental care due to other medical problems,
- Approved by your PCP or contracted dentist,
- Approved by your medical group

General anesthesia services and supplies and associated facility charges, rendered in a hospital or surgery center setting are covered for dental and oral surgical services without a copayment for members who are:

- Less than seven years old;
- Developmentally disabled; or
- Health is compromised, and general anesthesia is medically necessary.

Diabetes Treatment

Supplies, equipment and services for the treatment and/or control of diabetes are covered without a copayment even when available without a prescription, including:

- Blood glucose monitors and testing strips.
- Blood glucose monitors designed for the visually impaired.
- Insulin pumps and all related necessary supplies.
- Ketone urine testing strips.
- Lancets and lancet puncture devices.
- Pen delivery systems for the administration of insulin, if member meets criteria.
- Podiatric devices to prevent or treat diabetes-related complications.
- Insulin syringes.
- Visual aids (excluding eyewear) to assist the visually impaired with proper dosing of insulin.
- Self-management training, education and medical nutrition therapy.
- Laboratory tests appropriate for the management of diabetes.
- Dilated retinal eye exams.

Durable Medical Equipment (DME)

Durable medical equipment (DME) is covered without a copayment. Coverage is limited to the standard item of equipment that adequately meets your medical needs. MemorialCare Select Health Plan reserves the right to determine if covered DME will be purchased or rented.

DME is limited to equipment and devices that are:

- Intended for repeated use over a prolonged period,
- Not considered disposable, except for ostomy bags,
- Ordered by a licensed participating provider acting within the scope of their license,
- Intended for the exclusive use of the member,
- Not duplicative of the function of another piece of equipment or device already covered for the member,
- Generally, not useful to a person in the absence of illness or injury,
- Primarily serving a medical purpose,
- Appropriate for the use in the home. Lowest cost item necessary to meet the member's needs,
- Not for member's comfort or hygiene,
- Not for exercise; and
- Not intended for the sole reason of making a room or home comfortable, such as air conditioning or air filters.

Emergency Services

Hospital emergency room services provided inside or outside of the service area that are medically necessary for treatment of an emergency medical condition are covered without a copayment. An emergency medical condition means a medical condition, manifesting itself by symptoms of sufficient severity, including severe pain, which in the absence

of immediate attention could reasonably be expected to result in:

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

Emergency services and care include both physical and psychiatric emergency conditions, and active labor.

Out-of-area medical services are covered only for urgent and emergency medical conditions resulting from unforeseen illness or injury or complication of an existing condition, including pregnancy, for which treatment cannot be delayed until the member returns to the service area. Out-of-area medical services will be covered to meet your immediate medical needs. Follow-up care must be authorized by MemorialCare Select Health Plan. Follow-up care for urgent and emergency services will be covered until it is prudent to transfer your care into the plan's service area.

Family Planning Services

The following family planning services are covered without a copayment (see exception below):

- Prescription contraceptive supplies, devices (IUDs) and injections.
- Voluntary sterilization services.
- Interruption of pregnancy (abortion) services.
- Emergency contraception when dispensed by a contracting pharmacist.
- Counseling services.
- Diagnosis and testing for infertility is covered and requires a 50% copayment. The copayment made for infertility services will not be applied to the "Copay Limits".

Home Health Services

Home health services are covered without a copayment and provided at the home of the member. This includes visits by registered nurses, licensed vocational nurses and home health aides for physical, occupational, speech and respiratory therapy when prescribed by a participating provider acting within the scope of their licensure.

Visits on a short-term, intermittent basis are covered for the usual and customary time required to perform the skilled service(s), including diagnosis and treatment, for the following services:

- Skilled nursing services of a registered nurse, public health nurse, licensed vocational nurse and/or licensed home health aide.
- Rehabilitation, physical, occupational and speech therapy services.
- Home health aide services, consisting primarily of caring for members under arrangements with, a participating home health agency. Such home health aide services will be provided only when the member is receiving the services specified above and only when such home health aide services are ordered by a physician and supervised by a registered nurse as the professional coordinator employed by a participating home health agency.
- Medical social service consultations provided by a qualified medical social worker.
- Medical supplies, medicines, laboratory services and durable medical equipment (DME), when provided by a home health agency at the time the services are rendered.

Hospice Services

Hospice services are covered for members who have been diagnosed with a terminal illness and have a life expectancy of twelve months or less, and who elect hospice care for the illness instead of restorative services covered by MemorialCare Select Health Plan. Benefits are available on a 24-hour basis, during periods of crisis, to the extent necessary to meet the needs of individuals for care that is reasonable and necessary for the palliation and management of terminal illness and related conditions.

Covered Benefits include:

- Nursing care.
- Medical social services.
- Home health aide services, skilled nursing services and homemaker services under the supervision of a qualified registered nurse.
- Physician services.
- Drugs.

- Pharmaceuticals, medical equipment and supplies.
- Counseling and social services with medical social services provided by a qualified social worker. Dietary counseling by a qualified Provider shall also be provided when needed.
- Bereavement services.
- Physical, occupational and speech therapy as described in this section for short-term inpatient care for pain control and symptom management or to enable the member to maintain activities of daily living and basic functional skills.
- Interdisciplinary team care with development and maintenance of an appropriate plan of care.
- Short-term inpatient care arrangements.

Special coverage is also provided for:

- Periods of Crisis: Nursing care services are covered on a continuous basis for 24 hours a day during periods of crisis as necessary to maintain a member at home. Hospitalization is covered when the interdisciplinary team makes the determination that inpatient skilled nursing care is required at a level that cannot be provided in the home. Either homemaker or home health aide services or both may be covered on a 24-hour continuous basis during periods of crisis, but the care provided during these periods must be predominantly nursing care. A period of crisis is a period in which the member requires continuous care to achieve palliation or management of acute medical symptoms.
- Respite Care: Respite care is short-term inpatient care provided to the member only when necessary to relieve the family or other persons caring for the member. Coverage for respite care is limited to an occasional basis and to no more than five consecutive days at a time.

Hospital Facility Inpatient Services

Hospital facility inpatient services are covered without a copayment

Hospital inpatient services may include:

- A hospital room of two or more beds, private room only if medically necessary, ordered by your PCP and authorized by your medical group or MemorialCare Select Health Plan.
- Meals, services of a dietitian and general nursing care.
- Intensive care services.
- Operating and special treatment rooms.
- Surgical, anesthesia and oxygen supplies.
- Administration of blood and blood products.
- Ancillary services, including laboratory, pathology and radiology.
- Administrated drugs.
- Physical therapy, occupational therapy, speech therapy, radiation therapy, chemotherapy and hemodialysis.

Hospital Facility Outpatient Services

Hospital facility outpatient services are covered without a copayment in a hospital or surgery center and include:

- Emergency room use, supplies, other services drugs and medicines, including oxygen.
- Outpatient surgery.
- Upper and lower gastrointestinal (GI) endoscopy, cataract surgery, and spinal injection.
- X-ray and laboratory tests.
- Other outpatient hospital services and supplies, including physical therapy, occupational therapy, or speech therapy.
- Radiation therapy.
- Hemodialysis treatment.

Infusion Therapy

Infusion therapy refers to the therapeutic administration of drugs or the prepared or compounded substances administered intravenously and is covered without a copayment. The infusions must be administered in the member's home, in a physician's office or in an institution, such as a board and care, custodial care, assisted living facility or infusion center, that is not a hospital or institution primarily engaged in providing skilled nursing services or rehabilitation services.

Maternity and Pregnancy Services

The medical services for an member are provided for pregnancy and maternity care without a copayment and include the following services:

- Prenatal and postnatal services, including but not limited to participating physician visits.
- Ambulatory care services (including ultrasounds, fetal non-stress tests).
- Laboratory services (including the California Department of Health Services' Expanded Alpha Fetoprotein (AFP) Program).
- Involuntary complications of pregnancy.
- Inpatient hospital care including labor and delivery.
- Abortions including Mifepristone taken in the doctor's office.
- Radiology services.
- Prenatal diagnosis of genetic disorders of a fetus in high-risk pregnancy cases.
- Prenatal and postnatal office visits.
- Inpatient hospital care is covered for no less than 48 hours following a normal vaginal delivery and 96 hours following a delivery by cesarean section.

Mental Health Services

Members have direct access to mental health services without obtaining a PCP referral. Covered mental health benefits must be obtained through Windstone Behavioral Health Inc. (Windstone). MemorialCare Select Health Plan is contracted with Windstone, a specialty Independent Practice Association, to provide you with Behavioral Health care services, including Mental Health and Substance Use Disorder Treatment Services.

If you or your dependent(s) are receiving Mental Health, Behavioral Health or Substance Use Disorder Services, including Severe Mental Illness (SMI), Serious Emotional Disturbance of a Child (SED), autism or pervasive developmental disorder from a school district or a regional center, MemorialCare Select Health Plan and Windstone will coordinate with the school district or regional center to provide case management of your treatment program.

These services do not include programs to stop smoking, or to help with nicotine or tobacco abuse.

You can get services for the medically necessary treatment of the following without a copayment:

Inpatient-Facility Based Care:

- Inpatient facility-based care for the treatment of Severe Mental Illness (SMI) of a member of any age and Serious Emotional Disturbance of a Child (SED). This includes both inpatient psychiatric hospitalization and residential treatment.
- Inpatient facility-based care for the treatment of substance abuse disorder including inpatient detoxification.
- Inpatient physician visits during a stay for the treatment of Severe Mental Illness (SMI) of a member of any age, Serious Emotional Disturbance of a Child (SED) or substance abuse disorder, including voluntary psychiatric inpatient services.
- You must get prior approval before receiving facility-based care**.**

Outpatient Facility-Based Care:

- Outpatient facility-based care for the treatment of Severe Mental Illness (SMI) of a member of any age and Serious Emotional Disturbance of a Child (SED). This includes coverage for partial hospitalization.
- Outpatient facility-based care for the treatment of substance abuse disorder is covered and includes day treatment programs and intensive outpatient programs.
- Office or home visits to a physician for outpatient psychotherapy or psychological testing for the treatment of Severe Mental Illness (SMI) of a member of any age, Serious Emotional Disturbance of a Child (SED) of a child or substance abuse disorder. This includes individual and group evaluation and treatment.

Pervasive Developmental Disorder or Autism:

- Behavioral Health Treatment for pervasive developmental disorder or autism. **You must get prior approval before receiving services.**

Substance Use Disorder:

- Substance use disorder services include: inpatient detoxification, individual and group evaluation treatment, individual and group chemical dependency counseling, day treatment programs, day intensive outpatient programs, and medication treatment for withdrawal.

How to access services

To access services through Windstone, please call Windstone's toll-free line at: **1-800-577-4701** whenever you need mental health services. All calls are confidential.

Outpatient Prescription Drugs

Outpatient prescription drugs are covered. You may obtain covered outpatient prescription drug benefits from any contracted retail or mail order pharmacies. Some prescription drugs are subject to restricted distribution by the United States Food and Drug Administration or require special handling, provider coordination, or patient education that can only be provided by a specific pharmacy.

Except for emergency services and out-of-area urgent care, outpatient prescription drugs that are not obtained from a participating pharmacy are not covered, and you will be responsible for payment. The amount paid will not count toward your deductible, if any, or out-of-pocket maximum. In addition, you will be responsible for payment of outpatient prescription drugs not obtained through your pharmacy benefits with your MemorialCare Select Health Plan Member ID card (for example, paid for by cash, with a coupon or discount card), and such payment will not count toward your deductible, if any, or out-of-pocket maximum. If you pay for outpatient prescription drugs not obtained through your pharmacy benefits, you are eligible to receive reimbursement from plan, and credit towards your deductible, if any, and out-of-pocket maximum, subject to the terms and conditions of this Member Handbook, in the following circumstances:

- The prescription drug obtained was medically necessary for the treatment of an emergency medical condition or urgent care condition.
- You received preauthorization from plan for the prescription drug, and the drug was obtained from a participating pharmacy.
- The prescription drug obtained is listed as covered on the drug formulary, was obtained from a participating pharmacy, and all applicable utilization management criteria (e.g., step therapy, quantity limits, etc.) were satisfied.

You will be reimbursed for your share of the cost minus your applicable cost share and up to the contracted rate with the participating pharmacy, if applicable.

If the retail price for your prescription drug is less than your cost share, you will only pay the retail price. If you pay the retail price, your payment will apply to the deductible, if any, and the out-of-pocket maximum limit in the same manner as if you had purchased the prescription drug by paying the cost share. This applies whether you purchase your prescription drug from a retail pharmacy or a mail order pharmacy. Your cost share for covered orally administered anticancer medications will not exceed $250 for an individual prescription of up to a 30-day supply. In addition, orally administered anticancer medications will not be subject to a deductible.

You or your doctor may request a partial fill of an oral, solid dosage form of a Schedule II prescription drug from a pharmacy. A partial fill is when you receive less than the full quantity prescribed by your doctor. A Schedule II drug is one that has a high potential for abuse, with use potentially leading to severe psychological or physical dependence. The plan will prorate your copayment for a partial fill; however, if the pharmacy charges you two or more copayment for subsequent partial fills of the same prescription, the plan will reimburse you for the excess copayment.

Finding a Contracted Pharmacy

Our pharmacy network includes major drugstore chains as well as a variety of independent pharmacies. You can find a participating pharmacy by calling Member Services or on our website at **memorialcareselecthealthplan.org** and search for a pharmacy that is convenient for you by using the "Pharmacy Locator" function on the "Member" page. Always

present your MemorialCare Select Health Plan Member ID card. Ask the pharmacy to inform you if something is not going to be covered.

Covered outpatient prescription medications

The drug formulary is categorized into drug tiers as described below. The MemorialCare Select Health Plan drug formulary identifies the drugs included on each tier. Your cost share may vary based on the drug tier.

Tier 1: Lowest copayment – Drugs offering the greatest value within a therapeutic class. Some of these are generic equivalents of brand name drugs.

Tier 2: Medium copayment – Drugs on this tier are generally more affordable brand-name drugs. Other drugs are on this tier because they are "preferred" within their therapeutic classes, based on clinical effectiveness.

Tier 3: Highest copayment – These are higher cost brand-name drugs. Some tier 3 drugs may have generics or equivalents in tier 1. In addition, some drugs on this tier may have been evaluated to be less cost-effective than equivalent drugs on lower tiers.

Tier 4: Tier 4 drugs are those that have higher cost sharing than tier 3 drugs. This tier includes non-preferred drugs that may be generic, single source brand name drugs, multi-source brand, or specialty drugs.

When a generic is available, the pharmacy is required to fill your prescription with the generic equivalent unless preauthorization is obtained, and the brand name drug is determined to be medically necessary. The Food and Drug Administration (FDA) applies rigorous standards for identity, strength, quality, purity and potency before approving a generic drug. Generics are required to have the same active ingredient, strength, dosage form, and route of administration as their brand-name equivalents.

Some drugs are commercially available as both a brand and a generic version. It is the policy of MemorialCare Select Health Plan that when a generic is available, MemorialCare Select Health Plan does not cover the corresponding brand-name drug. If a generic version of a drug is available, the brand version will not be listed and will require preauthorization. The plan requires the dispensing pharmacy to dispense the generic drug unless preauthorization for the brand is obtained. The amount of drug you may receive at any one time is limited to a 30-day supply or, if the treatment is for less than 30 days, for the medically necessary amount of the drug, unless the prescription is for a maintenance drug dispensed through mail order. This limitation does not apply to FDA-approved, self-administered hormonal contraceptives, which are available in a 12-month supply.

MemorialCare Select Health Plan Drug List

The MemorialCare Select Health Plan Health pharmacy drug List (also known as a Formulary) is developed to identify the safest and most effective drugs for members while attempting to maintain affordable pharmacy benefits. The drug formulary is updated regularly, based on input from the MemorialCare Select Health Plan Pharmacy & Therapeutics (P&T) Committee, which meets quarterly. The Committee Members are clinical pharmacists and actively practicing physicians of various medical specialties. In addition, the P&T Committee frequently consults with other medical experts to provide input to the Committee.

Updates to the drug list and drug usage guidelines are made as new clinical information and new drugs become available. To keep the drug formulary current, the P&T Committee evaluates clinical effectiveness, safety and overall value through:

- Medical and scientific publications,
- Relevant utilization experience; and
- Physician recommendations.

Some drugs are commercially available as both a brand name version and generic version. It is the policy of MemorialCare Select Health Plan that when a generic is available, MemorialCare Select Health Plan does not cover the corresponding brand-name drug. If a generic version is available, the brand version will not be listed and will require preauthorization. MemorialCare Select Health Plan requires the dispensing pharmacy to dispense the generic drug, unless preauthorization for the bran is obtained. If the brand-name drug is medically necessary and preauthorization is obtained from MemorialCare Select Health Plan, the member must pay the cost share for the corresponding tier. To obtain a copy of MemorialCare Select Health Plan's current drug list, please visit our website at **memorialcareselecthealthplan.org** or call Member Services.

Preauthorization Process

Drugs with the PA symbol next to the drug name in the drug list are subject to preauthorization. This means that your doctor must contact MemorialCare Select Health Plan to obtain advance approval for coverage of the drug. To request preauthorization, your doctor must fill out a preauthorization form including information to demonstrate medical necessity and submit it to MemorialCare Select Health Plan. MemorialCare Select Health Plan processes routine requests within 72 hours and urgent request within 24 hours of MemorialCare Select Health Plan's receipt of the information reasonably necessary and requested by MemorialCare Select Health Plan to make the determination. Information reasonably necessary to decide, includes information the plan has requested to make a determination, as appropriate and medically necessary for the nature of the member's condition. Urgent circumstances exist when a member is suffering from a health condition that may seriously jeopardize the member's life, health, or ability to regain maximum function Upon receiving your physician's request for preauthorization, MemorialCare Select Health Plan will evaluate the information submitted and make a determination based on established clinical criteria for the particular drug.

Step Therapy

Drugs with the ST symbol next to the drug name in the drug list are subject to step therapy. This means that a member must try an alternative prescription drug first that MemorialCare Select Health Plan determines will be clinically effective. There may be a situation where it may be medically necessary for a member to receive certain medications without first trying an alternative drug. In these instances, your provider may request preauthorization. The list of prescription drugs subject to step therapy is subject to change by MemorialCare Select Health Plan.

The criteria used for preauthorization and step therapy are developed and based on input from the MemorialCare Select Health Plan P&T Committee as well as physician specialist experts. Your physician may contact MemorialCare Select Health Plan to obtain the usage guidelines for specific drugs.

If you have moved from another insurance plan to MemorialCare Select Health Plan and are taking a drug that your previous insurer covered, MemorialCare Select Health Plan will not require you to follow step-therapy in order to obtain that drug. Your physician may need to submit a request to MemorialCare Select Health Plan in order to provide you with this continuity of coverage.

Quantity Limits

Drugs with the QL symbol next to the drug name in the drug list are subject to quantity limits. It is the policy of MemorialCare Select Health Plan to maintain effective drug utilization management procedures. Such procedures include quantity limits on prescription drugs. The plan ensures appropriate review when determining whether or not to authorize a quantity of drug that exceeds the quantity limit. Quantity limits exist when drugs are limited to a determined number of doses based on criteria including, but not limited to, safety, potential overdose hazard, abuse potential, or approximation of usual doses per month, not to exceed the FDA maximally approved dose. Your doctor may follow the preauthorization process when requesting an exception to the MemorialCare Select Health Plan quantity limit for a drug.

Generic Substitution

The Food and Drug Administration (FDA) applies rigorous standards for identity, strength, quality, purity and potency before approving a generic drug. Generics are required to have the same active ingredient, strength, dosage form, and route of administration as their brand-name equivalents. When a generic is available, the pharmacy is required to switch a brand name drug to the generic equivalent unless MemorialCare Select Health Plan has authorized the brand name drug due to medical necessity.

Specialty Pharmacy Program

Specialty medications are usually dispensed as injectable drugs, but may be available in other forms, such as a pill or inhalant. They are used to treat complex conditions. prescriptions for specified specialty pharmacy drugs are covered only when ordered through the specialty pharmacy program unless you are given an exception from the specialty drug program. The specialty pharmacy program will deliver your medication by mail or common carrier (you cannot pick up your medication). You may have to pay the full cost of a specialty pharmacy drug if it is not obtained from the specialty pharmacy program. Specialty drugs that must be obtained through the specialty pharmacy program are limited to 30-day supply for each fill.

Copayment

The following copayments apply to prescription drugs prescribed by participating providers and dispensed by a participating pharmacy and to prescription drugs prescribed and dispensed for emergency services or out-of-area urgent care.

Supply limits[3]: 30-day supply; 60-day supply for federally classified Schedule II attention deficit disorder drugs that require a triplicate prescription form but require a double copay; 6 tablets or units/30-day period for impotence and/or sexual dysfunction drugs (available only at retail pharmacies. 90-day supply for mail order.

Retail Pharmacy – For up to a 30-day supply on the formulary	*Copay*
Preventive immunizations administered by a retail Pharmacy	*$0*
Female oral contraceptives, generic and single source brand	*$0*
Tier 1 drugs (includes diabetic supplies)	*$15*
Tier 2 drugs	*$35*
Tier 3 drugs (includes compound drugs)	*$50*
Tier 4[1] drugs	*$50*
Mail Order[2] – For up to a 90-day supply on the formulary	Copay
Tier 1 drugs (includes diabetic supplies)	*$30*
Tier 2 drugs	*$70*
Tier 3 drug[4]	*$100*
Tier 4 drugs[1]	*$100*

Specialty Pharmacy Program	Copay
*Certain specialty pharmacy drugs must be obtained through the specialty pharmacy program and are limited to a 30-day supply. Please contact Member Services to see if your drug is on the specialty pharmacy program or you can get a list of drugs required to be dispensed by our specialty pharmacy program at **memorialcareselecthealthplan.org**. Click on the pharmacy link and then click on the Specialty Pharmacy Program for details.*	*Applicable copay applies*

Non-Network Pharmacies	*Copay*
Compound drugs & certain specialty Pharmacy drugs are not covered.	*Member pays the above retail Pharmacy copay plus 50% of the remaining prescription drug maximum allowed amount & costs in excess of the prescription drug maximum allowed amount*

[1]Classified specialty drugs must be obtained through our Specialty Pharmacy Program and are subject to the terms of the program
[2]Walk-up service is available at MemorialCare Home Pharmacy
[3]Supply limits for certain drugs may be different.
[4]Compound drugs are not covered through mail order; only covered through certain retail Network pharmacies.

Mail Order

Mail order is a convenient cost-effective way to obtain maintenance drugs. Maintenance drugs are those prescribed on a regular, ongoing basis to maintain health. Not all drugs are available through this program.

To use this service, complete the home delivery form. You can obtain the form by calling Member Services or by going to our web site at **memorialcareselecthealthplan.org**.

The Prescription Drug Benefit covers the following:

- Preventive flu and pneumonia vaccines administered by a retail participating pharmacy
- Outpatient prescription drugs and medications which the law restricts to sale by prescription. Formulas prescribed by a physician for the treatment of phenylketonuria
- Insulin
- Syringes when dispensed for use with insulin and other self-injectable drugs or medications
- All FDA-approved contraceptives for women, including oral contraceptives; contraceptive diaphragms and over-the-counter contraceptives prescribed by a doctor
- Injectable drugs which are self-administered by the subcutaneous route (under the skin) by the patient or family. Drugs that have Food and Drug Administration (FDA) labeling for self-administration
- All compound prescription drugs that contain at least one covered prescription ingredient.

- Diabetic supplies (i.e., test strips and lancets)
- Prescription drugs for treatment of impotence and/or sexual dysfunction are limited to organic (non-psychological) causes.
- Inhaler spacers and peak flow meters for the treatment of pediatric asthma. These items are subject to the copayment for tier 2 or tier 3 copayment.
- Certain over-the-counter drugs approved by the Pharmacy and Therapeutics Process to be included in the prescription drug formulary. Prescription drug copayment are not applied toward the annual out-of-pocket maximums.

Outpatient Rehabilitation Therapy Services

Outpatient rehabilitation services, including occupational, physical and speech therapy, are covered without a copayment. Therapy may be provided in a medical office or other appropriate outpatient setting, Hospital, Skilled Nursing Facility, or home. The goal of rehabilitation therapy is to assist members to become as independent as possible, using appropriate adaptations if needed to achieve basic activities of daily living including bathing, dressing, feeding, toileting and transferring (e.g., moving from the bed to a chair).

Speech therapy is covered when there is a delay in obtaining services through the school system and when additional services are determined to be medically necessary, i.e., where injury, illness or congenital defect is documented (e.g., hearing loss, chronic otitis media, brain tumor, cerebral palsy, cleft palate, head trauma).

Phenylketonuria (PKU)

The diagnosis and treatment of phenylketonuria are covered as follows:

- medically necessary formulas and special food products prescribed by a contracted provider, to the extent that the cost of these items exceeds the cost of a normal diet.
- Consultation with a doctor who specializes in the treatment of metabolic diseases.

Preventive Care Services

Preventive care services include outpatient services, supplies and office visits. Screenings and other services are covered as preventive care services when you have no current symptoms or prior history of a medical condition associated with that screening or service. Preventive care services are provided to members without a copayment; however, reasonable medical management techniques may be used to determine the frequency, method, treatment or setting for a recommended preventive service, to the extent not specified in the recommendation or guideline regarding that preventive service.

- Well child physical examinations (including vision and hearing screening in the PCP's office), all periodic immunizations, related laboratory services, and screening for blood lead levels in children of any age who are at risk for lead poisoning, as determined by a contracted provider and surgeon, if the screening is prescribed by a MemorialCare Select Health Plan health care provider, in accordance with the current recommendations from the American Academy of Pediatrics, U.S. Preventive Services Task Force, Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, the Health Resources and Services Administration and the American Academy of Family Physicians.
- Well adult physical examinations, episodic immunizations and related laboratory services in accordance with the current recommendations from the U.S. Preventive Services Task Force, Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, the Health Resources and Services Administration and MemorialCare Select Health Plan medical policies.
- Routine gynecological examinations, mammograms and cervical cancer screening tests, in accordance with the guidelines of the American College of Obstetrics and Gynecology and the Health Resources and Services Administration. Members may directly access OB/GYN care within their medical group without a referral from their PCP.
- Women's contraceptives, sterilization procedures, and counseling. This includes injectable contraceptives and patches. Contraceptive devices such as diaphragms, intrauterine devices (IUDs), and implants are also covered.

This also includes a 12-month supply of FDA-approved hormonal contraceptives dispensed at one time.

- Brest feeding support, supplies and counseling ordered by your PCP or medical group. One breast pump will be covered per calendar year under this benefit.
- Gestational diabetes screening.
- All generally accepted cancer screening tests, as determined by the United States Preventive Services Task Force and approved by the federal Food and Drug Administration, including the conventional Pap test, any cervical cancer screening test and human papillomavirus screening test and prostate cancer screening.
- Other preventive diagnostic tests that may be delivered in an outpatient surgical facility, including but not limited to colonoscopy and endoscopy.
- HIV testing regardless of whether the testing is related to a primary diagnosis.
- Screening for tobacco use.
- For those who use tobacco products: All FDA-approved tobacco cessation medications (including over-the-counter medications) when prescribed by a health care provider, without preauthorization.
- Vision or hearing screenings are covered when ordered by your PCP to determine if it is medically necessary for you to have a complete vision exam by a vision specialist. If authorized by your PCP, this may include an exam with diagnosis, a treatment program and refractions. Hearing screenings include tests to diagnose and correct hearing.
- Health education programs provided by your PCP or medical group.

Professional Services

The following professional services (provided by a contracted provider or other licensed health professional) are covered without a copayment.

- Doctor office visits for consultation, treatment, diagnostic testing, etc.
- Surgery and assistant surgery.
- Inpatient hospital and Skilled Nursing Facility visits.
- Professional office visits.
- Doctor visits in the member's home when the member is too ill or disabled to be seen during regular office hours.
- Anesthesia administered by an anesthetist or anesthesiologist.
- Diagnostic radiology testing.
- Diagnostic laboratory testing.
- Radiation therapy and chemotherapy.
- Dialysis treatment.
- Supplies and drugs approved by the Food and Drug Administration and provided by and used at the doctor office or facility.

Prosthetic and Orthotic Services

Prosthetic and certain orthotic services are covered without a copayment if all the following requirements are met:

- The device is in general use, intended for repeated use and primarily and customarily used for medical purposes; and
- The device is the standard device that adequately meets your medical needs.

These services include corrective appliances, artificial aids and therapeutic devices, including fitting, repair, replacement and maintenance, as well as devices used to support, align, prevent or correct deformities of a movable part of the body (orthotics); devices used to substitute for missing body parts (prosthesis); devices implanted surgically (such as cochlear implants) and prosthetic devices relating to laryngectomy or mastectomy.

The following external prosthetic and orthotic devices are covered:

- Surgical implants
- Artificial limbs or eyes.
- The first pair of contact lenses or eyeglasses when needed after a covered and medically necessary eye surgery.
- Breast prostheses following a mastectomy.
- Prosthetic devices to restore a method of speaking when required because of a laryngectomy.
- Therapeutic shoes and inserts designed to treat foot complications due to diabetes.
- Orthopedic footwear used as an integral part of a brace; shoe inserts that are custom molded to the patient; orthotic devices.

- Colostomy supplies.

Radiation Therapy

Radiation therapy (standard and complex) is covered without a copayment.

Radiology Services

Radiology services provided in the doctor's office, outpatient facility, or inpatient hospital facility are covered without a copayment. Advanced radiology services are covered for the diagnosis and ongoing medical management of an illness or injury. Examples of advanced radiology procedures include, but are not limited to CT scan, PET scan, magnetic resonance imaging (MRI), magnetic resonance angiography (MRA) and nuclear scans.

Reconstructive Surgical Services

Plastic and reconstructive surgical services are covered only as described below without a copayment.

- Reconstructive surgical services following a mastectomy or lymph node dissection are covered. The length of a hospital stays associated with a mastectomy or lymph node dissection is determined by the attending physician and surgeon in consultation with the patient, consistent with sound clinical principles and processes. There is no preauthorization required in determining the length of hospital stay following these procedures. Members who elect to have breast reconstruction after a mastectomy are covered for all complications of the mastectomy and reconstructive surgery, prostheses for, and reconstruction of, the affected breast, and reconstructive surgery on the other breast as may be needed to produce a symmetrical appearance.
- Reconstructive surgical services, performed on abnormal structures of the body caused by congenital defects, developmental anomalies, trauma, infection, tumors, disease or medically necessary dental or orthodontic services that are an integral part of reconstructive surgery for cleft palate procedures are covered when performed to improve function or create a normal appearance, to the extent possible.
- Medically necessary dental or orthodontic services that are an integral part of reconstructive surgery for cleft palate procedures. "Cleft palate" means a condition that may include cleft palate, cleft lip, or other craniofacial anomalies associated with cleft palate.

Skilled Nursing Facility Services

Skilled Nursing Facility services are covered for up to a maximum of 100 days per benefit period in a semi-private room (unless a private room is medically necessary). Benefits for skilled nursing care are those services prescribed by a contracted provider and provided in a qualified licensed Skilled Nursing Facility. A benefit period begins the day you are admitted to a hospital or Skilled Nursing Facility at a skilled level of care. The benefit period ends on the date you have not been an inpatient in a hospital or Skilled Nursing Facility, receiving a skilled level of care, for 60 days in a row. If you go into a hospital or a Skilled Nursing Facility after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods.

Covered Benefits include:

- Physician and skilled nursing on a 24-hour basis.
- Room and board.
- Imaging and laboratory procedures.
- Respiratory therapy.
- Short term physical, occupational and speech therapy.
- Prescribed drugs and medications.
- Medical supplies, appliances and equipment normally furnished by the Skilled Nursing Facility.
- Behavioral Health Treatment for pervasive developmental disorder or autism.
- Blood, blood products and their administration.
- Medical social services.

Sterilization Services

Voluntary sterilization services are covered without a copayment. Reversal of sterilization services is no covered.

Termination of Pregnancy

Interruption of pregnancy (abortion), including Mifepristone taken in the doctor's office is covered without a copayment.

Transgender Surgery Benefit

MemorialCare Select Health Plan provides benefit for many of the services provided to members for transgender surgery (also known as sex reassignment surgery). Not all services are provided, and some are only eligible to a limited extent. Transgender surgery must be performed at a facility designated and approved by MemorialCare Select Health Plan for the type of transgender surgery requested and must be authorized by MemorialCare Select Health Plan prior to being performed. Services are covered without a copayment.

Urgent Care

urgent care means those services performed, inside or outside the plan's service area, that are medically required within a short timeframe, usually within 24 hours, in order to prevent a serious deterioration of a member's health due to an illness or injury or complication of an existing condition, including pregnancy, for which treatment cannot be delayed.

Urgently needed services are covered without a copayment and include maternity services necessary to prevent serious deterioration of the health of the member or the member's fetus, based on the member's reasonable belief that she has a pregnancy-related condition for which treatment cannot be delayed until the member returns to the plan's service area. If you are outside the plan's service area, urgent care do not require preauthorization from your PCP. However, if you are in the plan's service area and access urgent care that are not authorized, then those services will not be paid for by MemorialCare Select Health Plan and you will be responsible to pay for the care.

Vision Services

Vision screening includes vision check by your PCP to see if it medically necessary for you to have a complete vision exam by a vision specialist. If authorized by your PCP, this may include an exam with diagnosis, a treatment program and refractions.

WHAT'S NOT COVERED

Exclusions and Limitations

The services and supplies listed in this section are exclusions (not benefits) or are covered with limitations (benefits only in specific instances) in addition to those already described in this Member Handbook. These exclusions or limitations do not apply to medically necessary services to treat Severe Mental Illness (SMI) or Serious Emotional Disturbance of a Child (SED).

Exclusions include any services or supplies that are:

- Not medically necessary,
- Not specifically described as covered in this Member Handbook or supplemental benefit materials,
- In excess of the limits described in this Member Handbook,
- Specified as excluded in this Member Handbook,
- Not provided by participating provider (except for emergency services or out-of-area urgent care),
- Not prescribed by a participating physician and, if required, authorized in advance by your PCP, your medical group or the plan (Note: emergency services do not require preauthorization);
- Part of a treatment plan for non-covered benefits,
- Received prior to the member's effective date of coverage or after the member's termination from coverage under this plan; or
- Any services or supplies covered under any worker's compensation benefit plan.

Air Conditioners

Air purifiers, air conditioners, or humidifiers.

Blood

Benefits are not provided for the collection, processing and storage or self-donated blood unless it is specifically collected for a planned and covered surgical procedure.

Braces and Other Appliances or Services

For straightening the teeth (orthodontic services) except as described in the Dental Care benefit.

Commercial Weight Loss Programs

Weight loss programs, whether they are pursued under medical or physician supervision, unless specifically listed as covered by MemorialCare Select Health Plan. This exclusion includes, but is not limited to, commercial weight loss programs (Weight Watchers, Jenny Craig, LA Weight Loss, etc.) and fasting programs. This exclusion does not apply to medically necessary treatments for morbid obesity or for treatment of anorexia nervosa or bulimia nervosa.

Consultations

Given using telephone, facsimile machines, or electronic mail.

Cosmetic Surgery

Surgery or other services performed to alter or reshape normal structures of the body to improve appearance. This exclusion does not apply to medically necessary reconstructive surgery. Please see the reconstructive surgery under the "What's Covered" section for further details.

Custodial Care

Custodial care, domiciliary care, or rest cures, for which facilities of a general acute care hospital are not medically required, are not covered. Custodial care is care that does not require the regular services of trained medical or health professionals, including but not limited to, help in walking, getting in and out of bed, bathing, dressing, preparation and feeding of special diets, and supervision of medications that are ordinarily self-administered.

Dental Services or Supplies

The following dental services are not benefits. Dental services are defined as all services required for treatment of the teeth or gums.

- Oral exams, X-rays, routine fluoride treatment, plaque removal and extractions.
- Treatment of tooth decay, periodontal disease, dental cysts, dental abscess, granuloma, or inflamed tissue.
- Crowns, fillings, inlays or on lays, bridgework, dentures, caps, restorative or mechanical devices applied to the teeth and orthodontic procedures.
- Restorative or mechanical devices, dental splints or orthotics (whether custom fit or not) or other dental appliances, and related surgeries to treat dental conditions, except as specifically described under benefits.
- Dental implants (materials implanted into or on bone or soft tissue) and any surgery to prepare the jaw for implants or other dental services associated with surgery on the jawbone.

These exclusions do not apply to the following:

- Services which are required to be covered by law;
- Services specified as covered in this Member Handbook;
- Dental services to prepare the mouth for radiation therapy to treat head and/or neck cancer

Educational or Academic Services

MemorialCare Select Health Plan does not cover:

- Educational or academic counseling, remediation or other services that are designated to increase academic knowledge and skills.
- Educational or academic counseling, remediation, or other services that are designated to increase socialization, adaptive or communication skills.
- Academic or educational testing.
- Teaching skills for employment or vocational purposes.
- Teaching art, dance, horseback riding, music, play, swimming, or any similar activities.
- Teaching manners and etiquette or any other social skills.
- Teaching and support services to develop planning and organizational skills such as daily activity planning and project or task planning.

This exclusion does not apply to the medically necessary treatment of pervasive developmental disorder or autism.

Experimental or Investigational Services

Medical, surgical or other procedures, services, products, drugs or devices (including implants) are not covered if either:

- Experimental or investigational, or not recognized in accordance with generally accepted standards as being safe and effective for the use in question; or
- Outmoded or not efficacious, such as those defined by the federal Medicare and state Medicaid programs, or drugs or devices that are not approved by the Food and Drug Administration.

If a service is denied because it is deemed to be an investigational or Experimental therapy, a terminally ill member may be entitled to request an Independent Medical Review (IMR) of this coverage decision.

Family Planning Services

The following services are not covered benefits:

- Reversal of voluntary sterilization
- Nonprescription contraceptive supplies.

Food and Dietary Supplements

Nutritional and/or dietary supplements and counseling, except as provided by MemorialCare Select Health Plan or as required by law. This exclusion includes, but in not limited to, those nutritional formulas and dietary supplements that can be purchased over the counter, which by law do not require either a written prescription or dispensing by a licensed pharmacist.

Government Services or Treatment

Any services that a member receives from a local, state or federal governmental agency or by a public-school system or school district, are not covered, except when coverage under this health plan is expressly required by federal or state law.

Health Club Membership

Health/Fitness Club Memberships, exercise, charges from a physical fitness instructor or personal trainer, or any other charges for activities, equipment, or facilities used for developing or maintaining physical fitness, even if ordered by a physician. This exclusion also applies to health spas.

Infertility Services

The following services are not covered benefits:

- Infertility services, including diagnosis and treatment of the member's underlying infertility condition. infertility is defined as (1) the inability to conceive a pregnancy or to carry a pregnancy to a live birth after a year or more of regular sexual intercourse without contraception, or (2) the presence of a demonstrated condition recognized by a physician as a cause of infertility. A woman without a male partner who is unable to conceive may be considered infertile if she is unable to conceive or produce conception after at least 12 cycles of donor insemination; these 12 cycles are not covered by the plan.
- Assisted Reproductive Technologies (ART) procedures, otherwise known as conception by artificial means, including but not limited to artificial insemination, in vitro fertilization (IVF), gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), multi-cell embryo transfer (TET), intracytoplasmic sperm injections (ICSI), blastocyst transfer, assisted hatching and any other procedures that may be employed to bring about conception without sexual intercourse.
- Any service, procedure, or process which prepares the member for no covered ART procedures.
- Collection, preservation, or purchase of sperm, ova, or embryos.
- Reversal of voluntary sterilization.

Non-Licensed Providers

Treatment or services rendered by non-licensed health care providers and treatment or services for which the provider of services is not required to be licensed. This includes treatment of services from a non-licensed provider under the supervision of a licensed physician, except as specifically provided or arranged by MemorialCare Select Health Plan. This exclusion does not apply to the medically necessary treatment of pervasive developmental disorder or autism.

Non-Prescription Drugs

Non-prescription drugs, over-the-counter drugs or medicines.

Non-Preventive Physical or Psychological Examinations

Physical or psychological examinations required for court hearing, travel, premarital, preadoption, employment, school, cap, sports or other non-preventive health reasons are not covered. Court-ordered or other statutorily required psychological evaluation, testing and treatment are not covered unless medically necessary and authorized by the plan.

Orthopedic Shoes

Orthopedic shoes and shoe inserts. This exclusion does not apply to orthopedic footwear used as an integral part of a brace, shoe inserts that are custom molded to the patient, or therapeutic shoes and inserts designated to treat foot

complications due to diabetes, as specifically stated in "Prosthetic Devices" under the section "What's Covered".

Private Contracts

Services or supplies provided pursuant to a private contract between the member and a provider, for which reimbursement under the Medicare program is prohibited, as specified in Section 1802 (42 U.S.C.§ 1395a) of Title XVIII of the Social Security Act.

Private-Duty Nursing Services

Private-duty nursing services are not covered. Private-duty nursing services encompass nursing services for recipients who require more individual and continuous assistance with activities of daily living than is available from a visiting nurse or routinely provided by the nursing staff of a Hospital or Skilled Nursing Facility.

Scalp Hair Prostheses

Scalp hair prostheses, including wigs or any form of hair replacement.

Sexual Dysfunction Treatment

Treatment of sexual dysfunction or inadequacy is not covered, including but not limited to medicines/drugs, procedures, supplies and penile implants/prosthesis.

Sterilization Services

Reversal of sterilization services is not covered.

Vision Services

The following services are not covered benefits (unless, specifically listed as covered in this Member Handbook):

- Eye surgery for the sole purpose of correcting refractive error (e.g., radial keratotomy).
- Orthoptic services (a technique of eye exercises designed to correct the visual axes of eyes not properly coordinated for binocular vision.
- Eyeglasses or contact lenses.
- Routine vision examinations.
- Eye refractions for the fitting of glasses.

LOSS OF COVERAGE

The group subscriber agreement between MemorialCare Select Health Plan and your employer is renewed annually. The group subscriber agreement may be amended, canceled or discontinued at any time and without your consent, either by your employer or by the plan. Your employer will notify you if the agreement is terminated or amended. Your employer will also notify you if your contribution to premiums changes. If the group subscriber agreement is canceled or discontinued, you will not be able to renew or reinstate the group coverage.

In the event of an amendment to the group subscriber agreement that affects any copayment, benefits, services, exclusions or limitations described in this Member Handbook, you will be given a new Member Handbook or amendments to this Member Handbook updating you on the change(s). The services and covered benefits to which you may be entitled will depend on the terms of your coverage in effect at the time services are rendered.

Termination by the Employee

You may terminate your coverage and/or your dependent (s) coverage by contacting your employer . Your coverage will end at 11:59 p.m. on the last day for which premiums received by MemorialCare Select Health Plan from your employer . If you choose to terminate your coverage and/or your dependent (s) coverage, you will not be able to enroll in a new benefit plan until the next open enrollment period, unless you qualify for a special enrollment period.

Loss of Subscriber and Dependent Eligibility

Coverage for you and your dependent (s) will end at 11:59 p.m. on the earliest date of the following events triggering loss of eligibility:

- When the group subscriber agreement between your employer and the plan is terminated. If you are in the hospital on the effective date of termination, you will be covered for the remainder of the hospital stay if you continue to pay all applicable premiums and copayment, unless you become covered earlier under other group or COBRA coverage.
- When your employment is terminated. Coverage will end on the last day of the month in which your employment is terminated, unless otherwise determined by your employer. You may be eligible to continue coverage through COBRA (your employer will advise you if you are eligible), or Cal-COBRA (the plan will advise you if you are eligible). Members of the United States Military Reserve and National Guard who terminate coverage as a result of being ordered to active duty may have their coverage reinstated without waiting periods or exclusion of coverage for preexisting conditions. Please contact Member Services for information on how to apply for reinstatement of coverage following active duty as a reservist.

- When your employer otherwise determines that you no longer qualify for health coverage under the terms of your employment. Coverage will end on the last day of the month in which your eligibility for health coverage ends, unless otherwise determined by your employer. You may be eligible to continue coverage through COBRA (your employer will advise you if you are eligible) or Cal-COBRA (the plan will advise you if you are eligible).
- When your employer terminates coverage with the plan. Coverage will end on the last day of the month in which your employer terminated.
- When you no longer meet any of the other eligibility requirements under your plan contract. Coverage will end on the last day of the month in which your eligibility ended.

Coverage for your dependent (s) will end when a dependent (s) no longer meets the eligibility requirements, including divorce, no longer living or working inside of the service area or termination of total disability status. Coverage will end on the last day of the month in which eligibility ends. The dependent (s) may be eligible to elect COBRA or Cal-COBRA coverage.

Fraud or Intentional Misrepresentation of Material Fact

Coverage for you or your dependent(s) will end if either you or your dependent(s) commit(s) an act of fraud or intentional misrepresentation of a material fact to circumvent state or federal laws or the policies of the plan, such as allowing someone else to use your Member ID card, providing materially incomplete or incorrect enrollment or required updated information deliberately, including but not limited to incomplete or incorrect information regarding date of hire, date of birth, relationship to employee or dependent, place of residence, other group health insurance or workers' compensation benefits, or disability status.

In this case, MemorialCare Select Health Plan will send you a written notice 30 days before your coverage will end or 30 days prior to the effective date of any rescission. The notice will include information about your right to appeal the decision. Your
coverage may end retroactively to the date the fraud or misrepresentation occurred only if MemorialCare Select Health Plan identifies the act within your first 24 months of coverage. This type of retroactive termination is called a rescission.

Loss of Coverage for Nonpayment of Premiums

If the group subscriber agreement is cancelled because the employer failed to pay the required premium when due, then coverage for you and your dependent (s) will end at the end of your employer's 30-day grace period, effective on the 31st day after the notice of start of grace period is sent to your employer. The grace period begins on the day the notice of start of grace period is dated. If any required premium is not paid by your employer on or before the due date, it must be paid and received by MemorialCare Select Health Plan during the grace period.

MemorialCare Select Health Plan will mail your employer a notice of start of grace period at least 30 calendar days before any cancellation of coverage. This notice of start of grace period will provide your employer with information regarding the consequences of failure to pay the premiums due within 30 days of the date the notice was mailed.

If payment is not received from your employer within 30 days of the date the notice of start of grace period is mailed, MemorialCare Select Health Plan will cancel the group subscriber agreement and mail you and your employer a notice of end of coverage, which will provide the following information:

- That the group subscriber agreement has been cancelled for nonpayment of premiums.
- The specific date and time when the group coverage ended.
- MemorialCare Select Health Plan's telephone number to call to obtain additional information, including whether your employer obtained reinstatement of the group subscriber agreement.
- An explanation of your options to purchase continuation coverage, including coverage effective as of the termination date, so you can avoid a break in coverage, and the deadline by which you must elect to purchase such continuation coverage (63 calendar days after the date MemorialCare Select Health Plan mails you the a notice of end of coverage).
- Information about other health care coverage options and your potential eligibility for reduced-cost coverage through Covered California or no-cost coverage through Medi-Cal (a program that offers free or low-cost health

coverage for children and adults with limited income and resources).

- Your rights under the law, including your right to submit a grievance to MemorialCare Select Health Plan or to the California Department of Managed Health Care if you believe your benefit plan coverage has been improperly cancelled.

What to Do if You Believe Your Coverage Was Terminated Unfairly

MemorialCare Select Health Plan will never terminate your coverage because of your health status or your need for health services. If you believe that your coverage or your dependent's coverage was, or will be, cancelled, rescinded, or not renewed due to health status or requirements for health care services, you have a right to submit a grievance to MemorialCare Select Health Plan or to the Director of the Department of Managed Health Care, pursuant to Section 1365(b) of the California Health and Safety Code.

For information on submitting a grievance to MemorialCare Select Health Plan, see the section titled "Reporting and Solving Problems" in this Member Handbook. MemorialCare Select Health Plan will resolve your grievance regarding an improper cancellation, rescission or nonrenewal of coverage, or provide you with a pending status, within three calendar days of receiving your grievance.

If you do not receive a response from MemorialCare Select Health Plan within three calendar days, or if you are not satisfied in any way with the response, you may submit a grievance to the Department of Managed Health Care online at:

WWW.HEALTHHELP.CA.GOV

By Mail:

Help Center
Department of Managed Health Care
980 Ninth Street, Suite 500
Sacramento, California 95814-2725

You may contact the Department of Managed Health Care for more information on filing a grievance at:

- PHONE: 1-888-466-2219
- TDD: 1-877-688-9891
- FAX: 1-916-255-524

CONTINUATION OF COVERAGE

Total Disability

If the group subscriber agreement between MemorialCare Select Health Plan and your employer terminates while you or your dependent are totally disabled, benefits for the treatment of the disability may be temporarily extended. Application for extension of coverage and evidence of the total disability is required to be provided to the plan within 90 calendar days of termination of the group subscriber agreement; however, you or your dependent, as applicable, are covered during this 90-day period.

You are required to furnish the plan with evidence of the total disability upon request. The plan has sole authority for the approval of the extension of and will continue for the treatment of the disability until the earlier of:

- When the member is no longer totally disabled.
- When the member becomes covered under any other group health insurance that covers the disability.
- A maximum of 12 consecutive months from the date coverage would have normally terminated.

COBRA AND Cal-COBRA

If you lose coverage due to one of the qualifying events listed below and you were enrolled in MemorialCare Select Health Plan at the time of the loss of coverage, you are considered a qualified beneficiary entitled to enroll in Cal-COBRA continuation coverage.

1. As an employee, you may be eligible for Cal-COBRA continuation coverage if you would lose group health plan coverage due to the termination of your employment (for reasons other than gross misconduct) or due to a reduction in your work hours.

2. As a member who is the dependent of an employee, you may be eligible for Cal-COBRA continuation coverage if you would lose group health plan coverage under MemorialCare Select Health Plan for any of the following reasons.

- Death of the employee.
- Termination of the employee's employment (for reasons other than gross misconduct) or a reduction in the work hours.
- Divorce or legal separation from the employee.
- Medicare entitlement.
- Loss of dependent status.

3. A member who has exhausted COBRA continuation coverage may be eligible for Cal-COBRA continuation coverage if your COBRA coverage was less than 36 months and your COBRA coverage began on or after January 1, 2003. COBRA and Cal-COBRA continuation coverage is limited to a combined maximum of 36 months.

After the employer notifies the plan of a qualifying event, the plan will, within 14 calendar days, provide all of the information that is needed to apply for Cal-COBRA continuation coverage, including information on benefits and premiums, and an enrollment application.

COBRA

If your employer has 20 or more employees, and you or your dependents would otherwise lose coverage for benefits, you may be able to continue uninterrupted coverage through the Consolidated Omnibus Budget Reconciliation Act of 1985 and its amendments (referred to as COBRA), subject to your continuing eligibility and your payment of premiums. COBRA continuation coverage is a continuation of group health plan coverage when coverage would otherwise end because of a "qualifying event."

After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse and your dependent could become qualified beneficiaries if coverage under the group plan is lost because of the qualifying event. Please contact your employer for details about whether you qualify, how to elect COBRA coverage, how much you must pay for COBRA coverage and where to send your COBRA premiums. Coverage will be effective on the first day following the loss of coverage due to the qualifying event. No break in coverage is permitted.

COBRA continuation coverage consists of the coverage under the company health plan that you and other qualified beneficiaries had immediately before your coverage terminated. If your employer or MemorialCare Select Health Plan changes benefits, premiums, etc., your continuation coverage will change accordingly. If the contract between the employer and MemorialCare Select Health Plan terminates while you are still eligible for COBRA, you may elect to continue COBRA coverage under the employer's subsequent group health plan.

If you are no longer eligible for COBRA continuation coverage and your COBRA coverage was less than 36 months, you may be eligible for Cal-COBRA Continuation Coverage as described below.

How to Elect Cal-COBRA Coverage

If your employer consists of two to 19 employees and you or your dependents would lose coverage under MemorialCare Select Health Plan Health Plan due to a "qualifying event" , you may be able to continue your company health coverage upon arrangement with MemorialCare Select Health Plan through the California Continuation Benefits Replacement Act (referred to as Cal-COBRA), subject to your continuing eligibility and your payment of monthly premiums to MemorialCare Select Health Plan.

Continuation coverage consists of the coverage under the company health plan that you and other qualified beneficiaries had immediately before your coverage terminated. If your employer or MemorialCare Select Health Plan changes benefits, premiums, etc., your continuation coverage will change accordingly. If the contract between the employer and MemorialCare Select Health Plan terminates while you are still eligible for Cal-COBRA, you may elect to continue Cal-COBRA coverage under the employer's subsequent group health plan. If you fail to comply with all the requirements of the new plan (including requirements pertaining to enrollment and premiums payments) within 30 days of receiving notice of termination from the plan, Cal-COBRA coverage will terminate. If you move out of the plan's service area, Cal-COBRA coverage will terminate.

If a qualifying event occurs, it is the member's responsibility to notify his/her employer within 60 days of the date of the qualifying event. The notification must be in writing and delivered to the employer by first class mail or other reliable means of delivery. If you do not notify your employer within 60 days of the date of the qualifying event, you are not eligible for coverage under Cal-COBRA.

If you wish to elect Cal-COBRA coverage, you must complete and return the enrollment application to MemorialCare Select Health Plan. This must be done within 60 calendar days after you receive the enrollment application or 60 calendar days after your company health coverage terminates, whichever is later. Failure to have the enrollment application postmarked on or before the end of the 60-day period will result in the loss of your right to continuation coverage under Cal-COBRA. Coverage will be effective on the first day following the loss of coverage due to the qualifying event. No break in coverage is permitted.

Adding Dependents to Cal-COBRA

The qualified beneficiary who elects coverage can enroll a spouse or dependents at a later date when one of the following events occurs:

- Open enrollment.
- Loss of other coverage.
- Marriage.
- Birth of a dependent.
- Adoption.

The new dependent will not be considered a qualified beneficiary and will lose coverage when the qualified beneficiary is no longer enrolled in MemorialCare Select Health Plan.

Premiums for Cal-COBRA Coverage

The member is responsible for payment to MemorialCare Select Health Plan of the entire monthly premium for continuation coverage under Cal-COBRA. The initial premium payment must be made on or before the 45th calendar day after election of Cal-COBRA coverage and must be delivered by first-class mail, certified mail or other reliable means of delivery to the plan. The premium rate you pay will not be more than 110 percent of the rate charged by the plan for an employee covered under the employer. The premium rate is subject to change upon your previous employer's annual renewal.

If the full premium payment (including all premiums due from the time you first became eligible) is not made within the 45-day period, Cal-COBRA coverage will be cancelled. Subsequent premium payments are due on the premium due date listed on your monthly invoice for that month's Cal-COBRA coverage. If any premium payment is not made within 30 calendar days of the date it is due, Cal-COBRA coverage will be cancelled. No claims for medical services received under continuation coverage are paid until the premium for the month of coverage is paid. If, for any reason, a member receives medical benefits under the plan during a month for which the premium was not paid, the benefits received are not covered by the plan and the member will be required to pay the provider of service directly.

If you have any questions regarding continuation coverage under Cal-COBRA, please call Member Services.

GLOSSARY

Because we know health plan information can be confusing, we underlined these words throughout this Member Handbook to let you know that you can find their meanings in this glossary.

Active Labor means labor at a time at which either of the following would occur:

- There is inadequate time to effect safe transfer to another hospital prior to delivery; or
- A transfer may pose a threat to the health and safety of the patient or the unborn child.

Activities of Daily Living (ADLs) means the basic tasks of everyday life, such as eating, bathing, dressing, toileting and transferring (e.g., moving from the bed to a chair).

Acute Condition means a medical condition that involves a sudden onset of symptoms due to an illness, injury or other medical problem that requires prompt medical attention and that has a limited duration.

Appeal means a request made to the plan to ask that it solve a problem or change a decision because you are not satisfied. An appeal is sometimes called a complaint or a grievance.

Behavioral Health Treatment means professional services and treatment programs, including applied behavior analysis and evidence-based behavior intervention programs, that develop or restore, to the maximum extent practicable, the functioning of an individual with pervasive developmental disorder or autism and that meet all of the following criteria:

1. The treatment is prescribed by a licensed participating provider;
2. The treatment is provided by a qualified autism service provider, professional or paraprofessional contracted with the plan;
3. The treatment is provided under a treatment plan that has measurable goals over a specific timeline that is developed and approved by the qualified autism service provider for the specific patient being treated; and
4. The treatment plan is reviewed at least every six months by a qualified autism service provider and modified whenever appropriate and is consistent with the elements required under

the law.

Charges means the participating provider's contracted rates or the actual charges payable for covered services, whichever is less. Actual charges payable to non-participating provider shall not exceed usual and customary and reasonable charges as determined by MemorialCare Select Health Plan.

Child (ren) means a child or children of the employee including:

- The naturally born child (ren), legally adopted child (ren), or stepchild (ren) of the employee; child (ren) for whom the employee has been appointed a legal guardian by a court; or
- Child (ren) for whom the employee is required to provide health coverage pursuant to a qualified medical support order.
- Children for whom the employee has assumed a parent-child relationship as indicated by intentional assumption of parental duties by the employee as certified by the employee at the time of enrollment of the child and annually thereafter up to the age of 26 unless the child is totally disabled.

Chronic Condition means a medical condition due to a disease, illness, or other medical problem or medical disorder that is serious in nature and that persists without full cure or worsens over an extended period of time or requires ongoing treatment to maintain remission or prevent deterioration.

Copayment means a fixed amount (for example, $15) you pay for a covered health care service, usually when you receive the service. The amount can vary by the type of covered healthcare service.

Cost Sharing means your share for services that the plan covers that you must pay out of your own pocket (sometimes called "out-of-pocket costs"). Some examples of cost sharing are copayments, deductibles, and coinsurance.

Benefits means the services covered by the plan.

Deductible means an amount you could owe during a coverage period (usually one year) for covered health care services before the plan begins to pay. (For example, if your deductible is $1000, the plan won't pay anything until you've met your $1000 deductible for covered health care services subject to the deductible.)

Dependent means an employee's legally married spouse, registered domestic partner or child (ren), who meets the eligibility requirements set forth in this member handbook, who is enrolled in the plan, and for whom the plan receives premiums.

Drug Formulary means a list of prescription drugs covered by the plan. A formulary may include how much your share of the cost is for each drug. The plan puts drugs in different cost sharing levels or tiers. For example, a formulary may include generic drug and brand name drug tiers and different cost sharing amounts will apply to each tier.

Durable Medical Equipment (DME) means equipment and supplies ordered by a health care provider for everyday or extended use. DME may include: oxygen equipment, wheelchairs, and crutches.

Eligible Employee means any employee, employed for a specified period, who is actively engaged on a full-time basis (at least 30 hours per week) in the conduct of the business of the

employer at the employer's regular place or places of business.

The term includes sole proprietors or partners in a partnership, if they are actively engaged on a full-time basis in the employer's business and included as employees under the group subscriber agreement but does not include employees who work on a temporary, substitute or contract basis. Employees who waive coverage claiming they have other employer sponsored health coverage or coverage under Medicare shall not be considered or counted an eligible employee.

Emergency Medical Condition means an illness, injury, symptom (including severe pain), or condition severe enough to risk serious danger to your health and if you didn't get immediate medical attention you could reasonably expect one of the following: 1) Your health would be put in serious danger; or 2) You would have serious problems with your bodily functions; or 3) You would have serious damage to any part or organ of your body.

Emergency Medical Transportation means ambulance services for an emergency medical condition. Types of emergency medical transportation may include transportation by air, land, or sea.

Emergency Services means those benefits, including emergency services and care, provided inside or outside the service area, that are medically required on an immediate basis for treatment of an emergency medical condition.

Emergency Services and Care means:

1. Medical screening, examination, and evaluation by a physician or surgeon, or, to the extent permitted by applicable law, by other appropriate personnel under the supervision of a physician or surgeon, to determine if an emergency medical condition or active labor exists and, if it does, the care, treatment, and surgery, if within the scope of that person's license, necessary to relieve or eliminate the emergency medical condition, within the capability of the facility; and
2. An additional screening, examination and evaluation by a physician, or other personnel to the extent permitted by applicable law and within the scope of their licensure and clinical privileges, to determine if a psychiatric emergency medical condition exists, and the care and treatment necessary to relieve or eliminate the psychiatric emergency medical condition within the capability of the facility.

Employer means any person, firm, proprietary or nonprofit corporation, partnership, or public agency that is actively engaged in business or service, which was not formed primarily for purposes of buying health care service plan contracts and in which a bona-fide employer-employee relationship exists.

Employee (also known as "subscriber") means an eligible employee of the employer who meets the applicable eligibility requirements, has enrolled in the plan under the provisions of a group subscriber agreement, and for whom premiums have been received by the plan.

Evidence of Coverage (EOC) a written guide to the services the plan covers and does not cover and what you pay for services. An EOC is also called a member handbook.

Excluded Services means health care services that are not paid or covered by your plan.

Facility-Based Care means inpatient or outpatient care provided in a hospital, psychiatric health facility, or residential treatment center for the treatment of Severe Mental Illness (SMI) of a member of any age, Serious Emotional Disturbance of a Child (SED) or substance abuse.

Family means a subscriber and all their dependents.

Grievance means a request to the plan, asking to solve a problem or change a decision. A grievance is sometimes called an appeal or complaint.

Group means the entity, usually an employer, with which the plan has entered into the group subscriber agreement that includes this member handbook.

Group Subscriber Agreement means the contract between your group and the plan that established the benefits that members are entitled to and described in this member handbook.

Home Health Agency means licensed providers who provide skilled nursing and other services in your home. Home health agencies must be recognized by the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO).

Home Health Care means health services and supplies you get in your home under your doctor's orders. Services may be provided by nurses, therapists, social workers, or other licensed health care providers. Home health care usually doesn't include help with non-medical tasks, such as cooking, cleaning, or driving.

Hospice means care to relieve the physical and emotional plain of people who are dying of terminal illnesses, and to support the member's caregivers. Hospice care is usually provided at home, but it can also be provided in a health facility.

Independent Medical Review (IMR) means a review of the plan's denial, modification, or delay of a request for health care services or treatment. The review is provided by the Department of Managed Health Care (DMHC) and conducted by independent medical experts.

Infertility means either (1) the presence of a demonstrated condition recognized by a licensed physician and surgeon as a cause of infertility, or (2) the inability to conceive a pregnancy or to carry a pregnancy to a live birth after a year or more of regular sexual relations without contraception.

Investigational means those procedures or medication that have progressed to limited use on humans, but which are not generally accepted as proven and effective within the organized medical community.

Medical Group means a group of doctors who have a business together and contract with the plan to provide services to its members.

Medical Services means those professional services of physicians and other health care professionals, including medical, surgical, diagnostic and preventive services, which are included in your benefits and which are performed, prescribed or directed by a participating provider or health care professional otherwise authorized under California law to practice their profession in the State of California.

Medically Necessary means services or supplies needed to prevent, diagnose, or treat an illness, injury, condition, disease, or its symptoms, including habilitation, and that meet accepted standards of medicine.

Medicare means the federal health insurance program for persons 65 years of age or older, and some people who are permanently disabled.

Member means a person who is enrolled in the plan (also called an enrollee or subscriber).

Mental Disorder means a mental health condition identified as a "mental disorder" in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-4) that results in clinically significant distress or impairment of mental, emotional, or behavioral functioning. Mental Disorders include, but are not limited to, Serious Mental Illness (SMI) of a person of any age and Serious Emotional Disturbance of a Child (SED) under age 18.

Network means all the doctors, labs, hospitals, and other providers that have contracts with the plan to provide health care services to its members.

Non-Participating Provider means a medical group, physician, hospital, specialist, pharmacy or other licensed health professional or licensed health facility or other health professional otherwise authorized under California law to practice his or her profession in the State of California who or which at the time care or services are provided to a member, does not have a contract in effect with MemorialCare Select Health Plan to provide covered services to members.

Out-of-Area means services received while a member is outside the service area. Out-of-area coverage includes urgent or emergent services for the sudden onset of symptoms of sufficient severity to require immediate medical attention to prevent serious deterioration of a member's health resulting from unforeseen illness or injury or complication of an existing condition, including pregnancy, for which treatment cannot be delayed until the member returns to the service area. Out-of-area medical services will be covered to meet your immediate medical needs. Applicable follow-up for the urgent or emergent service must be authorized by the plan and will be covered until it is prudent to transfer your care into the plan's service area.

Out-of-Pocket Maximum means the yearly amount the federal government sets as the most each individual or family can be required to pay in cost sharing during the plan year for covered, services. Applies to most types of health plans and insurance. This amount may be higher than the out-of-pocket limits stated for your plan.

Participating Provider means a medical group, physician, hospital, specialist, pharmacy or other licensed health professional or licensed health facility or other health professional otherwise authorized under California law to practice his or her profession in the State of California who or which at the time care or services are provided to a member, has a contract in effect with the plan to provide covered services to members. A list of all participating providers is contained in the MemorialCare Select Health Plan provider directory.

Pervasive Developmental Disorder: Includes Autistic Disorder, Rett's Disorder, Childhood Disintegrative Disorder, Asperger's Disorder and Pervasive Developmental Disorder Not Otherwise

Specified (including Atypical Autism), in accordance with the Diagnostic and Statistical Manual for Mental Disorders – IV – Text Revision (June 2000).

Plan means the health coverage issued to you through an employer, that provides coverage for certain health care costs. Also called "health insurance plan", "policy", "health insurance policy" or "health insurance".

Preauthorization a decision by the plan that a health care service, treatment plan, prescription drug or durable medical equipment (DME) is medically necessary. Sometimes called prior authorization, prior approval or precertification. Your plan may require preauthorization for certain services before you receive them, except in an emergency. Preauthorization isn't a promise the plan will cover the cost.

Premium means the amount that must be paid for your health insurance or plan. You and/or your employer usually pay it monthly, quarterly, or yearly.

Preventive Care Services means services to help prevent illness, such as flu shots and mammograms.

Primary Care Provider (PCP) means your main doctor, who provides most of your care. Your PCP coordinates all your health care services and treatment and sends you to a specialist when you need one.

Professional Services means those professional diagnostic and treatment services which are listed in the member handbook and supplemental benefits brochures, if applicable, and provided by participating providers and other health professionals.

Provider Directory means a listing of plan contracted physicians, hospitals and other providers in the plan's network, which is updated periodically.

Referral a written order from your PCP for you to see a specialist or get certain health care services. You'll need to get a referral before you can get health care services from anyone except your PCP or emergency services. If you don't get a referral first, the plan may not pay for the services.

Serious Emotional Disturbance or SED means one or more mental disorders as identified in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, to include Rett's Disorder, Childhood Disintegrative Disorder, Asperger's Disorder and other pervasive developmental disorders no otherwise specified (including Atypical Autism), in accordance with the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM), other than a primary substance use disorder or developmental disorder, that result in behavior inappropriate to the child's age according to expected developmental norms.

One or more of the following must also be true:

1. As a result of the mental disorder, the child has substantial impairment in at least two of the following areas: self-care, school functioning, family relationships or ability to function in the community; and either of the following occur: a) the child is at risk of removal from the home or has already been removed from the home; or b) the mental disorder and impairments have been present for more than six months or

are likely to continue for more than one year if not treated; or

2. The child displays one of the following: psychotic features, risk of suicide or risk of violence due to a mental disorder; or meets special education eligibility requirements under Chapter 26.5 (commencing with Section 7570) of Division 7 of Title 1 of the Government Code.

Service Area all the zip codes that the plan serves.

Severe Mental Illness (SMI) means one or more of the following nine disorders in persons of any age: schizophrenia, schizoaffective disorder, bipolar disorder (manic depressive illness), major depressive disorders, panic disorder, obsessive-compulsive disorder, pervasive developmental disorder or autism, anorexia nervosa, bulimia nervosa.

Skilled Nursing Facility (SNF) means a comprehensive free-standing rehabilitation facility or a specially designed unit within a hospital licensed by the state of California to provide skilled nursing care.

Specialist means a provider focusing on a specific area of medicine or a group of patients to diagnose, manage, prevent, or treat certain types of symptoms and conditions.

Specialty Drug means a type of prescription drug that, in general, requires special handling or ongoing monitoring and assessment by a health care professional, or is relatively difficult to dispense. Generally, specialty drugs are the most expensive drugs on a formulary.

Spouse means an employee's legally married husband, wife, or partner. If coverage for domestic partners is specified by the employer in the group services agreement, it also means an employee's domestic partner.

Stabilize (or Stabilized) means to provide the medical treatment of the emergency medical condition that is necessary to assure, within reasonable medical probability that no material deterioration of the condition is likely to result from or occur during the transfer of the person from the facility. With respect to a pregnant woman who is having contractions, when there is inadequate time to safely transfer her to another hospital before delivery (or the transfer may pose a threat to the health or safety of the woman or unborn child), "Stabilize" means to deliver (including the placenta).

Subscriber means a person who is enrolled in the plan (also called an enrollee or member).

Summary of Benefits is a list of the most commonly used benefits and applicable copayments for the specific benefit plan purchased by the employer. membes receive a copy of the Summary of Benefits along with the member handbook.

Surgery Center means a facility (not a hospital or physician's office) where surgeries are performed when you do not need to say overnight. A surgery center must be licensed and meet the standards of the Joint Commission on the Accreditation of Healthcare Organizations (JCAHCO).

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Urgent Care means care for a health problem that is not an emergency but needs attention quickly, before you can get in to see your doctor or if your doctor's office is closed.

Utilization Management is the evaluation of the appropriateness, medical need and efficiency of health care services and facilities according to established criteria or guidelines and under the provisions of the applicable health benefits plan.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

MemorialCare Select Health Plan provides health care coverage for you. We are required by state and federal law to protect your health information. We have internal processes to protect your oral, written and electronic protected health information (PHI). And we must give you this Notice that tells you how we may use and share your information and what your rights are. We have the right to change the privacy practices described in this Notice. If we do make changes, the new Notice will be available upon request, in our office and on our website.

Your information is personal and private.

We receive information about you when you become eligible and enroll in our health plan. We also receive medical information from your doctors, clinics, labs and hospitals in order to approve and pay for your health care.

HOW WE MAY USE AND SHARE INFORMATION ABOUT YOU

MemorialCare Select Health Plan may use or share your information for reasons directly connected to your treatment, payment for that treatment or health plan operations. The information we use, and share includes, but is not limited to: your name, address, personal facts, medical care given to you and your medical history.

Some actions we take as a health plan include: checking your eligibility and enrollment; approving and paying for health care services; investigating or prosecuting fraud; checking the quality of care that you receive; and coordinating the care you receive. Some examples include:

For treatment: You may need medical treatment that requires us to approve care in advance. We will share information with doctors, hospitals and others in order to get you the care you need.

For payment: MemorialCare Select Health Plan reviews, approves and pays for health care claims sent to us for medical care. When we do this, we share information with the doctors, clinics and others who bill us for your care. And we may forward bills to other health plans or organizations for payment.

For health care operations: We may use information in your health record to judge the quality of the health care you receive. We also may use this information for audits, fraud and abuse programs, planning and general administration. We do not use or disclose PHI that is genetic information for underwriting purposes.

OTHER USES FOR YOUR HEALTH INFORMATION

When ordered by a court order to give out your health information. We also will give information to a court investigator or lawyer under certain circumstances. This may involve fraud or actions to recover money from others.

You or your doctor, hospital and other health care providers may appeal decisions made about claims for your health care. Your health information may be used to make these appeal decisions.

We also may share your health information with agencies and organizations that check how our health plan is providing services.

We must share your health information with the federal government when it is checking on how we are meeting privacy rules.

We may share your information with researchers when an Institutional Review Board (IRB) has reviewed and approved the reason for the research and has established appropriate protocols to ensure the privacy of the information.

We may disclose health information, when necessary, to prevent a serious threat to your health or safety or the health and safety of another person or the public. Such disclosure would be made only to someone able to help prevent the threat.

We provide employers only with the information allowed under the federal law. This information includes summary data about their group and information concerning premium

and enrollment data. The only other way that we will disclose your Protected Health Information to your employer is if you authorize us to do so.

WHEN WRITTEN PERMISSION IS NEEDED

If we want to use your information for any purpose not listed in this notice, we must get your written permission. If you give us your permission, you may take it back in writing at any time.

YOUR PRIVACY RIGHTS

- You have the right to ask us not to use or share your personal health care information in the ways described in this notice. We may not be able to agree to your request.
- If you pay for a service or a health care item out-of-pocket in full, you can ask your provider not to share that information with us or with other health insurers.
- You have the right to ask us to contact you only in writing or at a different address, post office box or by telephone. We will accept reasonable requests when necessary to protect your safety.
- You and your personal representative have the right to get a copy of your health information. You will be sent a form to fill out and may be charged a fee for the costs of copying and mailing records. (We may keep you from seeing certain parts of your records for reasons allowed by law.)
- You have the right to ask that information in your records be amended if it is not correct or complete. We may refuse your request if: (1) the information is not created or kept by MemorialCare Select Health Plan , or (2) we believe it is correct and complete. If we do not make the changes you ask, you may as that we review our decision. You may also send a statement saying why you disagree with our records, and that statement will be kept with your records.
- ***Important:*** *MemorialCare Select Health Plan does not have complete copies of your medical records. If you want to look at, get a copy of, or change your medical records, please contact your doctor or clinic.*
- When we share your health information after April 14, 2003, you have the right to request a list of what information was shared, with whom we shared it, when we shared it and for what reasons. This list will not include when we share information: with you; with your permission; for treatment, payment or health plan operations; or as required by law.
- You have a right to receive written notification if we discover a breach of your unsecured PHI and determine through a risk assessment that notification is required.
- You have the right to authorize any use or disclose of PHI that is not specified within this notice. For example, we would need your written approval to use or disclose your PHI for marketing, for most uses or disclosures of psychotherapy notes, or if we intend to sell your PHI.
- You may revoke an approval at any time, in writing, except to the extent that we have taken an action in reliance on the use or disclosure indication in the approval.
- You have a right to request a copy of this Notice of Privacy Practices. You can also find this notice on our website at memorialcareselecthealthplan.org.
- You have the right to complain about any aspect of our health information practices.

USING YOUR RIGHTS

If you want to use any of the privacy rights explained in this notice, contact or write us at:

MemorialCare Privacy Officer
17360 Brookhurst Street
Fountain Valley, CA 92708
1-844-805-8700

MemorialCare Select Health Plan cannot take away your health care benefits or do anything to get in the way of your medical services or payment in any way if you choose to file a complaint or use any of the privacy rights in this notice.

COMPLAINTS

If you believe that we have not protected your privacy and you wish to complain, you may file a complaint by contacting:

- MemorialCare Select Health Plan by sending a letter to the address shown above or by calling us at 1-844-805-8700.
- U.S. Department of Health and Human Services, Office of Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, by calling 1-877-

696-6775, or by visiting
www.hhs.gov/ocr/privacy/hipaa/complaints.

HELP IN YOUR LANGAGE

IMPORTANT: Can you read this letter? If not, we can have somebody help you read it. You may also be able to get this letter written in your language. For free help, please call right away at 1-844-805-8700. (TTY/TDD: 711)

In addition to the language assistance program, we make documents available in alternate formats, free of charge, for members with visual impairments. If you need a copy of this document in an alternate format, please call the Member Service telephone number on the back of your ID card.

English:
ATTENTION: If you speak a language other than English, language assistance services, free of charge, are available to you. Call 1-844-805-8700 (TTY: 711).

Español (Spanish):
ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-844-805-8700 (TTY: 711).

繁體中文 (Chinese):
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-844-805-8700 (TTY: 711)。

Tiếng Việt (Vietnamese):
CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-844-805-8700 (TTY: 711).

Tagalog (Tagalog – Filipino):
PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-844-805-8700 (TTY: 711).

한국어(Korean):
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-844-805-8700 (TTY: 711) 번으로 전화해 주십시오.

Հայերեն (Armenian):
ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ Եթե խոսում եք հայերեն, ապա ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Զանգահարեք 1-844-805-8700 (TTY (հեռատիպ)՝ 771):

فارسی :(Farsi)
توجه :اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما
فراهم می باشد .با 1-844-805-8700 (TTY: 711) ماس بگیری

усский (Russian):
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-844-805-8700 (телетайп: 711).

日本語 (Japanese):
注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-844-805-8700 (TTY: 711) まで、お電話にてご連絡ください。

العربية Arabic):
ملحوظة :إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر .
(TTY:711) لك بالمجان .اتصل برقم
هاتف الصم والبكم

ਪੰਜਾਬੀ (Punjabi):
ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 1-844-805-8700 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ

ខ្មែរ (Mon Khmer, Cambodian):
ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ
1-844-805-8700 (TTY: 711)។

Hmoob (Hmong):
LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-844-805-8700 (TTY: 711).

हिंदी (Hindi):
ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाए उपलब्ध हैं। 1-844-805-877 (TTY: 711) पर कॉल करें।

ภาษาไทย (Thai):
เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร
1-844-855-8700 (TTY: 711).


Los Angeles County
Torrance
Long Beach
Westminster
Anaheim
Yorba Linda
Fountain Valley
Huntington Beach
Irvine
Orange County
Laguna Hills
Laguna Niguel
Mission Viejo
Newport Beach
Dana Point
San Clemente
COMING SOON
COMING SOON
COMING SOON
MemorialCare Medical Centers
Miller Children's & Women's Hospital Long Beach
MemorialCare Shared Services
Children's Specialty Care Centers
Urgent Care Centers
MemorialCare Medical Group
Breast Centers
Dialysis Centers
MemorialCare Surgical Centers
Hospital-Based Imaging Centers
Community-Based Imaging Centers
Affiliated Physician Groups
(Includes Greater Newport Physicians)

MemorialCare
Select Health Plan

Member Services
17360 Brookhurst St.
Fountain Valley, CA 92708

Email: **MCSelectMemberServices@memorialcare.org**

844-805-8700 (TTY: 711)
8 a.m. to 5 p.m., Monday to Friday

www.memorialcareselecthealthplan.org

This COMBINED EVIDENCE OF COVERAGE AND DISCLOSURE FORM (EOC) constitutes only a summary of the Plan. The Group Subscriber Agreement between the Plan and your Employer must be consulted to determine the exact terms and conditions of coverage. A specimen copy of the Group Services Agreement will be furnished to you by the Plan or your Employer upon request.