

**COMBINED EVIDENCE OF COVERAGE AND DISCLOSURE FORM  
FOR SMALL EMPLOYER GROUPS**

SIMNSA Health Plan  
c/o International Healthcare, Inc.  
333 H Street Suite 6040  
Chula Vista, CA 91910  
(619) 407-4082

SIMNSA Health Plan  
Paseo Rio Tijuana 406  
1er Piso – Edificio SIMNSA  
Tel. 83-29-02

Please examine your options carefully before declining this coverage. You should be aware that companies selling individual health insurance typically require a review of your medical history that could result in a higher premium or you could be denied coverage entirely.

This Health Plan may be limited in benefits, rights and remedies  
under U.S. Federal and State Law.

Este Plan de Salud puede tener limitaciones en sus beneficios, derechos y resoluciones bajo  
las leyes federales estatales de Los Estados Unidos.

THIS COMBINED EVIDENCE OF COVERAGE AND DISCLOSURE FORM DISCLOSES THE TERMS AND CONDITIONS OF YOUR HEALTH CARE COVERAGE. THIS COMBINED EVIDENCE OF COVERAGE AND DISCLOSURE FORM CONSTITUTES ONLY A SUMMARY OF THE HEALTH PLAN. THE HEALTH PLAN CONTRACT MUST BE CONSULTED TO DETERMINE THE EXACT CONDITIONS OF COVERAGE. A COPY OF THE CONTRACT WILL BE FURNISHED TO YOU UPON REQUEST. IT SHOULD BE READ CAREFULLY AND COMPLETELY. INDIVIDUALS WITH SPECIAL HEALTH NEEDS SHOULD CAREFULLY READ THOSE SECTIONS THAT APPLY TO THEM. YOU HAVE THE RIGHT TO REVIEW THIS COMBINED EVIDENCE OF COVERAGE AND DISCLOSURE FORM PRIOR TO ENROLLMENT.

A “COVERAGE MATRIX” COMPARING THE DIFFERENT BENEFIT PRODUCTS OFFERED BY SIMNSA HEALTH PLAN HAS BEEN PROVIDED AS ATTACHMENT \_\_\_\_ TO THIS EVIDENCE OF COVERAGE AND DISCLOSURE FORM.

Welcome to the **SISTEMAS MEDICOS NACIONALES (SIMNSA)** health care program. This Combined Evidence of Coverage and Disclosure Form (“EOC”) describes the services that are covered and those that are not covered. For more information, refer to the Agreement entered into on your behalf by your employer or Group. This health care plan is designed not only to meet your needs in times of illnesses, but also to help in preventing and avoiding such illnesses. However, in order for this plan to be successful and effective, it is necessary to have competent providers, and Members that maintain good health habits. It is very important that Members want and understand that it is in their best interest to maintain these standards.

This EOC replaces and supersedes all others previously issued.

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

**1. HOW TO USE THE PLAN:**

Along with this book, you will receive an identification card. You will need to present this card every time health care services are needed. You will also be asked to provide a second form of identification with a picture on it, in order to prevent fraud should your card be lost or stolen.

1.1. Choice of Physicians and Providers

You will also receive a “Provider Directory” that lists all primary level Participating Physicians that participate in this program. You are free to choose any of these Participating Physicians for all your health care needs. This Provider Directory lists only the primary care physicians. The list of primary care physicians includes pediatricians, obstetricians, gynecologists, general and family practitioners, and internal medicine specialists. If a physician of another specialty is needed, your primary care physician will refer you to one. For female Members, benefits for services performed by a Participating gynecologist for diagnosis and treatment of gynecological problems may be rendered without a referral from your primary care physician. A list of specialist providers will be provided upon request. As a Member of SIMNSA you are required to always use these Participating Physicians except when Emergency Services or Out-of-Area Urgent Care Services are needed.

1.2. Facilities

Your Provider Directory also includes a list of Participating Facilities, including urgent care facilities that are Participating Facilities in the San Diego area. These urgent care facilities require higher Copayments and may have limitations in services and hours of operation.

If Emergency Services or Out-of-Area Urgent Care Services are required, you can go to any emergency room or urgent care center, even if it is not listed in the Provider Directory. Emergency Services and Urgent Care Services are covered by SIMNSA anywhere in the world, subject to the limitations set forth elsewhere in this EOC.

1.3 Reimbursement Method

Physicians and other professional providers are paid on either a capitated or fee-for-service basis, according to an agreed schedule. Hospitals and other healthcare facilities may be paid either a per diem rate or on a fee-for-service basis. For additional information, you may

contact us at 1-800-424-4652 in the United States, 6-83-29-02 in Mexico, or you may contact your participating Provider.

**2. MEMBER REIMBURSEMENT PROVISIONS:**

In the event that you have expenses for Covered Services authorized by SIMNSA in excess of the applicable Copayment, you have the right to reimbursement of these expenses. Simply mail or bring in your receipts to any of the offices listed below. Your reimbursement will be made within 10 days from receipt of your request and in accordance with SIMNSA's benefit schedule.

SIMNSA Health Plan  
c/o International Healthcare, Inc.  
333 H Street Suite 6040  
Chula Vista, CA 91910  
(619) 407-4082

SIMNSA Health Plan  
Paseo Rio Tijuana 406  
1er Piso-Edificio SIMNSA  
Tel. 83-29-02

**3. EMERGENCY CASES IN THE UNITED STATES OR IN MEXICO:**

If a Member requires Emergency Services (including emergency dental services, for Members who have elected one of SIMNSA's dental benefits plans), the Member should go to the nearest available emergency care facility. If the Emergency occurs in Mexico, you must go to the nearest available Emergency care facility in Mexico. If the Emergency occurs in California, you must go to the nearest available facility, in some cases, the nearest available facility may be in Mexico. If the Emergency occurs along the United States/Mexico border, you may be subject to an EMT-Paramedic or Critical Care Transport ambulance to ambulance transfer, if medically necessary, to transport you to the nearest available Emergency care facility.

If the Emergency (including a dental emergency, for Members who have elected one of SIMNSA's dental benefits plans) occurs out of the Plan's Service Area, go to the nearest available emergency care facility and notify the Plan within 48 hours. If it is not reasonably possible to call SIMNSA within 48 hours, SIMNSA should be notified as soon as possible with an explanation for the delay of said notification. A toll-free telephone number for calls within the U.S. is listed on the back of your identification card. If you are outside of the U.S. collect calls are accepted.

Once SIMNSA has been notified that you are hospitalized at a non-Participating Hospital, the Medical Director will offer to repatriate you to the Plan's Service Area once your treating physician agrees your condition is stable for transfer. You have the right to refuse the transfer, but may be financially liable for any costs incurred after the transfer is authorized by the non-Participating Provider and the Plan.

**4. WHAT CONSTITUTES AN EMERGENCY COVERED BY SIMNSA:**

An Emergency is a sudden change in a person's physical or mental condition which manifests itself by acute symptoms of sufficient severity (including severe pain) such that absence of immediate medical 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. Classification of situations as medical emergencies is based on signs and symptoms at the time of treatment, verified and documented by the treating physician. Emergency conditions include, but are not limited to, severe breathing difficulties, head injuries, unconsciousness, uncontrolled bleeding, major burns, heart attack symptoms, heat stroke, spinal injuries, cardiovascular accidents, poisonings, or shock. These examples are for clarification only, and are not intended to serve as an exhaustive list of conditions which constitute or may constitute Emergencies.

**5. YOUR COSTS:**

This health care program covers almost all Medically Necessary expenses. There are exclusions and limitations in some services (see list of benefits). If you require a service that is not covered by SIMNSA, then you must pay for the service and you are responsible for making payment arrangements with the physician and/or hospital before receiving this service (e.g., a cosmetic service). There are some services that require a Copayment by the patient, such as office visits, prescriptions, eye exams, etc., and must be made at the time of service.

In accordance with the requirements of the Knox-Keene Health Care Service Plan Act of 1975, as amended, every contract between SIMNSA and its Participating Providers provides that, in the event that SIMNSA fails to pay any Participating Provider for Covered Services provided to a Member, the Member shall not be liable to the Participating Provider for any sums owed by SIMNSA. However, in the event that SIMNSA fails to pay any non-contracting provider of Covered Services, the Member may be liable to pay the non-contracting provider for the cost of such Covered Services.

**5.1. Prepayment Fees**

Your Employer is responsible for prepayment of Monthly Premiums for SIMNSA coverage by the first business day of each month. You may be required to pay a portion of such charges to your Employer. If so, you will be notified by your Employer.

Health services are covered only for Members whose prepayment fees have been received by SIMNSA. Coverage extends only for the period for which such payment is received.

## 5.2. Other Charges

You will be required to make certain Copayments for the Covered Services. The amount of such Copayments are specified in the Copayment Schedule attachment. Copayments must be paid at the time the Covered Services are rendered. Copayments may be charged for missed appointments. In the event that you do not cancel an appointment without providing 24-hours notice, you may be required to make a Copayment, unless the appointment is missed due to circumstances beyond your control.

## 6. **MEMBER'S RESPONSIBILITIES:**

It is in the Member's best interest to assume responsibility beginning with good preventive health habits. The plan offers preventive medicine services such as physical exams, vaccinations, mammograms, etc., to prevent critical illnesses. All Eligible Employees are encouraged to use these services. It is also very important to follow your physician's instructions and recommendations. Finally, it is the Member's responsibility to use the medical services adequately and only when necessary, so that SIMNSA can continue to provide high quality services at a reasonable cost.

Never allow anyone to use your identification card other than your eligible Dependents.

Your Enrollment Form should only list your legally married spouse or Domestic Partner and all your unmarried dependent children under the age of 19 (or the age of 23 if enrolled as a full-time student in an accredited institution of higher learning). No other persons should be listed as "Dependents," and to do so is considered a fraudulent practice which may lead to termination of coverage.

SIMNSA urges Members to contact us if they become aware of a Member engaged in the fraudulent practices described in this Section. SIMNSA can be reached at the locations and telephone numbers found on the first page of this EOC.

## 7. **INQUIRY AND GRIEVANCE PROCEDURE:**

### 7.1. Purpose

SIMNSA offers its Members an Inquiry and Grievance Procedure that the Members may or may not use, at their own option and convenience. The purpose of the Inquiry and Grievance Procedure

("Procedure") is to address any matters causing Members to be dissatisfied with their health plan coverage. Members can call the Member Services Department at the numbers provided below if they have questions or concerns related to their membership in SIMNSA.

SIMNSA Health Plan  
c/o International Healthcare, Inc.  
333 H Street Suite 6040  
Chula Vista, CA 91910  
(619) 407-4082  
1-800-424-4652

SIMNSA Health Plan  
Paseo Rio Tijuana 406  
1er Piso-Edificio SIMNSA  
Tel. 6-83-29-02

## 7.2. Procedure

7.2.1. Members may submit a grievance to the Plan through any of the following methods: (1) a telephone call to any of the phone numbers listed above under subsection 7.1; (2) a written letter submitted to either of the addresses listed above under subsection 7.1; or (3) through the Plan's online grievance form located on our website: [www.simnsa.com](http://www.simnsa.com).

7.2.2. All grievances will be resolved by the Plan within 30 days of receipt.

7.2.3. Urgent Grievances: Notwithstanding anything to the contrary contained in this Section 7.2, the following shall apply to grievances involving an imminent and serious threat to the health of a Member, including, but not limited to, severe pain, potential loss of life, limb or major bodily function:

7.2.3.1. The person filing the grievance may contact the Department of Managed Health Care immediately, without participating in the Plan's grievance process.

7.2.3.2. The Plan will provide a written statement regarding the disposition or pending status of an urgent grievance within three (3) calendar days of receipt. Furthermore, the Plan will consider a Member's medical condition when determining its response time to the urgent grievance.

## 7.3. Right to Contact State Regulatory Agency

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at **(619)**

**407-4082** or **6-83-29-02** 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-HMO-2219**) and a TDD line (**1-877-688-9891**) for the hearing and speech impaired. The Department's Internet Web site <http://www.hmohelp.ca.gov> has complaint forms, IMR application forms and instructions online.

#### 7.4. Right to Independent Medical Review

7.4.1. You may request an independent medical review ("IMR") of Disputed Health Care services from the Department of Managed Health Care ("Department") if you believe that health services eligible for coverage and payment have been improperly denied, modified, or delayed by SIMNSA or one of its Participating Providers. A "Disputed Health Care Service" is any service eligible for coverage and payment under SIMNSA that has been denied, modified or delayed by SIMNSA or one of its Participating Providers, in whole or in part because the service is not Medically Necessary.

7.4.2. The IMR process is in addition to any other procedures or remedies that may be available to you. You pay no application or processing fees of any kind for IMR. You have the right to provide information in support of the request for IMR. SIMNSA will provide you with an IMR application form and SIMNSA grievance response letter that states its position on the Disputed Health Care Service. A decision not to participate in the IMR process may cause you to forfeit any statutory right to pursue legal action against SIMNSA regarding the Disputed Health Care Service. For more information regarding the IMR process, or to request an application, please call SIMNSA at (619) 407-4082 or 6-83-29-02.

#### 7.5. Independent Medical Review for Denials of Experimental/ Investigational Therapies

- 7.5.1. You may also be entitled to an Independent Medical Review, through the Department of Managed Health Care, of the Plan's decision to deny coverage for treatment we have determined to be experimental or investigational.
- 7.5.2. The treatment must be for a life-threatening or seriously debilitating condition.
- 7.5.3. We will notify you in writing of the opportunity to request an Independent Medical Review of a decision denying an experimental/ investigational therapy within five (5) business days of the decision to deny coverage.
- 7.5.4. You are not required to participate in the Plan's grievance process prior to seeking an Independent Medical Review of our decision to deny coverage of an experimental/ investigational therapy.
- 7.5.5. The review will be completed within thirty (30) days of receipt of your application and supporting documentation. If your physician determines that the proposed therapy would be significantly less effective if not promptly initiated, the Independent Medical Review decision shall be rendered within seven (7) days of the completed request for an expedited review.

7.6. Arbitration

- 7.6.1. All disputes which in any manner arise out of or relate to this EOC/Agreement or the subject matter hereof, including claims of medical malpractice, shall be resolved exclusively by binding arbitration in accordance with the provisions of this Section 7.6. Either party may commence arbitration by sending a written demand for arbitration to the other party, setting forth the nature of the controversy, the dollar amount involved, if any, the remedies sought, and attaching to such demand a copy of this Section 7.6.
- 7.6.2. It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their

constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

- 7.6.3. There shall be one arbitrator. If the parties shall fail to select a mutually acceptable arbitrator within ten (10) days after the demand for arbitration is mailed, then the parties stipulate to arbitration before a single arbitrator sitting on the San Diego JAMS/Endispute panel, who is a retired judge and is selected in the sole discretion of the JAMS/Endispute San Diego office administrator. The parties shall share all costs of arbitration. The prevailing party shall be entitled to reimbursement by the other party of such party's attorneys' fees and costs and any arbitration fees and expenses incurred in connection with the arbitration hereunder.
- 7.6.4. The substantive law of the State of California shall be applied by the arbitrator. The parties shall have the rights of discovery as provided for in Part 4 of the California Code of Civil Procedure and as provided for in Section 1283.05 of said Code. The California Code of Evidence shall apply to testimony and documents submitted to the arbitrator.
- 7.6.5. Arbitration shall take place in San Diego, California unless the parties otherwise agree. As soon as is reasonably practicable, a hearing with respect to the dispute or matter to be resolved shall be conducted by the arbitrator. As soon as is reasonably practicable thereafter, the arbitrator shall arrive at a final decision, which shall be reduced to writing, signed by the arbitrator and mailed to each of the parties and their legal counsel. All decisions of the arbitrator shall be final, binding and conclusive on the parties and shall constitute the only method of resolving disputes or matters subject to arbitration pursuant to this Agreement. The arbitrator or a court of appropriate jurisdiction may issue a writ of execution to enforce the arbitrator's judgment. Judgment may be entered upon such a decision in accordance with applicable law in any court having jurisdiction thereof.
- 7.6.6. Notwithstanding the foregoing, (1) because time is of the essence of this Agreement, the parties specifically reserve the right to seek a judicial temporary restraining order, preliminary injunction, or other similar short term equitable relief, and grant the arbitrator the right to make a final determination of the parties' rights, including whether to

make permanent or dissolve such court order; and (2) any and all arbitration proceedings are conditional upon such proceedings being covered within the parties' respective risk insurance policies, if applicable.

7.6.7. In cases of extreme hardship, the Plan shall assume a portion or all of a subscriber's share of fees and expenses of the neutral arbitrator. The subscriber shall bear the burden of demonstrating extreme financial hardship to the Plan.

## **8. UTILIZATION REVIEW**

- 8.1. The Plan's process for authorizing, modifying or denying health care services is made by the Plan on a case-by-case basis, using sound clinical principles and processes. Emergency and Urgent Care Services provided to Plan's enrollees in California are reviewed on a retrospective basis.
- 8.2. The Plan shall have the full and exclusive power and authority, in its sole discretion, to determine all questions of coverage and eligibility for benefits, methods of providing or arranging for benefits and all other related matters. The Plan shall have the full power and authority, in its sole discretion, to construe and interpret the provisions and terms of this Plan document and all other written documents, and any such construction and interpretation adopted by the Plan in good faith shall be binding upon all Members, all Providers, all Group Contract Holders, and all other persons.
- 8.3. Only the Plan's Medical Director may determine which services were or were not Medically Necessary. If the Medical Director does not have personal experience and training sufficient to determine that such services are not Medically Necessary, then the Medical Director consults with an appropriately qualified Participating Physician before the Medical Director may deny such services. If an appropriately qualified Participating Physician is unavailable, then the Medical Director consults with an appropriately qualified out-of-plan physician before the Medical Director may deny such services.
- 8.4. Utilization review decisions are communicated to enrollees within 5 business days of receipt of all information reasonably necessary and requested by the Plan to make the decision. In cases where the review is retrospective, the decision shall be communicated to the Member who received the services, or their designee, within 30 days of the Plan's receipt of all information that is reasonably necessary to make the decision. The decision letters denying services include: (1) the clinical reasons for any decisions regarding medical necessity; (2) information regarding how an enrollee may file a grievance with the

Plan; (3) notice to enrollees of the right to file a complaint with the Department after thirty days of initiating the grievance process; and (4) the direct telephone number of the health care provider responsible for the decision.

- 8.5. A STATEMENT DESCRIBING SIMNSA'S POLICIES AND PROCEDURES FOR REVIEWING EMERGENCY AND URGENT CARE SERVICES IS AVAILABLE AND WILL BE FURNISHED TO YOU UPON REQUEST.

**9. CONTINUITY OF CARE:**

- 9.1. SIMNSA Health Plan understands the importance of continuity of care and a Member's ongoing relationship with his or her treating physician. We are proud to say that our Participating Provider turnover rate over the past four years has been less than 1%.

It is our goal to continue this trend and offer our members the benefit of being under the care of the same Participating Provider as long as it is possible. In the unlikely event that a Provider from whom you've received services leaves SIMNSA, we will provide you with at least 60 days' notice of this change. You have the option to switch to another Participating Provider by selecting one that is convenient to you from our Provider Directory. In addition, in the event a Participating Hospital is terminated from the Plan's Network, the Plan will send a notice to all Members who live within 15 miles of the terminating hospital.

If your treating provider or hospital ceases to be a Participating Provider or Hospital, or if you are a new enrollee who was receiving Covered Services from a non-Participating Provider or a non-Participating Hospital at the time your coverage became effective with SIMNSA, you may be entitled to complete your course of treatment with the terminated or non-Participating Provider or Hospital if you were receiving treatment for any the following: Acute Medical Condition, Serious Chronic Condition, Pregnancy, or Terminal Illness. A Newborn child may also be entitled to complete his or her course of treatment with a terminated or non-Participating Provider or Hospital. In addition, a scheduled surgery or other procedure that is authorized by SIMNSA or, in the case of new enrollees, by a plan as part of a documented course of treatment and has been recommended and documented by a provider to occur within 180 days of their termination date or within 180 days of the effective date of coverage for a newly covered enrollee may still be performed. Please contact the Plan to request a copy of our continuity of care policy for further information on how to qualify for completion of your course of treatment with a terminated or non-Participating Provider or Hospital.

If you desire completion of services, you must affirmatively submit your request in writing to the Plan. Requests for completion of care must contain the following information: Member name; Plan membership number; current Member address; current Member telephone number; the name and contact information for the provider or hospital from which you would like to continue to receive care; and the specified condition for which you desire completion of care services.

Please contact SIMNSA at either of the following locations for assistance in securing the continuity of your care:

SIMNSA Health Plan  
c/o International Healthcare, Inc.  
333 H Street Suite 6040  
Chula Vista, CA 91910  
(619) 407-4082

SIMNSA Health Plan  
Paseo Rio Tijuana 406  
1er Piso-Edificio SIMNSA  
Tel. 83-29-02

If a terminated or non-Participating Provider or Hospital and the Plan do not agree to terms, the Plan is not obligated to provide completion of services.

- 9.2. If you have been receiving care from a health care provider, you may have the right to keep your provider for a designated time period. Please contact your HMO's customer service department, and if you have further questions, you are encouraged to contact the Department of Managed Health Care, which protects HMO customers, by telephone at its toll-free number, 1-888-HMO-2219, or at a TDD number for the hearing impaired at 1-877-688-9891, or online at [www.hmohelp.ca.gov](http://www.hmohelp.ca.gov).
- 9.3. SIMNSA Health Plan understands the importance of continuity of care for new enrollees who have been receiving services for an acute, serious, or chronic mental health condition from a non-Participating Provider, including a psychiatrist, licensed psychologist, licensed marriage and family therapist, or licensed social worker who is not part of the Health Plan. If you have been receiving such mental health services, subject to certain conditions, you may be eligible to continue your course of treatment for a reasonable period determined by the Plan with the non-Participating Provider prior to transferring to a Participating Provider.

A written statement describing SIMNSA's continuity of care policy and information regarding the process for an enrollee to request a

review under the policy is available and will be furnished to you upon request.

**10. DEFINITIONS:**

- 10.1. Acute Medical 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.
- 10.2. Agreement - means the Group Medical and Hospital Service Agreement between Health Plan and Group, including Group Application, Combined Evidence of Coverage and Disclosure Form, Summary of Benefits and Schedule of Copayments, Coverage Matrix, and any riders, amendments, and attachments to any of the above. A copy of the Agreement will be provided upon request by the Member.
- 10.3. Certified Confinement - means an admission and length of stay of a Member in a hospital, which has been certified by the Medical Coordinator prior to admission or retrospectively for Emergency admissions.
- 10.4. Chemical Dependency - means the abuse of, or psychological or physical dependence on, or addiction to alcohol, controlled substances, illegal drugs or barbiturates.
- 10.5. Child or Children - means a Subscriber's natural or adopted child, as well as any other child primarily dependent on the Subscriber for financial support and maintenance, including foster and stepchildren.
- 10.6. Chronic - means a condition lasting a long time.
- 10.7. Copayment - means the charge a Member is required to pay a Participating Provider at the time services are rendered to receive certain Covered Services described in the Summary of Benefits and Schedule of Copayments.
- 10.8. Covered Services, coverage, or covered - means those Medically Necessary services and supplies, including those for coverage of Serious Emotional Disturbances of a Child or Adolescent and Severe Mental Illness, set forth in this EOC, the Summary of Benefits and Schedule of Copayments, or any riders, which are subject to all of the terms, conditions, exclusions and limitations of the Agreement,.
- 10.9. Dependent - means a Subscriber's legal spouse, Domestic Partner, or child whom the SIMNSA Health Plan determines meets all the applicable eligibility requirements set forth in the Eligibility Sections of the Agreement and this EOC, who has enrolled in accordance with

the Agreement and EOC, and for whom premium payments required under the Agreement have been received and accepted by the SIMNSA Health Plan in accordance with the Agreement's terms.

- 10.10. Domestic Partner – means a Subscriber's legal domestic partner, whose partnership with the Subscriber meets the definition set forth in Section 297 of the California Family Code, and with whom the Subscriber has filed a Declaration of Domestic Partnership with the California Secretary of State or an equivalent document issued by a local agency of California, another state, or a local agency of another state under which the partnership was created. This Plan shall provide Domestic Partners with coverage that is equal to that offered to a Subscriber's spouse, to the extent permitted under all applicable State and Federal laws.
- 10.11. Durable Medical Equipment - means durable items or appliances which, as determined by the SIMNSA Health Plan, are: a) made to withstand prolonged use; b) made for and mainly used in the treatment of a disease or injury; c) suited for use in the home; d) not normally of use to persons who do not have a disease or injury; e) not for use in altering air quality or temperature; f) not for exercise or training.
- 10.12. Effective Date - means the date stated in the Group Application as the effective date of the Agreement between SIMNSA and the Group.
- 10.13. Eligible Employee – means any bona fide employee who is actively engaged in the Group Contract Holder's business at least thirty (30) hours within a normal workweek. This term includes sole proprietors or partners of a partnership, if they are actively engaged in the Group Contract Holder's business at least thirty (30) hours per week and are included under Group Contract Holder's health benefits plan for Group Contract Holder's employees, but does not include independent contractors or part-time, temporary or substitute employees. The term eligible employee includes any bona fide employee who works between twenty (20) and twenty-nine (29) hours within a normal workweek if the employee worked at least twenty (20) hours per normal workweek for at least fifty (50) percent of the weeks in the previous calendar year. In addition, the Group Contract Holder must offer health coverage to all employees, including all those in a similar situation as the employee.
- 10.14. Emergency - means a sudden change in a person's physical or mental condition which manifests itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in placing the patient's health in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

Classification of situations as medical emergencies is based on signs and symptoms at the time of treatment, verified and documented by the treating physician. Emergency conditions include, but are not limited to, severe breathing difficulties, head injuries, unconsciousness, uncontrolled bleeding, major burns, heart attack symptoms, heat stroke, spinal injuries, cardiovascular accidents, poisonings, or shock.

- 10.15. Emergency Services – means Covered Services rendered by a health care professional for the immediate diagnosis and treatment of an Emergency. “Emergency Services” also means 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.
- 10.16. Employee - means a person who satisfies the Group’s employee requirements to qualify as an Eligible Employee for coverage as provided in the Agreement.
- 10.17. Enrollment Application or Enrollment/Change Form - means the form required by SIMNSA to be completed, signed and submitted by the Group to SIMNSA, for the purpose of enrollment, altering the enrollment of the Subscriber and the Subscriber’s Dependents as Members, and/or for notifying SIMNSA of any applicable changes in Member information. A copy of the Enrollment Application or Enrollment/Change Form will be provided to the Subscriber .
- 10.18. Inpatient - means: a) an individual who requires routine or specialized hospital services and is confined as a bed patient in a hospital; or b) services rendered to an individual confined as a bed patient in a hospital.
- 10.19. Medical Coordinator - means a physician, designated by SIMNSA, who is responsible for the administration of the Health Plan’s medical programs.
- 10.20. Medical Group - means a group of physicians practicing in a professional corporation or association, which has contracted with the SIMNSA Health Plan to provide Covered Services to said Members who have selected a Primary Care Physician who is a member of that Medical Group.
- 10.21. Medically Necessary – means a health care service, treatment or supply that the Plan determines to be (a) rendered for the treatment or

diagnosis of a condition, disease, bodily injury or Mental Disorder, including Severe Mental Illness or Serious Emotional Disturbances; (b) consistent with the patient's symptoms and diagnosis; (c) of a type, level of intensity and duration, and in a setting that is appropriate for safe and adequate care and treatment; (d) consistent with generally accepted standards for good medical practice within the organized medical community; (e) not mainly for the convenience of the treating provider, the Member or the Member's family; (f) rendered at the least restrictive level of care providing effective treatment of the patient's condition; and (g) in the case of an Emergency, a health care service, treatment or supply rendered at the nearest available facility.

- 10.22. Member - means any person enrolled in the SIMNSA Health Plan as a Subscriber or Dependent.
- 10.23. Mental Disorder - means a disease, including Severe Mental Illness and Serious Emotional Disturbance of a child, whether or not it has a physiological or organic basis, and for which treatment is generally provided by or under the direction of a mental health professional, such as a psychiatrist or psychologist. A mental disorder includes, but is not limited to: schizophrenia, schizoaffective disorder, bipolar disorder (manic-depressive illness), major depressive disorders, panic disorder, pervasive mental developmental disorder or autism, psychotic depression, obsessive-compulsive disorder anorexia nervosa, and bulimia nervosa.
- 10.24. Mexican National - means a) a person born in Mexico; b) a person born in another country with a Mexican father or a Mexican mother, or both; c) a foreign woman or man who marries a Mexican man or woman and lives in Mexico; or d) a foreigner who becomes naturalized in Mexico.
- 10.25. Newborn child –A child between birth and age 36 months.
- 10.26. Pregnancy – A pregnancy is three trimesters of pregnancy and the immediate postpartum period.
- 10.27. Occupational Illness or Injury - means a disease or accidental bodily injury that arises out of (or in the course of) any work for pay or profit, or in any way results from a disease or injury which does. However, if proof is furnished to the SIMNSA Health Plan that the Member is covered under a worker's compensation law or similar law, but is not covered for a particular disease or injury under such law, that disease or injury will not be considered "occupational," regardless of cause.
- 10.28. Open Enrollment Period - means a period of time established by the Group and SIMNSA during which eligible Employees and their

eligible Dependents may be enrolled as Members. Members may also add and/or delete eligible Dependents at this time.

- 10.29. Out-of-Area Care/Out-of-Area Services - means those services and supplies provided outside the SIMNSA Health Plan's service area. Coverage for such services is limited to Medically Necessary Emergency Services and Urgent Care Services only.
- 10.30. Outpatient - means medical services rendered in a physician's office, in an appropriate licensed facility, or as non-hospitalized treatment in that part of a hospital designed to accommodate ambulatory or Emergency patients.
- 10.31. Participating Provider/Facilities - means a licensed health care professional or licensed facility who or which, at the time care is rendered to a Member, has a contract in effect with SIMNSA to furnish care to Members.
- 10.31.1. Participating Physician - means any recognized practitioner, rendering a service covered by the Agreement, licensed in the state or jurisdiction of practice, and practicing within the scope of his or her license, who has entered into a written agreement with SIMNSA to provide Covered Services to Members in accordance with the terms of the Agreement.
- 10.31.2. Participating Facility - means a facility that is owned by or has contracted with SIMNSA to provide Covered Services to Members.
- 10.32. Plan's Service Area – The Plan's service area consists of the border cities of Tijuana, Tecate and Mexicali, Mexico.
- 10.33. Pregnancy – A pregnancy is three trimesters of pregnancy and the immediate postpartum period.
- 10.34. Premium - means the periodic prepayment fees, including any contributions to Group by Subscribers s, which Group agrees to pay SIMNSA for Covered Services.
- 10.35. Prescription Drugs – In the United States all pharmaceuticals approved by the F.D.A. In Mexico, any pharmaceutical approved by the government of Mexico and by SIMNSA as a plan prescribed drug.
- 10.36. Serious Chronic Condition – A serious chronic condition is 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.

- 10.37. Serious Emotional Disturbance(s) of a Child or Adolescent means the mental disorder(s), as identified in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, of a minor under the age of eighteen (18) years. A Serious Emotional Disturbance of a Child is a mental disorder that is other than a primary substance use disorder or developmental disorder, and which results in behavior inappropriate to the child's age according to expected developmental norms.
- 10.38. Severe Mental Illness means a mental disorder:  
  
Which is severe in degree and persistent in duration,  
  
Which may cause behavioral functioning which interferes substantially with the primary activities of daily living, and  
  
Which may result in an inability to maintain stable adjustment and independent function without treatment, support, and rehabilitation for a long or indefinite period of time.  
  
Severe Mental Illnesses include, but are not limited to, 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, as well as other affective disorders or other severely disabling mental disorders.
- 10.39. SIMNSA Health Plan – means Sistemas Medicos Nacionales, S.A. de C.V.
- 10.40. Subscriber – means the person whose employment or other status, except for family dependency, is the basis for eligibility for membership in SIMNSA. Effective January 1, 2005, the Subscriber must be employed in San Diego or Imperial counties, and must be a Mexican National.
- 10.41. Terminal Illness – A terminal illness is an incurable or irreversible condition that has a high probability of causing death within one year or less.
- 10.42. Totally Disabled or Total Disability - means that an individual is prevented, because of injury, illness or other physical condition, from performing all of his or her normal activities (those of a person of like age and sex in good health prior to the occurrence of the disability), including, but not limited to, the ability to engage in any work or other gainful activity for which he or she is, or could reasonably become, fitted by reason of education, training or experience. A person who is able to work, attend school, or perform household activities on a part-

time basis is not totally disabled. Determinations regarding the existence of total disability shall be made on the basis of medical examination of the person claiming such disability, in accordance with the provisions of the Agreement.

- 10.43. Urgent Care Services – means the Covered Services (including urgent dental services, for Members who have elected one of SIMNSA’s dental benefits plans), that are needed to prevent serious deterioration of a Member’s physical or mental health resulting from an unforeseen illness or injury for which treatment cannot be delayed until the Member is able to see his or her primary care physician during regular office hours.

## **11. ELIGIBILITY:**

If you are an employee of Group who meets the eligibility requirements established by your Group Contract Holder, you and your Dependents may be eligible for “SIMNSA” Health Plan coverage. The Eligible Employee may enroll himself or herself as a Subscriber , and may enroll his or her Dependents if he or she and they meet the Group’s waiting period and meet the requirements stated below.

- 11.1. Subscriber - To be eligible to enroll as a Subscriber, you must:
- 11.1.1. Be an Eligible Employee of the contracting group and reside within 50 miles of the Plan’s service area; and
  - 11.1.2. Desire and be willing to obtain all medical services (except in cases of Emergency and Urgent Care) from Participating Providers within the Plan’s Service Area in Mexico.
- 11.2. Dependents - Eligible Dependents must be willing to obtain all medical services (except in cases of Emergency and urgent care) from Participating Providers within the service areas in the Republic of Mexico. Eligible Dependents include:
- 11.2.1. The Subscriber’s spouse or, for contracts issued, renewed or amended on or after January 2, 2005, Domestic Partner;
  - 11.2.2. The Subscriber’s unmarried natural or adopted children under age 19;
  - 11.2.3. Any other unmarried children up to age 19, including stepchildren and foster children, living with the Subscriber on a full-time basis in a regular parent-child relationship, and for whom, upon the Plan Administrator’s request, the Subscriber can furnish satisfactory evidence of eligibility.

- 11.2.4. The Subscriber's natural or adopted children, step children, or children in the Subscriber's custody, who are from age 19 to age 23 and who are regularly attending school qualify as Dependents. Written verification of eligibility from an official of the school where the child attends may be requested at any time by the Plan Administrator. Students becoming totally disabled while attending school continue to be eligible for coverage until the earlier of the end of the semester in which the Dependent is no longer disabled, or the Dependent reaches age 23. *Student Dependents attending school and receiving care outside the service area are eligible for Health Plan coverage for medical emergencies and urgent care services only.*
- 11.2.5. A Dependent child who is both incapable of self-sustaining employment because of mental incapacity or physical handicap and chiefly Dependent upon the Subscriber for support may be eligible for coverage beyond the maximum age for dependent children, as long as the child continues to be incapacitated. It is the Subscriber's responsibility to furnish the Plan Administrator with appropriate medical documentation of incapacitation and proof of dependency within 31 days after the Dependent reaches the maximum age.
  - 11.2.5.1. Once eligibility has been verified, the Plan Administrator may request yearly evidence that a child continues to qualify for coverage as an incapacitated child.

### 11.3. Ineligible Persons

- 11.3.1. An Employee is not eligible to subscribe if he or she is retired at the time that the Group Contract Holder first contracts with the Plan for the provision of Covered Services.
- 11.3.2. A Dependent is not eligible to subscribe if covered by Medicare.
- 11.3.3. An applicant is not eligible to enroll if he/she has had his or her membership in the Plan previously terminated because of:
  - 11.3.3.1. Behavior that threatens the safety of Plan employees, Providers, Members or other patients, or repeated behavior that substantially impairs the

Plan's ability to furnish or arrange services for the Member or other Members or a Provider's ability to provide services to other patients.

- 11.3.3.2. Intentional failure to furnish required information, or intentionally furnishing incorrect or incomplete information.
- 11.3.3.3. Misuse of a Health Plan identification card, including permitting the use of a Member's Health Plan identification card by any other person, or using another person's card. A misused card may be retained by SIMNSA, as well as the Member's own ID card; and all rights of the Member or Members involved and all such Member's Dependents may be terminated effective immediately upon written notice from the SIMNSA Health Plan.
- 11.3.3.4. Failure to pay a required Copayment or any other payment which the Member is obligated to pay according to the SIMNSA Health Plan Evidence of Coverage.
- 11.3.3.5. Failure to pay the required contribution due for contributory coverage.

## **12. ENROLLMENT:**

Application for enrollment may only occur as specified below. The Subscriber must obtain an Enrollment/Change Form from the benefits office of the Group. The Enrollment/Change Form must contain all the required information regarding the employee and his/her Dependents who are eligible and applying for coverage. It must be signed by the Subscriber and a representative of Group and must be submitted to SIMNSA. Eligible persons may be enrolled regardless of health status, age or requirements for health services, as long as they satisfy the eligibility requirements from Section 12. However, no person is eligible to re-enroll who has had coverage terminated as stated in Section 12.3.3 of this EOC.

### 12.1. Open Enrollment

Eligible Employees may apply for coverage for themselves and their eligible Dependents during an open enrollment period specified in the Group Application. SIMNSA Health Plan may decline coverage of any Employee or Dependent if it does not receive a completed Enrollment/Change Form within 31 days after the open enrollment period has ended.

## 12.2. Enrollment of Newly Eligible Employees

New Employees of Group who become eligible for coverage at other than during an open enrollment period shall be entitled to apply for coverage in the SIMNSA Health Plan within 31 days after becoming eligible, or during a subsequent open enrollment period.

## 12.3. Enrollment of Newly Eligible Dependents

12.3.1. Dependents who become eligible (e.g., by marriage) after the Subscriber's coverage commences may be enrolled within 31 days of their eligibility dates, or the Subscriber may wait until your Group's next open enrollment period to do so.

12.3.2. A Subscriber's newborn child is covered for 31 days from the date of birth. To continue coverage beyond this initial 31-day period, the Subscriber must submit a properly completed Enrollment/Change Form and premium, if applicable, for that child, within 31 days from the date of birth. If the Subscriber's coverage does not require the payment of an additional premium for a newborn child, the Subscriber must still enroll the child within that 31-day period.

12.3.3. A legally adopted child or a minor child placed for adoption in the Subscriber's custody will be treated as a covered Dependent from the moment the child is placed in the Subscriber's custody, provided coverage of the child's medical expenses is not provided by a public or private agency or entity. The child is automatically covered for 31 days from the date of custody. To continue coverage beyond the initial 31-day period, the child must be enrolled within 31 days from the date of such placement or adoption and additional premium paid, if applicable. For the purposes of this section, "custody" shall mean that the Subscriber is legally responsible for the child, even though the child may not have been physically placed in the Subscriber's home.

## 12.4. Late Enrollment

An employee or Dependent not enrolled in the SIMNSA Health Plan within 31 days of becoming eligible for coverage will be considered a late enrollee and will not be permitted to enroll until the Group's next open enrollment period.

12.5. Notification of Change in Status

It is the Subscriber's responsibility to notify Group of any change affecting the Subscriber's eligibility, or that of the Subscriber's family members, by submitting an Enrollment/Change Form to a designated representative of Group Contract Holder within 31 days of the change. This shall include, but not be limited to: change of address; deletion of a Dependent as a result of marriage, divorce or death; change of Dependent disability or dependency status; and enrollment or disenrollment in Medicare of any Member covered under the Agreement. Notification of status changes must be submitted by the Group to SIMNSA within 31 days of the event. If the Subscriber does not provide such notice and SIMNSA discovers the change, SIMNSA will use the true facts to determine whether coverage is in force.

12.6. Right to Receive and Release Necessary Information

Pursuant to the authorization contained in and upon the Subscriber's signature on the Enrollment/Change Form, the Medical Coordinator shall have the right to receive and release medical information necessary to implement and administer the terms of the Agreement and this Evidence of Coverage, subject to applicable requirements established by state or Federal law. Information from medical records of Members and information received by Health Plan staff related to the physician-patient relationship shall be kept confidential and, except as reasonably necessary to implement and administer the terms of the Agreement and this Evidence of Coverage, shall not be disclosed without the written consent of the Member involved. A STATEMENT DESCRIBING SIMNSA'S POLICIES AND PROCEDURES FOR PRESERVING THE CONFIDENTIALITY OF MEDICAL RECORDS IS AVAILABLE AND WILL BE FURNISHED TO YOU UPON REQUEST.

**13. EFFECTIVE DATES OF COVERAGE:**

The coverage for the Subscriber and his/her Dependents, under the terms of the Agreement, shall become effective as follows:

13.1. Effective Date of Agreement

For Subscribers and family members who are enrolled on the effective date of the Agreement, coverage will begin on the date the Plan becomes effective for your Group. The SIMNSA Health Plan reserves the right to assume control of care using Participating Providers, as

determined by the Medical Coordinator. Such services are not covered if the services are covered by another plan of benefits on that date or if they would not have been covered by SIMNSA if the person had been a Member when treatment commenced.

13.2. Newly Eligible Employees and Dependents

13.2.1. For Subscribers becoming eligible for coverage after the effective date of the Agreement, and for family members eligible to be enrolled at the same time as the Subscriber, coverage will begin on the date enrolled, if enrolled within 31 days of the Subscriber's eligibility date.

13.2.2. For family members becoming eligible after the Subscriber is enrolled, coverage will become effective on the date enrolled, provided the Dependent is enrolled within 31 days of his or her eligibility date. However, newborns and adopted children are automatically covered from birth or, if later, from the date the Subscriber obtains custody of an adopted child.

13.3. Open Enrollment

Coverage shall be effective on the first day of the month specified in the Group Application, following the open enrollment period.

13.4. Deferred Effective Date of Coverage

13.4.1. Total Disability

For individuals who are totally disabled, but otherwise eligible, on the effective date of the Agreement, coverage for expenses directly related to any conditions causing the Member's total disability will be effective on the date the period of extended benefits under the prior plan ends.

**14. TERMINATION OF BENEFITS:**

The following is a description of the circumstances under which a Subscriber's coverage may be terminated. The provisions are addressed to the Subscriber, but, where appropriate, also apply to your covered Dependents:

14.1. The Group Contract Holder can terminate a Subscriber's SIMNSA Health Plan coverage:

14.1.1. By giving 30 days written notice to Sistemas Medicos Nacionales, S.A. de C.V. that " SIMNSA " Health Plan coverage is to be discontinued.

14.2. SIMNSA can terminate a Subscriber's coverage:

14.2.1. At the end of the month in which any Member ceases to be eligible.

14.2.2. If premiums are not paid on the date specified in your Group Contract Holder's Contract, termination of the Contract will be effective at midnight on the fifteenth (15<sup>th</sup>) day after your Group Contract Holder has been duly notified and billed for the charge. In addition, coverage will terminate at midnight on the fifteenth (15<sup>th</sup>) day after your Group Contract Holder has been duly notified and billed for the charge. Your Group Contract Holder is responsible for notifying you fifteen (15) days before your coverage ends due to termination of the Group Contract.

14.2.2.1. If your Group Contract Holder submits payment of the past-due premium more than 15 days after the date of the Plan's notice of termination, the Plan will refund such payment within 20 business days and the Contract will not be reinstated.

14.2.3. If a Member permits any other person to use your Health Plan Member identification card, or if a Subscriber provides false information in order to obtain the benefits of this Plan, termination will be effective immediately upon written notice by SIMNSA Health Plan.

14.2.4. If the Subscriber acts such that he or she threatens the safety of Plan employees, Providers, Members or other patients, or their repeated behavior substantially impairs the Plan's ability to furnish or arrange services for the Member or other Members or a Provider's ability to provide services to other patients.

14.3. Reenrollment and Reinstatement

If the Subscriber terminates Health Plan coverage for him/herself or any of his/her family members (voluntarily or by non-payment of monthly premiums), the Subscriber may apply for re-enrollment during his/her Group Contract Holder's next open enrollment period, provided the Subscriber satisfies all Group Contract Holder and SIMNSA Health Plan eligibility requirements.

14.4. Renewal Provisions

The services and benefits covered under the Group Contract and Schedule of Benefits, and co-payments that may be charged to you,

may be changed by SIMNSA upon the completion of the contract year with at least 30 days notice. Your employer will notify you of any changes that affect you.

If the Subscriber believes that his/her membership was terminated improperly by SIMNSA, he/she may request a review of the termination by the Medical Coordinator and/or the California Director of the Department of Managed Health Care.

#### 14.5. Individual Continuation of Benefits

##### 14.5.1. Cal-COBRA Continuation Coverage

If an employer is subject to California Continuation Benefits Replacement Act (Cal-COBRA), a Subscriber has the right to continue his or her coverage and the right to continue his or her Dependents' coverage under the coverages of the Group contract under either state or federal law if the Subscriber's insurance under those coverages would have ended: (1) because the Subscriber's employment ended for a reason other than gross misconduct; (2) because the Subscriber's work hours were reduced. Continuation coverage will be provided pursuant to Cal-COBRA.

Each of a Subscriber's qualified Dependents has the right to continue insurance under the health care expense coverages of the Group Contract if the Subscriber's insurance for the qualified Dependent under those coverages would have ended due to the occurrence of a Qualifying Event, including (1) termination of the Subscriber's employment for a reason other than gross misconduct; (2) reduction in the Subscriber's work hours; (3) death of the Subscriber ; (4) in the case of Subscriber's spouse ceasing to be a qualified Dependent as a result of divorce or legal separation; (5) in the case of a Subscriber's qualified Dependent child's ceasing to be a qualified Dependent under the rules of the Group Contract; or (6) in the event the Subscriber becomes entitled to Medicare.

If your continued coverage begins on or after January 1, 2003, coverage may be extended up to thirty-six (36 months) after the date that your coverage would have otherwise have ended as a result of one of the reasons set forth in this Section 13.5. Your employer will give you a written election notice of the right to extend coverage. For more information concerning this extension of continuation coverage, including information regarding the length of time

for which coverage may be provided to members whose continuation coverage began prior to January 1, 2003, please contact the Plan at (619) 407-4082.

Continuation coverage may not be available to an individual who (1) is covered by or eligible for Medicare benefits under Title 18 of the Social Security Act; (2) is covered by or becomes eligible for coverage benefits under any arrangements of coverage for individuals in a group, whether insured or self-insured; (3) is covered, becomes covered, or is eligible for federal COBRA coverage; (4) is covered, becomes covered, or is eligible for coverage under Chapter 6A of the Public Health Service Act; (5) fails to meet the requirements for notification of a Qualifying Event or election of continuation coverage within the specified time limits; (6) fails to submit the correct premium amount in accordance with the terms and conditions of the plan contract; or (7) fails to satisfy other terms and conditions of the plan contract. For more information regarding the circumstances under which a member will not be eligible for COBRA or Cal-COBRA continuation coverage, please contact the Plan's Membership Coordinator at (619) 407-4082.

#### 14.5.2. Total Disability Continuation Coverage

If, when this Agreement is terminated as to the Group Contract Holder, a Member is receiving treatment for a condition for which benefits are available under this Agreement and which condition has caused Total Disability, then such Member will be covered, subject to all limitations and restrictions of this Agreement, including payment of Co-payments and premiums, for Covered Services directly relating to the condition causing Total Disability. After the first eighteen (18) months of continuation coverage under this Section, premiums will be increased up to 150% of the group plan rate. This extension of benefits terminates upon the earlier of (1) the end of the twelfth month after termination of this Agreement, or (2) the date the Member is no longer Totally Disabled as determined by the Plan, or (3) the date the Member's coverage becomes effective under any replacement contract or policy without limitation as to the disabling condition. A person is Totally Disabled if he or she satisfies the definition of Totally Disabled in this Agreement, as determined by the Plan.

#### 14.5.3. Notification of the Right to Continue Coverage

Pursuant to Cal-COBRA, you must notify the Plan in writing within sixty (60) days of the occurrence of the following Qualifying Events: (1) death of the Subscriber; (2) in the case of Subscriber's spouse ceasing to be a qualified Dependent as a result of divorce or legal separation; (3) in the case of a Subscriber's qualified Dependent child's ceasing to be a qualified Dependent under the rules of the Group Contract; or, (4) in the event the Subscriber becomes entitled to Medicare. If you fail to notify the Plan within sixty (60) days of any of these Qualifying Events, you will be disqualified and unable to receive continuation coverage.

The Plan will notify the Member's employer in writing within 5 working days of receipt of a Member's notification of the Qualifying Event,

Your employer will then give you a written election notice of the right to continue the insurance and the appropriate timelines for such election within fourteen (14) days of receiving notice of a Qualifying Event. It is the sole responsibility of your Employer to provide you with written notice. The Plan is not responsible for providing such notice.

#### 14.5.4. Election and Payment Requirements for Continuation Coverage

If you wish to continue coverage, you must submit a written request to the Plan by first class mail, or any other reliable means, within sixty (60) days of the later of: (1) the date your coverage under the group benefits plan terminated or will terminate by reason of a qualifying event, or (2) the date you were sent a notice that you may qualify for continuation coverage.

If you elect to continue coverage, you will pay the Plan the amount of the required premium payment, not to exceed 110% of the rate charged for a covered employee, or in the case of a covered dependent, not more than 110% of the rate charged to a similarly situated individual. For individuals who are determined to be disabled pursuant to Title II or Title XVI of the United States Social Security Act, the Plan will impose a higher premium after the first 18 months of continuation coverage. For disabled individuals the premiums will be increased up to 150% of the group plan rate after the first 18 months of continuation coverage.

Your first premium payment, required to establish coverage, must be delivered by first class mail, certified mail, or other reliable means of delivery within forty-five (45) days of the date you provided written election notice to the Plan. This first payment must equal an amount sufficient to pay any required premiums and all premiums due. If you fail to submit the correct premium amount within the forty-five (45) day period, you will be disqualified from receiving continuation coverage.

#### 14.5.5. Continuation Coverage under Prior or Successor Group Benefit Plan

If your continuation coverage terminates under a prior group benefit plan (prior to the date your continuation of coverage would terminate under the Cal-COBRA requirement), you may elect continuation coverage under this Plan for the balance of the period that you would have remained covered under the prior group benefit plan. However, the continuation coverage shall terminate if you fail to meet the successor plan's requirements pertaining to enrollment in, and payment of premiums in, the successor plan within thirty (30) days of receiving notice of termination of the Agreement between the Plan and the employer.

In the event that the group contract between the Plan and the employer is terminated prior to the date that the qualified beneficiary's continuation coverage terminates, the qualified beneficiary may elect to continue coverage with the successor plan for the balance of the period that the qualified beneficiary would have remained covered under the Plan. The successor plan will provide you with necessary information to allow you to elect continuation coverage, including information concerning enrollment and premium information. Qualified beneficiaries must meet the requirements of the successor plan related to election of continuation coverage and payment of premiums.

#### 14.5.6. Termination of Continuation Coverage

Members should contact the Plan Administrator at (619) 407-4082 for information regarding the circumstances under which continuation coverage will terminate.

### 14.6. Continuation Coverage for Former Employees and Former Spouses

#### 14.6.1. Former Employees

A former employee is eligible to extend continuation coverage beyond the coverage provided under Cal-COBRA if: (1) the former employee worked for the employer at least five years prior to the date of termination of employment; and (2) the employee was sixty (60) years of age or older on the date employment ended; and (3) the employee became eligible for continuation coverage prior to January 1, 2005.

Eligible former employees must notify the Plan in writing of his or her election to continue coverage beyond the date continuation coverage under Cal-COBRA is scheduled to end. Such written election notice must be received by the Plan thirty (30) days prior to the date continuation coverage is scheduled to end.

Coverage of benefits and premium payments will be subject to the same terms and conditions as if the continuation coverage under Cal-COBRA had remained in force.

#### 14.6.2. Former Spouses

The former spouse of an employee or former employee may be eligible to extend continuation coverage beyond the coverage provided under COBRA or Cal-COBRA if the former spouse was covered as a qualified beneficiary under COBRA or Cal-COBRA. Coverage of benefits and premium payments will be subject to the same terms and conditions as if continuation coverage under COBRA or Cal-COBRA had remained in force.

#### 14.6.3. Termination of Continuation Coverage

Continuation coverage provided pursuant to this section shall end automatically on the earlier of: (A) the date the individual reaches age sixty-five (65); or (B) the date the individual is covered under any group health plan not maintained by the employer or any other health plan; or (C) the date the individual becomes entitled to Medicare benefits; for a spouse, five years from the date on which continuation coverage under COBRA or Cal-COBRA was scheduled to end for the spouse; or the date on which the former employer terminates its group subscriber agreement with the Plan and ceases to provide coverage for any active employees through this Plan, in which case the Plan shall notify the former employee or spouse or both of the right to a

conversion plan. Continuation coverage under this Section may also terminate if the individual fails to pay the requisite premium.

Within fifteen (15) days of the Plan's receipt of the written request of an employer, the Plan shall provide employer replacing the Plan's contract with any information in possession of the Plan reasonably required to administer this coverage.

#### 14.7. Conversion Coverage

If a member's coverage under the group contract has been terminated by the employer, eligible employees or members may be entitled to convert to non-group memberships ("conversion coverage"), without evidence of insurability.

There are several reasons for which a conversion contract may not be available with respect to Members subscribed under a group contract.

14.7.1. Conversion coverage will not be available if termination under the group contract occurred because: (1) the group contract terminated or the employer's participation terminated and the group contract is replaced by similar coverage under another group contract within fifteen (15) days of the date of termination of the group contract or the subscriber's participation; (2) the employee or member failed to pay amounts due to the Plan; (3) the employee or member was terminated by the Plan from the Plan for good cause; (4) the employee or member knowingly furnished incorrect information or otherwise improperly obtained benefits from the plan; or (5) the employer's benefit program is self-insured. In addition, a conversion contract may not be available if any beneficiary (1) is covered by or eligible for benefits under Title 18 of the Social Security Act; (2) is covered by or so eligible for coverage benefits under any arrangements of coverage for individuals in a group, whether insured or self-insured; (3) is covered for similar benefits by an individual policy or contract; or (4) has not been continuously covered during the three-month period immediately preceding the termination of coverage.

14.7.2. Election and payment requirements for Conversion Coverage

Unless waived in writing by the Plan, Members must make their written application and first premium payment for the conversion contract no later than 63 days after termination from the group. Members with conversion coverage following group contracts entered into, amended, or renewed prior to September 1, 2003 must make their written application and first premium payment for the conversion contract no later than 31 days after termination from the group.

#### 14.7.3. Notification Requirements for Conversion Coverage

It is the sole responsibility of your employer to notify you of the availability of terms and conditions of the conversion coverage within fifteen (15) days of the termination of group coverage.

### 13.10 Your Rights Under HIPAA If You Lose Group Coverage

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

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

- To be considered an eligible person under HIPAA you must meet the following requirements:
- You have 18 or more months of creditable coverage without a break of 63 days or more between any of the periods of creditable coverage or since your most recent coverage was terminated;
- Your most recent creditable coverage was a group, government or church plan that provided hospital, medical or surgical benefits. (COBRA and Cal-COBRA are considered group coverage);
- You were not terminated from your most recent creditable coverage due to nonpayment of premiums or fraud;
- You are not eligible for coverage under a group health plan, Medicare, or Medicaid (Medi-Cal);
- You have no other health insurance coverage; and

- You have elected and exhausted any continuation coverage you were offered under COBRA or Cal-COBRA.

There are important choices you need to make in a very short time frame regarding the options available to you following termination of your group health care coverage. You should read carefully all available information regarding HIPAA coverage so you can understand fully the special protections of HIPAA coverage and make an informed comparison and choice regarding available coverage. For more information, please call (619) 407-4082 or 83-29-02.

If you believe your HIPAA rights have been violated, you should contact the Department of Managed Health Care at 1-888-HMO-2219 or visit the Department's web site at [www.hmohelp.ca.gov](http://www.hmohelp.ca.gov).

#### **15. COVERED SERVICES:**

Members shall be entitled to the services described below when such services are: a) Medically Necessary; and b) (i) performed, prescribed, directed, provided or precertified by a Participating Provider or precertified by the Plan's Medical Coordinator, or (ii) Emergency or Out-of-Area Urgent Care Services.

MEMBERS ARE LIABLE FOR CERTAIN CO-PAYMENTS FOR SPECIFIC SERVICES, AS SPECIFIED IN THE SUMMARY OF BENEFITS AND SCHEDULE OF CO-PAYMENTS. IN THE EVENT SIMNSA HEALTH PLAN DOES NOT PAY NON-PARTICIPATING PROVIDERS, MEMBERS MAY BE LIABLE TO THE NON-PARTICIPATING PROVIDERS FOR THE COSTS OF SERVICES IF SAID SERVICES WERE NOT PRE-AUTHORIZED OR ARE NOT COVERED SERVICES UNDER THE PLAN'S SCHEDULE OF BENEFITS.

The Participating Provider shall not impose any charges on Members for Covered Services, other than Co-payments. Participating Provider will never, under any circumstances including nonpayment by group or health plan, the insolvency of group or health plan, or breach or termination of agreement, seek compensation from, have any recourse against or impose additional charges on any Member of this plan.

Some hospitals and other providers do not provide one or more of the following services that may be covered under your plan contract and that you or your family member might need: family planning; contraceptive services, including emergency contraception; sterilization, including tubal ligation at the time of labor and delivery; infertility treatments; or abortion. You should obtain more information before you enroll. Call your prospective doctor, medical group, independent

practice association, or clinic, or call the health plan at (619) 407-4082 or 683-29-02 to ensure that you can obtain the health care services that you need.

#### 15.1. Health Maintenance and Preventive Services

- 15.1.1. Well-child care, including physician hospital visits for newborn children.
- 15.1.2. Periodic health assessments for the prevention and detection of disease for adults and children, including: (1) routine cancer screening services on a reasonable periodic basis; (2) screening and diagnosis of prostate cancer when Medically Necessary and consistent with good professional practice; and (3) annual cervical cancer screening, including the human papillomavirus (HPV) screening test, upon referral of the patient's provider and operating within the scope of practice.
- 15.1.3. Annual physical examinations, including "well woman" services such as pap smears and mammography's.
- 15.1.4. Pediatric and adult immunizations and inoculations, including, but not limited to, diphtheria, poliomyelitis, tetanus, measles, pertussis, and tuberculosis (except when required for foreign travel or employment).
- 15.1.5. Vision and hearing screenings for the purpose of determining hearing losses and the need for vision correction.
- 15.1.6. Periodic patient education sessions for Members with certain illnesses and Chronic conditions, including diabetes, arterial hypertension, cancer, bronchial asthma and leukemia, requiring additional care other than just immediate treatment and follow-up. It is important that Members with these conditions understand more about their particular illness and what they can do as patients to help in their treatment. Your treating Participating Physician will refer you and assist you in scheduling you to attend these sessions.

Your primary care physician can also provide individual counseling and education on the best way to deal with these type of illnesses. It is in the best interest of both the Member and the Physician to keep these illnesses under control.

15.2. Physician Services for the Diagnosis and Treatment of Illness and Injury.

All physician services, except for medical emergencies and urgent care services, must be provided by a Participating Provider. Physician services include, but are not limited to:

- 15.2.1. Office visits; or home visits, when Medically Necessary or in connection with post-operative home health care, if the Member is too ill or disabled to be seen at the physician's office.
- 15.2.2. Surgical services on an inpatient or outpatient basis, including surgical assistance where Medically Necessary, and anesthesiology services.
- 15.2.3. Physician visits and examinations during Certified Confinement in a hospital.
- 15.2.4. Medical consultation services ordered by a Participating Physician.

15.3. Allergy Care

Allergy treatment, when certified by a Participating Provider and SIMNSA Health Plan, including testing, evaluation, allergenic extract, and Medically Necessary injections.

15.4. Family Planning

- 15.4.1. Voluntary sterilization (tubal ligation and vasectomy), when precertified by the Plan's Medical Coordinator.
- 15.4.2. Advice concerning contraception and family planning.

15.5. Reconstructive Surgery

- 15.5.1. Surgery performed to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors or disease to improve function and/or to create a normal appearance, to the extent possible.
- 15.5.2. Breast reconstruction and surgically implanted breast prostheses following a mastectomy.

## 15.6. Hospital Services

All hospital services, except in the case of a medical Emergency or urgent care situation, must be provided at Participating Facility, arranged by Participating Physician, and certified by the Medical Coordinator.

### 15.6.1. Inpatient Services

15.6.1.1. Inpatient services, including professional services, semi-private room and board (private room only when Medically Necessary and precertified by the Medical Coordinator), general nursing care (private duty nursing only when precertified by the Medical Coordinator), meals and Medically Necessary special diets, use of operating room and related facilities, use of intensive care unit and related services, use of delivery room and nursery, radiology services, laboratory and other diagnostic tests, casts and splints, surgically implanted prosthetic devices, drugs, anesthesia, oxygen services, radiation therapy, inhalation therapy, chemotherapy, and blood and blood plasma.

As used above (and under Section 15.15, Durable Medical Equipment and Prosthetic Devices), “prosthetic” means a mechanical device that replaces the function of an internal or external body part.

### 15.6.2. Outpatient Services

Outpatient services provided or precertified by a Participating Provider, including professional services, radiation therapy, chemotherapy, outpatient surgery and outpatient rehabilitation services; other facilities, services, supplies and appliances related to ambulatory care and listed under Inpatient Services, when provided or precertified by the Medical Coordinator. Outpatient services *do not* include emergency room services.

## 15.7. Maternity Care and Related Newborn Care Benefits

15.7.1. Services for any condition arising from pregnancy (including prenatal diagnosis of genetic disorders of the fetus with high-risk pregnancies) and childbirth, including

complications of pregnancy, involuntary abortion, delivery, prenatal and postpartum care.

15.7.2. The following coverage is provided for a mother and newly born child: (1) a minimum of 48 hours of inpatient care following a vaginal delivery; (2) a minimum of 96 hours of inpatient care following a cesarean section; or (3) a shorter inpatient stay, if requested by a mother, and if determined to be medically appropriate by the physician in consultation with the mother. If a Member requests a shorter inpatient stay and resides within the Plan's Service area, the Member will be covered for one home health care visit scheduled to occur within 24 hours of discharge. An additional visit will be covered when prescribed by the physician.

15.7.3. Newborn Care: Hospital nursery and well-baby care during the mother's hospital confinement, including circumcision and pediatrician's visits.

#### 15.8. Pediatric Asthma

The following equipment and supplies will be covered when Medically Necessary for the management and treatment of pediatric asthma: nebulizers, including face masks and tubing; peak flow meters; and inhaler spacers. We also provide education for pediatric asthma, including education concerning the proper use of all covered devices. All education provided shall be consistent with current professional medical practice.

#### 15.9. Mastectomies

Following Medically Necessary removal of all or part of a breast, we cover reconstruction of the breast, surgery and reconstruction of the other breast to produce a symmetrical appearance, and treatment of physical complications, including lymphedemas. The length of hospital stay associated with any of these procedures shall be determined by the attending physician and surgeon in consultation with the patient, consistent with sound clinical principles and processes. We (the Plan) shall not require the treating physician or surgeon to receive prior approval in determining the length of hospital stay following these procedures.

#### 15.10. Oral Surgery Services

Oral surgical services rendered to Members when such services consist of the reduction or manipulation of fractures of facial bones; excision of lesions of the mandible, other facial bones, mouth, lip, or

tongue; incision of lesions of the accessory sinuses, mouth, salivary glands, or ducts; reconstruction or repair of the mouth or lip to correct functional impairment caused by congenital defect or accidental injury. All oral surgical services must be precertified by the Medical Coordinator. Care of teeth or dental structures, extractions or corrections of impactions, and services related to malocclusion or malposition of the teeth and jaws are excluded from coverage, *with the exception of the following provision:*

#### 15.10.1. Limited Coverage of Associated Dental Charges

General anesthesia and associated facility charges for dental procedures rendered in a hospital or surgery center setting may be covered in the following circumstances, provided the clinical status or underlying medical condition of the patient requires dental procedures that ordinarily would not require general anesthesia to be rendered in a hospital or surgery center setting:

- Members who are under seven years of age.
- Members who are developmentally disabled, regardless of age.
- Members whose health is compromised and for whom general anesthesia is medically necessary, regardless of age.

Prior authorization from the Plan's Coordinator is required, except in case of an emergency.

Charges for the dental procedure itself, including, but not limited to, the professional fee of the dentist are not covered by this Plan.

#### 15.11. Medical Emergency and Urgent Care Services (see description of this benefit on pages 4-5 of this booklet)

##### 15.11.1. Follow-Up Treatment and Continuing Care

Follow-up treatment and continuing care following medical emergencies or urgent care services must be arranged by a Participating Provider. The Plan must be notified of any hospital confinement following a medical Emergency within 24 hours of such confinement, or as soon thereafter as is reasonably possible.

#### 15.12. Ambulance Services

#### 15.13. Laboratory and Radiology (Ancillary) Services

Diagnostic and therapeutic radiology services and laboratory tests, including mammography, provided on an outpatient basis by a Participating Provider, or at facilities designated by the Medical Coordinator, when certified by a Participating Provider.

15.14. Rehabilitation Services

Rehabilitation services by occupational, physical, or speech therapists, as Medically Necessary, upon certification.

15.15. Durable Medical Equipment and Prosthetic Devices

Purchase or rental of Durable Medical Equipment, such as wheelchairs, and the purchase of prosthetic devices, such as artificial limbs, when prescribed by a Participating Physician and precertified by the Medical Coordinator. Purchases of disposable items or supplies, except ostomy supplies, are not covered, unless such items and supplies are Medically Necessary for the management and treatment of insulin-using diabetes, non-insulin-using diabetes and/or gestational diabetes, in which case they are covered even if such items are available without a prescription.

15.15.1. Durable Medical Equipment

Coverage includes, but is not limited to, oxygen equipment, manual wheelchairs, crutches, glucometers, etc., and is provided when Medically Necessary and not solely for a Member's convenience upon prescription and recommendation by a Participating Provider, when precertified by SIMNSA Health Plan and obtained through a Participating Provider. SIMNSA Health Plan retains the option to provide coverage for the lease or purchase of Durable Medical Equipment. The initial purchase of such equipment and accessories needed to operate it is covered only if SIMNSA Health Plan is shown that long term use is planned, the equipment cannot be rented, or it is likely to cost less to buy than to lease. Replacement of such purchased equipment and accessories will be covered only if SIMNSA Health Plan is shown that replacement is needed due to a change in the Member's physical condition, or it is less costly to replace than to repair existing equipment or rent like equipment. Not included are charges for more than one item of equipment for the same or similar purpose.

#### 15.15.2. Orthotic and Prosthetic Devices

Custom fitted orthotics (except foot orthotics used solely as supportive devices) and other prosthetic devices, except surgically implanted prosthetic devices (see Inpatient Hospital Services), if determined to be Medically Necessary and precertified by a Participating Provider and Medical Coordinator. Replacement of an orthotic or prosthetic device is covered when the existing device cannot be repaired or it is less costly to replace than repair, or replacement is recommended by the attending physician because of a change in the Member's physical condition. Over-the-counter items are excluded from coverage.

As used above, "orthotic" means an appliance or apparatus used to support, align, prevent, or correct a deformity or to improve the function of a movable body part.

#### 15.16. Home Health Care

In limited instances, home health cares services are available to Members when such services are Medically Necessary. The Member must reside within the Plan's service area to obtain this service. It is not available to Members residing in the United States. Available only for post-operative patients and in cases when the patient is unable to seek care at the Doctor's office, upon prior authorization by the Plan's Coordinator.

#### 15.17. Mental Health Services

Diagnosis and Treatment for severe mental illness of all Members and serious emotional disturbances of child Members will be available when such services are Medically Necessary.

Mental health or Chemical Dependency treatment services from a Participating Provider who is a psychiatrist or physician, when ordered by a Participating Provider, for the short-term evaluation, diagnosis and treatment of mental disorders including Severe Mental Illness and Serious Emotional Distress or crisis intervention.

Services provided under the Plan's coverage of Mental Health benefits shall not be subject to limits on the number of days or visits.

#### 15.18. Phenylketonuria

This Plan covers testing for and Medically Necessary treatment of phenylketonuria (PKU). Coverage for treatment of PKU shall be limited to those formulas and special food products that are available within the Plan's Service Area. In addition, this Plan shall only cover the cost of PKU treatment formulas and special food products to the extent it exceeds the cost of a normal diet.

15.19. Transplants

Cornea, heart, heart/lung, kidney, skin and bone grafts, bone marrow transplants, liver transplants for end stage liver disease and for children with biliary atresia, and other non-experimental or non-investigational transplant procedures, if precertified by the Medical Coordinator and not experimental or investigational treatment excluded from coverage under section 19.8 of this EOC.

**16. SECOND MEDICAL OPINIONS**

16.1. When requested by you or a Participating Physician on behalf of an enrollee, the Plan will authorize a second medical opinion by an appropriately qualified Participating Physician. If no appropriately qualified Participating Physician is available, then a second opinion by another appropriately qualified physician (or other health care professional, as appropriate) will be authorized. Reasons for second medical opinions to be authorized include but are not limited to the following:

16.1.1. You question the reasonableness or necessity of recommended surgical procedures;

16.1.2. You question a diagnosis or plan of care for a condition that threatens loss of life, loss of limb, loss of bodily function, or substantial impairment, such as a serious chronic condition;

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

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

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

- 16.2. Requests for second medical opinions may be submitted to the Plan on an “expedited basis” when you face an imminent and serious threat to your health, including but not limited to potential loss of life, limb or other major bodily function, or when the lack of timeliness would be detrimental to your ability to regain maximum function.
- 16.3. Second medical opinion requests will be approved or denied (and, if approved, will be rendered) within the following time limits:
  - 16.3.1. For Emergency Services/Expedited Requests – in a timely fashion, as appropriate to your condition, but no more than 72 hours, whenever possible.
  - 16.3.2. For Non-Emergency Services/Standard Requests: Requests for decisions involving retrospective review of the Plan’s decision will be made within 30 calendar days or less, as appropriate to the Member’s condition and will be communicated to the Member who received services, or the Member’s designee, within 30 days of the Plan’s receipt of information that is reasonably necessary to make the decision. Requests for decisions made prior to or concurrent with the provision of health care services (that do not meet the 72-hour review requirements) will be made in a timely fashion appropriate to the nature of the Member’s condition, not to exceed 5 business days from the Plan’s receipt of information reasonably necessary to make the determination.

**17. REQUESTS FOR STANDING REFERRALS**

- 17.1. In certain circumstances, Members may request a referral by a primary care provider to a specialist for more than one visit to the specialist, as indicated in the treatment plan, if any, without the primary care provider having to provide a specific referral for each visit. Members with a condition or disease that is: (1) life-threatening; or (2) degenerative and disabling, either of which requires specialized medical care over a prolonged period of time, may request that a specialist assume responsibility for providing or coordinating the Member’s medical care, including primary and specialty care.
- 17.2. If the request for a standing referral is approved by the Plan, the Member may receive treatment from the specialist without further referral from the Member’s primary care provider. The specialist may authorize such referrals, procedures, tests and other Covered Services as the Member’s primary care provider would otherwise be permitted to provide or authorize, subject to the terms of the treatment plan.

**18. PRESCRIPTION DRUG BENEFITS:**

Prescription drugs are covered in full after you make the Copayment listed under your Schedule of Benefits. All prescribed drugs must be obtained at the Plan's Participating Pharmacies only. (Except in Urgent and Emergency Cases in the United States) Your Participating Physician is familiar with the Plan's drug benefit, and prescribes medicine according to Plan guidelines. The Plan covers all Medically Necessary prescription drugs prescribed by Plan Physicians, and all drugs previously approved for coverage by the Plan for a medical condition, as long as: (1) a Plan Provider continues to prescribe the drug for the medical condition; and (2) the drug is appropriately prescribed and is considered safe and effective for treating the enrollee's medical condition. Your prescribing Plan Provider may prescribe another drug covered by the Plan that is medically appropriate for your condition. The Plan generally does not discriminate between coverage of brand name pharmaceuticals versus generic drug compositions, and will always cover a brand name drug if use of a generic drug is medically contraindicated. Medication that is considered for "general use" or usually obtained over the counter and without a prescription or without "Physician Indications" is not covered by the Plan and will not be prescribed by the Plan's Physician. You must purchase these items on your own.

**19. EXCLUSIONS FROM COVERAGE:**

19.1. Alternative Therapies

Alternative therapies, such as acupuncture, biofeedback, hypnotherapy, and recreational, educational, manipulative or sleep therapy, primal therapy, rolfing, psychodrama, megavitamin therapy, bioenergetic therapy, vision perception training, carbon dioxide therapy, or services related to such types of treatment.

19.2. Chiropractic Services.

19.3. Cosmetic or Plastic Surgery

Surgery that is performed to alter or reshape normal structures of the body in order to improve appearance.

19.4. Custodial and Long Term Care

19.5. Donor Expenses

Medical and hospital services for a donor or prospective donor when the recipient of an organ or tissue transplant is not a Member (when the recipient of a transplant is a Member, only costs directly related to determining the acceptability of, and Medically Necessary services directly related to, securing and implanting the organ or tissue are covered if the donor is also a Plan Member).

19.6. Exclusions and Limitations to the Prescription Drug Benefit

Except as provided above, coverage is not provided under this Health Plan for:

- 19.6.1. Services rendered by a non-participating Provider except as Medically Necessary for treatment of an Emergency or urgent care condition.
- 19.6.2. More than a 30-day supply per prescription or refill; except oral contraceptives, which may be dispensed in quantities of up to a 90-day supply, subject to one Copayment per 30-day supply.
- 19.6.3. Any refill in excess of the amount specified by the prescription order. Before recognizing charges, SIMNSA may require a new prescription, or evidence as to need, if a prescription or refill appears excessive under accepted medical practice standards.
- 19.6.4. Drugs used for the purpose of weight reduction, including appetite suppressants. This exclusion shall not apply to prescription drugs that are determined to be Medically Necessary for the treatment of morbid obesity pursuant to the definition set forth in Section 10.21.
- 19.6.5. Contraceptive drugs, ointments, foams, jellies and implantable drugs or devices, except oral and injectable contraceptives and diaphragms.
- 19.6.6. Smoking cessation aids or drugs. This exclusion shall not apply to smoking cessation drugs that are determined to be Medically Necessary pursuant to the definition set forth in Section 10.21, or that are provided in conjunction with participation in a smoking cessation program.
- 19.6.7. Cosmetics, health or beauty aids, or other products used to retard or reverse the effects of aging on the skin, or drugs used in the treatment of baldness (e.g., Retin A, Rogaine).
- 19.6.8. Any charges for the administration of prescription drugs or injectable insulin to the extent medically appropriate that prescription drugs or injectable insulin can be self-administered.
- 19.6.9. Non-medical items, such as support garments and other therapeutic or testing devices or appliances, regardless of their intended use, even when prescribed by a physician.

Drugs not prescribed by a SIMNSA Provider (other than drugs prescribed in the context of out of area Emergency and Urgent Care Services) and “over the counter” drugs as known in the United States Standards.

- 19.6.10. Prophylactic drugs for travel; drugs to enhance athletic performance.
- 19.6.11. Prescription drugs for procedures and services that are not Covered Services. For example, if an enrollee has elective cosmetic surgery which is not covered by the Plan, then prescription drugs required in connection with the procedure, e.g. anesthesia, pain medication, etc. would not be covered.
- 19.6.12. Replacement of lost or damaged prescriptions.
- 19.6.13. Any medication prescribed in a manner other than in accordance with the SIMNSA Health Plan’s procedures.

19.7. Educational Services, Behavioral Disorders, and Learning Disabilities

Services for remedial education, including evaluation or treatment of learning disabilities or minimal brain dysfunction, or developmental and learning disorders; behavioral training; and cognitive rehabilitation. Services, treatment, or diagnostic testing related to behavioral (conduct) problems, learning disabilities, or developmental delays; or educational testing and training.

This Exclusion shall not apply to the diagnosis and Medically Necessary treatment of Severe Mental Illnesses of a person of any age, and of serious emotional disturbances of a child, including: schizophrenia, schizoaffective disorder, bipolar disorder, major depressive disorders, panic disorder, obsessive-compulsive disorder, pervasive developmental disorder or autism, anorexia nervosa, and bulimia nervosa.

19.8. Experimental or Investigational Treatment

Services, tests, treatments, supplies, devices or drugs which Plan determines are not generally accepted by informed medical professionals in the United States and Mexico, at the time the services, tests, treatments, supplies, devices or drugs are rendered, as safe and effective in treating or diagnosing the condition for which their use is proposed.

19.9. Voluntary Abortions

This exclusion does not apply to: (1) abortions in Mexico when the abortion is Medically Necessary based on a physician's determination that the mother's life is in jeopardy; or (2) lawful Out-of-Area abortions when the abortion is Medically Necessary for the treatment of an Emergency or Urgent Care Services.

19.10. Hearing Aids

19.11. Mental Retardation and Deficiencies

19.12. Hospice Care. This exclusion does not apply to hospice services, to the extent available in Mexico, including: (1) skilled nursing, pain management and other hospice services requested by a patient in an acute care hospital setting; (2) personal counseling, support group activities, crisis intervention and referrals to community resources through mental health professionals (excluding services related to economic or financial needs); and (3) in-home respiratory therapy through a home health care company.

19.13. Private Nursing Care in the Home (other than pre-authorized home health services)

19.14. Not Medically Necessary Services

Services or supplies which are not Medically Necessary. (To appeal a determination that requested services are not Medically Necessary, Members should refer to the Inquiry and Grievance Procedure set forth in Section 7 of this EOC.)

19.15. Out-of-Area Services

Services outside the service area which would not be provided by SIMNSA Health Plan within the service area, or which were furnished after a Member's condition would permit the Member to return to the service area for continued care. This limitation does not apply to services, including but not limited to prescription medications, provided in connection with out-of-area Emergency Services and Urgent Care Services, even if such services would not be Covered Services within the Plan's Service Area.

19.16. Outpatient Supplies

Outpatient medical consumable or disposable supplies, such as syringes and elastic stockings, except as specified. This exclusion does not apply to outpatient supplies that are Medically Necessary for the management and treatment of insulin-using diabetes non-insulin-

using diabetes, and/or gestational diabetes. Personal Comfort or Convenience Items

Non-medical services or supplies not directly related to the medical treatment of the Member, such as guest meals and accommodations, telephone charges, travel expenses other than ambulance services, take-home supplies, services or supplies for personal comfort, cosmetics, dietary supplements, health or beauty aids, and similar services; housekeeping and meal services as part of home health care.

19.17. Private Duty Nursing

Private duty nursing and private rooms, except when Medically Necessary and certified by the Medical Coordinator.

19.18. Services for which Member is not Financially Responsible

Services for which a Member would not be financially responsible, even in the absence of the health care coverage provided by the Plan pursuant to the Agreement, including services performed by a member of the Member's family.

19.19. Services Prior to Commencement and after Termination of Coverage

19.20. Services Required by Third Parties

Services required by a non-Member for which a Member may be financially liable (for example, injuries resulting from an automobile accident for which Member is responsible).

19.21. Sex Change or Transformation

19.22. Sexual Dysfunctions

This exclusion shall not apply to prescription drugs that are determined to be Medically Necessary pursuant to the definition set forth in Section 10.21.

19.23. Total Disability

Services or expenses directly related to any condition causing a Member's total disability when the Member is totally disabled on the date of termination of a prior health plan and is entitled to extended benefits for total disability under the prior plan.

19.24. Transportation Services

Transportation services, except as specified.

19.25. Vision Care

Vision care, except for vision screenings as specified, including, but not limited to: eyeglasses and frames; contact lenses or other corrective lenses (except following cataract surgery); eye exercises; visual, training- and radial keratotomy or any other surgery primarily to correct refractive errors.

19.26. Weight Control

Medical or surgical treatment for weight control and/or obesity, including, but not limited to, gastric stapling, balloon insertion and removal, gastric bypass surgery, and other services, supplies and procedures, and complications arising therefrom, unless determined to be Medically Necessary by the Medical Coordinator.

19.27. Non-Medical Supportive Services, Employment Counseling, or Vocational rehabilitation counseling

19.28. Counseling for marital relationships, unless associated with the Acute phase of a mental or emotional disorder and certified by the Medical Coordinator prior to the delivery of the service.

**20. LIMITATIONS:**

20.1. Home health care services are available to Members only in limited circumstances, when such services are Medically Necessary. The Member must reside within the Plan's service area to obtain this service. It is not available to Members residing in the United States. It is available only for post-operative patients and in cases when the patient is unable to seek care at the Doctor's office, upon prior authorization by the Plan's Coordinator.

**21. COORDINATION OF BENEFITS:**

Covered Services from SIMNSA are subject to coordination of benefits (COB) if other payors also provide coverage for those services. The purpose of COB is to avoid duplication of benefits by paying or providing more than 100% of the cost of allowable expenses or the services provided therefore profiting from injuries or illnesses. SIMNSA Subscribers are required to provide information at the time of initial enrollment or at any time during membership of existing "other coverage" on the Subscriber's spouse, Domestic Partner, or other eligible Dependents.

Order of benefit determination rules: The rules that determine the order of benefit are as follows:

- 21.1. The benefits of a payor which covers a person as an employee is always primary payor.
- 21.2. When two or more payors cover the same Dependent/child, the benefits of the payor whose birthday falls earlier in a year are used before the benefits of the other payor.
- 21.3. Any situation other than those listed above will be determined by the Plan Administrator and shall be governed by the rules prescribed by the Director of the California Department of Managed Health Care and the Laws of the State of California.
- 21.4. Recovery of Overpayments.
  - 21.4.1. When SIMNSA is the secondary payor and the Covered Services provided by SIMNSA Health Plan, plus the coverage provided by other payors, exceeds the total amount of allowable expenses, then SIMNSA has the right to recover the amount of that excess payment, from among one or more of the following: a) any person to or for whom such payments were made; b) other payors; or c) any other entity to which such payments were made.
  - 21.4.2. This right of recovery shall be exercised at SIMNSA's discretion. Members shall execute any documents and cooperate with SIMNSA to secure its right to recover such overpayments.

**22. THIRD PARTY LIABILITY AND NON-DUPLICATION OF BENEFITS:**

- 22.1. For injuries caused by a third party or resultant complications, SIMNSA Health Plan covers services and other benefits. By signing the enrollment application, the Subscriber and his or her Dependents agree to reimburse SIMNSA Health Plan for the charges for all such Covered Services and benefits immediately upon obtaining a monetary recovery for such injury. This reimbursement obligation will not exceed the lesser of: (1) the total amount of recovery obtained by the Member; or (2) the sum of the reasonable costs actually paid by SIMNSA. By enrollment, each Member agrees to cooperate in protecting SIMNSA Health Plan's interest under this provision and to provide documents that may be necessary to protect SIMNSA Health Plan's rights. If the Member receives a judgment or settles a claim for an injury and the judgment or settlement does not specifically include payment for medical costs, SIMNSA Health Plan will nevertheless

have a lien against any such recovery for the charge for the Covered Services and benefits. Notwithstanding anything to the contrary contained herein, any lien asserted by SIMNSA Health Plan pursuant to this Section for Covered Services provided in the United States shall not exceed the limits mandated by California Civil Code §3040. SIMNSA Health Plan does not delegate its lien rights under this Section to any Participating Provider(s), and no Participating Providers will seek to assert any such rights against any Member.

- 22.2. SIMNSA Health Plan coverage does not duplicate any benefits to which a Member is entitled under Workers' Compensation law, employer liability laws, Medicare or CHAMPUS. SIMNSA Health Plan retains all sums payable under these laws for services provided. By enrollment, the Member agrees to submit the necessary documents requested by SIMNSA Health Plan to assist in recovering the maximum value of services the Member receives under Medicare, CHAMPUS, the Workers' Compensation law, or any other health plans or insurance policies. If the Member fails to submit documents reasonably requested by SIMNSA Health Plan, the Member must pay the charges for services received. Duplicate coverage in no way reduces the Member's obligation to make all required Co-payments.



## HIPAA Notice of Privacy Practices for Personal Health Information

**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.**

Dear SIMNSA Member:

This is your Health Information Privacy Notice from SIMNSA Health Plan. **Please read it carefully**

This notice describes how we protect the personal health information we have about you which relates to your SIMNSA coverage and how we may use and disclose this information. Personal Health Information includes individually identifiable information which relates to your past, present or future health, treatment or payment for health care services. This notice also describes your rights with respect to the Personal Health Information and how you can exercise those rights.

We are required to provide this Notice to you by the Health Insurance Portability and Accountability Act ("**HIPAA**"). For additional information regarding our HIPAA Medical Information Privacy Policy or our general privacy policies, please feel free to contact our office directly.

We are required by law to:

- maintain the privacy of your Personal Health Information;
- provide you this notice of our legal duties and privacy practices with respect to your Personal Health Information; and
- follow the terms of this notice.

We **protect** your Personal Health Information from inappropriate use or disclosure. Our employees, and those of companies that help us service your SIMNSA insurance, are required to comply with our requirements that protect the confidentiality of Personal Health Information. They may look at your Personal Health Information only when there is an appropriate reason to do so, such as to administer our products or services.

We will **not disclose** your Personal Health Information to any other company for their use in marketing their products to you. However, as described below, we will use and disclose Personal Health Information about you for business purposes relating to your Health Insurance coverage.

The main reasons for which we may **use** and may **disclose** your Personal Health Information are to evaluate and process any requests for coverage and claims for benefits you may make or in connection with other health-related benefits or services that may be of interest to you. The following describe these and other uses and disclosures, together with some examples.

- **For Payment:** We may use and disclose Personal Health Information to pay for benefits under your Health Insurance coverage. For example, we may review Personal Health Information contained on claims to reimburse providers for services rendered. We may also disclose Personal Health Information to other insurance carriers to coordinate benefits with respect to a particular claim. Additionally, we may disclose Personal Health Information to a health plan or an administrator of an employee welfare benefit plan for various payment-related functions, such as eligibility determination, audit and review or to assist you with your inquiries or disputes.
- **For Health Care Operations:** We may also use and disclose Personal Health Information for our insurance operations. These purposes include evaluating a request for Health Insurance products or services, administering those products or services, and processing transactions requested by you. We may also disclose Personal Health Information to Affiliates and to business associates outside of the SIMNSA Health Plan if they need to receive

Personal Health Information to provide a service to us and will agree to abide by specific HIPAA rules relating to the protection of Personal Health Information. Examples of business associates are: billing companies, data processing companies, or companies that provide general administrative services. Personal Health Information may be disclosed to reinsurers for underwriting, audit or claim review reasons.

- **Where Required by Law or for Public Health Activities:** We disclose Personal Health Information when required by federal, state or local law. Examples of such mandatory disclosures include notifying state or local health authorities regarding particular communicable diseases, or providing Personal Health Information to a governmental agency or regulator with health care oversight responsibilities. We may also release Personal Health Information to a coroner or medical examiner to assist in identifying a deceased individual or to determine the cause of death.
- **To Avert a Serious Threat to Health or Safety:** We may disclose Personal Health Information to avert a serious threat to someone's health or safety. We may also disclose Personal Health Information to federal, state or local agencies engaged in disaster relief as well as to private disaster relief or disaster assistance agencies to allow such entities to carry out their responsibilities in specific disaster situations.
- **For Health-Related Benefits or Services:** We may use Personal Health Information to provide you with information about benefits available to you under your current coverage or policy and, in limited situations, about health-related products or services that may be of interest to you.
- **For Law Enforcement or Specific Government Functions:** We may disclose Personal Health Information in response to a request by a law enforcement official made through a court order, subpoena, warrant, summons or similar process. We may disclose Personal Health Information about you to federal officials for intelligence, counterintelligence, and other national security activities authorized by law.
- **Other Uses of Personal Health Information:** Other uses and disclosures of Personal Health Information not covered by this notice and permitted by the laws that apply to us will be made only with your written authorization or that of your legal representative. If we are authorized to use or disclose Personal Health Information about you, you or your legally authorized representative may revoke that authorization, in writing, at any time, except to the extent that we have taken action relying on the authorization or if the authorization was obtained as a condition of obtaining your Health Insurance coverage. You should understand that we will not be able to take back any disclosures we have already made with authorization.

#### **Your Rights Regarding Personal Health Information We Maintain About You**

- **Right to Inspect and Copy Your Personal Health Information:** In most cases, you have the right to inspect and obtain a copy of the Personal Health Information that we maintain about you. To inspect and copy Personal Health Information, you must submit your request in writing to the applicable administrator listed above. To receive a copy of your Personal Health Information, you may be charged a fee for the costs of copying, mailing or other supplies associated with your request. However, certain types of Personal Health Information will not be made available for inspection and copying. This includes psychotherapy notes; and also includes Personal Health Information collected by us in connection with, or in reasonable anticipation of any claim or legal proceeding. In very limited circumstances we may deny your request to inspect and obtain a copy of your Personal Health Information. If we do, you may request that the denial be reviewed. The review will be conducted by an individual chosen by us who was not involved in the original decision to deny your request. We will comply with the outcome of that review.
- **Right to Amend Your Personal Health Information:** If you believe that your Personal Health Information is incorrect or that an important part of it is missing, you have the right to ask us to amend your Personal Health Information while it is kept by or for us. You must provide your request and your reason for the request in writing, and submit it to the applicable administrator listed above. We may deny your request if it is not in writing or does not include a reason that supports the request. In addition, we may deny your request if you ask us to amend Personal Health Information that:
  - is accurate and complete;
  - was not created by us, unless the person or entity that created the Personal Health Information is no longer available to make the amendment;
  - is not part of the Personal Health Information kept by or for us; or
  - is not part of the Personal Health Information which you would be permitted to inspect and copy.

- **Right to a List of Disclosures:** You have the right to request a list of the disclosures we have made of Personal Health Information about you. This list will not include disclosures made for treatment, payment, health care operations, for purposes of national security, made to law enforcement or to corrections personnel or made pursuant to your authorization or made directly to you. To request this list, you must submit your request in writing to the applicable administrator listed above. Your request must state the time period from which you want to receive a list of disclosures. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.
- **Right to Request Restrictions:** You have the right to request a restriction or limitation on Personal Health Information we use or disclose about you for treatment, payment or health care operations, or that we disclose to someone who may be involved in your care or payment for your care, like a family member or friend. While we will consider your request, **we are not required to agree to it.** If we do agree to it, we will comply with your request. To request a restriction, you must make your request in writing to the applicable administrator listed above. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply (for example, disclosures to your spouse or parent). We will not agree to restrictions on Personal Health Information uses or disclosures that are legally required, or which are necessary to administer our business.
- **Right to Request Confidential Communications:** You have the right to request that we communicate with you about Personal Health Information in a certain way or at a certain location if you tell us that communication in another manner may endanger you. For example, you can ask that we only contact you at work or by mail. To request confidential communications, you must make your request in writing to the applicable administrator listed above and specify how or where you wish to be contacted. We will accommodate all reasonable requests.
- **Right to File a Complaint:** If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the Department of Health and Human Services. To file a complaint with us, please contact SIMNSA Health Plan, 333 H Street Suite 6040, Chula Vista, CA 91910. All complaints must be submitted in writing. You will not be penalized for filing a complaint. If you have questions as to how to file a complaint please contact us at (619) 407-4082 or at [info@simnsa.com](mailto:info@simnsa.com).

#### **ADDITIONAL INFORMATION**

**Changes to This Notice:** We reserve the right to change the terms of this notice at any time. We reserve the right to make the revised or changed notice effective for Personal Health Information we already have about you as well as any Personal Health Information we receive in the future.

**Further Information:** You may have additional rights under other applicable laws. For additional information regarding our HIPAA Medical Information Privacy Policy or our general privacy policies, please contact us at [info@simnsa.com](mailto:info@simnsa.com) or write to us at SIMNSA Health Plan, 333 H Street Suite 6040, Chula Vista, CA 91910.