COMBINED EVIDENCE OF COVERAGE AND DISCLOSURE FORM

FOR SMALL EMPLOYER GROUPS

SIMNSA Health Plan
c/o International Healthcare, Inc.
2088 Otay Lakes Road, Suite 102
Chula Vista, CA 91913
(619) 407-4082

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

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.

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.

FOR INFORMATION ON YOUR RIGHT TO REQUEST CONFIDENTIAL COMMUNICATIONS, SEE PAGE 58 OR CONTACT THE PLAN.

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. 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. You may also access the Provider Directory at www.simnsa.com. As a Member of SIMNSA you are required to always use these Participating Physicians except when Emergency or Urgent Care Services are needed.

1.2. Facilities

Your Provider Directory also includes a list of Participating Facilities.

If Emergency or Urgent Care Services are required, you can go to any emergency room or urgent care, 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. State of Emergency

In the event that the Governor of California declares a state of emergency and you have any questions, including questions about loss of identification cards, access to prescription refills, or how to access health care, call SIMNSA 24 hours a day, 7 days a week, toll-free at 1-800-424-4652.

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.

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

If a Member requires Emergency Services, the Member should go to the nearest available emergency care facility. If the Emergency occurs in Mexico, you should go to the nearest available Emergency care facility in Mexico.

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 transport 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 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. Review of coverage for emergency services will be based on whether the Member reasonably believed an emergency existed based on the Member's age, personality, education, background, and other similar factors.

An Emergency can also include a psychiatric medical condition, which manifests itself by acute symptoms of sufficient severity that it renders the patient as being an immediate danger to himself or herself or to others or immediately unable to provide for, or utilize, food, shelter, or clothing, due to the mental disorder. An Emergency includes medically necessary treatment of a mental health or substance use disorder, including, but not limited to, behavioral health crisis services, provided to an enrollee by a 988 center or mobile crisis team, regardless of whether the service is provided by an in-network or out-of-network provider.

An Emergency also includes emergency and urgent care services ordered by a court pursuant to the Community Assistance, Recovery, and Empowerment ("CARE Act"). The CARE Act allows specific people, called "petitioners," to request voluntary treatment, services, support, and a housing plan for people, called "respondents," who have certain untreated severe mental illnesses, specifically schizophrenia or another psychotic disorder. Your benefits will cover the evaluation and provision of court-ordered emergency or urgent care medical services without a cost-share and without a requirement for prior authorization whether such emergency or urgent care services are provided at an in-network or out-of-network facility. For more information regarding the CARE Act visit www. https://www.chhs.ca.gov/care-act/.

5. URGENT CARE IN THE UNITED STATES OR IN MEXICO:

If a Member requires Urgent Care Services, the Member should go to the nearest available urgent care. If Urgent Care Services are needed while you are in the Plan's Service Area, you should go to the nearest Participating Facility.

6. WHAT CONSTITUTES URGENT CARE COVERED BY SIMNSA:

Urgent care is care that is needed to prevent serious deterioration of a Member's physical or mental health resulting from unforeseen illness or injury for which treatment cannot be delayed until the Member is able to return to the Plan's Service Area.

7. 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, telehealth visits, prescriptions, eye exams, etc., and must be made at the time of service. Telehealth visits will be treated the same as in-person visits for purposes of copayment costs. Out-of-Area Emergency Services also have a Copayment which may be waived if the Emergency is serious enough for hospital admission.

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.

7.1. 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. Please see Section 16 of this EOC for information on termination of benefits.

7.2. 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-hour notice, you may be required to make a Copayment, unless the appointment is missed due to circumstances beyond your control.

7.3. Out-of-Pocket Maximum

The Out-of-Pocket Maximums (OOPM) represent the most an individual Member or family will have to pay during the contract year before SIMNSA will pay 100 percent of the allowed amount for Covered Services.

All of a Member's Co-payments, including those for pediatric dental services, count towards the OOPM. Premiums and costs associated with non-Covered Services do not count towards the OOPM.

Please refer to your Summary of Benefits and Schedule of Copayments to determine the OOPM for individuals as well as the total OOPM for a family covered under a single Subscriber. The individual OOPM represents the total amount of expenses one Member must accumulate before no copayments are due. The family OOPM is the amount that all covered family must accumulate before the OOPM is met for all family members and no copayments are due. Once the family OOPM is met, no individual family Member needs to accumulate additional expenses towards their individual OOPM and no additional copayments will be due for the remainder of the contract year. If an individual reaches his or her OOPM before the family OOPM is reached, that individual will not have to pay any more Copayments- for the remainder of the contract year.

Members can contact SIMNSA at any time by telephone, e-mail, or in-person to request their up-to-date accrual balance toward their annual OOPM. In addition to specific requests, SIMNSA will mail accrual reports to Members in any month that they receive a covered service. Members may choose to receive the report electronically by signing into their member portal and requesting electronic communication or by contacting SIMNSA via e-mail, telephone, or in-person and requesting electronic reports. Electronic reports will be sent to the Member's e-mail address on record with SIMNSA. Members may change their e-mail address by contacting SIMNSA via e-mail, telephone, or in-person. Members who have opted out of receiving mailed

notices may opt back in at any time by contacting SIMNSA via e-mail, telephone, or in-person. These accrual reports will include the amount of out-of-pocket costs incurred by a member in a given benefit year. The report will include any cost share incurred by a member, the time period during which the accrual is tracked, and will be up-to-date as of the month prior to the mailing date of the notice (e.g. a notice mailed in May will include all cost share payments for the benefit year through April).

7.4 Annual/Lifetime Limit on Benefits

There is no annual or lifetime dollar limit on benefits.

8. 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 Eligible Dependents. 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.

9. INQUIRY AND GRIEVANCE PROCEDURE:

9.1. 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.
2088 Otay Lakes Road, Suite 102
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9.2. Procedure

9.2.1. 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 9.1; (2) a written letter submitted to either of the addresses listed above under subsection 9.1; or (3) through the Plan's online grievance form located on our website: www.simnsa.com.

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

9.2.3. All grievance must be submitted within 180 calendar days following any incident or action that is the subject of the Member's dissatisfaction.

9.2.4. Any member grievance must be submitted within 180 calendar days following any incident or action that is the subject of the member's dissatisfaction

9.2.5. Urgent Grievances: Notwithstanding anything to the contrary contained in this Section 9.2, the following shall apply to grievances involving either 1.) 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, or 2.) the improper cancellation, rescission, or nonrenewal of a member's plan:

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

9.2.5.2. 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.

9.2.5.3.

9.3. 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 (**1-888-466-2219**) and a TDD line (**1-877-688-9891**) for the hearing and speech impaired. The Department's internet website ***http://www.dmhc.ca.gov*** has complaint forms, IMR application forms and instructions online. If you believe your health coverage has been, or will be improperly cancelled, rescinded, or not renewed, you may also call the Department for assistance.

9.4. Right to Independent Medical Review

9.4.1. 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 under the jurisdiction of the DMHC that is 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.

9.4.2. 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.

9.5. Independent Medical Review for Denials of Experimental/ Investigational Therapies

9.5.1. 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.

9.5.2. The treatment must be for a life-threatening or seriously debilitating condition.

9.5.3. 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.

9.5.4. 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.

9.5.5. 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.

9.6. Arbitration

9.6.1. 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 and Section 9.6.2 through Section 9.6.8. 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 9.6.

9.6.2. It is understood that any dispute regarding health care services rendered in the United States, including claims of medical malpractice, that is as to whether any medical services rendered in the United States and 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.

9.6.3. 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.

9.6.4. 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.

9.6.5. 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.

9.6.6. 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.

9.6.7. All disputes, including claims of medical malpractice, which in any manner arise out of or relate to health care services rendered in the Republic of Mexico shall be subject to the jurisdiction of the Republic of Mexico. Further, any such disputes shall be resolved exclusively by binding arbitration and take place in the Republic of Mexico.

9.6.8. 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.

10. UTILIZATION REVIEW:

10.1. 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. Prior authorization is required for the following services: inpatient admissions; select inpatient and outpatient services; select durable medical equipment; select radiological and all nuclear imaging services; select dental services (for those covered by a dental plan) and vision services; office-administered injectable drugs, and home-infusion-administered drugs. Prior authorization is not required for emergency hospital admission Emergency and Urgent Care Services provided to Plan's enrollees in California are reviewed after treatment has been given.

Prior authorization is required for certain mental health and chemical dependency services, including post-stabilization and elective inpatient admissions, residential treatment, partial hospitalization, intensive outpatient programs, and electroconvulsive therapy.

10.2. The Plan shall have the full and exclusive power and authority, in its sole discretion and when consistent with the law, 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.

10.3. Your Participating Provider will work with you to obtain prior authorization from the Plan's Medical Director for any services you may require. 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.

10.4. 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.

10.5. 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.

11. CONTINUITY OF CARE:

11.1. SIMNSA Health Plan understands the importance of continuity of care and a Member's ongoing relationship with his or her treating physician. SIMNSA has historically had a very low Participating Provider turnover rate.

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:

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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.

11.2. 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, 1-888-466-2219, or at a TDD number for the hearing impaired at 1-877-688-9891, or online at www.dmhc.ca.gov.

11.3. 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, including maternal mental health, 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.

12. DEFINITIONS:

12.1. 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.

12.2. 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.

12.3. Behavioral Health Treatment – means the Covered Services, including applied behavioral analysis and evidence-based behavior intervention programs (including as referenced in Sections 12.26 and 12.28), that develop or restore, to the maximum extent practicable, the functioning of an individual with a

pervasive development disorder or autism, Autism spectrum, or other neurodevelopmental disorders and that are: (1) prescribed and provided by a Participating Provider; (2) provided under a treatment plan that has measurable goals over a specific timeline that is developed and approved by the Participating provider for the specific Member being treated, and (3) the treatment plan is reviewed at least every six months by a Participating Provider, modified whenever appropriate, and is consistent with the elements required under the law.

12.4. 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.

12.5. Chemical Dependency - means the abuse of, or psychological or physical dependence on, or addiction to alcohol, controlled substances, illegal drugs or barbiturates.

12.6. 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.

12.7. Chronic - means a condition lasting a long time.

12.8. 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.

12.9. Covered Services, coverage, or covered - means those services required to be covered under the law or otherwise described in Section 17 of this EOC and those Medically Necessary services and supplies 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.

12.10. 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.

12.11. 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.

12.12. 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.

12.13. Effective Date - means the date stated in the Group Application as the effective date of the Agreement between SIMNSA and the Group.

12.14. Eligible Employee – means either (1) any permanent employee who is actively engaged on a full-time basis in the conduct of the business of the small employer with a normal workweek of at least 30 hours over the course of a month, at the small employer's regular places of business, who has met any statutorily authorized applicable waiting period requirements. The term does not include sole proprietors or the spouses of those sole proprietors, partners of a partnership or the spouses of those partners, or employees who work on a part-time, temporary, or substitute basis. It includes any eligible employee, as defined in this paragraph, who obtains coverage through a guaranteed association. Employees of employers purchasing through a guaranteed association are eligible employees if they would otherwise meet the definition except for the number of persons employed by the employer. Permanent employees who work at least 20 hours but not more than 29 hours are eligible employees if all four of the following apply: (a) they otherwise meet the definition of an eligible employee except for the number of hours worked (b) the employer offers the employees health coverage under a health benefit plan (c) all similarly situated individuals are offered coverage under the health benefit plan (d) the employee shall have worked at least 20 hours per normal workweek for at least 50 percent of the weeks in the previous calendar quarter. Or (2) any member of a guaranteed association as defined in Cal. Health & Safety Code §1357.500 (m).

12.15. 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. 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.

12.16. Emergency Psychiatric Medical Condition – means a mental disorder that manifests itself by acute symptoms of sufficient severity that a Member may expect the absence of immediate medical attention to result in the Member being either of the following: (a) An immediate danger to himself or herself or to others or (b) Immediately unable to provide for, or utilize, food, shelter,
or clothing, due to the mental disorder.

12.17. 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.

12.18. Employee - means a person who satisfies the Group's employee requirements to qualify as an Eligible Employee for coverage as provided in the Agreement.

12.19. 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.

12.20. Grace Period – means the 30 consecutive days following the day the Notice of Grace Period is dated. As set forth in Section 16.2.4, a Notice of Grace Period will be sent following failure to pay the required premium. The party responsible for payment may pay past due premiums in full during the Grace Period in order to avoid termination of coverage.

12.21. Habilitative Services – means health care services and devices that help a person keep, learn, or improve skills and functioning for daily living.

12.22. 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.

12.23. Medical Coordinator - means a physician, designated by SIMNSA, who is responsible for the administration of the Health Plan's medical programs.

12.24. 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.

12.25. Medically Necessary – means a health care or other service, treatment or supply that the Plan determines to be (a) rendered for the treatment or diagnosis of a condition, disease, or bodily injury; (b) consistent with the patient's symptoms and diagnosis; (c) of a type, level of intensity and duration, and in a setting that is clinically 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 primarily for the convenience of the Member or the Member's family, treating physician, or other health care provider; (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 appropriate facility. "Least restrictive level of care" means the level of care that offers sufficient safety and effective treatment, but with the least restriction on the patient's activities.

12.26. Medically Necessary Treatment of a Mental Health or Substance Use Disorder – means a service or product addressing the specific needs of that patient, for the purpose of preventing, diagnosing, or treating an illness, injury, condition, or its symptoms, including minimizing the progression of that illness, injury, condition, or its symptoms, in a manner that is all of the following: (a) in accordance with the generally accepted standards of mental health and substance use disorder care, (b) clinically appropriate in terms of type, frequency, extent, site, and duration, (c) not primarily for the economic benefit of the health care services plan and subscribers or for the convenience of the patient, treating physician, or other health care provider.

12.27. Member - means any person enrolled in the SIMNSA Health Plan as a Subscriber or Dependent.

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. A mental disorder also includes any mental health condition identified as a "mental disorder" in the Fifth Edition – Text Revision, of the Diagnostic and Statistical Manual of Mental Disorders (DSM)-5-TR published by the American Psychiatric Association. "Mental disorder" includes, but is not limited to:

Neurodevelopmental Disorders;

a) Schizophrenia-spectrum and Other Psychotic Disorders

b) Bipolar and Related Disorders

c) Depressive Disorders

d) Anxiety Disorders

e) Obsessive-Compulsive and Related Disorders

f) Trauma- and Stressor-Related Disorders

g) Dissociative Disorders

h) Somatic Symptom and Related Disorders

i) Feeding and Eating Disorders

j) Elimination Disorders

k) Sleep-Wake Disorders

l) Sexual Dysfunctions

m) Gender Dysphoria

n) Disruptive, Impulse-Control, and Conduct Disorders

o) Substance-Related and Addictive Disorders

p) Neurocognitive Disorders

q) Personality Disorders

r) Paraphilic Disorders

s) Other Mental Disorders

t) Medication-induced Movement Disorders and Other Adverse Effects of Medication

12.28. 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.

12.29. Newborn child – means a child between birth and age 36 months.

12.30. 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.

12.31. 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.

12.32. 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.

12.33. Out-of-Pocket-Maximum – means a limit on the total amount of copayments an individual Member or family must pay in a contract year for Covered Services. Once the out-of-pocket maximum is reached, SIMNSA will pay for all of the Covered Services for the remainder of the contract year. Please refer to Section 7.3 for more information.

12.34. 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.

12.35. 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.

12.35.1. 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.

12.35.2. Participating Facility - means a facility that is owned by or has contracted with SIMNSA to provide Covered Services to Members.

12.36. Plan's Service Area – The Plan's service area consists of the border cities of Tijuana, Tecate and Mexicali, Mexico. Emergency and Urgent Care Services are covered in and out of the Plan's Service Area. Please see Sections 4 – 5 of this EOC.

12.37. Pregnancy – A pregnancy is three trimesters of pregnancy and the immediate postpartum period.

12.38. Premium - means the periodic prepayment fees, including any contributions to Group by Subscribers s, which Group agrees to pay SIMNSA for Covered Services.

12.39. 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.

12.40. 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.

12.41. SIMNSA Health Plan – means Sistemas Medicos Nacionales, S.A. de C.V.

12.42. 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.

12.43. Terminal Illness – A terminal illness is an incurable or irreversible condition that has a high probability of causing death within one year or less.

12.44. 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.

12.45. 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.

13. 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.

13.1. Subscriber - To be eligible to enroll as a Subscriber, you must:

13.1.1. Be an Eligible Employee of the contracting group; employed in San Diego or Imperial Counties; and

13.1.2. 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.

13.2. 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:

13.2.1. The Subscriber's spouse or Domestic Partner;

13.2.2. The Subscriber's natural or adopted children, step children, or children in the Subscriber's custody, up to age 26. Dependents residing and receiving care outside the Plan's Service Area are eligible for Health Plan coverage for medical emergencies and urgent care services while outside the Service Area, and for both emergency and non-emergency services within the Plan's Service Area.

13.2.3. 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.

13.2.3.1. Once eligibility has been verified, the Plan Administrator may request yearly evidence that a child continues to qualify for coverage as an incapacitated child.

13.3. Ineligible Persons

13.3.1. 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.

13.3.2. A Dependent is not eligible to subscribe if covered by Medicare.

13.3.3. An applicant is not eligible to enroll if he/she has had his or her membership in the Plan previously terminated because of:

13.3.3.1. Intentional failure to furnish required information, or intentionally furnishing incorrect or incomplete information.

13.3.3.2. 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.

13.3.3.3. 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.

13.3.3.4. Failure to pay the required contribution due for contributory coverage.

14. 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 13. However, no person is eligible to re-enroll who has had coverage terminated as stated in Section 13.3.3 of this EOC.

14.1. 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.

14.2. 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.

14.3. Enrollment of Newly Eligible Dependents

14.3.1. Dependents who become eligible (e.g., by marriage) after the Subscriber's coverage commences may be enrolled within 60 days of their eligibility dates, or the Subscriber may wait until your Group's next open enrollment period to do so.

14.3.2. 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 60 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 60-day period.

14.3.3. 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 60 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.

14.4. 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.

14.5. Notification of Change in Status

It is the Subscriber's 's responsibility to notify Group of any change affecting the Subscriber's '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.

14.6. 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.

15. EFFECTIVE DATES OF COVERAGE:

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

15.1. 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.

15.2. Newly Eligible Employees and Dependents

15.2.1. 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.

15.2.2. 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.

15.3. Open Enrollment

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

15.4. Deferred Effective Date of Coverage

15.4.1. 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.

16. 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:

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

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

16.2. SIMNSA can terminate a Subscriber's coverage:

16.2.1. If any Subscriber ceases to be eligible.

16.2.2. If a Subscriber permits any other person to use their Health Plan Member identification card, or if a Subscriber provides false information in order to obtain the benefits of this Plan.

16.2.3. For terminations under Sections 16.2.1 and 16.2.2, the Plan will notify Group Contract Holders and/or Subscribers of the termination of coverage through a written "Notice of Cancellation, Rescission, or Nonrenewal." The "Notice of Cancellation, Rescission, or Nonrenewal" will be sent to the Group Contract Holder and/or Subscriber at least 30 days before the termination of coverage.

16.2.4. 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 thirtieth (30th) day after the Plan sends your Group Contract Holder a "Notice of Start of Grace Period." Your Group Contract Holder is responsible for notifying you promptly before your coverage ends due to termination of the Group Contract.

16.2.4.1. If your Group Contract Holder submits payment of the past-due premium more than 15 days after the date of the Plan's expiration of the "Notice of Start of Grace Period," the Plan will refund such payment within 20 business days and the Contract will not be reinstated.

16.3. 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.

16.4. 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 day 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.

16.5. Individual Continuation of Benefits

16.5.1. 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.

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 16.5. 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 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.

16.5.2. 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.

16.5.3. 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.

16.5.4. 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.

16.5.5. 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.

16.5.6. 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.

17. COVERED SERVICES:

Members shall be entitled to the services described below when such services are: a) Medically Necessary; b) covered under the law or otherwise described in Section 17 of this EOC; and c) (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.

17.1. Health Maintenance and Preventive Services

These services are provided without any cost-sharing on the member's part, however, if preventive care is received at the time of other services the applicable copayment for such services other than preventive care may apply:

17.1.1. Well-child care and screenings and all periodic immunizations and related laboratory services in accordance with the current recommendations from the American Academy of Pediatrics, U.S. Preventive Services Task Force, Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, the Health Resources and Services Administration and the American Academy of Family Physicians.

17.1.2. Well adult care, episodic immunizations and related laboratory services in accordance with the current recommendations from the U.S. Preventive Services Task Force, Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, the Health Resources and Services Administration and Plan medical policies.

17.1.3. Routine gynecological examinations, mammograms and cervical cancer screening tests, in accordance with the guidelines of the American College of Obstetrics and Gynecology and the Health Resources and Services Administration. Members may directly access OB/GYN care without a referral.

17.1.4. All generally accepted cancer screening tests, as determined by the United States Preventive Services Task Force and approved by the federal Food and Drug Administration, including the conventional Pap test, any cervical cancer screening test and human papillomavirus screening test and prostate cancer screening.

17.1.5. 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.

17.2. Vision Services

Routine vision screenings included as part of a preventive care visit are covered. Eye exams for refraction to determine the need for corrective lenses are a Covered Service.

We cover the following special contact lenses when prescribed by a Participating Provider:

17.2.1. Up to two Medically Necessary contact lenses per eye (including fitting and dispensing) in any 12-month period to treat aniridia (missing iris)/ We will not cover an aniridia contact lens if we provided an allowance toward (or otherwise covered) more than one aniridia contact lens for that eye within the previous 12 months (including when we provided an allowance toward, or otherwise covered, one or more aniridia contact lenses under any other evidence of coverage offered by your Group).

17.2.2. Up to six Medically Necessary aphakic contact lenses per eye (including fitting and dispensing) per calendar year to treat aphakia (absence of the crystalline lens of the eye) for Members. We will not cover an aphakic contact lens if we provided an allowance toward (or otherwise covered) more than six aphakic contact lenses for that eye during the same calendar year (including when we provided an allowance toward, or otherwise covered, one or more aphakic contact lenses under any other evidence of coverage offered by your Group).

17.3. Pediatric Vision Services for Children to Age 19

For Pediatric Vision Copayments, please refer to the Summary of Benefits and Copayments, which is included as part of this EOC.

Covered Services are limited to the following:

17.3.1. One comprehensive vision examination in a plan contract year. Lenses for glasses once every contract year at no cost to the Member, including single vision, bifocal, trifocal, and lenticular. Member has a choice of glass, plastic, or polycarbonate lenses. Scratch resistance and UV coating is also covered at no cost to the Member.

17.3.2. One pair of frames available from a Plan Provider once every contract year at no cost to the Member.

17.3.3. In lieu of eyeglasses, elective contact lens services and materials are covered at no cost to the Member with the following service limitations:

- Standard (one pair annually) = 1 contact lens per eye (2 total lenses)
- Monthly (six-month supply) = 6 lenses per eye (12 total lenses)
- Bi-weekly (three-month supply) = 6 lenses per eye (12 total lenses)
- Dailies (one-month supply) = 30 lenses per eye (total 60 lenses)

Medically necessary contacts are covered at no cost once every contract year. Contact lenses may be medically necessary when the use of contact lenses, in lieu of eyeglasses, will provide better visual correction, including avoidance of diplopia or suppression. Contact lenses may be determined to be medically necessary in the treatment of the following conditions: Keratoconus, pathological myopia, aphakia, anisometropia, aniseikonia, aniridia, corneal disorders, post-traumatic disorders, and irregular astigmatism.

17.3.4. Low Vision services: Low vision is a significant loss of vision but not total blindness. Low vision exams and low vision aids are covered at no cost to the Member once within a plan contract year with preauthorization.

Opthalmologists and optometrists specializing in low vision care can evaluate and prescribe optical devices, and provide training and instruction to maximize the remaining usable vision for pediatric members with low vision. Pre-authorization for these services is required.

17.3.5. Pediatric Vision Exclusions

a. Services and materials that are experimental or investigational;

b. Services or materials which are rendered prior to your effective date of coverage;

c. Services or materials incurred after the termination date of your coverage unless otherwise indicated;

d. Services and materials not meeting accepted standards of optometric practice;

e. Any services that are strictly cosmetic in natures including, but not limited to, charges for personalization or characterization of prosthetic appliances;

f. Charges for copies of your records, charts, or any costs associated with forwarding/mailing copies of your records or charts;

g. Government-imposed taxes on vision services performed;

h. Visual training or vision therapy;

i. Replacement or repair of lost or broken lenses or frames, except as provided in this EOC;

j. Non-prescription (Plano) lenses;

k. Two pairs of eyeglasses in lieu of bifocals;

l. Services not performed by licensed personnel;

m. Prosthetic devices and services;

n. Insurance of contact lenses

o. Professional services you receive from non-participating providers.

p. Any eye examination required by an employer as a condition of employment, unless otherwise covered as a covered benefit;

q. Services performed incident to an injury or disease arising out of, or in the course of, any employment if such injury or disease is covered by any workers' compensation law, occupational disease law, or similar legislation.

r. Services not specifically listed as a benefit.

17.4. Pediatric Dental Services up to Age 19

Pediatric dental coverage includes diagnostic and preventive services such as cleanings, X-rays, initial and periodic oral examinations, topical fluoride treatment, fillings and sealants. Orthodontia and major services are also covered as medically necessary (cost-share may apply).

For more information, and for the specific copayments that will apply, please refer to the separate Pediatric Dental Disclosure document, which is appended to this EOC.

17.5. 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:

17.5.1. 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.

17.5.2. Surgical services on an inpatient or outpatient basis, including surgical assistance where Medically Necessary, and anesthesiology services.

17.5.3. Physician visits and examinations during Certified Confinement in a hospital.

17.5.4. Medical consultation services ordered by a Participating Physician.

17.5.5. Telehealth consultations, provided remotely via communication technologies, for examination, diagnosis, counseling, education, and treatment. (subject to provider's determination of appropriate)

17.6. Allergy Care

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

17.7. Family Planning

17.7.1. Voluntary sterilization (tubal ligation and vasectomy), when precertified by the Plan's Medical Coordinator.

17.7.2. All U.S. Food and Drug Administration approved contraceptive methods, sterilization procedures, and patient education and counseling for all women with reproductive capacity and which are prescribed by a Participating Provider, without cost-sharing. Coverage includes all drugs, devices and other products for women as approved by the Food and Drug Administration included within each of the following methods: (1) sterilization surgery for women; (2) surgical sterilization implant for women; (3) implantable rod; (4) IUD copper; (5) IUD with progestin; (6) shot/injection; (7) oral contraceptives (combined pill); (8) oral contraceptives (progestin only); (9) oral contraceptives extended/continuous use; (10) patch; (11) vaginal contraceptive ring; (12) diaphragm; (13) sponge; (14) female condom; and (15) emergency contraception (Plan B).

17.7.3. A 12-month supply of FDA-approved, self-administered hormonal contraceptives dispensed at one time when requested by the Member and not clinically contraindicated.

17.7.4. Counseling concerning contraception and family planning.

17.8. Reconstructive Surgery

17.8.1. 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.

17.8.2. Breast reconstruction and surgically implanted breast prostheses following a mastectomy.

17.9. 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.

17.9.1. Inpatient Services

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 17.21, Durable Medical Equipment and Prosthetic Devices), "prosthetic" means a mechanical device that replaces the function of an internal or external body part.

17.9.2. Outpatient Services

Outpatient services provided or precertified by a Participating Provider, including professional services, radiation therapy, chemotherapy, outpatient surgery and outpatient rehabilitative and habilitative 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.

17.10. Maternity Care and Related Newborn Care Benefits

17.10.1. Services for any condition arising from pregnancy (including prenatal diagnosis of genetic disorders of the fetus) and childbirth, including complications of pregnancy, abortion (as permitted under the laws of Baja California, Mexico), delivery, prenatal and postpartum care.

17.10.2. 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.

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

17.11. 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.

17.12. Clinical Trials

We will not deny a Member participation in an approved clinical trial, or discriminate against any Member based on such participation. The term "approved clinical trial" means a phase I, phase II, phase III and phase IV clinical trial conducted in relation to the prevention, detection or treatment of cancer or other life-threatening disease or condition (as defined below). Coverage will be provided for routine health care services associated with a Member's participation in an approved clinical trial, if all of the following conditions are met:

17.12.1. The Member is eligible to participate in an approved clinical trial according to the trial protocol with respect to the treatment of cancer or other life-threatening disease or condition. The term "life-threatening condition" means any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

17.12.2. A Participating Provider has concluded that the Member's participation in the approved clinical trial would be appropriate based on the Member meeting the conditions described in Section 17.9.1, or the Member furnishes medical and scientific information establishing that his or her participation in the trial would be appropriate based on the individual meeting the conditions described in Section 17.9.1. The requirements in

Sections 17.9.1 and 17.9.2 are in lieu of any additional requirements related to Medical Necessity.

17.12.3. The routine health care service is provided within the Plan's network or, if outside the Plan's network, on an Emergency basis or as an Urgent Care Service.

17.13. 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.

17.14. 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:

17.14.1. 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.

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

17.15.1. 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.

17.16. Ambulance Services

Emergency services or transportation services that are provided to you by a licensed ambulance company as a result of a "911" emergency response system request for assistance, if you believe you have an Emergency medical condition requiring such assistance. In the event that air ambulance services are necessary because of an emergency, the Member shall not pay more out-of-pocket costs/copays for a non-contracted air ambulance provider than for a contracted air ambulance provider to the extent the Plan has a contracted air ambulance provider.

Non-emergency ambulance and psychiatric transport van services are covered within the Plan's Service Area if a Participating Provider determines that your condition requires the use of services that only a licensed ambulance (or psychiatric transport van) can provide and that the use of other means of transportation would endanger your health. These services are covered only when the vehicle transports you to or from Covered Services.

17.17. 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.

17.18. Acupuncture Services

Typically provided only for the treatment of nausea or as part of a comprehensive pain management program for the treatment of chronic pain).

17.19. Massage Therapy

Covered when referred by a Plan Provider and provided by a SIMNSA practitioner in one of SIMNSA's clinics.

17.20. Rehabilitative and Habilitative Services

Rehabilitative and habilitative services by occupational, physical, mental health, behavioral health, or speech therapists, as Medically Necessary, upon certification.

17.21. Durable Medical Equipment, Ostomy and Urological Supplies, and Prosthetics-Orthotics Services and Devices

This Plan covers the purchase or rental of Durable Medical Equipment, the purchase of Prosthetic or Orthotic devices and the purchase of Ostomy and Urological Supplies under the same terms and conditions as the benchmark plan identified by the California Department of Managed Health Care, 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.

17.21.1. 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.

17.21.2. 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.

17.22. Home Health Care

In limited instances, home health care 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.

17.23. Mental Health and Chemical Dependency Services

17.23.1. Mental Health Services

Diagnosis and Treatment for mental health services including, but not limited to maternal mental health services, as defined within the most recent edition of the DSM.

Outpatient Treatment - Outpatient mental health services from a Participating Provider who is a psychiatrist or physician, when ordered by a Participating Provider, for the evaluation, diagnosis and treatment of mental disorders or crisis intervention. This Plan also covers Behavioral Health Treatment for the treatment of pervasive developmental disorders or autism, when ordered and performed by a Participating Provider.

Outpatient mental health services include office visits, individual and group evaluation and therapy, outpatient monitoring of drug therapy, psychological testing, home-based applied behavioral analysis for the treatment of pervasive developmental disorder of autism, intensive outpatient program (usually less than 5 hours/day), partial hospitalization program (generally greater than 5 hours/day) and non-emergency ambulance and psychiatric transportation.

Inpatient Treatment - Inpatient mental health services, including psychiatric observation and inpatient psychiatric hospitalization, from a Participating Provider who is a psychiatrist or physician,

when ordered by a Participating Provider, for the evaluation, diagnosis and treatment of mental disorders.

Inpatient residential treatment for mental health is not available in the Service Area in a separate facility, but services are provided via monitoring in a hospital setting, as deemed appropriate by the Participating Provider. Upon a Member's request, residential treatment for Mental Health and/or Chemical Dependency may be provided via monitoring in a home based setting, as deemed appropriate by the Participating Provider within the Plan's Service Area.

Treatment in a crisis residential program is not available in the Service Area in a separate facility, but services are provided via monitoring in a hospital setting, as deemed appropriate by the Participating Provider. Upon a Member's request, crisis residential programs may be provided via monitoring in a home based setting, as deemed appropriate by the Participating Provider within the Plan's Service Area.

Services provided under the Plan's coverage of Mental Health benefits shall be provided in compliance with applicable mental health parity laws.

17.23.2. Chemical Dependency Services

Outpatient Treatment – Outpatient Chemical Dependency treatment services from a Participating Provider, when ordered by a Participating Provider, including outpatient day-treatment programs, intensive outpatient programs, and individual and group dependency counseling.

Inpatient Detoxification - Hospitalization in a Participating Hospital is covered only for medical management of withdrawal symptoms, including room and board, Participating Provider Services, drugs, dependency recovery services, education, and counseling.

Inpatient Treatment - Residential treatment for Chemical Dependency are not available in the Service Area in a separate facility, but services are provided via monitoring in a hospital setting, as deemed appropriate by the Participating Provider. Upon a Member's request, residential treatment for Mental Health and/or Chemical Dependency may be provided via monitoring in a home based setting, as deemed appropriate by the Participating Provider within the Plan's Service Area.

Transitional residential recovery services are not available in the

Service Area in a separate facility, but transitional services are provided via monitoring in a hospital setting, as deemed appropriate by the Participating Provider. Upon a Member's request, transitional residential recovery services may be provided via monitoring in a home based setting as deemed appropriate by the Participating Provider within the Plan's Service Area.

Members can access Mental Health and/or Chemical Dependency benefits by referral through their primary care physician. Authorization is not needed.

17.24. 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.

17.25. 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 21.8 of this EOC.

17.26. Hospice Care

This Plan covers hospice care to the extent that it is 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.

17.27. Fertility Preservation for Iatrogenic Infertility

Benefits are available for fertility preservation for medical reasons that cause infertility such as chemotherapy, radiation treatment, and oophorectomy due to cancer or other illnesses, injuries and conditions. Examples of fertility preservation services include the following procedures: collection of sperm, cryo-preservation of sperm, ovarian stimulation and retrieval of eggs, oocyte cryo-preservation, ovarian tissue cryo-preservation, in vitro fertilization (fertilization of egg) and embryo cryo-preservation. Benefits are not available for future implantation or general infertility treatment. Please contact the Plan for additional information.

17.28. Sexually Transmitted Disease Testing

This Plan covers sexually transmitted disease home test kits, and the laboratory costs for processing those kits, that are deemed medically necessary or appropriate and ordered directly by an in-network provider or furnished through a standing order for patient use based on clinical guidelines and individual patient health needs. For purposes of this section, "home test kit" means a product used for a test recommended by the federal Centers for Disease Control and Prevention guidelines or the United States Preventive Services Task Force that has been CLIA-waived, FDA-cleared or -approved, or developed by a laboratory in accordance with established regulations and quality standards, to allow individuals to self-collect specimens for STDs, including HIV, remotely at a location outside of a clinical setting.

18. SECOND MEDICAL OPINIONS:

18.1. 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:

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

18.1.2. 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;

18.1.3. 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;

18.1.4. 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

18.1.5. 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.

18.2. 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.

18.3. Second medical opinion requests will be approved or denied (and, if approved, will be rendered) within the following time limits:

18.3.1. For Emergency Services/Expedited Requests – in a timely fashion, as appropriate to your condition, but no more than 72 hours, whenever possible.

18.3.2. 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.

19. REQUESTS FOR STANDING REFERRALS:

19.1 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.

19.2 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.

20. 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.

A Member will not be required to pay more than the retail price for a prescription drug if the Plan's Participating Pharmacy's retail price is less than the applicable Copayment. The payment rendered by the Member would constitute the Member's applicable cost-sharing. The applicable cost-sharing paid by the Member will apply to both the deductible, if any, and the out-of-pocket maximum limit in the same manner as if the Member had purchased the prescription drug by paying the cost-sharing amount.

21. EXCLUSIONS FROM COVERAGE:

21.1. Alternative Therapies

Alternative therapies, such as 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.

21.2. Chiropractic Services

21.3. Cosmetic Surgery

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

21.4. Custodial and Long Term Care

21.5. 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, tissue or bone marrow and treatment of complications are covered if the donor or potential donor is also a Plan Member).

21.6. Exclusions and Limitations to the Prescription Drug Benefit

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

21.6.1. Services rendered by a non-participating Provider except as Medically Necessary for treatment of an Emergency or urgent care condition.

21.6.2. 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. When requested by the Member and not clinically contraindicated, a 12-month supply of FDA-approved self-administered hormonal contraceptives may be dispensed at one time.

21.6.3. 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.

21.6.4. 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 12.25.

21.6.5. 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 12.26, or that are provided in conjunction with participation in a smoking cessation program.

21.6.6. 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).

21.6.7. 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.

21.6.8. 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. This exclusion shall not include a) FDA-approved contraceptive drugs and devices that may be available over-the-counter but that are prescribed by a Plan Provider or b) items and supplies that 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.

21.6.9. Drugs not prescribed by a Plan 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. This exclusion shall not include FDA-approved contraceptive drugs and devices or smoking cessation therapies that may be available over-the-counter and which are prescribed by a Plan Provider.

21.6.10. Prophylactic drugs for travel; drugs to enhance athletic performance.

21.6.11. Prescription drugs for procedures and services that are not Covered Services, except for prescription drugs that would otherwise be covered to treat complications of the non-covered service. 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.

21.6.12. Replacement of lost or damaged prescriptions.

21.6.13. Any medication prescribed in a manner other than in accordance with the SIMNSA Health Plan's procedures.

21.7. 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 diagnosis and treatment provided under Section 12.26 Medically Necessary Treatment of a Mental Health or Substance Use Disorder.

21.8. 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.

21.9. Abortions Considered Illegal in the Plan Service Area

SIMNSA is a Mexican health plan that is licensed in California by the Department of Managed Health Care pursuant to California Health and Safety Code § 1351.2. SIMNSA operates under the laws of Baja California, Mexico. The laws of Baja California, Mexico prohibit abortions beyond the twelfth (12) week except in cases where the life of the mother is in jeopardy or other circumstances as allowed by law. To that extent, this plan only covers abortion in Mexico where legally permissible and Out-of-Area where the service is Medically Necessary for the treatment of an Emergency or Urgent Care Service. The Plan will cover legal abortion services, as described above, without any cost share (e.g. copayment) to the member.

21.10. Hearing Aids

21.11. Hospice Care

Hospice services are not covered, except as described in Section 17.26 of this EOC.

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

21.13. Not Medically Necessary Services

Services or supplies which are not Medically Necessary, except those services required to be covered under the law or otherwise described in Section 17 of this EOC. (To appeal a determination that requested services are not Medically Necessary, Members should refer to the Inquiry and Grievance Procedure set forth in Section 9 of this EOC.)

21.14. 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.

21.15. 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.

21.16. 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.

21.17. Private Duty Nursing

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

21.18. 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.

21.19. Services Prior to Commencement and after Termination of Coverage

21.20. 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).

21.21. 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 12.25.

21.22. 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.

21.23. Transportation Services

Transportation services, except as specified.

21.24. Vision Care

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

21.25. 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.

21.26. Non-Medical Supportive Services, Employment Counseling, or Vocational Rehabilitation Counseling

This exclusion shall not apply to diagnosis and treatment provided under Section 12.26 Medically Necessary Treatment of a Mental Health or Substance Use Disorder.

21.27. 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.

22. LIMITATIONS:

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.

23. 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:

23.1. The benefits of a payor which covers a person as an employee is always primary payor.

23.2. 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.

23.3. 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.

23.4. Recovery of Overpayments.

23.4.1. 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.

23.4.2. 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.

24. THIRD PARTY LIABILITY AND NON-DUPLICATION OF BENEFITS:

24.1. 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. Further, the Subscriber and his or her Dependents agree that SIMNSA Health Plan is entitled to all rights of recovery to the extent of its payment notwithstanding the "Made Whole" doctrine of each individual state where applicable by law. 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.

24.2. 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.

Notice of Privacy Practices

Effective Date: August 1, 2022

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW THIS NOTICE CAREFULLY.

If you have any questions about this notice, please contact our Privacy Officer at 2088 Otay Lakes Road, Suite 102, Chula Vista, CA 91913; telephone (619) 407-4082.

1. Summary of Rights and Obligations Concerning Health Information

SIMNSA is committed to preserving the privacy and confidentiality of your health information, which is required by applicable law, as well as by ethics of the licensed health professions. We are required by law to provide you with this notice of our legal duties, your rights, and our privacy practices, with respect to using and disclosing your health information that is created or retained by SIMNSA.

Each time you visit us, we make a record of your visit. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. We have an ethical and legal obligation to protect the privacy of your health information, and we will only use or disclose this information in limited circumstances. In general, we may use and disclose your health information to:

- plan your care and treatment;
- provide treatment by us or others;
- communicate with other providers such as referring physicians;
- receive payment from you, your health plan, or your health insurer;
- make quality assessments and work to improve the care we render and the outcomes we achieve, known as health care operations;
- make you aware of services and treatments that may be of interest to you; and
- comply with state and federal laws that require us to disclose your health information.

We may also use or disclose your health information where you have authorized us to do so.

You have certain rights to your health information. You have the right to:

- ensure the accuracy of your health record;
- request confidential communications between you and your physician and request limits on the use and disclosure of your health information; and
- request an accounting of certain uses and disclosures of health information we have made about you.

We are required to:

- maintain the privacy of your health information;
- provide you with notice, such as this *Notice of Privacy Practices*, as to our legal duties and privacy practices with respect to information we collect and maintain about you;
- abide by the terms of our most current *Notice of Privacy Practices*;
- notify you if we are unable to agree to a requested restriction; and
- accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

We reserve the right to change our practices and to make the new provisions effective for all your health information that we maintain.

Should our information practices change, a revised *Notice of Privacy Practices* will be available upon request. If there is a material change, a revised Notice of Privacy Practices will be distributed to the extent required by law.

We will not use or disclose your health information without your authorization, except as described in our most current *Notice of Privacy Practices.*

In the following pages, we explain our privacy practices and your rights to your health information in more detail.

If you have limited proficiency in English, you may request a Notice of Privacy Practices in Spanish.

2. We May Use or Disclose Your Medical Information In The Following Ways

A. ***Treatment.*** We may use and disclose your medical information to provide you with medical treatment or services. For example, we may use your health information to write a prescription or to prescribe a course of treatment. We will record your current healthcare information in a record so, in the future, we can see your medical history to help in diagnosing and treatment, or to determine how well you are responding to treatment. We may provide your health information to other health providers, such as referring or specialist physicians, to assist in your treatment. Should you ever be hospitalized, we may provide the hospital or its staff with the health information it requires to provide you with effective treatment.

B. ***Payment.*** We may use and disclose your health information so that we may bill and collect payment for the services that we provided to you. For example, we may contact your employer or health insurer to verify your eligibility for benefits, and may need to disclose to it some details of your medical condition or expected course of treatment. We may use or disclose your information so that a bill may be sent to you, your health insurer, or a family member. The information on or accompanying the bill may include information that identifies you and your diagnosis, as well as services rendered, any procedures performed, and supplies used. Also, we may provide health information to another health care provider, such as an ambulance company that transported you to our office, to assist in their billing and collection efforts.

C. ***Health Care Operations.*** We may use and disclose your health information to assist in the operation of our practice. For example, members of our staff may use information in your health record to assess the care and outcomes in your case and others like it as part of a continuous effort to improve the quality and effectiveness of the healthcare and services we provide. We may use and disclose your health information to conduct cost-management and business planning activities for our practice. We may also provide such information to other health care entities for their health care operations. For example, we may provide information to your health insurer for its quality review purposes.

D. ***Business Associates.*** SIMNSA sometimes contracts with third-party business associates for services. Examples include transcriptionists, billing services, consultants, and legal counsel. We may disclose your health information to our business associates so that they can perform the job we have asked them to do. To protect your health information, however, we require our business associates to appropriately safeguard your information.

E. ***Appointment Reminders.*** We may use and disclose Information in your medical record to contact you as a reminder that you have an appointment at MEDYCA or another SIMNSA location. We usually will call you at home the day before your appointment and leave a message for you on your answering machine or with an individual who responds to our telephone call. However, you may request that we provide such reminders only in a certain way or only at a certain place. We will endeavor to accommodate all reasonable requests.

F. ***Treatment Options.*** We may use and disclose your health information in order to inform you of alternative treatments.

G. ***Release to Family/Friends.*** Our health professionals, using their professional judgment, may disclose to a family member, other relative, close personal friend or any other person you identify, your health information to the extent it is relevant to that person's involvement in your care or payment related to your care. We will provide you with an opportunity to object to such a disclosure whenever we practicably can do so. We may disclose the health

information of minor children to their parents or guardians unless such disclosure is otherwise prohibited by law.

H. ***Health-Related Benefits and Services***. We may use and disclose health information to tell you about health-related benefits or services that may be of interest to you. In face- to-face communications, such as appointments with your physician, we may tell you about other products and services that may be of interest you.

I. ***Newsletters and Other Communications.*** We may use your personal information in order to communicate to you via newsletters, mailings, or other means regarding treatment options, health related information, disease management programs, wellness programs, or other community based initiatives or activities in which our practice is participating.

J. ***Disaster Relief.*** We may disclose your health information in disaster relief situations where disaster relief organizations seek your health information to coordinate your care, or notify family and friends of your location and condition. We will provide you with an opportunity to agree or object to such a disclosure whenever we practicably can do so.

K. ***Marketing.*** In most circumstances, we are required by law to receive your written authorization before we use or disclose your health information for marketing purposes. However, we may provide you with promotional gifts of nominal value. Under no circumstances will we sell our patient lists or your health information to a third party without your written authorization.

L. ***Public Health Activities.*** We may disclose medical information about you for public health activities. These activities generally include the following:

- licensing and certification carried out by public health authorities;
- prevention or control of disease, injury, or disability;
- reports of births and deaths;
- reports of child abuse or neglect;
- notifications to people who may have been exposed to a disease or may be at
- risk for contracting or spreading a disease or condition;
- organ or tissue donation; and
- notifications to appropriate government authorities if we believe a patient has been the victim of abuse, neglect, or domestic violence. We will make this disclosure when required by law, or if you agree to the disclosure, or when authorized by law and in our professional judgment disclosure is required to prevent serious harm.

M. ***Funeral Directors.*** We may disclose health information to funeral directors so that they may carry out their duties.

N. ***Psychotherapy Notes.*** Under most circumstances, without your written authorization we may not disclose the notes a mental health professional took during a counseling session. However, we may disclose such notes for treatment and payment purposes, for state and federal oversight of the mental health professional, for the purposes of medical examiners and coroners, to avert a serious threat to health or safety, or as otherwise authorized by law.

O. ***Workers Compensation.*** We may disclose your health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

P. ***Law Enforcement.*** We may release your health information:

- in response to a court order, subpoena, warrant, summons, or similar process if authorized under state or federal law;
- to identify or locate a suspect, fugitive, material witness, or similar person;
- about the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement;
- about a death we believe may be the result of criminal conduct;
- about criminal conduct at a SIMNSA contracted-facility or office;
- to coroners or medical examiners;
- in emergency circumstances to report a crime, the location of the crime or victims, or the identity, description, or location of the person who committed the crime;
- to authorized federal officials for intelligence, counterintelligence, and other
- national security authorized by law; and
- to authorized federal officials so they may conduct special investigations or provide protection to the President, other authorized persons, or foreign heads of state.

Q. ***De-identified Information.*** We may use your health information to create "de-identified" information or we may disclose your information to a business associate so that the business associate can create de-identified information on our behalf. When we "de-identify" health information, we remove information that identifies you as the source of the information. Health information is considered "de-identified" only if there is no reasonable basis to believe that the health information could be used to identify you.

R. ***Personal Representative.*** If you have a personal representative, such as a legal guardian, we will treat that person as if that person is you with respect to disclosures of your health information. If you become deceased, we may disclose health information to an executor or administrator of your estate to the extent that person is acting as your personal representative.

S. ***Limited Data Set.*** We may use and disclose a limited data set that does not contain specific readily identifiable information about you for research, public health, and health care operations. We may not disseminate the limited data

set unless we enter into a data use agreement with the recipient in which the recipient agrees to limit the use of that data set to the purposes for which it was provided, ensure the security of the data, and not identify the information or use it to contact any individual.

3. Authorization for Other Uses of Medical Information

Uses of medical information not covered by our most current *Notice of Privacy Practices* or the laws that apply to us will be made only with your written **authorization**.

If you provide us with authorization to use or disclose medical information about you, you may revoke that authorization, in writing, at any time. If you revoke your authorization, we will no longer use or disclose medical information about you for the reasons covered by your written authorization, except to the extent that we have already taken action in reliance on your authorization or, if the authorization was obtained as a condition of obtaining insurance coverage and the insurer has the right to contest a claim or the insurance coverage itself. We are unable to take back any disclosures we have already made with your authorization, and we are required to retain our records of the care that we provided to you.

4. Your Health Information Rights

You have the following rights regarding medical information we gather about you:

A. ***Right to Obtain a Paper Copy of This Notice.*** You have the right to a paper copy of this Notice of Privacy Practices at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy.

B. ***Right to Inspect and Copy.*** You have the right to inspect and copy medical information that may be used to make decisions about your care. Usually, this includes medical and billing records, but does not include psychotherapy notes.

To inspect and copy medical information, you must submit a written request to our privacy officer. We will supply you with a form for such a request. If you request a copy of your medical information, we may charge a reasonable fee for the costs of labor, postage, and supplies associated with your request. We may not charge you a fee if you require your medical information for a claim for benefits under the Social Security Act or any other state or federal needs-based benefit program.

We may deny your request to inspect and copy in certain limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. A licensed healthcare professional who was not directly involved in the denial of your request will conduct the review. We will comply with the outcome of the review.

If your medical information is maintained in an electronic health record, you also have the right to request that an electronic copy of your record be sent to you or to another

individual or entity. We may charge you a reasonable cost based fee limited to the labor costs associated with transmitting the electronic health record.

C. ***Right to Amend.*** If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as we retain the information.

To request an amendment, your request must be made in writing and submitted to our privacy officer. In addition, you must provide a reason that supports your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- is not part of the medical information kept by or for SIMNSA;
- is not part of the information which you would be permitted to inspect and copy; or
- is accurate and complete.

If we deny your request for amendment, you may submit a statement of disagreement. We may reasonably limit the length of this statement. Your letter of disagreement will be included in your medical record, but we may also include a rebuttal statement.

D. ***Right to an Accounting of Disclosures.*** You have the right to request an accounting of disclosures of your health information made by us. In your accounting, we are not required to list certain disclosures, including:

- disclosures made for treatment, payment, and health care operations purposes or disclosures made incidental to treatment, payment, and health care operations, however, if the disclosures were made through an electronic health record, you have the right to request an accounting for such disclosures that were made during the previous 3 years;
- disclosures made pursuant to your authorization;
- disclosures made to create a limited data set;
- disclosures made directly to you.

To request an accounting of disclosures, you must submit your request in writing to our privacy officer. Your request must state a time period which may not be longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form you would like the accounting of disclosures (for example, on paper or electronically by e-mail). The first accounting of disclosures you request within any 12 month period will be free. For additional requests within the same period, we may charge you for the reasonable costs of providing the accounting of disclosures. We will notify you of the costs involved and you may choose to withdraw or modify your request at that time, before any costs are incurred. Under limited circumstances mandated by

federal and state law, we may temporarily deny your request for an accounting of disclosures.

E. ***Right to Request Restrictions.*** You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment, or health care operations. If you paid out-of-pocket for a specific item or service, you have the right to request that medical information with respect to that item or service not be disclosed to a health plan for purposes of payment or health care operations, and we are required to honor that request.

You also have the right to request a limit on the medical information we communicate about you to someone who is involved in your care or the payment for your care.

Except as noted above, we are not required to agree to your request. If we do agree, we will comply with your request unless the restricted information is needed to provide you with emergency treatment. To request restrictions, you must make your request in writing to our privacy officer. In your request, you must tell us:

- what information you want to limit;
- whether you want to limit our use, disclosure, or both; and
- to whom you want the limits to apply.

F. ***Right to Request Confidential Communications.*** You have the right to request that we communicate with you directly about medical matters in a form or format of your choosing.

A member who is able to consent to medical care under the laws of Mexico (over the age of 19) and is not the primary subscriber may obtain “sensitive services” without prior authorization from the primary subscriber. A member who receives “sensitive services” in the U.S. may request confidentiality if the member has the right to consent to such services in the U.S. “Sensitive services” means all health care services related to mental or behavioral health, sexual and reproductive health, sexually transmitted infections, substance use disorder, gender affirming care, and intimate partner violence. SIMNSA will not require a member to obtain authorization from a primary subscriber to receive sensitive services or to submit a claim for sensitive services if the member has the right to consent to care where the services are rendered. A member who is able to consent to medical care may request confidential communications related to any billing, benefit determination, explanation of benefit, request for additional information, contested claim, provider referral, or any other written, oral, or electronic communication containing protected health information related to “sensitive services.” Valid requests will be implemented within 7 calendar days of receipt of an electronic or telephonic request or within 14 days of receipt by first-class mail. A member may designate an alternative mailing address, email address, or telephone number to direct all communications regarding the receipt of sensitive services. If the member has not designated any alternative communication preference, SIMNSA will send communication to the address or telephone number on file. SIMNSA will not disclose medical information related to sensitive services to the policyholder or primary

subscriber, or any other plan enrollee other than the protected individual receiving care without an express written authorization from the protected individual.

To request confidential communications, you may contact our Privacy Officer at 2088 Otay Lakes Road, Suite 102, Chula Vista, CA 91913 or by calling (619) 407-4082. You can also request a confidential communication by visiting our website at www.simnsa.com. SIMNSA will not ask you the reason for your request and will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted. Your confidential communication request will be valid until you submit a request to change or revoke the confidentiality.

G. Right to Receive Notice of a Breach. We are required to notify you by first class mail or by e-mail (if you have indicated a preference to receive information by e-mail), of any breaches of Unsecured Protected Health Information as soon as possible, but in any event, no later than 60 days following the discovery of the breach.

"Unsecured Protected Health Information" is information that is not secured through the use of a technology or methodology identified by the Secretary of the U.S. Department of Health and Human Services to render the Protected Health Information unusable, unreadable, and undecipherable to unauthorized users. The notice is required to include the following information:

- a brief description of the breach, including the date of the breach and the date of its discovery, if known;
- a description of the type of Unsecured Protected Health Information involved in the breach;
- steps you should take to protect yourself from potential harm resulting from the breach;
- a brief description of actions we are taking to investigate the breach, mitigate losses, and protect against further breaches;
- contact information, including a toll-free telephone number, e-mail address, Web site or postal address to permit you to ask questions or obtain additional information.

In the event the breach involves 10 or more patients whose contact information is out of date we will post a notice of the breach on the home page of our Web site or in a major print or broadcast media. If the breach involves more than 500 patients in the state or jurisdiction, we will send notices to prominent media outlets. If the breach involves more than 500 patients, we are required to immediately notify the Secretary. We also are required to submit an annual report to the Secretary of a breach that involved less than 500 patients during the year and will maintain a written log of breaches involving less than 500 patients.

5. Complaints

If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the U.S. Department of Health and Human Services, 200 Independence Ave, S.W., Washington, D.C. 20201. To file a complaint with us, contact

our privacy officer at the address listed above. All complaints must be submitted in writing and should be submitted within 180 days of when you knew or should have known that the alleged violation occurred. See the Office for Civil Rights website, www.hhs.gov/ocr/hipaa/ for more information.

You will not be penalized for filing a complaint.