Report of

The Interim Committee
On
Binational Health Benefit
Plan Coverage

INTERIM COMMITTEE ON BINATIONAL HEALTH BENEFIT PLAN COVERAGE

Senator Eddie Lucio, Jr., Co-Chair
Senate District 27

Representative Jim Solis, Co-Chair
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January 29, 2003

The Honorable Rick Perry
Governor of Texas
P.O. Box 12428
Austin, Texas 78711

The Honorable David Dewhurst
Lieutenant Governor of Texas
P.O. Box 12068
Austin, Texas 78711

The Honorable Tom Craddick
Speaker, Texas House of Representatives
P.O. Box 2910
Austin, Texas 78768-2910

Dear Governors and Mr. Speaker:

HB 2498 and SB 496, which were passed in regular session by the 77th Legislature, established an interim committee to study the need for binational health benefit plan coverage.

In accordance with this legislative mandate, we respectively submit the following report of the Interim Committee on Binational Health Benefit Plan Coverage for your consideration.

Respectfully submitted,

Senator Eddie Lucio, Jr.
Co-Chair

Representative Jim Solis
Co-Chair

Members of the Committee: Albert Hawkins, Commissioner of HHSC
(Don A. Gilbert, Former Commissioner of HHSC)*
Jose Montemayor, Commissioner of Insurance
Irene A. Armendariz
Elena Longoria Marin, M.D.
James G. Springfield

* Mr. Gilbert served as a member during his tenure as HHSC Commissioner

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Binational Health Benefit Plan Report
Pursuant to HB 2498 and SB 496

I. Legislative mandate

House Bill 2498, enacted by the 77th Legislature in 2001, established an interim committee for the purpose of determining the need for binational health benefit plan coverage; to assess the health care needs of the border region and how those needs can be served by various types of providers; and to assess the affordability, cost-effectiveness, economic impact, and improved health status achievable through binational health benefit plan coverage. Senate Bill 496, enacted by the 77th Legislature in 2001, directed the Texas Department of Insurance and the Texas Department of Health to jointly study the provision of health benefit plan coverage in Texas to people who are not residents of this state or any other state of the United States, to identify legal and practical impediments to providing binational health plan coverage. The interim committee held three hearings, in Austin, Harlingen and El Paso, at which invited testimony and public testimony was presented. With the permission of the bills' authors and the interim committee, the two reports required pursuant to HB 2498 and SB 496 are combined in this document.

II. Definition of border region

For purposes of this report, the border region of Texas is defined as a 32-county area that extends approximately 100 kilometers from the Texas-Mexico border, also known as the La Paz agreement area. The counties include Brewster, Brooks, Cameron, Crockett, Culberson, Dimmit, Duval, Edwards, El Paso, Frio, Hidalgo, Hudspeth, Jeff Davis, Jim Hogg, Kenedy, Kinney, La Salle, McMullen, Maverick, Pecos, Presidio, Real, Reeves, Starr, Sutton, Terrell, Uvalde, Val Verde, Webb, Willacy, Zapata, and Zavala.

III. Health care needs of the border region

It has been stated that health conditions on the Texas-Mexico border are among the worst in the U.S., so distressful at times that reports on health conditions suggest a remote country in need of medical missionaries, not a part of Texas.**1** The population of the border region exceeds two million, and is estimated to be 84% Hispanic.**2** Average annual wages in the border region in 2000 ranged from $15,213 in Real County to $25,148 in El Paso County. By comparison, the average annual wage in Harris County was $41,229 and in Dallas County it was $43,956.**3** In 2000, the federal poverty level was $8,350 for one person, and $17,050 for a family of four. **4** Thirty-four percent (34%) of the border residents had incomes below the federal poverty guidelines, compared to 14% for the remainder of the state. Communicable diseases such as Hepatitis A and tuberculosis occur at much higher rates in the border region. The diabetes-related death rate in the border region is nearly 25 percent higher than the statewide rate.**5**

The region's health care delivery system is inadequate to serve the needs of the residents. The U.S. Department of Health and Human Services assigns a Health Professional Shortage Area (HPSA) designation to U.S. counties based on their ability to provide health services to local residents. Counties may also be designated as Medically Underserved Areas (MUA), based on a shortage of personal health services for local residents. The majority of the counties in the border region have been designated as MUAs and HPSAs, which indicates poor access to care. Geographic isolation from major health care facilities creates access problems. For example, indigent patients in the Rio Grande Valley faced with conditions such as kidney disease or cancer may be referred to the closest medical facility for indigent care--the University of Texas Medical Branch in Galveston nearly 400 miles away. In 1998, Presidio, in the western part of the border region, had no full-time physician, no hospital, nor even a pharmacy. The nearest emergency care facility on the U.S. side of the river was 90 miles away--a $200 trip by ambulance. Presidio residents simply crossed the river to obtain health care services and medicine in Ojinaga, Chihuahua, Mexico. **6**

One of the issues that affect health care in the border region is that many of the residents are uninsured. In 1999, an average 29.6% of children ages 0 - 18 years were uninsured and an average 35.1% of adults ages 19 - 64 years were uninsured.**7** One reason for the high uninsured rate is the low incidence of private coverage, which stems largely from the region's employment profile. A greater portion of border residents work for small employers than do non-border residents. In the early 1990's, more than 50 % of border workers worked in small businesses.**8** Studies show that small employers are less likely than larger employers to pay for employee insurance, and that the most common reason cited by small employers for failure to provide health insurance is the cost of insurance.**9** Additionally, border workers are more likely to work in low-wage jobs than non-border workers, as illustrated by the average wages described earlier, and low-wage jobs typically do not include insurance coverage.

A study of health insurance coverage by the Commonwealth Fund and the UCLA Center for Health Policy Research compared a number of metropolitan statistical areas (MSA). The study found that in terms of the percentage of population uninsured, the El Paso MSA ranks last among 85 MSAs studied in the U.S., with 37 % of the non-elderly population (age 0-64) uninsured. Of the MSAs studied, it was found that those with less insurance coverage have higher unemployment rates, lower per capita incomes, higher rates of poverty, and higher rates of residents employed in firms with fewer than 10 employees. **10**

One of the causes of a high rate of uninsured residents is the fact that the cost of health insurance is rising. Premiums for employer-provided insurance now averages $3,060 per year for singles and $7,954 for families. **10** If a worker earns the average wage in Real County, or $15,213 per year, the average cost of coverage of the worker alone would amount to over 20 percent of gross wages. To purchase family coverage would cost more than half of the worker's gross wages. Either the employee or a small business owner would have difficulty affording such premiums. For a region where the majority of

employees work in low-wage jobs for small employers, it is believed to be critical that affordable private health insurance products be made available.

When a large percentage of the residents in a region are uninsured, several things happen. The federal, state, and local tax burdens of public programs become much higher because of the lack of private funding of health care. The Institute of Medicine of the National Academy of Sciences reports that working-age Americans without health insurance are more likely to:

- receive too little medical care as well as receive it too late: for example, they receive less frequent or no cancer screening, resulting in delayed diagnosis and treatment and premature mortality for cancer patients;
- be sicker and die sooner: they go without care that meets professionally recommended standards for managing chronic diseases like diabetes and lack regular access to medications needed to manage conditions like hypertension or HIV infection;
- receive less comprehensive care when they are hospitalized, even for acute situations like a motor vehicle crash; obtain fewer diagnostic and treatment services after a traumatic injury or a heart attack, resulting in an increased risk of death.

Over the long term, uninsured adults are more likely to die prematurely than people with private insurance coverage.**11**

Texas is not unique in the health care issues identified in the border region. California also shares a border with Mexico, and has identified some of the same issues that affect the health of the residents of that area. Arizona has recently begun research into border health issues as well. To develop proposals in response to its charges from HB 2498 and SB 496, the committee has examined the binational health plans currently being utilized in California to provide health coverage to more border residents. One of the methods currently used to provide affordable health care plans in California is a binational health plan.

IV. Binational health plans

The working definition of binational health plans that has been developed for this report is that of a fully-insured individual or group health benefit plan that would be one of two types:

- A network plan that includes U.S. and Mexican physicians, pharmacies, hospitals or other types of healthcare providers in its network, reimburses both U.S. and Mexican providers for routine healthcare services, and could be offered by a health maintenance organization (HMO), preferred provider organization (PPO), or a point-of-service (POS) plan; or
- An indemnity plan that reimburses for care provided by U.S. and Mexican providers and hospitals for routine healthcare services.

Based on the binational health plans currently in existence in California, two models can be identified: (1) North-to-South model and (2) South-to-North model. Characteristics of the models are summarized in the following table.

North-to-South model	• HMO or insurance company based in the U.S. and licensed in the appropriate state • May also need to be licensed in Mexico • Coverage may or may not be limited to Mexican nationals • May be HMO, PPO, indemnity, or POS plan • Regulation primarily performed by the appropriate state agency • Would have the same financial reserve requirements and legal requirements as other health plans of the same type in the appropriate state •
South-to-North model	• HMO or insurance plan based in Mexico and licensed in both Mexico and the appropriate state • May be HMO, PPO, indemnity or POS plan • Regulation primarily performed by Mexico • Would have financial reserve requirements and legal requirements in the appropriate U.S. state, in addition to Mexican requirements • Coverage may or may not be limited to Mexican nationals.

V. Cost-effectiveness and economic effect of binational plan

A. California experience

A number of years ago, the California agricultural industry was interested in providing health care coverage for their Mexican national employees who lived or who had families living in Mexico. The industry contracted with Mexican insurers to provide the coverage in Mexico. More recently, California has developed a method of providing health care coverage for Mexican nationals who are legally employed by California companies and U.S. citizens who live near the California-Mexico border by licensing HMOs to deliver binational health plans.

The law that regulates HMOs in California is the Knox-Keene Act of 1975. In 1999, the California Legislature passed SB 1658, which amended the Knox-Keene Act to allow Mexican plans to sell their health care plans in California, subject to a portion of the requirements for HMOs. Those requirements are primarily financial in nature. This type of plan fits the definition of the South-to-North plan. California also has recently licensed California-based HMOs to deliver the North-to-South model of health plan.

Regulation of the two models in California is currently achieved by the Legislature's giving the Director of the Department of Managed Health Care, the state agency that regulates HMOs, the power to waive requirements for licensure of Mexican-based plans at his discretion. Therefore, each company that is licensed by the Department of Managed Health Care has a Director's order stating which requirements are waived, if any, and which apply. An exception to the waiver authority is that the companies must meet the same financial solvency requirements as California-licensed companies, and must meet certain legal requirements such as having a California resident for service of process and different types of required bonds. Quality assurance standards, grievance process requirements, and independent review access are waived for the South-to-North model, except that they are required for emergency services provided in California.

Two California-based companies, HealthNet and Blue Shield, have binational North-to-South group health plans. One Mexican-based company, Sistemas Medicos Nacionales, S.A. de C.V. (SIMNSA), is also licensed to sell its group plan, a South-to-North model, in California. Blue Shield and SIMNSA have HMO plans, and HealthNet has HMO, PPO and EPO (Exclusive Provider Organization) plans, which use the SIMNSA network of physicians and other providers for care in Mexico. (NOTE: The Health Net PPO and EPO plans are regulated by a different agency, the California Department of Insurance.**12**)

The plans are marketed differently:

- SIMNSA, under the terms of its order, may only sell its plan to Mexican nationals who are working in California and their families in Mexico.
- Blue Shield markets its plans to both California residents and Mexican nationals who work in California. In June 2002, Blue Shield began to offer its plan to the Mexican workers' families, who continue to live in Mexico.
- HealthNet markets its plan to any workers and their families who live or work in California and the cities of Tijuana, Mexicali and Tecate, Baja California.

Benefits under the binational health plans in California are comparable to usual commercial HMO benefits in California. The plans include prescription drug coverage, medical and hospital coverage, and diagnostic services. Most of the services are anticipated to be provided by Mexican providers. Emergency services and those services that are not available in Mexico are authorized to be provided in California. Copayments and other cost-sharing features are lower for the enrollee than those of comparable commercial plans. For example, when Blue Shield began offering their two binational plans, the copayments for physician office visits were $2 and $4, respectively. Those same copayments are now $5 and $10, due to medical inflation that has occurred in

Mexico.**13** A summary comparison of selected out-of-pocket costs for members of four California binational plans, with out-of-pocket costs for Texas state employees under ERS plans is illustrated on Exhibit A.

Medical costs under the binational health plans are estimated to be 40 - 50% lower in Mexico than in California, according to a representative of Blue Shield. Mexican physicians are reimbursed by the capitation method, in which they are paid a set amount of money per member per month. Hospitals may or may not be capitated. An example of the difference in costs between Mexico and California, based on Blue Shield's experience, relates to the cost of hospital care: in Mexico the cost is $600 - $700 per day, while in California the cost is $1100 - $1200 per day. Premiums for the binational plans are about 25 - 40% lower than those for other plans. **14** Written testimony received by the interim committee states that the premiums for Health Net's binational plan are about $303 per month for a family of four, compared to about $600 per month for a California-only HMO plan. **15**

When proposed, the binational health plans did not encounter substantial opposition in California. The Governor and the Legislature fully support the plans, and have expanded the coverage available. California regulators have recently begun a dialogue with Mexican regulators with the goal of reaching a consensus on standards and developing cooperative regulatory processes for the binational health plans.**16**

The California regulators and health plans identified several issues encountered during the implementation of their binational health plans that required resolution. For the South-to-North model, the regulators found that it was difficult for SIMNSA to obtain the required bonds and reinsurance to meet the financial requirements of California law. The plan was able, after some effort, to obtain coverage through Lloyd's insurance companies. Licensure of the Mexican plan was also an issue. At the time California passed its cross-border statute, Mexico did not license HMOs. So, although the California law required licensure in Mexico, the plan was not licensed as an HMO but rather had a type of business license. More recently, Mexico has started licensing HMOs, through collaboration between the agency that oversees insurance and the department of health. Another issue related to regulation of the Mexican plan pertains to language barriers--the plan submitted some of the documents required for regulatory approval in Spanish, which delayed review. **17**

For the North-to-South model, because of the different provider contracting structures used by the two health plans, the issues identified are distinct. Blue Shield contracts with a physician group in Mexico to provide healthcare services, in a manner similar to that used by Texas HMOs to form a physician network. Credentialing of the Mexican physicians has been an issue, because of the different methods of licensing and certification of specialty physicians in Mexico. The plan has contracted with a physician who is dually licensed in Mexico and California and is therefore knowledgeable about Mexican licensing and regulatory systems and can oversee quality of care and credentialing with the Mexican physician group. Since Blue Shield's Access Baja plan can be used by both U.S. citizens and Mexican citizens working in the U.S., there was a

concern that employers would purchase the less expensive binational plan and force employees who would not prefer Mexican health care to use it. Because of this concern, Blue Shield requires that employers offer one of their California-based commercial plans at the same time as the binational plan , and requires that the employer's cost-share of the premium be the same for both plans. This method eliminates any financial incentive on the part of the employer to choose only the binational health plan. **18**

HealthNet has an agreement with SIMNSA to provide physician, hospital and pharmacy services in Mexico. Oversight of the quality of care and credentialing processes is performed by HealthNet, and the processes are required to be performed to the same level of standards as for California-licensed health plans. **19**

California requires that each plan document must contain an advisory statement concerning health care in Mexico. The language for the advisory statement that is used by Blue Shield may be found on page 2 of the attached copy of the Access Baja plan document (Exhibit C), titled "Mexican Health Care Standards", and the English version is as follows:

> "Legal requirements for and generally accepted practice standards of medical care in Mexico are different than those of California or elsewhere in the United States. Therefore, the care to be received through providers in Mexico in the Access Baja HMO Health Plan will be care that is consistent with generally accepted medical standards of Mexico, not of California. It is Blue Shield's policy to contract only with providers who meet all applicable laws, licensing requirements and professional standards of Mexico and who provide their services in accordance with the generally accepted standards of the organized medical community relating to professional and hospital services in Mexico. With the exception of out-of-area emergency and urgently needed services, as well as services for covered transplants, elective interruption of pregnancy, severe burns, acute rehabilitation, neonates requiring continuous cardiopulmonary support, pediatric cardiovascular and thoracic surgery and critical trauma cases, services under this Plan are covered only when provided by the contracting Plan providers in Mexico; the member may not seek such services from Non-Plan Providers outside of Mexico. Any member who is not completely comfortable with the standards of care for the practice of medicine in Mexico should not enroll in the Access Baja HMO Health Plan."

B. Projected cost savings to Texas

The development of an affordable health insurance product could result in a number of cost savings for Texas. For some of the children of low-income workers who currently qualify for CHIP, affordable private insurance could replace the CHIP coverage. For example, in the 32-county border region, there are 92,219 children enrolled in the CHIP program as of September 1, 2002. **20**Based on the statewide averages, there are estimated to be 81,153 parents of children in the CHIP program. Of the estimated 81,153 parents of these children, 25% (20,288) have access to private health insurance, but the insurance is unaffordable since it is very difficult for low-income parents to pay the cost of private

coverage for their dependent children at today's prices. The other 75% (60,865) do not have access to insurance. **21** To the extent that an affordable employer-based health insurance plan such as a binational health plan is made available, it could replace CHIP coverage for a portion of program participants and therefore save both federal and state money. Such coverage could allow more members of the family to have health insurance, and could allow all the family to use the same doctor for their primary care, which would streamline receiving care.

Texas hospitals in the border region provided more than $600 million in uncompensated care in 1997, amounting to about 8 percent of gross patient revenues for the providing hospitals.**22** One such hospital, Valley Baptist Medical Center, reports caring for 42,000 patients in their emergency room in 2001, with 20% of the patients being uninsured. Most of this cost is never paid to the hospital by the uninsured patients. On a statewide level, 69% of the uninsured are employed.**23** A significant reduction in the amount of uncompensated care rendered to employed uninsured patients could result if affordable binational health plans are purchased by the employers in the region. For example, if even 30% of the uncompensated care provided in 1997 were to be paid for under private insurance, the reduction would be $180 million.

Because some of the hospitals providing uncompensated care are publicly supported hospitals, a reduction in uncompensated care could lead to a savings of tax dollars as well. The Texas Indigent Health Care and Treatment Act of 1989, Health & Safety Code, Chapter 61 provides state matching funds for counties that spend more than 10 percent of their gross revenue tax levies on qualified indigent care. In 1997, border counties accounted for six of 16 counties qualifying for state matching funds. Four border counties were among the state's five leaders in the share of gross tax levies devoted to indigent care. Border counties spent $8.8 million of the $14.6 million, 60% of the total spent by the 16 qualifying counties. Hidalgo County alone spent $6.5 million.**24** To the extent that the indigent residents are employed, affordable employer-based health insurance could reduce state and local taxes currently spent on indigent care.

A further cost saving to Texas is found in the fact that a healthier workforce leads to less absenteeism due to illness of the worker or family members. Chronic conditions could be treated and complications prevented. Preventive care could be provided. Communicable diseases could be controlled. A healthier workforce will allow higher production, which will contribute to the economic outlook for Texas. It is not possible to precisely quantify the cost savings due to these measures, but the savings could be significant.

VI. Legal Impediments

This report addresses some of the major legal issues facing a binational health care plan. However, as with any new product, other issues may arise depending on the implementation methods of the health care plans and corresponding law.

A framework for cooperative dialogue exists between the two governments. In 1994, the Texas Insurance Commissioner signed a Letter of Intent with the Presidente de Comision

Nacional de Seguros Y Fianza of Mexico (CNSF), the Mexican agency that oversees insurance and financial services. The purpose of the agreement is to stimulate and promote effective communication relating to information and measures to enhance the protection of the insurance consuming public of both Texas and the United Mexican States, and to provide assistance on a reciprocal basis relating to market oversight and protection of markets against fraudulent insurance transactions. This agreement, though not having the force of law, lays the groundwork for cooperative activities related to binational health plans.

A review of federal statutory and case law, as summarized in Exhibit D, identifies issues related to establishing binational health plans. Of the issues identified, the applicability of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) is of direct interest in developing binational health plans. If a South-to-North model is adopted, the Mexican-licensed issuer who becomes licensed in Texas and insures a Texas employer group will come under the requirements of HIPAA. The Texas High Risk Pool, which is an approved alternative mechanism to some of the HIPAA requirements related to guaranteed issue in the individual insurance market, will be available to enrollees in a binational health plan. Because HIPAA regulates health plans, and is not directed at the status of the enrollee, Mexican nationals who are enrollees in binational health plans will have the protections of HIPAA.

A review of state law indicates that various issues would need to be addressed in order to effect the implementation of the above-described plans. Provisions in the Texas Insurance Code pertaining to jurisdiction, enforcement, licensing and credentialing, quality of care and mandated benefits, eligibility requirements, etc. would need to be reconciled with the models described above. Should it be determined that state mandated benefits are applicable to the above plans, the authority to waive them would have to be considered. Furthermore, Mexican law and regulations need to be reviewed to assess the feasibility of binational health plans as a viable option.

The Texas Insurance Code (TIC) contains a number of provisions that may be difficult to enforce if a South-to-North model binational health plan is contemplated. For example, the definition of "physician" in both Chapter 3 and Chapter 20A of TIC specifies that the physician must be licensed in the State of Texas. Other providers that would be expected to be included under a binational plan are also defined by Texas licensure. Absent an agreement with Mexican agencies, the Texas Department of Insurance may lack jurisdiction to enforce many of the patient protection provisions of TIC, unless the medical care was provided in Texas. The contracting and advertising requirements in TIC may also be unenforceable in Mexico. Premium tax and other tax provisions would need to be analyzed for applicability to a Mexican-based insurer. The California Legislature handled similar difficulties by allowing the Director of the Department of Managed Health Care to waive certain provisions on a case-by-case basis of the HMO law in regard to their South-to-North plan and by limiting the sale of that plan to Mexican nationals only.

For a North-to-South model, TIC poses fewer impediments. Because the company would have a Texas certificate of authority and would be a domestic company, most of the TIC requirements would be enforceable as written. Definitions of physicians and other types of providers that specify Texas licensure would continue to present impediments, greater for HMOs than for indemnity companies and PPOs, and would require legislative change. Enrollees would be afforded the patient protections for services received on both sides of the border, such as continuity of care provisions, complaint processes, and independent reviews, available to all other enrollees in Texas. Contracting and advertising requirements would apply to the issuer. Tax provisions would apply to the health benefit plan issuer.

By contrast to our health care system, in Mexico access to health care is a guaranteed right under the Mexican constitution. Two major public sector institutions cover basic medical care, medications, hospital expenses and catastrophic events for 55% of the Mexican population. The institutions are the Social Security Institute for State Employees (ISSSTE), which covers government personnel and their dependents, and the Mexican Social Security Institute (IMSS), which covers non-governmental workers employed in Mexico and their families. Since approximately 1995, the Mexican Ministry of Health (Secretaria de Salud) has adopted various reforms to the health care system with the goals aimed at increased coverage, improved efficiency, and decentralization of health care. An important effort towards this goal is the integration of the private sector health care plans. Recent changes to the health care system include allowing individuals not employed in the private sector in Mexico to purchase IMSS health insurance at a subsidized rate. So far, only 250,000 out of the 25 million people who are eligible to purchase coverage under this program have chosen it. IMSS also has an insurance program for Mexican workers in the United States, commonly referred to as IMSS Amigos, that provides coverage for the workers' dependents residing in Mexico and for the workers themselves when they are physically present in Mexico. For those residents who are not covered by IMSS or other institution, Mexico has recently established a low income health insurance program (Seguro Popular de Salud) to provide basic coverage by promoting prepaid plans, encouraging primary care and reducing catastrophic expenditures. Individual Mexican states are responsible for providing the services under the program. For the estimated 48 million Mexicans who remain uninsured, the Ministry of Health and local departments of health provide basic services. **25**

Private sector options in Mexico account for 52% of health care spending. Of this amount, more than 95% is financed through out-of-pocket payments. Utilization of private health insurance is relatively small, however there has recently been an increase in private sector participation in prepaid health plans. In December 1999 the Mexican insurance law was amended to allow for the creation of the Instituciones de Seguros Especializadas en Salud (ISES). ISES are the institutions authorized to sell prepaid private or voluntary insurance designed to offer services to establish or restore the health care of the insured, such as preventive and primary care. These newly formed institutions are authorized and regulated by both the Comision Nacional de Seguros y Fianzas (CNSF) or National Insurance Commission and the Secretaria de Salud or Ministry of

Health. CNSF supervises the financial and actuarial aspects of the ISES and the Ministry of Health is responsible for the medical component. **26**

To become licensed under the 1999 law, companies must present required financial information in terms of projections and reserves for a three-year period, information systems to be used, and the market for the plan. Contracts and advertising are also addressed in the regulations. Once the Minister of Finance approves the technical and financial information, the Ministry of Health must approve the medical aspects of the plan. The ISES must designate a Medical Control Officer who is approved by the Ministry of Health. The regulations also cover requirements for patient access and coverage limitations, exceptions, exclusions and waiting periods. There are provisions that address the right to choose providers outside the network and the cost of choosing out-of-network providers. **27**

Since the 1999 insurance amendments, three ISES have been authorized and certified by Mexico's Internal Revenue Service, while another six have been authorized and are currently awaiting final certification. All the plans are based in Mexico City and provide coverage throughout Mexico. **28**

Prior to these amendments there was not a regulatory system in Mexico that regulated prepaid private health benefit plans. Thus, it is difficult to know what issues, if any, have resulted from these new regulations. It is evident after a review of the Regulations for the Operation of the Health Care Sector that these rules parallel many of the U.S./Texas concepts for regulating health care such as maintaining financial accountability, patient protections, and utilization review.

In a South-to-North model, consideration of the licensure of the Mexican-based company as an ISES would be crucial. If the entity were to be exempted from the patient protection and quality of care provisions in our state insurance laws, it would be necessary to work cooperatively with the Mexican agencies that regulate prepaid health plans to assess the quality of care and access to care for enrollees.

VII. Practical Impediments

At hearings held in Harlingen and El Paso in September and October, 2002, providers raised a number of concerns regarding the possible implementation of binational health plans. One concern voiced by representatives of the Hidalgo-Starr Counties Medical Society, Border Health Caucus, El Paso County Medical Society, and Texas Medical Association, is that Texas Department of Insurance (TDI) would not have the ability to monitor compliance with Texas insurance laws related to quality of care delivered in Mexico by Mexican-licensed physicians. The Texas providers are concerned that the standards in the Mexican health care system are not equivalent to Texas standards relating to access, quality and safety. Dr. Manuel Feliberti, a plastic surgeon in El Paso, testified that he has personally taken care of several patients who received cosmetic surgeries in Juarez, and then developed severe infections that necessitated hospitalization for several weeks. During the course of the patients' care in El Paso, physicians were

unable to obtain any medical records, operative reports or laboratory reports from the Mexican providers. Dr. Feliberti also testified that clinics in Mexico are not regulated by such standards as OSHA, HIPAA, and other safety monitoring, as are required in United States clinics. He also testified that x-ray equipment and other technology in Mexico is not as advanced as in the United States. Dr. Luis Acosta-Corrales, who received his medical education in Mexico City, Canada and the United States and who practiced in Mexico City for 15 years, testified that the standards of medical care in Mexico are not regulated as they are in the U.S. Dr. Acosta also testified that medical support teams are not required to be relicensed and are not regulated for quality, and diagnostic equipment, surgical supplies and infection control procedures are not subject to the same quality control as in the U.S. Medical malpractice is not pursued in the same manner as in the U.S., according to Dr. Acosta.

Another area of concern expressed by physicians during testimony before the committee includes the safety and efficacy of medicines obtained in Mexico. One of the benefits of a binational health plan would presumably be a prescription drug benefit. The U.S. Food and Drug Administration (FDA), in its Information Sheet on the Importation of Drugs published this year, states "We appreciate that there is a significant cost differential between drugs available here and those in other countries. However, many drugs sold in foreign countries as "foreign versions" of approved prescription drugs sold in the United States are often of unknown quality with inadequate directions for use and may pose a risk to the patient's health. FDA approves a drug on the basis of scientific data proving it to be safe and effective. FDA approved labeling provides information on how and when the drug can be used to maximize effectiveness and minimize any harmful side effects. The manufacturing facilities and procedures for approved products are also carefully regulated by FDA to ensure product integrity. Since FDA cannot assure the consumer that the drug purchased in the foreign country would be the same product his or her physician's prescription is written for, we recommend the product covered by the prescription be acquired in the United States." The FDA has also warned that even though imported medications that bear the name of a U.S.-approved product may in fact be counterfeit versions that are unsafe or even completely ineffective. These warnings must be taken into account as the development of binational health plans is considered.

Other concerns expressed by the providers in the border region are the possible impact of binational plans on medical liability rates in Texas and the inability of the Texas State Board of Medical Examiners to oversee the Mexican physicians. As has been well reported, the cost of medical malpractice insurance in Texas is rising due to the number and amount of malpractice lawsuits. The border region has been affected disproportionately by this issue. For example, TDI's analysis of data received from medical liability insurers shows that the increase in the cost of insurance is due to the increase in claims in the Lower Rio Grande, primarily Hidalgo County, where the number of claims filed is increasing at the rate of 60% per year. Physicians in the border region cities of McAllen, Brownsville and El Paso pay approximately twice as much for malpractice insurance as physicians in other urban areas of the state. For example, a neurosurgeon in one of the three border cities can pay as much as $143,000 per year for malpractice insurance, while a neurosurgeon in Lubbock will pay $67,000 and in San

Antonio he will pay $75,000 for the same coverage. The physicians are concerned that if binational health plans allow more patients to receive care in Mexico and those patients develop complications that require extensive care in the U.S., the medical liability insurance rates and the number of lawsuits will increase. Representatives of two hospitals, the South Texas Health System and Sierra-Providence Health Network, testified regarding the same concerns as expressed by the physicians.

Statistics reflecting accessibility of physicians, dentists and hospitals in Mexico's border region are not currently available in detail. However it seems reasonable to assume that just as large stretches of Texas' border region have few if any hospitals, dentists or physicians, corresponding rural areas in Mexico may be underserved. Larger urban border areas in Mexico will presumably have more resources, just as the urban areas in Texas' border region have more resources. Mannti Cummins, a consultant with the firm Gonzalez, Kieschnick, Cross & Farias, testified at the Harlingen hearing that the private hospitals in the Mexican border region are relatively small in size (50 to 60 beds). Such geographic variances could limit development of adequate provider networks for HMOs and PPOs in certain parts of the border region; however adequate networks could probably be more easily developed in the more urban areas. The variances will not necessarily have an effect on an indemnity plan, because there is generally no network adequacy issues involved in indemnity plans. Monitoring access to care must be a key part of TDI's oversight of a binational health plan, and will require a cooperative effort with the Mexican authorities to ensure that enrollees have adequate access.

Credentialing of Mexican physicians, dentists and hospitals is an area that will be complicated for Texas-licensed HMOs and PPOs, due to the differences in Mexican licensing and specialty certifications as compared to U.S. processes. In Mexico, once a student completes a four-year medical program, and completes both an internship and a year of social service work, he or she can register to practice medicine in Mexico. Mexican universities award a medical diploma which is endorsed by the Secretariat of Public Education through the General Directorship for professions. This office grants the physician a Cédula or permanent license, valid nationally, to practice medicine. There is some movement in Mexico towards a requirement for medical school graduates to pass a national exam prior to receiving a license.

In Mexico, there are no laws that prohibit a general physician from performing the services of a specialist. However, many group practices and hospitals in Mexico are now requiring board certification. The Academia Nacional de Medicina (ANM), or National Academy of Medicine, acts in an oversight capacity for specialty certification, focusing on standards of practice. There are at least 43 different specialty boards recognized by the ANM, that are formed by the respective affiliated medical societies and that operate as a system of certification for medical specialists. A non-governmental group known as Consejos de Certificacion de Especialidades Medicas (Certification Boards for Medical Specialties) serves as the administrative institution, which manages the various boards. The certification process includes a national examination to enter into postgraduate training at hospitals and universities authorized by the Secretariat of Health. Upon completion of the required training, graduates receive a diploma and the majority take an

examination for board certification. There is also a re-certification process, which must occur between five and seven years from the date of initial certification.

By comparison, in the U.S. physicians attend four years of medical school followed by a minimum of one year of graduate medical education prior to licensing. Licensing is performed by each state, and requirements differ among states. In order to become a specialist, a physician completes from three to seven years of graduate medical education, depending upon the particular specialty. During the first year the physician is in graduate education, he is issued a temporary license which is a limited license allowing him to practice with supervision for the first year. At the end of the first year, the physician is eligible to take a state board examination. After the graduate medical education is completed, the physician takes specialty examinations administered by the appropriate specialty board. There are 24 medical specialty boards approved by a private organization known as the American Board of Medical Specialties (ABMS) and the American Medical Association. **29**

Generally, Mexican Public Health Law governs hospitals in Mexico but there are inconsistencies in the system because although the laws are federally mandated, enforcement is by state and local authorities, which vary from one locality to another. The law requires hospitals to maintain a license, which is renewed annually. State inspectors conduct surprise inspections and check primarily for compliance with sanitation requirements, not hospital operations. State health inspectors also monitor specific departments such as narcotics administration and radiation emission but they are looking for egregious noncompliance problems. The performance of hospitals in Mexico is not measured by the same standards or in the same detail as those utilized by the Joint Commission of Acceditation of Healthcare Organizations (JCAHO) in the United States. In the U.S., most hospitals are accredited by JCAHO, a private nonprofit organization. The process involves an initial accreditation survey, followed by triennial reaccreditation surveys of the facility and its operational processes. In Texas, hospitals are licensed by the Texas Department of Health as a facility and the hospital's x-ray equipment is separately licensed. **30**

For several years there have been efforts in Mexico to establish standards similar to the standards set by JCAHO which accredits hospitals in the United States. "Qualimed, S.A." is an independent consulting organization that has established voluntary hospital standards which were close to being adopted in Mexico. Dr. Enrique Ruelas, President and CEO of Qualimed, S.A., modeled standards after the JCAHO regulations and other standards currently in place in Canada. The goal of Qualimed is to contribute to the improvement of quality and efficiency of health care services through the setting and monitoring of quality standards, benchmarking information, clinical database design and analysis, training programs on quality improvement, and consulting. According to Dr. Ruelas, the demand for certification by Qualimed, S.A. is continually increasing. **31**

A variety of other issues will need to be addressed by binational health plans.

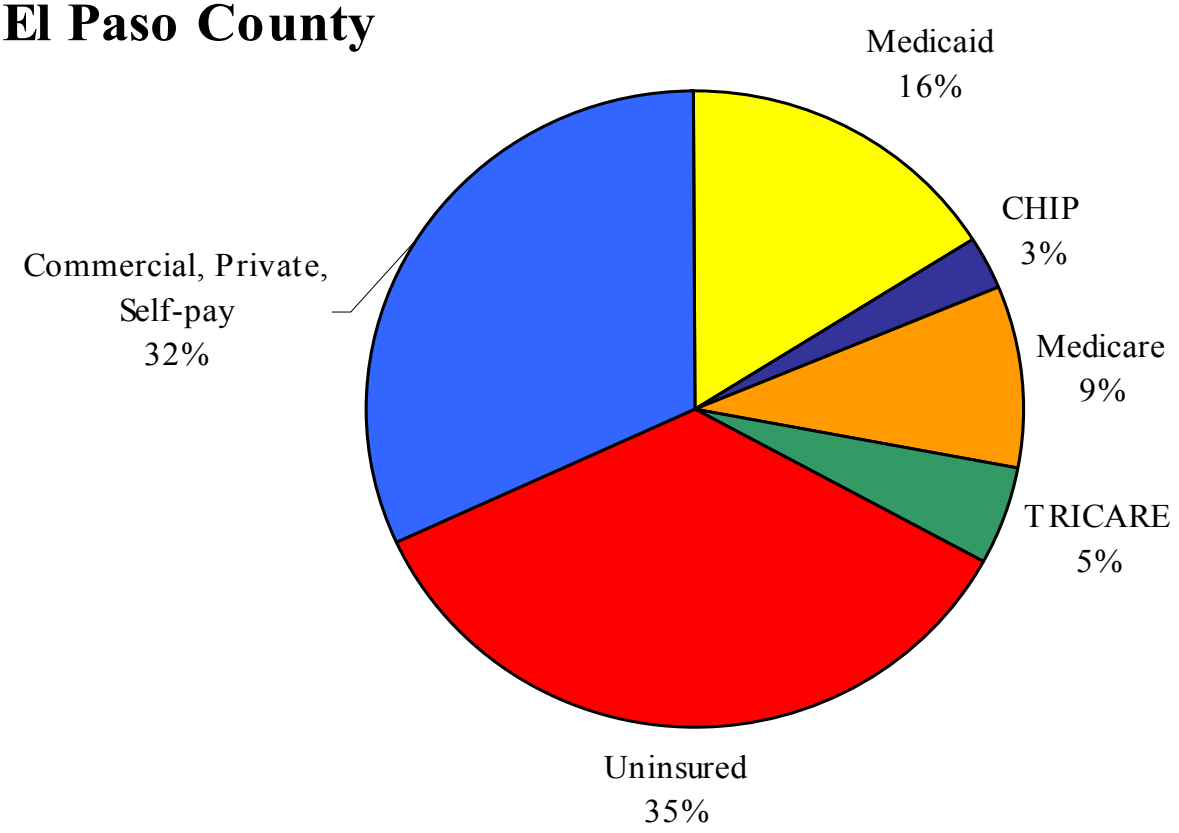
- Claim payment processes will require attention due to the fact that issuers' claim payment computer systems are set up to use forms promulgated by Centers for Medicaid and Medicare Services (CMS), and the systems are based on dollars rather than pesos.
- Physicians and hospitals in Mexico may not be accustomed to using the standard CMS forms and coding procedures, so insurers and HMOs will need to educate the providers, in the absence of some sort of accommodation.
- Fluctuating values of the peso may affect provider contracting and claim payment processes, particularly if a large devaluation of either currency were to occur.
- Language differences will be a factor affecting all written and verbal communications between the health plans, providers, enrollees and regulators.
- Actuarial processes used by the health plans will have to be altered to include data from Mexico.

A final practical impediment to be considered is related to regulatory oversight of binational health plans. TDI processes for oversight of binational health plans will need to be altered somewhat from processes currently in use. For the South-to-North model, if all the current statutory requirements were to be applied, TDI would require a number of bilingual staff. Examinations would have to be performed at the company offices in Mexico. If a portion of the statutory requirements related to quality improvement and credentialing is waived in return for oversight by the Mexican regulators, fewer bilingual staff would be required by TDI. For the North-to-South model, since the companies would be Texas-based, examinations could be performed by the current staff, with support from a minimal number of bilingual staff. Examinations would be performed in Texas at the company offices.

VIII. Economic Implications

At the El Paso hearing, Senator Eliot Shapleigh and several physicians from the community testified that binational health plans that allow the enrollees to receive medical care in Mexico could present an economic hardship issue for physicians in the El Paso area. The majority of patients treated by the physicians in El Paso are covered by Medicaid and CHIP or are uninsured, as seen in the illustration below, which was furnished by Sen. Shapleigh during his testimony. Reimbursement rates for those patients is lower than for patients who are covered by private insurance. Therefore, increasing the number of patients in their practices who have private insurance is an important economic issue for physicians in El Paso. Physicians are concerned that if the patients covered under binational health plans choose to receive their care in Mexico, they will lose the revenue they might otherwise receive from a new source of private insurance payments.

El Paso County



Currently, many Mexican nationals seeking quality medical care come to Texas healthcare facilities and physicians. For example, the Texas Medical Center in Houston, the emerging Health Science Center in South Texas, and the Health Science Center in San Antonio have provided quality health care services to thousands of Mexican nationals for years. According to Sen. Eliot Shapleigh, some estimates indicate that 20 percent of the beds at the Texas Medical Center are occupied by Mexican nationals seeking health services in the United States due to the quality of sub-specialists. Any private insurance that could shift these patients to receiving their care in Mexico could have an economic impact on the providers of care who currently rely on this business. At the same time, an insurance plan that would reimburse for care received in the U.S. by Mexican nationals could increase the number of such persons who travel to the U.S. for care, because those who can afford the premiums for the insurance but could not have afforded to pay cash for the care could now come to the U.S. for care.

IX. Options

To summarize, the border region of Texas has a large percentage of uninsured persons who are employed, most often in small businesses. If an affordable employer-based health plan were made available to those employees, cost savings to Texas could be realized due to less uncompensated care being provided, a healthier workforce, and possibly by a reduction in the number of CHIP enrollees. An employer-based binational health plan would not benefit those uninsured residents who are not employed or whose income is so low that the plan remains unaffordable. For those uninsured persons in the border region who are not employed or who do not have access to employer-based coverage, individual binational health plans are an option. The cost savings to Texas would be similar to those that could be realized from employer-based insurance. Additionally, the individual coverage could be marketed to Mexican residents who wish to come into Texas for health care services from our physicians and hospitals.

If the Legislature determines that binational health plans are a viable option to provide affordable health plans, there are a number of options that can be considered. As each option is considered, new issues beyond those raised in this report will arise. For example, if the independent review process is made available to enrollees of binational plans, questions that will need to be considered include whether Independent Review Organizations (IROs) will be required to add Mexican physicians to their panels of reviewers so that reviews are performed based on the prevailing standard of care in Mexico rather than the U.S., and also so that the reviewer can review Spanish language medical records or interview Mexican physicians as part of the review process. Another issue to be considered in implementing the IRO process for binational plans is the required timelines for reviews, which may need to be adjusted to allow for international mail service or documents needed. Mandated notices and forms that are utilized in the IRO process are created and maintained by TDI, and will need to be translated into Spanish. Similar issues will arise for other processes besides the IRO process, and may require legislation to implement them.

- One option that is available is to maintain the status quo, which would allow indemnity and preferred provider health benefit plans to offer group and/or individual

binational plans The plans would fit the North-to-South model as described previously. All current regulatory requirements, mandates and consumer protections would apply to the plans.

- HMOs could offer group and/or individual binational plans with legislative changes to the HMO law. The plan would fit the North-to-South model, and all current regulatory requirements, mandates and consumer protections would apply. Cooperative ventures with Mexican-licensed ISES could be an option under this model. Bilingual staff will be necessary for TDI's oversight process.

- Requiring the issuer to offer a standard Texas-based health plan at the same time that a binational plan is offered in order to maintain the enrollee's right to choose must be considered. Requiring notices to enrollees regarding differing standards of care in Mexico, similar to that utilized by California plans should also be considered.

- To allow flexibility in designing binational plans so that cost is reduced as much as possible, legislation could be enacted to allow the plans to have an exemption from the state-mandated benefits.

- If the South-to-North model is adopted, consideration should be given to granting the Commissioner of Insurance the authority by legislation to waive requirements as necessary to allow a Mexican-licensed plan to obtain a certificate of authority in Texas. Exempting solvency requirements and tax provisions from the Commissioner's waiver authority must also be considered. TDI financial examinations will have to be conducted in Mexico, and bilingual staff will be required. Consideration must also be given to requiring the Mexican issuer to be licensed as an ISES in addition to obtaining a Texas certificate of authority.

- For the South-to-North model, if waiver authority is not granted to the Commissioner, enact legislation with specific licensure requirements. If the Mexican company obtains a certificate of authority as an HMO in Texas, TDI quality of care examinations will have to be conducted in Mexico in addition to the financial examinations, and a larger number of bilingual staff will be necessary.

- Consideration of limiting the availability of South-to-North binational health plans to Mexican nationals, as California has done, will be necessary.

- Enact legislation authorizing a formal grant-funded or university study of the economic impact of payment by health plans for care received in Mexico in addition to Texas. Impact could be measured on both Mexican and Texas providers and hospitals in the border region. Any differences in economic impact on rural and urban settings could be addressed. Changes in access to and utilization of health care services by enrollees could also be measured.

- Enact legislation authorizing formal grant-funded or university studies of quality of care in Mexico and in the Texas border region. The committee received testimony

regarding anecdotes and concerns about standard of care differences between the two countries, which could be measured by a formal study.

- A final consideration is that of enacting legislation to authorize a binational health plan as a pilot project limited to certain geographic areas in the border region, perhaps in El Paso and an urban area in the Lower Valley. Coverage could be offered through employers, as group coverage, and it could also be offered as individual health plans marketed directly to Mexican nationals working in Texas and allowing coverage for their families who remain in Mexico. After a stated period of time, if the pilot project is determined to be successful, legislation could provide that other geographic areas would be made available for binational health plans.

Endnotes

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27 Regulations for the Operation of the Health Care Sector, Article 7, General Law of Institutions and Mutual Insurance Corporations**, Official Diary of the Federation**, December 31, 1999.

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Exhibit A
Comparison of California Binational Plans with Texas State Employees Plans
Out-of-Pocket Costs

Benefit	***Access Baja Gold (HMO)***	***Access Baja Silver (HMO)***	***Salud con Health Net (HMO)***	***Salud con Health Net (PPO)***		***Health Select Plus (HMO)***	***Health Select (PPO)***	
				In-network	Out-of-network		In-network	Out-of-network
Deductible	None	None	No charge Mexico/ $100 CA	$0 Mexico/$100 CA	$1000	None	None	$500 individual; $1500 family
Office visits	$5	$10	$5 Mexico/$15 CA	$5 Mexico/$15 CA	$50%	$10	$15	30%
Maternity care	No charge	No charge except $100/day for CA hospital or private room in Mexico	No charge Mexico/ $250 deductible in CA	10% fees Mexico/ $250 deductible +20% of fees CA	$250 deductible + 50% of fees	No charge	$15 first visit then no charge for fees/10% hospital charges	30%
Inpatient surgery	No charge	No charge except $100/day for CA hospital or private room in Mexico	No charge Mexico/ $250 deductible in CA	10% fees Mexico/ $250 deductible +20% of fees CA	$250 deductible + 50% of fees	No charge	10%	30%
Prescription Drugs (generic/brand name/brand name not on formulary)	$5/$10/NA	$10/$20/NA	$5/$5/NA Mexico; $5/$15/$35 CA	$10/$10/NA Mexico; $10/$35/50% CA	$10/$35/50%	$5/$20/$35	$5/$20/$35	70% of lesser of: cost minus copay or AWP +$2.50 minus copay
Emergency Room	$25 Mexico/$50 CA	$25 Mexico/ $50 CA	$10 Mexico/ $50 CA	$25 Mexico/ $50 CA	$50	$50	$50 copay, then 10% of charges	30%

Mexican Regulations for the Operation of the Health Care Sector

In the margin appears a seal with the National Emblem, which says: United States of Mexico-Department of Health and Public Credit

REGULATIONS FOR THE OPERATION OF THE HEALTH CARE SECTOR

The General Law of Institutions and Mutual Insurance Corporations, known originally as the General Law of the Insurance Institutions, was published in the **Official Diary of the Federation** on August 31, 1935. From then until the present, it has undergone various modifications to bring its provisions in line with the evolution of the country's financial sector, within which the insurance industry operates.

Even though the changes to the cited Law in the last ten years have been oriented toward deregulating the activity of the insurers, toward liberalization with a goal toward self management, a fundamental goal of the changes has been to maintain adequate, prudent regulations that protect the interests of the users and supervision to ensure strict compliance with the technical norms and solvency management that the insurers should maintain.

Through the National Development Plan, the Federal Government, aware of the importance that insurance activity represents for society, has established, as one of its goals, the expansion of its protective functions for people and goods faced with the risks to which they are exposed, and thus to foster its contribution to the growth of internal savings. In this way, in the last three years, the Congress of the Union has approved important reforms to the General Law of Institutions and Mutual Insurance Corporations, such as those contained in the Decrees published in the **Official Diary of the Federation** on January 3, 1997 and December 31, 1999.

The first of those decrees recognizes how important it is for Mexico that many people depend on private insurance to cover the risks of the accidents and illnesses to which they are exposed; therefore, the functions of accident and illness insurance were divided into three sectors: personal accidents, medical costs, and health care.

The health care sector provides the basis by which the Corporations or organizations known as administrative entities of prepaid medicine are transformed into Insurance Institutions Specializing in Health Care.

The second decree describes the health care sector as a provider of services directed at establishing or restoring health care through actions that are taken for the benefit of the insured; and it specifies that even when this activity is carried out with private resources and payments it shall be considered an active operation of insurance since its practice can only be granted to insurance institutions, those same institutions which additionally can be empowered to manage the medical costs sector.

It is appropriate to emphasize that providing health care services can only be considered an active operation of insurance if those services are traded/provided in the future and the fulfillment of the obligation of providing the services depends on a future uncertain event, foreseen by the parties, whether said provision of services be satisfied with the private or non-private resources and payments of the obligor.

Accordingly, the active operation of insurance does not include the rendering of health care services in which the costs of each service are covered by the user, either directly or through a third party, without assuming the commitment and financial contingency that stem from not covering the costs of each service that is provided, but rather only if the costs are incurred by the probability of having to provide services when a future uncertain event that is foreseen by the parties occurs.

Therefore, the commercialization of a service or the joining of certain, predetermined health care services, whose total cost is covered by the user in one or various forms, before, during, or after providing services, is not considered an active operation of insurance. However, it is considered an active operation of insurance when providing certain predetermined health care services is offered together with the providing of health care services tied to the occurrence of future uncertain events.

With an end toward achieving complete oversight of the authorized insurance institutions in the health care sector, the General Law of Institutions and Mutual Insurance Corporations entrusts the supervision of the institutions to the National Commission on Insurance and Finances and to the Ministry of Health.

Therefore, the Ministry of Health is exclusively authorized to carry out the functions of inspection and oversight over health care services and products that authorized insurance institutions in the health care sector provide; likewise, the Ministry of Health is to issue judgments (provisional, definitive and annual) through which it will be clear that the insurance institution is equipped with the necessary elements to offer quality standards in health care matters.

Along with the provisional rulings issued by the Ministry of Health, requests can be made to this Ministry for authorization to operate as Insurance Institutions Specializing in Health Care. Such requests should include the documents necessary to guarantee financial viability.

The basis for the issuance of the present Regulations is found in Article 7 of the General Law of Institutions and Mutual Insurance Corporations, in which is anticipated that the operation and development of the health care sector will be tied to provisions of a general nature that this Ministry issues, as well as to earlier opinions of the National Commission on Insurance and Finances and of the Ministry of Health**,** to which it has complied; it is also tied to the commitments assumed in the Protocol of Understanding undersigned by the Senators of the Republic to establish in the Regulations general criteria of a medical, technical, and financial nature, which stem from the concerns and comments voiced by diverse groups of the corporation who appeared before the Senate Chambers.

Also, the content of the present regulation is consistent with one the basic principles of the National Health Care System, which is to guarantee, in this case through the Insurance Institutions Specializing in Health Care, the offering of services for the promotion, encouragement, establishment, diagnosis, treatment and rehabilitation of health care, by establishing a series of requirements of a medical nature to adequately handle users demands. It also requires that, through an adequate integration of its infrastructure and team members, the medical services be of a high quality,

For purposes of the present Regulations, the Insurance Institutions Specializing in Health Care (ISES) are understood to be the institution or institutions authorized by this Ministry to practice in the health care sector within the field of insurance for accidents and illnesses. They are authorized to sell private or voluntary insurance designed to offer services to establish or restore the health care of the insured directly with private resources, through third parties, or in a combination of both, through actions that are taken on behalf of the insured.

In insurance, the practice in the health care sector presents certain distinct characteristics from the other two sectors of the operation of accidents and illnesses (personal accidents and medical costs), such as set out below:

Its origin does not exclusively stem from an external, violent, unexpected, fortuitous event or from an accident or illness that affects the health of the insured but rather is part of the objective of maintaining the health of the insured through actions which are preventive as well as restorative;
The objective of private or voluntary insurance in the health care sector is to provide services through the administration and organization of private and direct resources as well as those contracted through third party providers, or a combination of both, which differs from the other sectors whose purpose is to cover or reimburse the necessary costs that the insured incurs;
The health sector includes direct services to encourage the establishment of the health care of the insured, through the early detection of diseases, from tests based in factors of epidemiological risks, such as following up on the health of the insured, particularly in the case of chronic diseases, where timely intervention can prevent later complications from arising; and,
Finally, to facilitate the offering of services in the health sector, a health professional will be charged with providing continuity and coordination of health care actions together with other required providers, always for the benefit of the insured.

The Regulations direct that this Ministry be the competent organ to interpret, apply, and resolve, for administrative purposes, everything that is related to the Regulations; therefore, it shall seek the opinion of the National Commission on Insurance and Finances and the Ministry of Health, which in the exercise of their authority can determine the form and terms by which the institutions authorized to practice in the health care sector shall inform them and provide to them everything concerning the practice of this insurance. They are also authorized to establish procedures for consulting with different market participants to obtain information that will assist in achieving a balanced development of the system.

As insurance institutions, the function and operation of the ISES shall be fundamentally controlled by that which is set out in the General Law of Institutions and Mutual Insurance Corporations and in the Law on Insurance Contracts, as well as in the present Regulations that

make reference to the General Health Law and the Official Mexican Health Norms. The institutions shall follow the latter when offering services with their own resources and when offering them through contracts with third parties, who shall have to comply with the applicable Official Mexican Norm.

The Regulations, in compliance with that which is set out in the General Law of Institutions and Mutual Insurance Corporations, indicate the necessary documentation and activity plan that should be presented together with the authorization petition to this Ministry in order to organize and form an Insurance Institution Specializing in Health Care; in addition to including the provisional ruling issued by the Ministry of Health to verify that it possesses the necessary elements and sufficient medical criteria to offer, directly, through contracts with third parties, or in a combination of both, health services stemming from respective insurance contracts.

To begin operations, the institutions should have a favorable ruling from the National Commission on Insurance and Finances, resulting from an inspection visit performed to determine if the institution possesses the necessary systems and administrative infrastructure to offer its own services of a business nature. In addition, the institution should be in possession of ratification from the Ministry of Health for the appointment of its Medical Control Officer.

In accordance with that which is set out in Article 29 Section I of the General Law of Institutions and Mutual Insurance Corporations and the present Regulations, the ISES shall possess a minimum paid capital whose expressed amount in UDIS. shall be made known to this Ministry during the first trimester of each year. The Agreement regarding the minimum paid capital that the insurance institutions should obtain for each operation or sector was published in the **Official Diary of the Federation** on April 3 of the current year. Thus the capital for the operation of accidents and illness in one or several of its sectors is 1,704, 243 UDIS.

In the Agreement, it is set out that the costs for setting up and organizing the movable assets, equipment, and fixed assets of the ISES will be computed jointly until they reach 60% of the minimum paid capital. In the case of the formation of a new insurer in the health care sector, the minimum paid capital shall be totally underwritten and paid on the date that this Ministry grants the corresponding authority.

In accordance with Regulations, the insured shall be able to access health plans that include services offered by medical and hospital networks themselves or those contracted, where follow-up health care is provided as a preventative as well as curative measure, with schemes of reference and counter reference whose timeliness will provide an emphasis on health maintenance.

For this purpose, as already discussed, the participation of the Ministry of Health shall be determinative in the organization, establishment and formation of the ISES.

This Department, based on what was established in Articles 15, 105, and 106 of the General Law on Institutions and Mutual Insurance Corporations and in the present Regulations, possesses extensive and exclusive authority to supervise the medical aspects through which the Ministry of

Health shall carry out its duties to supervise and oversee the institutions authorized to practice in the health care sector, such as the issuance of provisional, definitive and annual rulings to confirm that the institutions are in satisfactory compliance with elements necessary to offer health care services stemming from insurance contracts and to establish the indispensable requirements to receive and maintain the authorization to operate. Upon receiving the authorization from the Ministry, the health insurance institution has three months to present the definitive ruling issued by the Ministry of Health. Later the institution shall present the annual report issued by the Ministry of Health together with the institution's financial status to verify that it maintains the elements necessary to offer health care services.

The Regulations set out the general criteria to which the institutions shall satisfactorily comply in medical matters to obtain rulings for which, based on certain criteria, the Ministry of Health shall additionally establish specific requirements through provisions of a general nature.

To obtain the rulings mentioned above, the institutions should, along with other requirements, satisfactorily ensure that:
the material and human resources, their own, those contracted to third parties and those that are a combination of both, be sufficient to comply with the plans offered to the users to be insured;
that the contract or agreement executed with third parties to provide services, which are the objective of respective private insurance contracts, guarantee an adequate offer regarding the quality, sufficiency, level of resolution, and geographic coverage;
that the institution possess the necessary mechanism to communicate to the insured changes in the infrastructure which the institution depends on to deliver services;
that the institution possess a flexible and timely internal mechanism to perform the intake, follow-up, and resolution of consultations and claims of the insured, etc.

the exclusive authority to supervise institutions authorized to practice in the health care sector in matters of health services and products, which are the subject matter of the private insurance contracts which they execute;
independent of the party responsible in the medical arena, the Insurance Institutions Specializing in Health Care (ISES) in charge of policies and mechanisms of a medical nature shall have a Medical Control Officer, named by the administrative board whose meetings s/he should attend with a voice, but without a vote. The Ministry of Health shall be required to ratify the Medical Control Officer through an internal committee of the same that will review his/her qualifications.

The various duties of the Medical Control Officer include, among others, the responsibility for supervising the workings of the medical services network of the institution with a goal toward adequately meeting the sufficiency requirements, satisfactory performance of the doctors and hospitals, the quality of care, utilization of services, consultation management, complaints, and compliance with the Official Mexican Health Norm.

The Regulations guarantee the honorability and independence of the Medical Control Officer, as well as the avoidance of possible conflicts of interest, by including strict measures not to have familial or patrimonial ties to the institution nor to its providers; therefore, the Medical Control Officer should be made aware of contracts before their execution. Upon failing to carry out

his/her duties appropriately, the Medical Control Officer can be subject to removal or suspension by the authorities.

The Medical Control Officer shall permit the institutions to preview and, when the case arises, to detect and correct, in a timely manner, any deviation that s/he finds through recommendations that shall be formulated by the administration of the institution and which must be submitted to the Ministry of Health and the National Commission on Insurance and Finances in a report every four months to fulfill his/her obligations, and when s/he finds significant anomalies, s/he shall issue a special report within ten working days from the date on which the anomalies are discovered.

Patients' rights are set out in the Regulations. These include: the expedient access to services, respectful treatment during services as well as a right to privacy; the right to accept the proposed therapies or not, the right to choose a doctor and hospital for treatment, the right to obtain additional opinions about their ailments according to the agreement in the insurance contract, the right to communicate with their family at all times, the right to personal safety for themselves as well as for their belongings and for people accompanying them, the right to know the identity and level of preparation of the health care providers that are taking care of them as well as that of the person responsible for the health care team, the right to be kept informed about their ailment, diagnostic methods, and their risks, benefits, and alternatives.

Doctors are required to possess a professional identification card that validates their technical knowledge, and in cases where specialty certification boards exist, doctors are require to maintain authorization from the same. At the same time, hospitals are required to possess certification from the General Health Council in addition to the other necessary authorizations and permits.

In virtue of the fact that the certification process is subject to programs that are presently being implemented, the Ministry of Health, at the request of the institution and considering the circumstances of each case, is authorized to establish a regularization period of between six months and two years.

In addition, for the benefit of the insured, the institutions shall permanently maintain adequate medical care by implementing the following programs:

A program to control the utilization of medical services which will include a mechanism to detect and correct problems of access, competency, and efficiency of services, as well as adequate levels of utilization of the same.
A continuous program for improving services that includes an increase in the quality of services, the furtherance of medical teaching and research, and the gradual development of indicators that permit the evaluation of advances as well as performance in providing the institutions' services.

The Ministry of Health shall issue rulings of a general nature to which the institutions shall adhere in the formation and implementation of said programs.

So that the institutions authorized to practice in the health sector shall be able to face future obligations that might arise stemming from health insurance contracts, they shall create, increase, and invest the technical reserves in accordance with the terms of the General Law of Institutions and Mutual Insurance Corporations, and with the general rulings stemming from the same and from the present Regulations. These reserves include risks in the current payments to confront the eventual payments of the policies in force; the pending obligations to meet disasters, which occur pending a liquidation; and that of foresight to cover the possible losses through statistical deviations in the event of a disaster.

As part of the insurer's own resources, the minimum guaranteed capital will strengthen its patrimony and its development so that, in accordance with the volume of its operations, the tendency for disaster, its practice of reinsuring, and the makeup of its investments, it is permanently maintained at levels sufficient to face adverse changes with respect to the fulfillment of obligations contracted with its insurers, reducing the possible financial-economic inequities that could be produced in its operations. In this way its financial viability is preserved and its stability and patrimonial security are consolidated.

The determination of the minimum guaranteed capital conforms to that established in the General Law of Institutions and Mutual Insurance Corporations and the Regulations for the minimum guaranteed capital for Insurance Institutions published in the **Official Diary of the Federation** on December 30, 1999; thus, the investment of their calculated assets to the said capital shall take place as established in the Regulations cited.

The institutions shall have an Investment Committee, which shall meet at least once a month and provide proof of the applicable methodology used to ensure that adequate risk levels are maintained, and, in the case of securities issued by private enterprises, the institutions shall acquire them only when they possess the proper rating of a qualifying institution of authorized securities.

For the institutions to provide information to the authorities, the Regulations establish that the National Commission on Health and Finance shall function as the exclusive vehicle for receipt of such information, with a responsibility to communicate it to the Ministry of Health to provide assistance, particularly as an evaluative tool to expedite the rulings for which it is responsible.

To perform their accounting functions and to establish a database, as well as a respective statistical system, the institutions shall subject themselves to that which is established by the administrative rulings that the National Commission on Insurance and Finance issues. In addition, they shall present to the Commission itself the technical notes by which they substantiate each of their coverages, plans, and premiums; they shall also present the contracts to provide services that are executed with other entities. Additionally, they shall record adhesion contracts offered to the public in general, in which applicable terms and conditions are established to contract for private health insurance.

The advertising of the institutions shall express itself in a clear, precise form so that there exists no confusion on the part of the user public. For the benefit of the user public, the advertising

shall be subject to the administrative rulings that the National Commission on Insurance and Finance dictates, which, at the same time, shall have the authority to modify or suspend the advertising.

To keep the insured informed in a clear and precise manner as to the coverage of their policy, the institutions shall provide, along with the policy, an informative brochure that includes, but is not limited to, a description of the insurance plan, the benefits contracted, the coverages, the limitations, exceptions, exclusions, and waiting periods. Likewise, it shall contain the means to access medical services, including all the clinics, hospitals and doctors employed by the institution, detailing relevant information for each of them.

To make the operation and commercialization of private health insurance clear and to specify certain rulings to provide a greater protection to the user public, the Regulations establish a series of requirements that the institutions shall observe in formulating and underwriting their plans and contracts, as well as in the operation and commercialization of the same.

Based on the foregoing, in formulating plans the institutions shall strive to incorporate integrated criteria so that the offered coverages encompass fostering, preventative, therapeutic and rehabilitative actions, which shall be evaluated by the Ministry of Health, which can make recommendations to comply with the objective of integrated care for the insured.

To facilitate the free choice of the insured, the Regulations create an obligation for the institutions to offer at least some plans in which the beneficiary can choose doctors outside the network through the payment of the difference between the institution's tabulation and the cost of the services that the doctor offers. At all times, the user public will be aware of these plans since the institution shall describe them in the informative brochure of any insurance plan that is offered for contract.

Timely access to services is reinforced through various rulings, such as the requirements that the service networks that make up the institutions have a territorial distribution that coincides with places where the insurance contracts are sold and underwritten. In addition, they shall inform the insured in writing of changes in the network hospital infrastructure and, in cases where, for reasons of saturation, lack of disposable services, or diagnostic errors the insured would need services outside the network and when medical emergencies present themselves, the institution shall reimburse the costs that have been incurred.

The present Regulations clearly establish the scope of the health insurance contracts when considering that an ailment is pre-existing. Likewise, it sets out the terms under which the institutions will be obligated to comply in providing services, once the life of the contract has expired, provided that the contingency has occurred within the life of the contract.

Toward this goal, the insurance contracts shall establish that the obligations of the institutions to comply in providing services directed at encouraging or restoring health if an eventuality foreseen in the contract occurs within the life of the contract shall end: 1) upon certifying the cure for the ailment which is being treated through medical release; or 2)

the exhaustion of the maximum limit of responsibility agreed upon by the parties; or 3) upon the conclusion of the term that for these pruposes has been agreed upon for providing of services. The term shall be not less than two years from the date on which the life of the contract ends.

On the other hand, to protect the insurers themselves the Regulations indicate that the institutions should establish in their policies whether an obligatory renewal exists or not and the maximum age for renewal. In these cases, certain arbitrary criteria that allow for selective discrimination of the insured cannot be used when renewing the plans.

For consultations and complaints, the public shall have at its disposal the mechanisms and authority that the Law for the Protection and Defense of the User of Financial Services establishes to assist the National Commission of Medical Arbitration. To help the user make consultations or submit claims, as the case may be, the institutions shall detail in the brochure that is provided to the insured, along with the policy, the internal policy and mechanism of the institutions themselves, as well as means of accessing the same. Infractions of the present Regulations shall be sanctioned in the terms set out in the General Law of Institutions and Mutual Insurance Corporations.

On the other hand, the General Law of Institutions and Mutual Insurance Corporations set out reasons for revoking the authority including, but not limited to: 1) if an institution with authorization in the health care sector does not present to this Ministry a definitive ruling or does not present to the National Commission on Insurance and Finance an annual ruling; or if at any time, this Ministry or the Commission has knowledge that the institution has not maintained the elements necessary to offers the services, which are the subject matter of the corresponding insurance contracts.

As already indicated, the prepaid medical businesses and organizations that because of the kind of activity they engage in fall within the concept of the active operation of insurance, shall become incorporated within the Insurance Institutions Specializing in Health, and in the case of those insurers that are currently authorized to operate within the health sector as well as within other operations and insurance areas, the Regulations specify the actions and time by which the operative lineaments set out in the present Regulations expire when related to certain operations, including, but not limited to, accounting operations, reserves and investments, statistical system, submission of the records of technical notes and contractual documentation, request for ratification of the Medical Control Officer and submission of the annual rulings by the Ministry of Health.

In cases where the user has contracted for insurance of medical costs and the insurance institutions propose to substitute them with contracts of health insurance, the regulations establish a clear and transparent process that guarantees the interests of the insured, including the continuation of the rights acquired through seniority and preexistence.

Toward this goal, those choosing insurance of medical costs shall be informed in writing of the proposed change or substitution of the respective contract, with advanced notice of at least thirty

working days prior to the termination date of the life of the insurance contract for medical costs. The institutions should, in this case, specify the continuation of the rights acquired including those in relation to seniority and preexistence. Also, it shall specify if there are any added benefit and the impact of those benefits on fees. This way, the holder of the insurance will accept the corresponding change or substitution through a signed agreement.

In virtue of the aforementioned and after having heard the opinion of the Ministry of Health and the National Commission on Insurance and Finance, this Ministry with a basis in the aforementioned through Article 31, Section VIII of the Organic Law of Federal Public Administration; 2nd, 5th , 7th, 8th , Section IV and V, 29 Section I, 33-B, 76 and 76-A of the General Law of Institutions and Mutual Insurance Corporations, and exercising the attributions that Section XXXIV of Article 6 of the Interior Regulation of the Ministry of Housing and Public Credit confers on me, I hereby issue the following:

REGULATIONS FOR THE OPERATIONS OF THE HEALTH CARE SECTOR

FIRST TITLE General Provisions, Requirements of Authorization, Minimum Paid Capital, Ruling, Medical Control Officer, Clinical Records, Utilization Of Medical Services and Continual Improvement in Providing Services

FIRST CHAPTER **General Provisions**

FIRST - For purposes of the present Regulation, the following is understood:

1. Ministry - the Ministry of Housing and Public Credit.

2. Commission - the Commission on National Insurance and Finance.

LGISMS - the General Law of Institutions and Mutual Insurance Corporations
ISES - Insurance Institutions Specializing in Health Care: the institution(s) authorized by the Ministry of Housing and Public Credit to operate in the area of accidents and illnesses in the health sector of the insurance industry.

SECOND - The ISES shall be authorized to operate insurance companies whose objective is to offer services directed at the establishment or restoration of health care for the insured, directly with their own resources, through third parties, or through a combination of both, by actions that are carried out for benefit of the insured. For the purpose of these Regulations, the following is understood:

Establish or set out - the completion of actions to promote health care that are accomplished to further healthier means of living, diminish or eliminate health risks, provide follow-up health care for the insured, prevent the later resurgence of illnesses or complications from the same, or to carry out actions of early detection of the illnesses based on epidemiological factors, as well as

providing services through a health professional who will coordinate the health activities for the benefit of the insured. Restoration - the offering of direct services to carry out therapeutic and rehabilitative actions necessary for the recovery of the health of the insured.

Insurances that have as their objective that which is foreseen in Number 1 and 2 above, through the offering of services, directly or through third parties, can only operate through the ISES.

Likewise, only the medical costs sector can additionally authorize the ISES to cover medical, hospital and other costs deemed necessary for the recovery of the health or vitality of the insured, when it has been affected by an accident or illness.

THIRD - The Ministry shall be the competent organ to interpret, apply, and resolve for administrative purposes, everything related to the present Regulations, and for such purposes, it shall solicit the opinion of the Commission and the Ministry of Health.

FOURTH - The ISES shall control through that which is already set out by the LGISMS, the Law of Insurance Contract, and other laws that are related to health care insurance and medical costs as well as that which, when applicable, is set out in the Regulations for the Establishment of Affiliates of Foreign Financial Entities and, likewise, they shall adhere to the regulations issued by the Ministry and to those criteria and general provisions that are set out by the Ministry of Health or the Commission in insurance matters, in agreement with the LGISMS and these regulations.

FIFTH - The Commission and the Ministry of Health, in the exercise of its authority to provide inspection and oversight that the GLIMLS authorized, can establish the form and terms in which the ISES shall inform them and prove everything concerning the practice of insurance in the health sector.

SIXTH - The Ministry, after hearing the opinion of the Commission, and, where relevant, from the Ministry of Health, can modify the form and intervals in which the ISES shall evaluate and present all aspects to which the present regulations refer.

SEVENTH - The Ministry of Health and the Commission can establish mechanisms of consultation with different market participants to receive information related to this type of insurance to help to procure a balanced development in the health care sector.

SECOND CHAPTER Authorization Requirements

EIGHTH - The organization and makeup of the ISES shall be subject to that which is set out in the LGISMS, as well as to the provisions set out in the present Regulations. The request for the authorization to practice in the health care sector of the insurance industry and, as the case may be, the medical costs sector, shall be presented to the General Management of Insurance and Securities of the Ministry, along with the following documentation:

Relation of shareholders who form the control group and the shareholders who retain more than 5% of the shares of the institution in question. An activity plan that includes, at a minimum, the following:
The initial capital that the institution will count on, as well as the resources with which it will support its operation during the first three years, indicating the origin of the same.
The technical concept of health insurance, a model contract and the remaining relevant technical and judicial documentation per the terms of Articles 36, 36-A, 36-B, and 36-C of the LGISMS and the present Regulations.
Financial estimate, including the makeup and increase of the technical reserves and capital, administrative and acquisition costs, balance projections, status of results, working capital and minimum guaranteed capital, with a three-year projection, considering macroeconomic assumptions with respect to the evolution of the internal gross product, inflation, interest rates, types of changes, and others which, as the case may be, the Ministry or the Bank of Mexico publicizes. The projections to which this clause refers shall be carried out based on the technical parameters that the LGISMS establish and in provisions that emanate from the LGISMS.
Policies to contain risks and reinsurance that it foresees being employed in its operation.
A program for the organization, administration, and internal control that includes:
Organizational chart and administrative structure.
Relationship of the first two levels of directors and members of the institution's administrative council, with their curriculum vitae attached.
Training programs for its employees and agents.
Structure to provide service to the insured, as well as policies to adequately satisfy the necessities of service.
Mechanisms to handle complaints and payments of claims.
Systems that will be employed to record, control, and report on the statistics relative to these insurance policies.
Systems that will be used to record, control, and report on its accounting operations.
Systems that will be employed to effectuate the evaluation of the technical reserves.
Form and terms in which the institution foresees the offering of services related to the insurance contracts which it executes, specifying if its own resources will be used and if contracts offering services will be executed with third parties for this purpose or if both will be used.
Mechanism or module, conforming to the legislation in force, that the institution will employ to back up its civil responsibility that, when the case arises, could result in the disengagement of its activities.

NINTH - With the request for authorization to operate in the health care sector, in addition to the information referred to in the Eighth Regulation above, the requester shall present the provisional ruling issued by the Ministry of Health, in compliance with what was already set out in Article 16 of the LGISMS and in the terms of the Fourth Chapter of the First Title of the present Regulations.

TENTH - Once authorization is obtained from the Ministry, the ISES will not be able to begin their operations until they possess a favorable ruling that the Commission extends to them as a result of an inspection that is conducted to determine if they possess the necessary administrative systems and infrastructure to offer their own services from their business objectives; likewise they shall have the ratification of the Medical Control Officer from the Ministry of Health in the terms set out in Chapter Five of the present Title.

THIRD CHAPTER **The Minimum Paid Capital**

ELEVENTH - in accordance with what is already set out in Article 29, Section 1 of the LGISMS, the ISES shall, in the exercise of their activities, possess a minimum paid capital for the health insurance. Said amount shall be made known during the first trimester of each year by the Ministry in the Agreement through which the minimum paid capital that the insurance institutions should have for each operation or sector is established and it shall be totally underwritten and paid no later than June 30 of each year.

The amount of the costs for the set up and organization, movable asset, equipment and fixed assets of the ISES, with the exception of those to which Article 67 of the LGISMS refer, can be computed jointly until 60% of the minimum paid capital is reached.

TWELFTH - Without prejudicing what is established in the previous Regulation, the minimum paid capital shall be totally underwritten and paid on the date in which the Ministry authorizes the establishment of the ISES. If the business capital exceeds the minimum paid capital to which the previous Regulation refers, it shall be paid when it reaches no less than 50%, provided that the application of this percentage is not less than the established minimum.

THIRTEENTH - The countable capital of the ISES can, at no time, be less than the amount of the minimum paid capital that they are to maintain by the terms of Number Eleven and Twelve of the present Regulations.

When the Commission advises that an institution has not complied with what is set out in the previous paragraph it shall make it known to the Ministry, who will concede to the ISES a period of fifteen calendar days from the date of notification to explain what its rights are. If the Ministry itself judges that it is proven that the countable capital which the ISES possesses is less than the minimum paid capital, it shall set a period not less than sixty nor more than one hundred twenty calendars for the institution to increase its paid capital to the quantity necessary to ensure that the countable capital, when at its minimum, reaches the amount of the minimum paid capital that it is required to maintain.

If the ISES does not increase its paid capital within the established time period, the Ministry shall proceed as is set out in paragraphs three and four of Article 74 of the LGISMS.

FOURTEENTH - When the Ministry changes the amount of the minimum paid capital to conform with that which is already set out in the present Chapter, approval of a general character shall be granted to modify the business statutes of the ISES, provided that said change is in accordance with the applicable provisions and that its sole objective is to include in the protocol the variations in the capital with an end toward having the required minimum paid capital , with the ISES only being obligated to present to Ministry or the Commission a certified copy of the notarized testimony, in which appears the registration data of the Public Registry of Property and Business, and the Ministry, in turn, will proceed to modify the assistance authorization under which they are operating.

FOURTH CHAPTER **Provisional, Definitive, and Annual Rulings**

FIFTEENTH - In accordance with what is already set out in Article 16 and 105 of the LGISMS, the ISES shall present the respective rulings which are issued by the Ministry of Health to obtain its authorization, as well as to verify annually that they are maintaining the elements necessary to offer, directly, through contracts with third parties, or in a combination of both, the health services which are the subject matter of the respective insurance contracts.

To obtain the provisional, definitive, and annual rulings, the ISES shall submit the necessary documentation in accordance with the specific requirements that shall be established by the Ministry of Health itself through administrative provisions of a general nature, adhering to the general criteria that are seen in Number Sixteen of the present Regulations.

SIXTEENTH - To obtain the decisions that Regulation Number Fifteen above refers to, the requester or the ISES, as the case may be, shall satisfactorily comply with the following elements:

That the human and material resources, whether their own, those contracted with third parties or a combination of both-in a three-year projection- be sufficient to comply with the plans offered to the population it intends to insure. That, as the case may be, the contracts or agreements executed with third parties to provide services that are the objective of the respective contracts, guarantee an adequate offer regarding its quality, sufficiency, level of resolution and geographic coverage for the proper compliance regarding its insured. That it has and that it adequately complies with its control program for the utilization of medical services, which shall adhere to that which is already set out in Chapter Sixteen of the First Title of the present Regulations. The plan shall have organizational manuals and respective procedures. That it possess the necessary mechanism to communicate to its insured any changes undergone by the infrastructure that the institutions counts on to offer services which are the objective of the insurance contracts, such as changes in their own installations or installations contracted with third parties and provider networks, among others. That when rendering services offered through insurance contracts fulfilled by their own resources, the ISES guarantee compliance with the requirements established in General Health Law, the Official Mexican Norms and any other provisions applicable to the subject matter at hand. When offering services fulfilled through contracts with third parties, the ISES shall establish in these third parties providers an obligation to comply with the requirements set out in the General Health Law, the Official Mexican Norms and any other provisions applicable to the subject matter at hand.

That the health professionals contracted by the institution who will be offering services to the contracting parties, possess a professional identification that accredits his/her technical-medical knowledge. Also, in cases where specialty certification boards exist, the health care professional shall also maintain current certification from these boards and preferably be a member of the professional college.

To help the ISES in the formation of the service provider networks, the Ministry of Health shall place at their disposal the relative information that it receives from the professional academies, colleges, and boards of medicine.

To the insurance holders or their beneficiaries, that the hospital infrastructure, its own or that contracted by the institution for providing services to the contracting parties possess, certification From the General Health Council.

That in the health plans that the ISES offers, the clinical judgment of the doctor directly responsible for the care of the patient shall prevail at all times.

That the ISES has plans that encompass and act as an incentive for services that promote the health and preventative care of its insurers, while abiding by that which is already set out in the General Health Law, the Official Mexican Norms and any other provisions applicable to the subject matter at hand.

That the ISES possess mechanisms of information for its insured, that detail the rights and obligations, so that the consumer maintains his/her freedom of choice in accordance with that which is agreed upon in the respective insurance contracts.

That the ISES possess a flexible and timely internal mechanism to accomplish the intake, follow-up, and resolution of consultations and the claims of its insured.

That the ISES possess a program for the continued improvement of providing services that anticipate an increase in the quality of care.

That it possess organizational manuals and respective procedures for providing the health care services that it offers.
That the ISES, in the direct offering of medical services stemming from its insurance contracts, possess the mechanism to preserve the rights of the patients as follows:
Access: those insured shall have the same opportunity for expedient access to services.
Respect and dignity: the treatment of the patient shall proceed at all time in a respectful manner.
Privacy and confidentiality: the services provided shall at all times ensure strict privacy. Likewise, relative information shall be kept confidential.
Personal safety: during his/her care, the individual shall have a right to safety not only for him/herself but also for his/her belongings and for those accompanying him/her.
Identity: the patient shall have the right to know the identity and degree of preparation of the health care givers that are caring for him/her and also that of the person responsible for the health care team.
Information: the user shall have the right to be informed of his/her ailment, the diagnostic method and its risks, benefits and alternatives, the same for those caused by therapeutic means, and for the prognosis of his/her ailment.
Communication: the patient shall have the right to maintain communication with his/her family at all time and to receive information in a manner understandable by the patient.
Consent: the patient shall not be subjected to any diagnostic or therapeutic procedure without being informed in detail as to its risks, benefits and alternative. S/he shall have the right to participate in the decisions related to his/her treatment and the diagnosis of his /her ailment.
Consultations: The patient shall have the right to seek other opinions about his/her ailment, in accordance with that which is stipulated in the respective insurance contract.

Rejection of treatment: the patient shall have the right to reject the therapeutic proposals.
Choice of doctor and hospital: the patient has the right to choose the doctor or hospital for his/her care and to change them when s/he feels it is necessary, in accordance with that which is stipulated in the respective insurance contract.

When the services are provided through a third party contract, the ISES shall create in the third party providers an obligation to possess the mechanisms to maintain the rights of patients as set out above.

SEVENTEENTH - Article 16 of the LGISMS references the provisional ruling and Article 105 of the same law references the annual ruling. No more than sixty calendars days shall have passed from the time they are issued by the Ministry of Health until they are presented to the Ministry and the Commission.

Within three months of receiving the respective authorization, the ISES in question shall present to the Ministry the definitive ruling referred to in Article 16 of the LIMIS and issued by the Ministry of Health, with the understanding that failure to do so shall result in the initiation of procedures to revoke the authorization in accordance with that which is set out in clause a) section II Bis of Article 75 of the LGISMS.

If the ISES in question does not present the ruling referred to in Article 105 of the LGISMS and issued by the Ministry of Health to the Commission in the forms and terms set out in these Regulations, it shall result in the initiation of proceedings to revoke the authorization, in accordance with that which is set out in clause b) of Section II Bis of Article 75 of the LGISMS; the opinion of the Ministry of Health should also be heard.

If at any time, the Ministry or Commission becomes aware that the ISES in question has not maintained the elements necessary to offer services, which are the subject matter of the insurance contracts referred to in Article 8 Section V of the LGISMS, and, having reviewed the opinion of the Ministry of Health, it shall initiate proceedings to revoke the respective authorization, in accordance with that which is set out in Article 75 Section II Bis, clause c) of the LGISMS.

FIFTH CHAPTER **Medical Control Officer**

EIGHTENTH - Independent of the party responsible in the medical area of the ISES, the ISES shall employ a Medical Control Officer, who shall be in charge of overseeing that the officials and employees of the ISES comply with the internal and external normatives in the matter of offering applicable medical services. The ISES shall make available to the Medical Control Officer the resources that s/he needs to satisfactorily carry out the functions with which s/he is charged.

NINTEENTH - The Medical Control Officer shall be named by the administrative board of the ISES and ratified by the Ministry of Health through an internal committee established for that purpose. The administrative board itself can suspend, remove, or revoke his appointment. The ISES shall notify the Ministry of Health and the Commission of the appointment as well as, if the case arises, the suspension, removal, or revocation of the same within the next ten working days.

In the case of an assumed suspension, removal, or revocation of the appointment, the said communication shall also set out the reasons for which the administrative board adopted its decision, without this being a motive for questioning the board's decision.

The Medical Control Officer of the ISES shall act independently in the medical arena and shall answer only to the administrative board and, if the case arises, the shareholder's assembly. S/he shall not be subordinate to any other company organism or official in the insurance institution. Additionally, by the terms of Twenty, number 13 and Twenty-Four of the present Regulations, the Medical Control Officer shall keep the Ministry of Health and the Commission informed of his compliance with the obligation to which s/he is charged. Due to the nature of his/her duties, the Medical Control Officer shall have the level of a director or manager within the structural organization of the ISES.

TWENTIETH- The Medical Control Officer shall carry out the following duties:
To oversee that the integration of the network of providers of health care comply with the requirements established in these Regulations and in the applicable judicial provisions.
To oversee the correct working of the network of the ISES's medical services, so that its coverage is appropriate and timely.
To validate the medical aspects of the contracts with ISES providers of services.
To oversee the compliance of the control program for the utilization of ISES medical services, of clinical guidelines or medical protocols, and of the provision of medical services, which are the objective of the respective insurance contract.
To oversee the adequate application of the policies and procedures that define the ISES in order to guarantee the appropriate compliance of the services offered to its insured in the different plans.
To oversee that the capacity of the providers and the infrastructure itself of the ISES is sufficient to provide the services contracted by the insured.
To oversee the instrumentation of the program for continual improvement in the rendering of services, that envisions an increase in the quality of care and that shall be defined by the ISES itself.
To be knowledgeable of the commission reports, decisions of the external auditors and the rulings of the Secretary of Health.
To oversee compliance by the ISES in all that relates to these Regulations in health matters.
To formulate recommendations to the administration of the ISES for the self-correction of deviations in the matter of the offering of health services; s/he should specify a time period in these cases for its correction.
To oversee the adequate intake, follow-up, and resolution on the part of the ISES of controversies of a medical character that present themselves.
To oversee that in the ISES the clinical judgment of the doctor is safeguarded at all times during his practice, provided that it is based on scientific advances, in medicine based on evidence, and in medical ethics.
To inform the Commission and the Ministry of Health every four months, in the form and terms that the Ministry of Health establishes through administrative provisions of a general character, of his compliance with the obligations under his charge.

TWENTY-FIRST - The Medical Control Officer Shall attend the sessions of the administrative board of the ISES in question, at all times participating with a voice, but without vote. In accordance with applicable provisions, the duties of the Medical Control Officer shall be exercised without prejudice to those that correspond to the commissioner and the external auditors of the ISES in question.

TWENTY-SECOND – To avoid possible conflicts of interest, contracts for the offering of services which are the objective of the respective insurance contracts executed by the ISES with any business with which it has a patrimonial nexus, shall be made known to the Medical Control Officer prior to their execution .

For the purpose of the present Regulations, a nexus patrimonial is understood to exist between an ISES and the following persons.
people who participate in its business capital;
as the case may be, any other entities that form part of the commercial, industrial, or service group that pertains to the ISES in question;
as the case may be, the entities that have a patrimonial nexus as set out in clauses 1and 2 above with entities that form part of the commercial, industrial, or service group that pertains to the ISES itself; and,
as the case may, the entities that directly or indirectly have a patrimonial nexus as set out in clauses 1, 2, and 3 above, with the entity that participates in the business capital of the ISES in question.

TWENTY-THIRD - To be Medical Control Officer, s/he shall comply with the following minimum requirements:
Be a medical doctor who has a professional identification card, prestigious recognition the medical matters and professional experience in the subject matter.
Have accredited moral solvency, as well as a clinical specialization with current certification or the demonstrated technical and administrative capacity in health services through corresponding studies and, in both cases, a minimum of five years professional experience.
Not have been convicted of any crime with a sentence of corporal punishment or any patrimonial crime, intentional crime, or crime related to his/her medical activities.
Not have been condemned in any finding issued by the National Commission of Medical Arbitration.
Not be the spouse or have any civil or blood familial relationship within two degrees or any working or professional ties with:
the controlling shareholders in the ISES;
the general director of the ISES or the officials who hold positions in the two levels immediately beneath the general director;
the controlling shareholders of the providers of the SES
the officials of the first three levels of the administration of the providers of the ISES when they account for more than 5% of the material and human resources needed to comply with the plans offered to the insured population.
Not have any patrimonial nexus with the authorized ISES, or any working ties with the ISES in question.

Not be a provider of the ISES itself or have any patrimonial nexus with the providers of the ISES in question.
Not be found within any of the assumptions that are referred to clauses b), c), d), e), f), g), and h) of Section VII bis of Article 29 of the LGISMS.
Reside within the national boundaries.
Be in possession of ratification from the Ministry of Health through the internal committee formed for this purpose.

TWENTY-FOURTH - The Medical Control Officer shall ensure that the decisions that are taken at the administrative board meetings and the committees on which s/he participates adhere to the external and internal normative in medical matters as well as sound decisions in matters of health care. Whenever the Medical Control Officer has knowledge of irregularities that are contrary to the applicable legal provisions or the applicable internal normative, or of situations that have not been corrected according to Regulation Twenty, number 10, s/he shall present to the president of the administrative board, to the internal auditor, to the Commission and to the Ministry of Health a detailed report about the observed situation within a period not to exceed ten working days.

TWENTY-FIFTH - The Medical Control Officer who does not fulfilled his oversight duties in accordance with that which is set out above can be subject to removal or suspension by the commission, according the to terms of Article 31 of the LGISMS.

SIXTH CHAPTER **Clinical Records**

TWENTY-SIXTH - When the ISES offer services with their own resources, they shall comply with the requirements established in the Official Mexican Norm on clinical records. When the services are offered through contracts executed with third parties, the ISES shall establish in the third party providers the obligation to comply with the requirement established in the Official Mexican Norm.

Upon the request of the insured, the ISES shall insure that its providers transfer a clinical summary (of the insured medical records) to the institution or provider that the user indicates, maintaining the confidentiality of the case.

SEVENTH CHAPTER **Control of the Use of Medical Services**

TWENTY-SEVENTH,- The ISES shall possess a program for the control of the use of medical services with which it is charged, whose oversight shall be the responsibility of the Medical Control Officer. Said program shall adhere to the provisions of a general nature, which to that purpose the Ministry of Health issues. The program shall include mechanisms to detect and correct problems of access, competency, and efficiency of offered services, as well as the underutilization, overuse or misuse of the same.

TWENTY-EIGHTH -The Ministry of Health shall periodically evaluate the compliance of programs for the control of the utilization of medical services, issuing recommendations that it deems pertinent. These are part of the elements that shall be considered for the purpose of the issuance of the rulings referred to in Articles 16 and 105 of the LGISMS. For that purpose, the

ISES shall maintain minutes, reports from the Medical Control Officer and other documents that prove that the program has been set in motion and provided with follow-up actions for the fulfillment of the program.

TWENTY-NINTH - The contracts that the ISES execute with providers of health care services shall not include clauses that provide an incentive for the underutilization or the overuse of resources.

EIGHTH CHAPTER **Continual Improvement in Providing Services**

THITIETH - The ISES shall create and formulate a program for the continued improvement of service that envisions an increase in the quality of care and encourages medical teaching and research. The program shall include the gradual development of indicators that allow the ISES's advancement to be evaluated, as well as its performance in providing services. The indicators shall coincide with the database of the statistical system that Title Eight of the present Regulations refers to. This program shall adhere to the provisions of a general nature that the Ministry of Health issues. For that purpose, the ISES shall maintain minutes and other documents that prove that the program has been set in motion and provided with follow-up actions for the fulfillment of the same.

SECOND TITLE **Technical Reserves**

FIRST CHAPTER **General Provisions**

THIRTY-FIRST - The ISES shall establish and increase technical reserves corresponding to the health insurance, in accordance with that which is established in the LGISMS and in the provisions that LGISMS issues.

THIRTY-SECOND - the valuation of the technical reserves shall contain the name and signature of the actuary responsible for the certification of the same, along with his professional identification number that demonstrates his accreditation as an actuary or the equivalent, in the case of the professional who without having the title of actuary has the major or degrees conferred by higher educational institutions officially recognized by Mexico or by a foreign government, that provide him/her with the accreditation to practice in actuarial matters.

THIRTY-THIRD - the Commission, through administrative provisions, shall make known the form, terms, content, and format needed to carry out the evaluation of the technical reserves for their presentation before the Commission itself.

THIRTY-FOURTH - the submission of information relative to the evaluation of the technical reserves shall be made every three months, no later than the first twenty calendar days following the closing of the trimester in question, except that which corresponds to the closing of a practice, in which case, the results of the evaluation shall be presented within thirty calendar days following the closing of the practice in question. If the last day of the time period is not a working day the deadline shall be extended to the first working day immediately following the deadline.

In cases in which the Commission finds situations that require special follow-up of the evolution of the ISES in question, it can establish a different interval for submission of this information.

SECOND CHAPTER **Formation and Increase of Current Risk Reserves**

THIRTY-FIFTH - The ISES shall create and increase current risk reserves in accordance with that which was previously set out in Articles 46 Section I and 47 Section III of the LGISMS and in the administrative provisions that LGISMS issues.

THIRTY-SIXTH - In dealing with policies that protects insurance contracts with superior oversight for one year, the current risk reserves can be determined, as the case may be, in accordance with the procedures for that purpose that the Commission establishes through administrative provisions of a general nature. When the nature of the plan so justifies, the institutions can implement other procedures to build up and increase of the current risk reserves. In this case, for the purpose of authorization and registration, they shall send to the Commission, the procedure in question, with the technical note of the corresponding plan.

THIRTY-SEVENTH - The ISES shall maintain a "magnetic file" as a detailed backup of the calculation of the evaluations of reserves for at least the last four trimesters before the date of evaluation. The Commission can request the evaluations when deemed necessary in its judgment.

THIRD CHAPTER **Formation and Increase of Contingency Reserves**

THIRTY-THIRD -The ISES shall create and increase contingency reserves, in accordance with that which is set out in Articles 46 Section III and 51 of the LGISMS and in the provisions that LGISMS issues.

THIRTY-NINTH - The creation and increase for the contingency reserves shall be calculated and recorded monthly by the ISES for the preparation of its financial status report on December 30th of each year.

FORTIETH - the ISES shall build a reserve for pending compliance obligations in accordance with that which is set out in Articles 46 Section II and 50 of the LGISMS and in provisions that LGISMS issue.

FORTY-FIRST - The reserve for disasters that happen but are not reported, as well as the reserve for adjusted costs assigned to the disaster that the ISES shall create and increase, shall adhere to that which is established in Article 50 Section II of the LGISMS and the in the provisions that the LGISMS issues.

THIRD TITLE **Recording of Technical Bases and Contractual Documentation**

FIRST CHAPTER **Recording of Technical Bases**

FORTY-SECOND - The ISES shall present to the Commission in the form and terms which the Commission establishes through administrative provisions of a general nature, the technical notes which support each one of its coverages, plans, and net risk premiums, in accordance with that which is established by Article 36-A of the LGISMS.

The Commission will make known to the Ministry of Health the present information for the purpose of serving as an evaluative element for expediting the rulings referenced in the Fourth Chapter of the First Title of the present Regulations.

FORTY-THIRD - Together with the technical notes that are recorded with the Commission in the form and terms, which the Commission has determined, the ISES shall present the contracts that are executed with other entities for providing services related to sheltered coverages in respective contracts with its insured.

SECOND CHAPTER **Recording of Contractual Documentation**

FORTY-FOURTH - The ISES shall record with the Commission, in the form and terms which the Commission determines through administrative provisions of a general nature, the adhesion contracts through which the operations of the insurance that is offered to the public in general are formalized and in which the applicable terms and conditions for the contracting of health care insurance are established, as well as models for the finished clauses to be incorporated through additional endorsements to these contracts, in accordance with Article 36-B of the LGISMS. The insurance institutions shall expressly demonstrate which technical note will be related to the contractual documentation in question.

The Commission shall make known to the Ministry of Health the information it is presented so that it can serve as an evaluative element for expediting the rulings referenced in the Fourth Chapter of the First Title of the present Regulations.

FORTY-FIFTH - The ISES shall provide the contracting party with an informative brochure together with the insurance policy. Said brochure shall describe in clear and precise form both the insurance plan that has been contracted and the plans referenced in the Sixty-sixth regulation of the present Regulations, as well as the manner to access medical services and other contract benefits, and relevant characteristics of the policies, such as: coverage, limitations, exceptions, exclusion, waiting periods and extinguishment limitations, among others.

Likewise the brochure shall detail the policy and the internal mechanism for making and following up on the consultations and claims of the insured, in the terms of Article 50 Bis of the Law for the Protection and Defense of the User of Financial Services.

The brochure shall contain a supplement that includes all the clinics and hospitals employed by the ISES for the care of its insured, indicating whether or not they hold certification from the

General Health Council, as well as the names, addresses, and telephone numbers of the doctors authorized for coverage in the relevant geographic area of the insured, and other providers that can be utilized by the insured, as well as the entity specializing in taking care of consultations and claims. Additionally, the supplement shall establish a mechanism to obtain up-to-date relevant information.

This brochure shall be presented to the Commission at the time that the contractual documentation is recorded. The Commission shall make known to the Ministry of Health the information that is presented, with the purpose of using it as an evaluative element for expediting the rulings referenced in the Fourth Chapter of the First Title of the present Regulations.

FOURTH TITLE **Reinsuring**

SINGLE CHAPTER **General Provisions**

FORTY-SIXTH - The activities of reinsuring that the ISES carry out shall conform with that which is established in the LGISMS and in the provisions which the LGISMS issues.

FIFTH TITLE **Minimum Guaranteed Capital**

SINGLE CHAPTER **General Provisions**

FORTY-SEVENTH - The ISES shall determine, maintain, and invest, at all time, the minimum guaranteed capital of health insurance in adherence to that which is set out in Articles 60 and 61 of the LGISMS and the provisions which the LGISMS issues.

FORTY-EIGHTH - The ISES shall present, inform, and prove to the Commission the calculation and coverage of its minimum guaranteed capital as well its margin of solvency, in accordance with the Regulations and applicable provisions.

FORTY-NINTH - when the Commission advises that an institution has presented documentation lacking coverage of the minimum guaranteed capital, in the terms set out by the applicable Regulations, it shall proceed in accordance with that which is set out in Article 60 of the LGISMS.

SIXTH TITLE **Regime for the Investment of Technical Reserves**

FIRST CHAPTER **General Provisions**

FIFTIETH - In relation to the investing of the resources affecting the coverage of the technical reserves that are referenced in the present Regulations, the ISES shall subject itself to that which is established in the LGISMS and to the provisions, which emanate from the LGISMS.

SECOND CHAPTER **Investment Committee**

FIFTY-FIRST - The ISES shall have an investment committee in accordance with that which is established in the Regulations for the Investments of Technical Reserves of the Institutions and Mutual Insurance Corporations, which shall be responsible for choosing the securities that will be acquired by the institution in accordance with the investment regime previously seen in the preceding Chapter.

It shall fall on the administrative board of the ISES to designate and remove the members of the investment committee. The committee, through its president, shall inform the board itself of the decision made by the committee. The board can modify or revoke the resolutions of the committee.

FIFTY-SECOND - The investment committee of the ISES shall meet no less than once a month to ensure compliance with these Regulations and to ensure that the securities affected in the coverage of their technical reserves maintain adequate risk levels. The investment committee shall provide proof of the applicable methodology used to evaluate the risk.

The president of the investment committee shall be responsible for informing the ISES's general director of decisions made by the committee, so that the director can notify the operative areas of the institution and they can be timely applied. For this purpose, the president of the committee shall send the general director a signed copy of the document in which said decisions are set forth.

THIRD CHAPTER **Securities Rating**

FIFTY-THIRD - The securities issued by private businesses shall be rated by a rating institution for securities, which is authorized by the National Banking and Securities Commission.

FIFTY-FOURTH - Instruments of short term and long term debt issued, endorsed, or accepted by credit institutions shall be rated when the National Banking and Securities Committee so determined through administrative provisions.

FIFTY-FIFTH - The ISES can only acquire securities rated by rating institutions for authorized securities that make known to the Commission the criteria for rating that is employed to carry out the respective rating as well as any modifications.

FIFTY-SIXTH - When the Commission, in the exercise of its duties, considers that the ratings given to certain securities that make up the investments of the ISES by the rating institution for authorized securities, do not incorporate information divulged in the market or if it is found not to be up-to-date thereby representing an increase in the risks of the ISES's investments, then the regime established in the present Regulations is adjusted, unless the securities issuer in question will solicit an evaluation and rating of the securities from another rating institution.

SEVENTH CHAPTER **Accounting**

SINGLE CHAPTER **General Provisions**

FIFTY-SEVENTH - The ISES should independently perform their accounting according to that which the LGISMS set out; the institutions should adjust their accounting procedures along the lines established in the present Regulations, as well as in the administrative provisions that the Commission issues for that purpose.

EIGHTH CHAPTER **Statistical Systems**

SINGLE CHAPTER **Statistical System**

FIFTY-EIGHTH - The ISES shall possess a statistical database and present to the Commission, in the form and terms that the Commission establishes, the necessary statistical information to build on the statistical and actuarial bases that support the risk premiums in the health sector, the fulfillment of studies and research in matters of health, the development of the sector itself, the evaluation of medical aspects, as well as the analysis of its growth in accordance with that which is established in the present Regulations and in the general provisions that the Commissions issues for that purpose.

The Commission shall make known to the Ministry of Health the information presented so that it can serve as an evaluative element for expediting the rulings referenced in the Fourth Chapter of the First Chapter of the present regulations.

FIFTY-NINTH - To comply with that which is set out in the previous Regulation, the ISES shall have its own statistical system that allows it to process and prepare the minimum statistical information the Commission determines, while complying with the Ministry of Health, through provisions of a general nature, in which the forms and terms in which the ISES shall submit said information to the Commission are established.

In this sense, when the statistical information stems from providing services and these services are offered through third party contracts, the ISES shall establish in the third party providers the obligation to process, prepare, and present statistical information that allows the ISES to comply with that which is set out in this chapter.

SIXTIETH- The Commission shall be in charge of the statistical database that centralizes the information and the Commission shall be in charge of receiving, managing, and processing the information the ISES furnish. The Commission and the Ministry of Health shall make known the information and indicators relative to the operation of the health sector that is oriented toward the public and which contributes to the healthy competency of the system.

NINTH TITLE **Operation and Organization of Health Insurance**

SINGLE CHAPTER

SIXTY-FIRST- The ISES shall be obligated to underwrite insurance contracts in accordance with that which the LGISMS establishes, the Law on Insurance Contracts, the present Regulations, and the administrative provisions the Commission issues for that purpose.

The ISES shall carry out the negotiations of their products in a direct manner or through insurance agents duly authorized by the Commission.

SIXTY-SECOND - In the preparation of their insurance plans, the ISES shall strive to incorporate criteria of integration that envision promotional, preventative, therapeutic and rehabilitative actions for the coverage offered in the plans. In any case, they are to comply with that which is established in Article 59 of the Law on Insurance Contracts.

The Ministry of Health, as part of the actions it carries out to grant the rulings referenced in the Fourth Chapter of the First Title of the present Regulations, can make recommendations to the ISES so that it complies with that which is set out in the previous paragraph.

SIXTY-THIRD - The ISES shall have a network of its own services, contracted services, or a combination of both that coincides in its territorial distribution with the places where it does business and where the contracts mentioned are underwritten.

SIXTY-FOURTH - The ISES shall include in their contracts a clause that obligates them to reimburse the cost of medical services that the insured needs in cases of emergency, through the terms of Article 72 of the Regulations of the General Health Law in Matters of Providing Medical Care Services, in which the ISES's service network itself does not offer the necessary are for rights set out in the contract, or for reasons attributed to saturation, or lack of disposable services or diagnostic error.

In the terms of the previous paragraph, diagnostic error is understood to mean the case in which the insured has previously received care from the network services itself and because of the failure to reach a correct diagnosis, the individual has required the care of the medical services in questions from an institution outside the provider network of the ISES for the same medical emergency.

SIXTY-FIFTH - the ISES shall inform the insured in writing within fifteen working days of any change in the network hospital infrastructure.

SIXTY-SIXTH - The ISES shall offer plans in which the beneficiaries can choose a doctor outside the institution network by paying the difference between the respective tabulation of the institution and the cost of services provided by the doctor, in accordance with the agreement.

SIXTY-SEVENTH - The ISES shall establish in their polices whether or not there exists an obligatory renovation in the plans contracted by the insured and, when the case arises, the

maximum age of renovation. In cases where there exists an obligatory renovation of plans previously contracted, the ISES shall use the criteria established in the corresponding technical note to avoid selective discrimination in the renovation of plans.

SIXTY-EIGHTH - The ISES shall be obligated to comply with providing services directed at the furtherance or restoration of health car as a consequence of an eventuality foreseen in the respective contract occurring while the contract is in effect.

The insurance contracts shall establish that said obligation shall terminate upon the happening of any of the following events:
upon certifying through superior treatment that the ailment in question has been cured, or
upon exhausting the maximum limit of the responsibility agreed upon by the parties, or
upon the conclusion of the term for these purposes which had been agreed upon for providing of services. The term cannot be less than two years from the date on which the life of the contract ends.

In the case of non-adhesion contracts, the ISES can agree to conditions different from those of the previous paragraph with the prior authorization of the Commission

SIXTY-NINTH - In health insurance contracts, a condition shall be considered pre-existing when the event that defines it as such has arisen before the beginning of the totality of successively uninterrupted operation of the insurance and from the precedents that constitute renovation, known and not declared, in terms of Article 8 of the Law on Insurance Contracts.

For the purpose of pre-existence, the operation shall not be considered interrupted if a rehabilitation policy is in operation.

SEVENTIETH - The ISES can offer plans under the name of "minimum plans" or "complete plans." In each case, said plans shall include all the components of the minimum health plan that for these purposes the Ministry of Health defines.

SEVENTY-FIRST - In accordance with that which Article 71 of the LGISMS establishes, advertising of the ISES is subject to administrative provisions of a general nature that the Commission dictates. Said provisions shall provide that advertising be expressed in clear and precise form, so as not to induce the public by deceit, error, or confusion about the offering of the services of the ISES. In terms of Article 71 itself of the LGISMS, the Commission can order, after a previous hearing from the interested party, a change or suspension of the advertising when it determines that it is not following that which is set out in the LGISMS and the present Regulations.

SEVENTY-SECOND - In consultations and claims arising from a health insurance contract, the ISES shall be subject to that which is set out in the Law for the Protection and Defense of the User of Financial Services, and wherever relevant, the Decree which creates the National Commission on Medical Arbitration, published in the **Official Diary of the Federation** on June 3, 1996.

TENTH TITLE **Sanctions**

SINGLE CHAPTER **Sanctions**

SEVENTY-THIRD - The infrastructure as set out in the present Regulations shall be sanctioned according to the terms of the applicable provisions of the LGISMS.

TRANSITION

FIRST - The present Regulations shall become effective on the first working day after their publication in the **Official Diary of the Federation**.

SECOND - The insurance institutions, which upon the present Regulations going into effect have authorization from the Ministry in the health sector, as well as authorization for other operations and insurance sectors, and find themselves in the transition period referenced in the Second Transition Article of the Decree that reforms the General Law of Institutions and Mutual Insurance Corporations published in the **Official Diary of the Federation** on December 31, 1999 and that independently conform to the previously mentioned Transition, shall proceed before June 30, 2001 to divide, to form a new Corporation or to affect the transfer of its portfolio to effectuate the following actions with an end toward adhering to the operative alignments of the health sector as set out in the present Regulations:

They shall carry out the necessary adjustments so that accounting record of their operations in the health sector are established in countable accounts separate from the other operations and insurance sectors in which it has authorization to practice.
The adjustments in accounting to which the previous paragraph refers, shall likewise permit that the accounts and countable records include the financial information necessary to allow the elaboration of specific financial statuses in the management of insurance in the health sector, and, at the same time, the consolidation of these insurances with the rest of the operations for which the institution in question has authority.

Such adjustments shall provide for respective accounting separation as of October 1, 2000.

As of October 1, 2000, the technical reserves, the minimum guaranteed capital, the minimum legal paid capital, the investments that guarantee these obligations as well as the capital and capital reserves and, in general, the assets, liabilities and results of operations related to insurance in the health sector shall be accounted for and managed in a form independent from the other operations and insurance sectors for which the insurance institution is authorized to practice.
As of October 1, 2000, the investment that the insurance institution makes with its resources of technical reserves shall be recorded in separate accounts and the investment controls that are implemented shall be independent of the rest of the investments of other technical reserves that the insurance institutions should form in accordance with the LGISMS. When investments that guarantee insurance in the health sector, other sectors, and operations of insurance that the

insurer practices are under the custody of depositories, the depositories should also be obligated to present separate account statuses.

In no case can the institutions compensate or transfer investments of the insurance in the health care sector to other operations or vice versa. This means that once an investment has been made that covers the reserves of insurance in the health care sector, said encumbrance cannot be changed to cover other technical reserves in the institution.

Within a time period not to extend beyond September 30, 2000, the institutions shall design and implement the statistical system referenced in Fifty-eight, Fifty-nine and Sixty of the present Regulations.
Within a time period not to extend beyond September 30, 2000, the institutions shall submit to the Commission the adjustment to recording the technical notes and the relevant contractual documentation on the health insurance products that are offered, paying attention to that which is set out in Forty-two, Forty-three, Forty-four and Forty-five of the present Regulations.
Before September 30, 2000, the institutions shall request that the Ministry of Health ratify their Medical Control Officer, keeping in mind that which is set out in Eighteen, Nineteen, Twenty, Twenty-one, Twenty-two, Twenty three, Twenty-four and Twenty-five of the present Regulations.
The institutions shall negotiate before the Ministry of Health to obtain the Annual Ruling referenced in Article 105 of the LGISMS and present it for the first time before the Commission together with its financial documentation related to the close of business for the year 2000.

THIRD - In relation to the obligation referenced in number 6 of the Sixteenth of these present regulations, in the sense that health professionals contracted by the ISES possess active certification issued by the respective board of specialization, in the case where the medical population at hand has no existing specialists, the Ministry of Health, through an express request, can authorize a regularization period from six months to two years so that a contracted doctor can obtain active certification from the respective board; however, said period of regularization shall not extend beyond June 30, 2002.

FOURTH - In relation to the obligation referenced in Number 7 of the Sixteenth of these present Regulations, in the sense that the hospital infrastructure itself or that contracted by the ISES possesses certification from the General Health Council, the Ministry of Health, through a direct request, can authorize a period of regularization from six months to two years so that the hospital can obtain the corresponding certification; however, said regularization period shall not extend beyond June 30, 2002.

FIFTH - The insurance institutions that have executed insurance contracts for medical costs by the terms referenced in the Sixth Transition Article of the Decree which reformed the General Law of Institutions and Mutual Insurance Corporations, published in the **Official Diary of the Federation** on December 31, 1999 can propose as a single objective to holders of insurance of medical costs to change such contracts to insurance health contracts or substitute them with health insurance contracts. In accordance with that which is set out in said Transition, the following requirements shall be observed:

The agreements discussed in the previous paragraph shall be executed no later than June 30, 2001 or within thirty working days following the end of the life of the respective medical costs, if this occurs after June 30, 2001.
The holders of insurance for medical costs shall be informed in writing of the proposed modification or substitution no less than 30 working days in advance of the date of the end of the life of the insurance for medical costs. In this case, the ISES should also specify what acquired rights are continued, including those related to seniority and preexistence.
In the information referred to in the previous point, it shall specify, as the case may be, if benefits are increased and the impact these increased benefits will have on fees.
The holder of insurance shall accept the change or substitution by signing the respective agreement.

Sincerely

Effective Suffrage. No Reelection. The present Regulations are issued in the Federal District of Mexico on May 15, 2000.

In the absence of the Secretary and in accordance with Article 105 of the Interior Regulation of the Ministry of Housing and Public Credit, the Assistant Secretary of Housing and Public Credit, **Carlos Noriega Curtis- Seal**

Evidence of Coverage

ACCESS BAJA HMO GOLD PLAN

NOTICE

This Evidence of Coverage booklet describes the terms and conditions of coverage of your Blue Shield health plan. It is your right to view the Evidence of Coverage prior to enrollment in the health plan.

Please read this Evidence of Coverage carefully and completely so that you understand which services are covered health care services, and the limitations and exclusions that apply to your plan. If you or your dependents have special health care needs, you should read carefully those sections of the booklet that apply to those needs.

At the time of your enrollment, Blue Shield of California provides you with a Matrix summarizing key elements of the Blue Shield of California Group Health Plan you are being offered. This is to assist you in comparing group health plans available to you.

If you have questions about the benefits of your plan, or if you would like additional information, please contact Blue Shield Member Services at the address or telephone number listed at the back of this booklet.

PLEASE NOTE

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 Blue Shield's Member Services telephone number provided on the last page of this booklet to ensure that you can obtain the health care services that you need.

MEXICAN HEALTH CARE STANDARDS

Legal requirements for and generally accepted practice standards of medical care in Mexico are different than those of California or elsewhere in the United States. Therefore, the care to be received through providers in Mexico in the Access Baja HMO Health Plan will be care that is consistent with generally accepted medical standards of Mexico, not of California. It is Blue Shield's policy to contract only with providers who meet all applicable laws, licensing requirements and professional standards of Mexico and who provide their services in accordance with the generally accepted standards of the organized medical community relating to professional and hospital services in Mexico. With the exception of Out-of Area emergency and urgently needed services as well as services for covered transplants, elective abortions, severe burns, acute rehabilitation, neonates requiring continuous cardiopulmonary support, pediatric cardiovascular and thoracic surgery, critical trauma cases and approved clinical trials for cancer, services under this plan are covered only when provided by the contracting Plan providers in Mexico; the Member may not seek such Services from Non-Plan Providers outside of Mexico. Members obtaining Hospice Care Benefits in Mexico may receive different types of services than they would obtain in California. Any Member who is not completely comfortable with the standards of care for the practice of medicine in Mexico should not enroll in the Access Baja HMO Health Plan.

LEGAL AUTHORIZATION TO ENTER THE UNITED STATES

Please note that an approved referral(s) by Access Baja HMO and Blue Shield of California to receive medical services in California does not constitute nor grant legal authorization for the Member to enter the United States. Individuals who lack the necessary border documentation for the purpose of seeking medical services in the United States should apply to the United States Immigration and Naturalization Service (INS) for authorization.

Table of Contents

The Access Baja HMO Health Plan

Member Bill of Rights

As an Access Baja HMO Plan Member, you have the right to:

1. Receive considerate and courteous care, with respect for personal privacy and dignity.
2. Receive information about all health services available to you, including a clear explanation of how to obtain them.
3. Receive information about your rights and responsibilities.
4. Receive information about your HMO Health Plan, the services we offer you, the physicians and other practitioners available to care for you.
5. Select a Personal Physician and expect his/her team of health workers to provide or arrange for all the care that you need.
6. Have reasonable access to appropriate medical services.
7. Participate actively with your physician in decisions regarding your medical care. To the extent permitted by law, you also have the right to refuse treatment.
8. Receive from your physician an understanding of your medical condition and any proposed appropriate or Medically Necessary treatment alternatives, including available success/outcomes information, regardless of cost or benefit coverage, so you can make an informed decision before you receive treatment.
9. Receive preventive health services.
10. Know and understand your medical condition, treatment plan, expected outcome and the effects these have on your daily living.
11. Have confidential health records, except when disclosure is required by law or permitted in writing by you. With adequate notice, you have the right to review your medical record with your Personal Physician.
12. Communicate with and receive information from Member Services in a language you can understand.
13. Know about any transfer to another hospital, including information as to why the transfer is necessary and any alternatives available.
14. Obtain a referral from your Personal Physician for a second opinion.
15. Be fully informed about the Blue Shield appeals procedure and understand how to use it without fear of interruption of health care.
16. Voice complaints or appeals about the HMO Health Plan or the care provided to you and present your appeal in person to Blue Shield if you choose to do so.
17. Participate in establishing Public Policy of the Blue Shield HMO or Access Baja HMO, as outlined in your Evidence of Coverage or Health Service Agreement.

The Access Baja HMO Health Plan

Member Responsibilities

As an Access Baja HMO Plan Member, you have the responsibility to:

1. Carefully read all Access Baja HMO materials immediately after you are enrolled so you understand how to use your benefits and how to minimize your out of pocket costs. Ask questions when necessary. You have the responsibility to follow the provisions of your Access Baja HMO membership as explained in the Evidence of Coverage or Health Service Agreement.

2. Maintain your good health and prevent illness by making positive health choices and seeking appropriate care when it is needed.

3. Provide, to the extent possible, information that your physician, and/or the Plan need to provide appropriate care for you.

4. Follow the treatment plans and instructions you and your physician have agreed to and consider the potential consequences if you refuse to comply with treatment plans or recommendations.

5. Ask questions about your medical condition and make certain that you understand the explanations and instructions you are given.

6. Make and keep medical appointments and inform the Plan physician ahead of time when you must cancel.

7. Communicate openly with the Personal Physician you choose so you can develop a strong partnership based on trust and cooperation.

8. Offer suggestions to improve the Access Baja HMO Plan.

9. Help Blue Shield to maintain accurate and current medical records by providing timely information regarding changes in address, family status and other health plan coverage.

10. Notify Blue Shield as soon as possible if you are billed inappropriately or if you have any complaints.

11. Select a Personal Physician for your newborn before birth, when possible, and notify Blue Shield as soon as you have made this selection.

12. Treat all Plan personnel respectfully and courteously as partners in good health care.

13. Pay your dues, Copayments and charges for non-covered services on time.

The Access Baja HMO Health Plan

Evidence of Coverage

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

I. YOUR INTRODUCTION TO THE ACCESS BAJA HMO HEALTH PLAN

Your interest in the Access Baja HMO Health Plan is truly appreciated. Blue Shield has served California for over 60 years, and we look forward to serving your health care needs.

By choosing this Health Maintenance Organization (HMO) you've selected some significant differences from not only the other health care coverage provided by Blue Shield, but also from that of most other health plans.

You will be able to select your own Personal Physician from the Access Baja HMO Provider and Pharmacy Directory of general practitioners, family practitioners, internists and pediatricians. Each of your eligible family members may also select a Personal Physician. All covered services must be provided by or arranged through your Personal Physician, except for OB/GYN services provided by an obstetrician/gynecologist or family practice physician within the same Medical Group/IPA as your Personal Physician, or Emergency Services.

NOTE: Members enrolled in the Access Baja HMO Plan are entitled to select Personal Physicians only from an IPA/Medical Group which has contracted specifically with Blue Shield for the Access Baja HMO Plan. That selection may be limited to only one or to just a few IPAs/Medical Groups, as shown in the Access Baja HMO Provider & Pharmacy Directory. Members in the Access Baja HMO Plan are not permitted to select physicians/IPAs/Medical Groups in Blue Shield's HMO network in California.

NOTE: Blue Shield will respond to all requests for prior authorization of services as follows:

for Urgent Services, within 1 calendar day from receipt of the request;
for other services, within 5 business days from receipt of the request.

You will have the opportunity to be an active participant in your own health care. We'll help you make a personal commitment to maintain and, where possible, improve your health status. Like you, we believe that maintaining a healthy life-style and preventing illness are as important as caring for your needs when you are ill or injured.

As a partner in health with Blue Shield, you will receive the benefit of Blue Shield's commitment to service an unparalleled record of more than 60 years.

Please review this booklet which summarizes the coverage and general provisions of the Access Baja HMO.

If you have any questions regarding the information, you may contact us through our Member Services Department at 1-800-248-5451 from California or 001-800-248-5451 from Mexico. This is a toll-free call from California and Mexico. These phone numbers are staffed by representatives who speak Spanish.

II. EVIDENCE OF COVERAGE

This Evidence of Coverage constitutes only a summary of the health plan. The health plan contract must be consulted to determine the exact terms and conditions of coverage. The group health service contract is available through your employer or a copy can be furnished upon request. Your employer is familiar with this health plan, and you may also direct questions concerning coverage or specific plan provisions to the Blue Shield Member Services Department.

III. CHOICE OF PHYSICIANS AND PROVIDERS

SELECTING A PERSONAL PHYSICIAN

A close physician-to-patient relationship is an important ingredient that helps to ensure the best medical care. Each Member is therefore required to select a Personal Physician at the time of enrollment. This decision is an important one because your Personal Physician will:

1. Help you decide on actions to maintain and improve your total health;
2. Coordinate and direct all of your medical care needs;
3. Arrange your referrals to Specialty Physicians, hospitals and all other health services, including the prior authorization you will need;
4. Authorize emergency services when appropriate;
5. Prescribe those lab tests, X-rays and services you require, and
6. Assist you in applying for admission into a Hospice Program through a Participating Hospice Agency, if you reside in or temporarily relocate to California.

To ensure access to services, each Member must select a Personal Physician who is located sufficiently close to the Member's home or work address to ensure reasonable access to care, as determined by Blue Shield. If you do not select a current Personal Physician at the time of enrollment, the Plan will designate a Personal Physician for you and you will be notified. This designation will remain in effect until you notify the Plan of your selection of a different Personal Physician.

A Personal Physician must also be selected for a newborn or child placed for adoption, preferably prior to birth or adoption, but always within 31 days from the date of birth or placement for adoption. The Personal Physician selected for the month of birth must be in the same Medical Group or IPA as the mother's Personal Physician when the newborn is the natural child of the mother. If the mother of the newborn is not enrolled as a Member or if the child has been placed with the Subscriber for adoption, the Personal Physician selected must be a physician in the same Medical Group or IPA as the Subscriber. If you do not select a Personal Physician within 31 days following the birth or placement for adoption, the Plan will designate a Personal Physician from the same Medical Group or IPA as the natural mother or the Subscriber. This designation will remain in effect for the first calendar month during which the birth or placement for adoption occurred. If you want to change the Personal Physician for the child after the month of birth or placement for adoption, see the section below on "Changing Personal Physicians". If your child is ill during the first month of coverage, be sure to read the information about changing Personal Physicians during a course of treatment or hospitalization

Remember that if you want your child covered beyond the 31 days from the date of birth or placement for adoption, you must submit a written application as explained in the Plan Service Area and Eligibility section of this Evidence of Coverage.

CHANGING PERSONAL PHYSICIANS

You or your dependent may change Personal Physicians by calling the Member Services Department at 1-800-248-5451 from California or 001-800-248-5451 from Mexico or submitting a Member Change Request Form to the Member Services Department. The change will be effective the first day of the month following notice of approval by Blue Shield. Once your Personal Physician change is effective, all care must be provided or arranged by the new Personal Physician, except for OB/GYN services provided by an obstetrician/gynecologist or family practice physician within the same Medical Group/IPA as your Personal Physician. Member Services will assist you with the timing and choice of a new Personal Physician.

Changing your Personal Physician during a course of treatment, during hospitalization or while pregnant may interrupt the quality and continuity of your care. For this reason, the effective date of your new Personal Physician, when requested during a course of treatment, during an inpatient hospital stay or during the third trimester of pregnancy, will be the first of the month following:

1. discharge from the hospital,
2. delivery, or
3. the date it is medically appropriate to transfer your care to your new Personal Physician, as determined by the Plan.

Exceptions must be approved by the regional Blue Shield Medical Director. For information about approval for an exception to the above provision, please contact Member Services.

If your Personal Physician discontinues participation in the Plan, Blue Shield will notify you in writing and designate a new Personal Physician for you in case you need immediate medical care. You will also be given the opportunity to select a new Personal Physician of your own choice within 15 days of this notification. Your selection must be approved by Blue Shield prior to receiving any services under the Plan.

CONTINUITY OF CARE BY A TERMINATED PROVIDER

Members who are being treated for acute conditions, serious chronic conditions, high-risk pregnancies or pregnancies that have reached the second or third trimester can request continuation of covered services in certain situations with a provider who is terminated. Contact Member Services to receive information regarding eligibility criteria and the policy and procedure for requesting continuity of care from a terminated provider.

RELATIONSHIP WITH YOUR PERSONAL PHYSICIAN

The physician-patient relationship you and your Personal Physician establish is very important. The best effort of your Personal Physician will be used to ensure that all Medically Necessary and appropriate professional services are provided to you in a manner compatible with your wishes.

If your Personal Physician recommends procedures or treatments which you refuse, or you and your Personal Physician fail to establish a satisfactory relationship, you may select a different Personal Physician. Member Services can assist you with this selection

Your Personal Physician will advise you if he believes that there is no professionally acceptable alternative to a recommended treatment or procedure. If you continue to refuse to follow the recommended treatment or procedure, Member Services can assist you in the selection of another Personal Physician.

Repeated failures to establish a satisfactory relationship with a Personal Physician may result in termination of your coverage.

IV. HOW TO USE YOUR HEALTH PLAN

USE OF PERSONAL PHYSICIAN

At the time of enrollment, you will choose a Personal Physician who will coordinate all covered services. **You must contact your Personal Physician for all health care needs including preventive services, routine health problems, consultations with Plan Specialists (except as provided under Obstetrical/Gynecological (OB/GYN) Physician Services), admission into a Hospice Program through a Participating Hospice Agency, if you reside in or temporarily relocate to California, urgent services and for hospitalization.** The Personal Physician is responsible for providing primary care and coordinating or arranging for referral to other necessary health care services. You should cancel any scheduled appointments at least 24 hours in advance. This policy applies to appointments with or arranged by your Personal Physician and self-arranged appointments for OB/GYN services. Because your physician has set aside time for your appointments in a busy schedule, you need to notify the office within 24 hours if you are unable to keep the appointment. That will allow the office staff to offer that time slot to another patient who needs to see the physician. Some offices may advise you that a fee (not to exceed your copayment) will be charged for missed appointments unless you give 24-hour advance notice or missed the appointment because of an emergency situation.

If you have not selected a Personal Physician for any reason, you must contact Member Services at 1-800-248-5451 from California or 001-800-248-5451 from Mexico, Monday through Friday, between 8 a.m. and 5 p.m. to select a Personal Physician to obtain benefits.

Obstetrical/Gynecological (OB/GYN) Physician Services

A female Member may arrange for OB/GYN services by an obstetrician/gynecologist or family practice physician within the same Medical Group/IPA as her Personal Physician without referral from her Personal Physician.

It is important to note that services by an OB/GYN or family practice physician outside of the Personal Physician's Medical Group without referral will not be covered under this Plan. Before making the appointment, the Member should call the Member Services Department at 1-800-248-5451 from California or 001-800-248-5451 from Mexico to confirm that the OB/GYN or family practice physician is in the same Medical Group/IPA as her Personal Physician.

REFERRAL TO SPECIALTY SERVICES

Blue Shield encourages you to receive specialty services through a referral from your Personal Physician. The Personal Physician is responsible for coordinating all of your health care needs and can best direct you for required specialty services. Your Personal Physician will generally refer you to a Plan Specialist or Plan Non-Physician Health Care Practitioner in the same Medical Group or IPA as your Personal Physician, but you can be referred outside the Medical Group or IPA if the type of specialist or Non-Physician Health Care Practitioner needed is not

available within your Personal Physician's Medical Group or IPA. The Plan Specialist or Plan Non-Physician Health Care Practitioner will provide a complete report to your Personal Physician so that your medical record is complete.

If there is a question about your diagnosis, plan of care, or recommended treatment, including surgery, or if additional information concerning your condition would be helpful in determining the diagnosis and the most appropriate plan of treatment, or if the current treatment plan is not improving your medical condition, you may ask your Personal Physician to refer you to another physician for a second medical opinion. The second opinion will be provided on an expedited basis, where appropriate. If you are requesting a second opinion about care you received from or that was recommended by your Personal Physician or a specialist, the second opinion will be provided by a physician within the same Medical Group/IPA, and, if care by a specialist is involved, by a Plan Specialist of the same or equivalent specialty. All second opinion consultations must be authorized by the Plan. Your Personal Physician may also decide to offer such a referral even if you do not request it. State law requires that health plans disclose to Members, upon request, the timelines for responding to a request for a second medical opinion. To request a copy of these timelines, you may call the Member Services Department at the number listed at the back of this booklet.

To obtain referral for specialty services, including lab and X-ray, you must first contact your Personal Physician. If the Personal Physician determines that specialty services are Medically Necessary, the physician will complete a referral form and notify the Plan. Your Personal Physician will designate the Plan Provider from whom you will receive services.

When no Plan Provider is available to perform the needed service, the Personal Physician will refer you to a Non-Plan Provider in Mexico after obtaining authorization from the Plan. If the needed specialty Non-Plan Provider is not available in Mexico, then the Personal Physician will refer you to a Non-Plan Provider in California. This authorization procedure is handled for you by your Personal Physician. Specialty Services are subject to all of the benefit and eligibility provisions, exclusions and limitations described in this booklet. You are responsible for contacting Blue Shield to determine that services are covered Services, before such services are received.

EMERGENCY SERVICES

Members who reasonably believe that they have an emergency medical condition which requires an emergency response are encouraged to appropriately use the "911" emergency response system where available.

Members should go to the closest Hospital for emergency services whenever possible.

If you obtain emergency services, you should notify your Personal Physician within 24 hours after care is received unless it was not reasonably possible to communicate with the Personal Physician within this time limit. In such case, notice should be given as soon as possible.

An emergency means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in any of the following: (1) placing the Member's health in serious jeopardy; (2) serious impairment to bodily functions; (3) serious dysfunction of any bodily organ or

part. **If you receive non-authorized services in a situation that the Access Baja HMO determines was not a situation in which a reasonable person would believe that an emergency condition existed, you will be responsible for the costs of those services.**

INPATIENT, HOME HEALTH CARE, HOSPICE PROGRAM AND OTHER SERVICES

The Personal Physician is responsible for obtaining prior authorization from the Plan before you can be admitted to the hospital or a skilled nursing facility, including Subacute Care admissions. The Personal Physician is responsible for obtaining prior authorization from the Plan before you can receive home health care and certain other services or before you can be admitted into a Hospice Program through a Participating Hospice Agency, if you reside in or temporarily relocate to California. If the Personal Physician determines that you should receive any of these services, he or she will request authorization from the Plan. Your Personal Physician will arrange for your admission to the hospital, skilled nursing facility, or a Hospice Program through a Participating Hospice Agency, if you reside in or temporarily relocate to California, as well as for the provision of home health care and other services.

NOTE: For Hospital admissions for mastectomies or lymph node dissections, the length of hospital stays will be determined solely by the Member's Physician in consultation with the Member. For information regarding length of stay for maternity or maternity related Services, see Section VI., Plan Benefits, D. Pregnancy and Maternity Care, for information relative to the Newborns' & Mothers' Health Protection Act.

URGENT SERVICES

The Access Baja HMO has made arrangements for an added benefit for you and your family for your urgent service needs when you or your family are temporarily traveling outside of your Plan Service Area outside Mexico and cannot establish contact with the Personal Physician.

Urgent services are defined as those covered services (other than Emergency Services) which are medically necessary to prevent serious deterioration of a Member's health, alleviate severe pain, or treat an unforeseen illness, injury or medical condition with respect to which treatment can not reasonably be delayed until the Member returns to the Plan's service area.

A 24-hour toll-free number is available when you are in the U.S., but outside California, or outside the U.S. or Mexico, and need urgent services. By calling 1-800-810-BLUE (2583), you will be informed about the nearest BlueCard participating provider. While outside the U.S. or Mexico, urgent care services are available through the BlueCard Worldwide Network.

Under BlueCard, when you obtain health care services outside the geographic area Blue Shield of California serves, the amount you pay, if not covered by a flat dollar copayment, for covered services is calculated on the **lower** of:

1. The billed charges for your covered services, or
2. The negotiated price that the on-site Blue Cross and/or Blue Shield plan ("Host Blue") passes on to us.

Often, this "negotiated price" will consist of a simple discount which reflects the actual price paid by the Host Blue. But sometimes it is an estimated price that factors into the actual price expected settlements, withholds, any

other contingent payment arrangements and non-claims transactions with your health care provider or with a specified group of providers. The negotiated price may also be billed charges reduced to reflect an **average** expected savings with your health care provider or with a specified group of providers. The price that reflects average savings may result in greater variation (more or less) from the actual price paid than will the estimated price. The negotiated price will also be adjusted in the future to correct for over-or underestimation of past prices. However, the amount you pay is considered a final price.

Statutes in a small number of states may require the Host Blue to use a basis for calculating Member liability for covered services that does not reflect the entire savings realized or expected to be realized on a particular claim or to add a surcharge. Should any state statutes mandate Member liability calculation methods that differ from the usual BlueCard method noted above or require a surcharge, Blue Shield of California would then calculate your liability for any covered health care services in accordance with the applicable state statute in effect at the time you received your care.

You will be entitled to benefits for health care services received by you either inside or outside the geographic area Blue Shield of California serves, if this Plan covers those health care services. Due to variations in Host Blue medical practice protocols, you may also be entitled to benefits for some health care services obtained outside the geographic area Blue Shield of California serves, even though you might not otherwise have been entitled to benefits if you had received those health care services inside the geographic area Blue Shield of California serves. But in no event will you be entitled to benefits for health care services, wherever you received them, that are specifically excluded or limited from coverage by this Plan.

Please Note: If you are temporarily traveling within California, but are outside of your Personal Physician Service Area, you should contact your Personal Physician. If you are in California, and are unable to establish contact with your Personal Physician, you should call Blue Shield Member Services at 1-800-248-5451 for assistance in receiving urgent services. Remember that when you are within your Personal Physician Service Area, urgent services must be provided or authorized by your Personal Physician just like all other non-emergency services of the Plan. When you are in Mexico, but outside of your Personal Physician Service Area, urgent services must be authorized by your Personal Physician. Whenever possible, you should contact your Personal Physician. When in the U.S., or outside of the U.S. or Mexico, urgent services obtained that are not authorized by your Personal Physician or provided by a BlueCard participating provider will be reviewed retrospectively for coverage.

MEMBER MAXIMUM CALENDAR YEAR COPAYMENT

Your maximum Copayment responsibility each Calendar Year for covered Services is $1,000 per Member and $2,000 per Family.

Copayments for Outpatient Psychiatric Care for other than Severe Mental Illnesses or Serious Emotional Disturbances of a Child excluding the initial visit, and for substance abuse excluding the initial visit do not apply towards the Member Maximum Calendar Year Copayment Responsibility.

Charges for services not covered and services not prior approved by the Personal Physician, except those meeting the emergency and urgent care requirements, are your responsibility, do not apply towards the

Member Maximum Calendar Year Copayment Responsibility and may cause your payment responsibility to exceed the Member Maximum Calendar Year Copayment Responsibility defined above.

Note that copayments and charges for services that are not included in the calculation of the Member Maximum Calendar Year Copayment continue to be the Member's responsibility after the Maximum Calendar Year Copayment Responsibility is reached.

NOTE: It is your responsibility to maintain accurate records of your Copayments and to determine and notify Blue Shield when the Member Maximum Calendar Year Copayment Responsibility has been reached.

You must notify Blue Shield Member Services in writing when you feel that your Member Maximum Calendar Year Copayment Responsibility has been reached. At that time, you must submit complete and accurate records to Blue Shield substantiating your Copayment expenditures for the period in question. Member Services addresses and telephone numbers may be found on the last page of this booklet.

LIABILITY OF SUBSCRIBER OR MEMBER FOR PAYMENT

It is important to note that all services in the U.S., except for those meeting the emergency and out of service area urgent services requirements and Hospice Program Services received from a Participating Hospice Agency after the Member has been accepted into the Hospice Program, must have prior approval by the Personal Physician. All services in Mexico, except those meeting the emergency services requirements must have prior approval by the Personal Physician. The Member will be responsible for payment of services that are not authorized by the Personal Physician or those that are not an emergency or covered out of service area urgent service procedures. (See the previous Urgent Services paragraphs for information on receiving urgent services out of the service area.) Members must obtain services from the Providers that are authorized by their Personal Physician. Hospice Program Services rendered in California must be received from a Participating Hospice Agency.

If your condition requires services which are available from the Plan, payment for services rendered by Non-Plan Providers will not be considered unless the medical condition requires emergency services or urgent services in Mexico, but outside of the Personal Physician Service Area, that have been authorized by the Personal Physician.

LIMITATION OF LIABILITY

Members shall not be responsible to Plan Providers for payment for services if they are a benefit of the Plan. When covered services are rendered by a Plan Provider, the Member is responsible only for the applicable Copayments. Members are responsible for the full charges for any non-covered services they obtain.

If a Plan Provider ceases to be a Plan Provider, you will be notified if you are affected. The Plan will make every reasonable and medically appropriate provision to have another Plan Provider assume responsibility for services to you. You will not be responsible for payment (other than Copayments) to a former Plan Provider for any authorized services you receive. Once provisions have been made for the transfer of your care, services of a former Plan Provider are no longer covered

CURRENCY

All monetary references in this Evidence of Coverage are stated in U.S. Dollars.

CORRESPONDENCE SENT TO RESIDENTS OF MEXICO

Blue Shield will send all correspondence to you at your address as shown on your enrollment form. However, if you reside in Mexico and if you so elect at the time of enrollment, Blue Shield will send correspondence to you at your employer's address. Your employer has agreed to respect the privacy and confidentiality of the correspondence sent in this manner and will distribute it to you unopened and normally within 2 working days of receipt.

UTILIZATION REVIEW

State law requires that health plans disclose to Members and health plan providers the process used to authorize or deny health care services under the Plan.

Blue Shield has completed documentation of this process ("Utilization Review"), as required under Section 1363.5 of the California Health and Safety Code.

To request a copy of the document describing this Utilization Review process, call the Member Service Department at the number listed in the back of this booklet.

V. SUMMARY OF BENEFITS

What follows is a summary of your benefits and the Copayments applicable to the benefits of your plan. A more complete description of your benefits is contained in Section VI. Plan Benefits. Please be sure to read that section and the exclusions and limitations in Section VII. for a complete description of the benefits of your plan.

You should know that all benefits described in this summary and throughout this Evidence of Coverage apply only when provided or authorized by your Personal Physician and/or the Access Baja HMO, except in an emergency or as otherwise specified.

Should you have any questions about your plan, please call the Member Services Department at:

1-800-248-5451 from California, or

001-800-248-5451 from Mexico.

These phone numbers are staffed by representatives who speak Spanish

V.Summary of Benefits[1] Access Baja HMO Gold Plan

Services	Member's Copayment
Preventive Health Services	
• Routine physical exams, including well-baby, well-child, women's gynecological exams and adult exams according to schedule.	*You Pay Nothing*
• Medically Necessary immunizations as defined	*You Pay Nothing*
• Health education/health promotion services	*You Pay Nothing*
• Vision/hearing screening by Personal Physician for Members under 18	*You Pay Nothing*
Physician Services	
• Inpatient hospital and skilled nursing facility services by physicians, including the services of a surgeon, assistant surgeon, anesthesiologist, pathologist and radiologist	*You Pay Nothing*
• Office visits, including visits for chemotherapy, radiation therapy, and diabetic counseling, audiometry examinations, second opinion consultations when authorized by the Plan; or OB/GYN services from an obstetrician/gynecologist or family practice physician who is within the same Medical Group/IPA as the Personal Physician	*$5.00 per Visit*
• Lab, X-ray, diagnostic tests	*You Pay Nothing*
• Injectable medications	*You Pay Nothing*
(Note: See Section VI., B., Professional Services in the Description of Benefits for information on separate coverage for allergy injectable medications, subject to the applicable Copayments.)	*$5.00 per Visit*
• Audiometry Examinations. Audiometry examinations when performed by a physician or by an audiologist at the request of a physician.	
Pregnancy and Maternity Care	
• Prenatal and postnatal physician office visits and delivery, including prenatal diagnosis of genetic disorders of the fetus by means of diagnostic procedures in cases of high-risk pregnancy	*You Pay Nothing*
• All necessary inpatient hospital services for normal delivery, routine newborn circumcision, Cesarean section, and complications of pregnancy	*You Pay Nothing*
• Outpatient routine newborn circumcision	*In the office - $5.00* *In an Outpatient Facility – $25.00*
Family Planning Services	
• Family planning counseling	*$5.00 per Visit*
• Elective abortion	*$100.00*
• Tubal ligation	*$100.00 (Unless performed in conjunction with delivery or abdominal surgery)*
• Vasectomy	*$50.00*
• Physician office visits for diaphragm fitting	*Physician Services Copayments Apply*

V.Summary of Benefits[1] Access Baja HMO Gold Plan

Services	Member's Copayment
Allergy Testing	
• Office visits	*$5.00 per Visit*
Allergy Treatment	
• Office visits (includes visits for allergy serum injections)	*$5.00 per Visit*
• Allergy serum purchased separately for treatment	*You Pay Nothing*
Hospital Services	
• Inpatient services, including private room and board in Mexico, and semi-private room and board outside of Mexico, operating room, intensive cardiac care units, general nursing care, subacute care, drugs, medications, oxygen, blood and blood plasma***	*You Pay Nothing*
• Inpatient hospital services for acute medical detoxification due to substance abuse	*You Pay Nothing*
• Outpatient services for treatment or surgery, and necessary supplies – excluding emergency services	*$25.00 per Visit or Surgery*
• Outpatient services for renal dialysis, radiation therapy, and chemotherapy	*You Pay Nothing*
Skilled Nursing Facility Services	
• Inpatient skilled nursing facility services, including subacute care and other necessary services and supplies for up to 100 days per Calendar Year[2]*** Note: Free-standing Skilled Nursing Facilities are not available in Mexico. However, care that is generally provided in a Skilled Nursing Facility environment is available in an Inpatient Hospital.	*You Pay Nothing*
Mental Health and Substance Abuse Services	
• Inpatient hospital and professional services and psychiatric day care for the treatment of mental illness (Note: No benefits are provided for Inpatient substance abuse Services except for Inpatient substance abuse detoxification which is covered as a medical benefit. For copayments for Inpatient substance abuse detoxification, see the Hospital Services and Physician Services sections of this Summary.)	*You Pay Nothing*
• Outpatient Psychiatric Care for other than Severe Mental Illnesses or Serious Emotional Disturbances of a Child, and substance abuse counseling up to 20 visits per Calendar Year The Member copayment for the initial visit to determine the condition and diagnosis of the Member will be the Physician office visit copayment amount. Initial visits which are subsequently diagnosed as being for other than Severe Mental Illnesses or Serious Emotional Disturbances of a Child or for substance abuse care will also accrue toward the 20 visit maximum.	*$5.00 per Visit*
• Outpatient psychiatric care for Severe Mental Illnesses of a Member of any age and of Serious Emotional Disturbances of a Child	*$5.00 per Visit*
• Psychological testing	*You Pay Nothing*

V.Summary of Benefits[1] Access Baja HMO Gold Plan

Services	Member's Copayment
Home Health Care and PKU Related Formulas and Special Food Products*** • Home health care agency services, including home visits by a nurse, home health aide, physical therapist, speech therapist, respiratory therapist or occupational therapist in the home by home health care providers for up to a total of 100 home health care visits per Calendar Year*[2]	*$5.00 per Visit*
• Home visits by Plan Physicians	*$20.00 per Visit*
• Medical Social Worker**	*You Pay Nothing*
• Medical supplies including parenteral and enteral nutritional services and supplies and related pharmaceutical and laboratory services to the extent the benefits would have been provided had the Member remained in the hospital	*You Pay Nothing*
• PKU related formulas and Special Food Products	*You Pay Nothing*
* For home health care visits in Mexico, services will be rendered by a Mexican Registered Nurse contracted by the IPA. **Not available to render services in Mexico.	
Hospice Care **Hospice Program Services rendered in California when the Member resides in or temporarily relocates to California and the Hospice Program Services are received and authorized by a Participating Hospice Agency**	
• Continuous Home Care provided during a Period of Crisis	*You Pay Nothing*
• General Inpatient care	*You Pay Nothing*
• Inpatient Respite Care	*You Pay Nothing*
• Routine home care	*You Pay Nothing*
Hospice Care Services rendered in Mexico	
• Hospice Care Services that are rendered in Mexico consist of a combination of various Physician, Hospital, Skilled Nursing, Home Health Care, Respiratory Therapy, and Other Services. See Section VI.T. for detailed benefit information.	*The Member's Copayments for Hospice Care Services rendered in Mexico will be paid per Service, and are the same Copayments as noted under the same categories of Services that are listed in this Summary of Benefits, depending on the type of Service provided.*

V. Summary of Benefits[1] Access Baja HMO Gold Plan

Services	Member's Copayment
Rehabilitative Therapy Services	
• Rehabilitative therapy services by a physical, occupational, respiratory or speech therapist in the following settings:	
1. in the rehabilitation unit of a hospital for Medically Necessary days, or	*You Pay Nothing*
2. in the skilled nursing facility rehabilitation unit for Medically Necessary days,	*You Pay Nothing*
3. for outpatient services in the office or hospital the plan will provide benefits for as long as continued treatment is Medically Necessary and when provided pursuant to a written treatment plan.	*$5.00 per Visit*
Organ Transplant Benefits	
• Inpatient hospital and professional services for transplants of a cornea, kidney, skin, human heart, lung, heart and lung in combination, liver, kidney and pancreas in combination, human bone marrow transplants, pediatric human small bowel transplants, pediatric and adult human small bowel and liver transplants in combination, and Autologous Chondrocyte Implantation/Transplantation as specified in the Description of Benefits, and services to obtain the human transplant material with prior written authorization of Blue Shield's Medical Director	*You Pay Nothing*
Reconstructive Surgery	
• Inpatient or outpatient surgery to correct or repair abnormal structures of the body and which result in more than a minimal improvement in function or appearance, and reconstructive surgery incident to a mastectomy	*Inpatient- You Pay Nothing* *Outpatient- $5.00 per Visit*
Medical Treatment of the Teeth, Gums, Jaw Joints or Jaw Bones	
• Inpatient or outpatient treatment of gum tumors, damaged natural teeth resulting from Accidental Injury, TMJ as specifically stated and orthognathic surgery for skeletal deformity (be sure to read the Plan Benefits section for a complete description)	*Inpatient- You Pay Nothing* *Outpatient- $5.00 per Visit*
Emergency Services	
• Emergency room services rendered in Mexico	*$25.00 per Visit (Waived if Member is admitted directly to the Hospital as an Inpatient)*
• Emergency room services rendered in the U.S. or outside of Mexico	*$50.00 per Visit (Waived if Member is admitted directly to the Hospital as an Inpatient)*
• Ambulance service	*$50.00*
Urgent Services	
• Urgent services outside your Plan Service Area, but outside of Mexico	*$50.00 per visit*
• Urgent services outside your Plan Service Area, but within Mexico	*$25.00 per visit*

V. Summary of Benefits[1] Access Baja HMO Gold Plan

Services	Member's Copayment
Other Services	
• Home Medical Equipment and oxygen***	*50% of Allowed Charges*
• Prostheses and orthoses	*50% of Allowed Charges*
• Surgically implanted devices and supplies	*You Pay Nothing*
• Non-emergency ambulance services	*$50.00*
Diabetes Care	
• Diabetic Equipment	*50% of Allowed Charges*
• Diabetes Self-Management Training and Education	*$5.00 per Visit*
Outpatient Prescription Drugs at a Participating Pharmacy [3]	
• Generic Drugs – 30-day supply	*$5.00 for each new or refill Drug*
• Brand Name Drugs – 30-day supply	*$10.00 for each new or refill Drug*
.	
Member's Maximum Calendar Year Copayment [4]	
• Member's maximum Calendar Year Copayment for all covered Services **except for:** outpatient Psychiatric Care for other than Severe Mental Illnesses or Serious Emotional Disturbances of a Child and substance abuse Services excluding the initial visit.	*$1,000 per Member,* *$2,000 per Family*

(1) All benefits must be provided or authorized by your Personal Physician and/or the Access Baja HMO, except in an emergency or as otherwise specified.

(2) See Section VI., T. for information concerning Hospice Care.

(3) Drugs obtained at a **Non-Participating Pharmacy** are not covered, unless Medically Necessary for a covered emergency.

(4) All services in the U.S., except those meeting the emergency and urgent services requirements must have prior approval by the Personal Physician, including those the Member obtains after the Maximum Calendar Year Copayment has been met. All services in Mexico, except those meeting the emergency services requirements, must have prior approval by the Personal Physician, including those the Member obtains after the Maximum Calendar Year Copayment has been met. The Member will be responsible for payment of services that are not authorized by the Personal Physician or those that are not an emergency or covered urgent service procedures. Members must obtain services from the Providers that are authorized by their Personal Physician.

Note that copayments and charges for services that are not included in the calculation of the Member Maximum Calendar Year Copayment continue to be the Member's responsibility after the Maximum Calendar Year Copayment Responsibility is reached.

***For care received by a Participating Hospice Agency in California, see the Hospice Program Services section.

VI. PLAN BENEFITS

The Plan benefits available to you under the Plan are listed in this section. The Copayments for these services, if applicable, are in the Summary of Benefits. Note: An authorization from Blue Shield for a particular service to be provided in the United States does not constitute legal authorization for the Member to enter the United States.

IMPORTANT INFORMATION

The services and supplies described here are covered only if they are Medically Necessary and are provided, prescribed, or authorized by your Personal Physician. Your Personal Physician will also designate the Plan Provider from whom you must obtain authorized services and will assist you in applying for admission into a Hospice Program through a Participating Hospice Agency, if you reside in or temporarily relocate to California. The Plan will not pay charges incurred for services without your Personal Physician's authorization, except for OB/GYN services by an obstetrician/ gynecologist or family practice physician within the same Medical Group/IPA as your Personal Physician, Hospice Services obtained through a Participating Hospice Agency after you have been admitted into the Hospice Program, if you reside in or temporarily relocate to California, and emergency or urgent services obtained in accordance with Section IV., How to Use Your Health Plan.

The determination of whether services are Medically Necessary or are an emergency or urgent will be made by the Plan. This determination will be based upon the Plan's review consistent with generally accepted medical standards, and will be subject to appeal in accordance with the procedures outlined in Section XIII., Grievance and Appeals Process.

DESCRIPTION OF BENEFITS

The following are the basic health care services covered by the Access Baja HMO without charge to the Member, except for Copayments where applicable. The Copayments are listed in the Summary of Benefits. These services are covered when Medically Necessary, and when provided by the Member's Personal Physician or other Plan Provider or authorized by the Member's Personal Physician or the HMO or are OB/GYN services from an obstetrician/gynecologist or family practice physician who is within the same Medical Group/IPA as the Personal Physician. Coverage for these services is subject to all terms, conditions, limitations and exclusions of the contract.

A. PREVENTIVE HEALTH SERVICES

Preventive Care Services are those primary preventive medical Services provided by a Physician for the early detection of disease when no symptoms are present and for those items specifically listed below.

1. Scheduled routine physical examinations as follows:

   a. Well-baby care through age 2 years;

   b. Exams every year, age 3-19 years;

   c. Exams every 5 years, age 20-40 years;

   d. Exams every 2 years, age 41-50 years;

   e. Exams every year over age 50 years;

   f. Routine breast and pelvic exams and Pap tests or other government approved cervical cancer screening tests every year. A woman may self-

refer to an OB/GYN or family practice physician who is in the same Medical Group/IPA as her Personal Physician for a routine annual gynecological exam;

g. Mammography for screening purposes recommended by Member's Personal Physician.

2. Pediatric and adult immunizations and the immunizing agent, as recommended by the American Academy of Pediatrics and the United States Public Health Service through its U.S. Preventive Services Task Force and/or the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control (CDC).

3. Hearing screening by the Personal Physician for Members under the age of 18 to determine the need for an audiogram or for hearing correction, as well as newborn hearing screening services.

4. Vision screening by the Personal Physician for Members under the age of 18 to determine the need for a refraction for vision correction.

5. Health education and health promotion services provided by Blue Shield's Center for Health Improvement offer a variety of wellness resources including, but not limited to: a Member newsletter and a prenatal health education program.

6. Blue Shield's Internet site is located at http://www.mylifepath.com. Members with Internet access and a Web browser may view and download healthcare information.

B. PROFESSIONAL SERVICES (OTHER THAN FOR MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES)

1. Physician Office Visits. Office visits for examination, diagnosis and treatment of a medical condition, disease or injury, including specialist office visits, second opinion or other consultations, office surgery, outpatient chemotherapy and radiation therapy, diabetic counseling; audiometry examinations, and OB/GYN services from an obstetrician/gynecologist or family practice physician who is within the same Medical Group/IPA as the Personal Physician.

2. Allergy Testing and Treatment. Office visits for the purpose of allergy testing and treatment, including injectables and serum.

3. Inpatient Medical and Surgical Physician Services. Physicians' services in a hospital or skilled nursing facility for examination, diagnosis, treatment and consultation including the services of a surgeon, assistant surgeon, anesthesiologist, pathologist and radiologist. Inpatient professional services are covered only when hospital and skilled nursing facility services are also covered.

4. Treatment of physical complications of a mastectomy, including lymphedemas.

5. Audiometry Examinations. Audiometry examinations when performed by a physician or by an audiologist at the request of a physician.

C. OTHER OUTPATIENT SERVICES

1. Laboratory, X-ray, Major Diagnostic Services. All outpatient diagnostic X-ray and clinical laboratory tests and services, including diagnostic imaging, electrocardiograms and diagnostic clinical isotope services.

2. Renal Dialysis. Outpatient renal dialysis unless covered by Medicare. unrelated to Illness or injury. Routine circumcisions after this time period are covered for sick babies when authorized by the Blue Shield Access Baja HMO.

3. Injectable Medications. Injectable medications are covered for the Medically Necessary treatment of medical conditions when prescribed or authorized by the Personal Physician and the Plan. Insulin will be covered under the Outpatient Prescription Drugs Benefit.

   (Note: See Section B., Professional Services for information on separate coverage for allergy injectable medications, subject to the applicable Copayments.)

D. PREGNANCY AND MATERNITY CARE

The following pregnancy and maternity care is covered subject to the exclusion listed in VII., 10.

1. Prenatal and postnatal physician office visits and delivery, including prenatal diagnosis of genetic disorders of the fetus by means of diagnostic procedures in cases of high-risk pregnancy.

2. Inpatient Hospital Services. Hospital services for the purposes of a normal delivery, routine newborn circumcision*, Cesarean section, complications or medical conditions arising from pregnancy or resulting childbirth.

3. Outpatient routine newborn circumcision.*

   *For the purposes of this benefit, routine newborn circumcisions are circumcisions performed within 31 days of birth unrelated to Illness or injury. Routine circumcisions after this time period are covered for sick babies when authorized by the Blue Shield Access Baja HMO.

Note: The Newborns' and Mothers' Health Protection Act requires group health plans to provide a minimum hospital stay for the mother and newborn child of 48 hours after a normal, vaginal delivery and 96 hours after a C-section unless the attending physician, in consultation with the mother, determines a shorter hospital length of stay is adequate.

If the hospital stay is less than 48 hours after a normal, vaginal delivery or less than 96 hours after a C-section, a follow-up visit for the mother and newborn within 48 hours of discharge is covered when prescribed by the treating physician. This visit shall be provided by a licensed health care provider whose scope of practice includes postpartum and newborn care. The treating physician, in consultation with the mother, shall determine whether this visit shall occur at home, the contracted facility, or the physician's office.

E. FAMILY PLANNING SERVICES

1. Family Planning Counseling.

2. Tubal Ligation.

3. Elective Abortion. This benefit service will only be rendered in California. You should call Member Services Department at 1-800-248-5451 from California or 001-800-248-5451 from Mexico to obtain the closest provider location.

4. Vasectomy.

5. Physician office visits for diaphragm fitting.

F. HOSPITAL SERVICES

The following hospital services customarily furnished by a hospital will be covered when Medically Necessary and authorized by the Access Baja HMO.

1. Inpatient hospital services include:

   a. For Hospitals in Mexico, private room and board; for Hospitals outside of Mexico, semi-private room and board,

   unless a private room is Medically Necessary;

   b. General nursing care, and special duty nursing when Medically Necessary;

   c. Meals and special diets when Medically Necessary;

   d. Intensive care services and units;

   e. Operating room, special treatment rooms, delivery room, newborn nursery and related facilities;

   f. Hospital ancillary services including diagnostic laboratory, X-ray services and therapy services;

   g. Drugs, medications, biologicals, and oxygen administered in the hospital, and up to 3 days' supply of drugs supplied upon discharge by the Plan Physician for the purpose of transition from the hospital to home;

   h. Surgical and anesthetic supplies, dressings and cast materials, surgically implanted devices and prostheses, other medical supplies and medical appliances and equipment administered in hospital;

   i. Administration of blood or blood plasma including the cost of blood or blood plasma and in-hospital blood processing;

   j. Radiation therapy, chemotherapy and renal dialysis;

   k. Subacute Care;

   l. Inpatient Services including general anesthesia and associated facility charges in connection with dental procedures when hospitalization is required because of an underlying medical condition or clinical status and the Member is under the age of seven or developmentally disabled regardless of age or when the Member's health is compromised and for whom general anesthesia is Medically Necessary regardless of age. Excludes dental procedures and services of a dentist or oral surgeon;

   m. Inpatient hospital services for substance abuse for medically necessary acute medical **detoxification only**. Inpatient substance abuse treatment, day care, residential care, and rehabilitation are not covered.

   NOTE: See section VI.T. for Inpatient Hospital Services provided under the "Hospice Care" benefit.

2. Outpatient Hospital Services.

   a. Services and supplies for treatment (including radiation and chemotherapy) or surgery in an

outpatient hospital setting or ambulatory surgery center.

b. Services for general anesthesia and associated facility charges in connection with dental procedures when performed in a hospital outpatient setting or ambulatory surgery center because of an underlying medical condition or clinical status and the Member is under the age of seven or developmentally disabled regardless of age or when the Member's health is compromised and for whom general anesthesia is Medically Necessary regardless of age. Excludes dental procedures and services of a dentist or oral surgeon.

G. MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES

Benefits are provided for the following covered Mental Health and substance abuse Services, subject to applicable copayments and charges in excess of any benefit maximums, and other limitations and exclusions.

1. Inpatient Services

Inpatient hospital and professional services in connection with hospitalization or psychiatric day care*, for the treatment of mental illness (including treatment of Severe Mental Illnesses of a Member of any age and of Serious Emotional Disturbances of a Child), are covered **when authorized by the Access Baja HMO Personal Physician and the Access Baja HMO.** Residential care is not covered.

*Psychiatric day care (partial hospital services) is care at a hospital in which patients receive treatment during the day, returning to their home or other community placement during the evening and night.

NOTE: Medically Necessary Inpatient substance abuse medical **detoxification** is not included in this benefit. It is included as an **Inpatient Hospital Services** benefit.

2. Outpatient Services

a. Medically necessary Outpatient Psychiatric Care for other than Severe Mental Illnesses or Serious Emotional Disturbances of a Child, and substance abuse visits or sessions. This benefit is limited to a combined maximum of **20 visits** for diagnosis and treatment in any Calendar Year. Day care and intensive Outpatient treatment are not covered under this benefit.

b. Medically necessary Outpatient Psychiatric Care for the diagnosis and treatment of Severe Mental Illnesses and of Serious Emotional Disturbances of a Child. Intensive Outpatient treatment is covered under this benefit.

3. Psychological testing

H. MEDICAL TREATMENT OF THE TEETH, GUMS, JAW JOINTS OR JAW BONES

Hospital and professional services provided for conditions of the teeth, gums, or jaw joints and jaw bones, including adjacent tissues are a benefit only to the extent that these services are provided for:

1. the treatment of tumors of the gums;

2. the treatment of damage to the natural teeth caused solely by an

Accidental Injury is limited to Medically Necessary Services until the Services result in initial, palliative stabilization of the Member as determined by the Plan;

Note: Dental services provided after initial medical stabilization, prosthodontics, orthodontia and cosmetic services are not covered. This benefit does not include damage to the natural teeth that is not accidental, e.g., resulting from chewing or biting.

3. Medically Necessary non-surgical treatment (e.g., splint and physical therapy) of Temporomandibular Joint Syndrome (TMJ);

4. Surgical and arthroscopic treatment of TMJ if prior history shows conservative medical treatment has failed; or

5. Orthognathic Surgery (surgery to reposition the upper and/or lower jaw) which is Medically Necessary to correct skeletal deformity.

This benefit does not include:

1. Services customarily provided by dentists and oral surgeons, including hospitalization incident thereto;

2. Orthodontia (dental services to correct irregularities or malocclusion of the teeth) for any reason, including treatment to alleviate TMJ;

3. Any procedure (e.g., vestibuloplasty) intended to prepare the mouth for dentures or for the more comfortable use of dentures;

4. Dental implants (endosteal, subperiosteal or transosteal).

I. SKILLED NURSING FACILITY SERVICES

Subject to all of the inpatient hospital services provisions, Medically Necessary skilled nursing services, including subacute care, will be covered when provided in a Skilled Nursing Facility and authorized by the Access Baja HMO. This benefit is limited to 100 days during any Calendar Year, except when received in connection with Hospice Care. Custodial care is not covered.

Note: Free-standing Skilled Nursing Facilities are not available in Mexico. However, care that is generally provided in a Skilled Nursing Facility environment is available in an Inpatient Hospital.

Note: For information concerning Hospice Care, see Section T.

J. HOME HEALTH CARE SERVICES AND PKU RELATED FORMULAS AND SPECIAL FOOD PRODUCTS

1. Home Health Care Services

The following home health care services will be covered when the patient is required to be at home for Medically Necessary purposes at the direction of the Personal Physician, and the services are Medically Necessary and authorized by the Access Baja HMO. Home health benefits are limited to a combined total of 100 visits during any Calendar Year for all providers other than Plan Physicians, except when received in connection with Hospice Care.

Note: For information concerning Hospice Care, see Section T.

For services rendered in California:

a. Intermittent and part-time home visits by a home health agency to provide skilled services up to 4 visits

per day, 2 hours per visit not to exceed 8 hours per day by any of the following professional providers:

(1)Registered nurse,

(2)Licensed vocational nurse,

(3)Physical therapist, occupational therapist, speech therapist or respiratory therapist,

(4)Certified home health aide in conjunction with the services of (1), (2) or (3) above.

b. Medical Social Worker. Medical social services provided by a licensed medical social worker for consultation and evaluation.

c. In conjunction with the professional services rendered by a home health agency, medical supplies (including disposable supplies), and medications administered by the home health agency necessary for the home health care treatment plan, and related pharmaceutical and laboratory services to the extent the benefits would have been provided had the Member remained in the hospital. This benefit includes: parenteral and enteral nutritional services and associated supplies and supplements.

d. Medically Necessary home visits by Plan Physician.

For services rendered in Mexico:

a. Intermittent and part-time home visits by a Mexican Registered Nurse to provide skilled services up to 4 visits per day, 2 hours per visit not to exceed 8 hours per day.

b. In conjunction with the professional services rendered by the registered nurse, medical supplies (including disposable supplies), and medications necessary for the home health care treatment plan, and related pharmaceutical and laboratory services to the extent the benefits would have been provided had the Member remained in the hospital. This benefit includes: parenteral and enteral nutritional services and associated supplies and supplements.

c. Medically Necessary home visits by Plan Physicians.

2. PKU Related Formulas and Special Food Products

Benefits are provided for enteral formulas and Special Food Products that are medically necessary to avert the development of serious physical or mental disabilities or to promote normal development or function as a consequence of phenylketonuria (PKU). These benefits must be prior authorized by the Blue Shield Access Baja HMO and must be prescribed or ordered by the appropriate health care professional.

Note: For information concerning diabetes self-management training see Section S. Diabetes Care.

K. REHABILITATIVE THERAPY SERVICES

Rehabilitative therapy includes physical therapy, occupational therapy, speech therapy and/or respiratory therapy. Inpatient benefits will be provided for Medically Necessary inpatient days of care in an acute hospital rehabilitation unit or skilled nursing facility rehabilitation unit. Outpatient benefits will be provided when outpatient rehabilitative therapy services are Medically Necessary, and are provided pursuant to a written treatment plan, and when this care is rendered in the

provider's office or outpatient department of a hospital.

Note: See Section J. Home Health Care Services and PKU Related Formulas and Special Food Products for information on coverage for Rehabilitation Services rendered in the home, including visit limits.

L. HOME MEDICAL EQUIPMENT, PROSTHESIS, ORTHOSIS AND OTHER SERVICES

Medically Necessary Home Medical Equipment and supplies needed to operate Home Medical Equipment, oxygen and its administration, and ostomy and medical supplies to support and maintain gastrointestinal, bladder or respiratory function are covered. Benefits are provided at the most cost effective level of care that is consistent with professionally recognized standard of practice. If there are two or more professionally recognized items equally appropriate for a condition, benefits will be based on the most cost effective item. Rental charges for Home Medical Equipment in excess of purchase price are not covered. Routine maintenance or repairs, even if due to damage, are not covered.

Medically Necessary prostheses and orthoses to meet the daily needs of living are covered, including the following:

1. Supplies necessary for the operation of prostheses and orthoses;
2. Initial fitting and replacement after the expected life of the item;
3. Repairs, even if due to damage;
4. Blom-Singer prostheses for speech following a laryngectomy;
5. Special footwear required for foot disfigurement which includes but is not limited to foot disfigurement from cerebral palsy, arthritis, polio, spina bifida, diabetes or by accident or developmental disability;
6. Functional foot orthoses;
7. Contact lenses, if Medically Necessary to treat eye conditions such as keratoconus and keratitis sicca or when required as a result of cataract surgery when no intraocular lens has been implanted;
8. Prosthetic devices provided to restore and achieve symmetry incident to a mastectomy are covered.

Benefits for Medically Necessary prostheses and orthoses are provided at the most cost effective level of care that is consistent with professionally recognized standards of practice. If there are two or more professionally recognized appliances equally appropriate for a condition, this Plan will provide benefits based on the most cost effective appliance. Routine maintenance is not covered. Benefits do not include wigs for any reason, home testing devices, environmental control equipment, self-help/educational devices or any type of speech or language assistance devices except as specifically provided above.

NOTE: If you reside in or temporarily relocate to California, and are enrolled in a Hospice Program through a Participating Hospice Agency, medical equipment and supplies that are reasonable and necessary for the palliation and management of Terminal Illness and related conditions are provided by the Hospice Agency. For information see Section T.

M. ORGAN TRANSPLANT BENEFITS

Blue Shield will provide benefits for certain procedures, listed below, only if (1)

performed at a Special Transplant Facility in California or other approved facility contracting with Blue Shield of California to provide the procedure, (2) prior authorization is obtained, in writing, from Blue Shield's Medical Director and (3) the recipient of the transplant is a Subscriber or Dependent. The following conditions are applicable:

1. Blue Shield reserves the right to review all requests for prior authorization for these Organ Transplant Benefits, and to make a decision regarding benefits based on (a) the medical circumstances of each patient and (b) consistency between the treatment proposed and Blue Shield of California medical policy. Failure to obtain prior written authorization as described above and/or failure to have the procedure performed at a contracting Special Transplant Facility or other approved facility in California will result in denial of claims for this benefit.

2. The following procedures are eligible for coverage under this provision:

   a. Human heart transplants;

   b. Human lung transplants;

   c. Human heart and lung transplants in combination;

   d. Human kidney and pancreas transplants in combination (pancreas-only transplants are not covered);

   e. Human liver transplants;

   f. Human bone marrow transplants including autologous bone marrow transplantation (ABMT) or autologous peripheral stem cell transplantation used to support high-dose chemotherapy, when such treatment is Medically Necessary and is not Experimental or Investigational;

   g. Pediatric human small bowel transplants;

   h. Pediatric and adult human small bowel and liver transplants in combination;

   i. Autologous Chondrocyte Implantation/Transplantation;

   j. Transplant of a cornea, kidney or skin when the recipient of such transplant is a Member.

3. Services incident to obtaining the transplant material from a living donor or an organ transplant bank will be covered.

N. RECONSTRUCTIVE SURGERY

Medically Necessary services in connection with reconstructive surgery to correct or repair abnormal structures of the body and which result in more than a minimal improvement in function or appearance. In accordance with the Women's Health & Cancer Rights Act, prosthetic devices and reconstructive surgery on either breast provided to restore and achieve symmetry incident to a mastectomy are covered.

Surgery must be authorized by the Plan. Any such services must be received while the Plan is in force with respect to the Member. Benefits will be provided in accordance with guidelines established by the Plan and developed in conjunction with plastic and reconstructive surgeons.

O. EMERGENCY SERVICES

1. Emergency Services. Members who reasonably believe that they have an emergency medical or Mental Health condition which requires an emergency response are encouraged to appropriately use the “911” emergency response system where available. The Member should notify the Personal Physician by phone

within 24 hours of the commencement of the emergency services, or as soon as it is medically possible for the Member to provide notice. The services will be reviewed retrospectively by the Plan to determine whether the services were for a medical condition for which a reasonable person would have believed that they had an emergency medical condition. Emergency services Copayment is waived if the Member is admitted directly to the hospital as an Inpatient from the emergency room.

2. Continuing or Follow-up Treatment. The Plan will provide care in a Non-Plan hospital only for as long as the Member's medical condition prevents transfer to a Plan Hospital in the Member's Personal Physician Service Area, as approved by the Plan. Unauthorized continuing or follow-up care after the initial emergency has been treated in a Non-Plan hospital, or by a Non-Plan Provider is not a covered service.

P. AMBULANCE SERVICES

The Plan will pay for ambulance services as follows:

1. Emergency Ambulance Services. Transportation will be provided to the nearest hospital which can provide such emergency care, only if a reasonable person would have believed that the medical condition was an emergency medical condition which required ambulance services.

2. Non-Emergency Ambulance Services. Medically Necessary ambulance services to transfer the Member from a Non-Plan hospital to a Plan Hospital or between Plan facilities when in connection with authorized confinement/ admission and the Access Baja HMO authorizes the use of the ambulance.

Q. URGENT SERVICES

Urgent Services required when the Member is within his or her Personal Physician Service Area must be obtained in accordance with Section IV., How to Use Your Health Plan.

When outside the Plan Service Area, Members may receive care for urgent services:

Within California

When within California, but outside of his or her Personal Physician Service Area, the Member should contact the Personal Physician or Blue Shield Member Services at 1-800-248-5451 in accordance with Section IV.

Within Mexico

When within Mexico, but outside of his or her Personal Physician Service Area, the Member should contact the Personal Physician.

In the U.S., but Outside California, or Outside the U.S. or Mexico

When temporarily traveling in the U.S., but outside California, or outside the U.S. or Mexico, call the 24-hour toll-free number 1-800-810-BLUE (2583) to obtain information about the nearest BlueCard participating provider. If urgent services are not available through a BlueCard participating provider and you received services from a non-Blue Shield provider, you must submit a claim to Blue Shield for payment. The services will be reviewed retrospectively by the Plan to determine whether the services were urgent services. See Section V., Claims for Emergency and Out-of-Area Urgent Services for additional information.

Outside the U.S. or Mexico, urgent services are available through the BlueCard Worldwide Network.

Before traveling outside of the U.S. or Mexico, Members should call Blue Shield Member Services for the most current listing of participating providers worldwide and to obtain a copy of The BlueCard Worldwide Network brochure that provides helpful information on receiving covered services outside the U.S. or Mexico, or they can visit Blue Shield's internet site at http://www.mylifepath.com. If the Member does not use the BlueCard Worldwide Network, a professional care claim must be submitted as described in Section V., Claims for Emergency and Out-of Area Services.

R. OUTPATIENT PRESCRIPTION DRUGS

Unless otherwise specifically excluded, Benefits are provided for Medically Necessary outpatient prescription Drugs which meet all of the requirements specified in this Section and, except for covered outpatient prescription Drugs for emergency services or out-of-area urgent care, are prescribed by the Member's Access Baja HMO Personal Physician or a provider referred by the Member's Access Baja HMO Personal Physician, and are obtained from a Participating Pharmacy.

DEFINITIONS

Drugs — (1) Drugs which are approved by the Mexican government for sale in Mexico, (2) compounded medications containing at least one drug, (3) Insulin, glucagon and disposable hypodermic needles and syringes needed for these medications, (4) pen delivery systems for the administration of Insulin as determined by Blue Shield to be Medically Necessary, (5) diabetic testing supplies (including lancets, lancet puncture devices, and blood and urine testing strips and test tablets), (6) Bee Sting Kits and injectors, (7) oral contraceptives and diaphragms, (8) smoking cessation drugs which require a Prescription Order – coverage limited to one 12-week course of treatment per lifetime.

Note: No Prescription Order is necessary to purchase the items shown in (4) and (5) above.

Brand Name Drugs — Government approved Drugs under patent to the original manufacturer and only available under the original manufacturer's branded name.

Generic Drugs — Drugs that (1) are approved by the Mexican government as safe and effective, (2) are produced and sold under the chemical name after the original patent expired, and (3) cost less than the Brand Name Drug equivalent.

Participating Pharmacy — a pharmacy which participates in the Access Baja HMO Plan Pharmacy Network.

To select a Participating Pharmacy, the Member may review the Access Baja HMO Provider and Pharmacy Directory or may call Member Services at 1-800-248-5451 from California or 001-800-248-5451 from Mexico.

OBTAINING OUTPATIENT PRESCRIPTION DRUGS AT A PARTICIPATING PHARMACY

1. To obtain prescription Drugs at a **Participating Pharmacy**, the Member must present his Prescription Order from the Access Baja HMO Physician and his Access Baja Identification Card. NOTE:

Except for Emergency coverage, claims for Drugs obtained at a Participating Pharmacy without the Prescription Order from the Access Baja HMO Physician and the Member's Access Baja ID Card will be denied.

2. The Member is responsible for paying the applicable Copayment for **each** new and refill Drug. The pharmacist will collect from the Member the applicable Copayment at the time the Drugs are obtained.

Generic Drugs	**$5.00**
Brand Name Drugs*	**$10.00**

*Note: For diabetic supplies (including needles and syringes), diaphragms, bee sting kits and smoking cessation therapy drugs, the brand name Copayment applies.

3. Except for Emergency coverage, Drugs obtained at a **Non-Participating Pharmacy** are not covered. If the Member must obtain Drugs from a Non-Participating Pharmacy due to an Emergency, the submission of a Prescription Drug Claim is required. Claim forms are provided upon request from the Blue Shield Service Center. Please note "Emergency Request" on the claim form and mail it to Blue Shield Pharmacy Services – Emergency Claims, P.O. Box 7168, San Francisco, CA 94120. Claims must be received within 1 year from the date of service to be considered for payment. Reimbursement will be made for the purchase price of covered prescription Drug(s) minus any applicable Copayment(s).

4. Members are reminded that California pharmacies are not allowed by law to fill a prescription ordered by a physician who is licensed only in Mexico.

LIMITATION ON QUANTITY OF DRUGS THAT MAY BE OBTAINED PER PRESCRIPTION OR REFILL

1. Outpatient Prescription Drugs are limited to a 30-day supply.

2. Prescriptions may be refilled at a frequency that is considered to be Medically Necessary.

EXCLUSIONS

No benefits are provided for:

1. Drugs obtained from a Non-Participating Pharmacy, except for Emergency coverage;

2. Any Drug provided or administered while the Member is an Inpatient, or in a Physician's office;

3. Take home Drugs received from a Hospital, convalescent home, Skilled Nursing Facility, or similar facility;

4. Drugs for which charges are less than or equal to the applicable Copayment;

5. Drugs for which the Member is not legally obligated to pay, or for which no charge is made;

6. Drugs that are considered to be experimental or investigational in the organized medical community where dispensed;

7. Medical devices or supplies except as specifically listed as covered herein;

8. Blood or blood products;

9. Cosmetic drugs, including but not limited to Drugs used to retard or reverse the effects of skin aging or to treat hair loss;

10. Dietary or nutritional products;

11. Injectable drugs, except insulin and Medically Necessary Bee Sting Kits and injectors which are covered under this Outpatient Prescription Drug benefit. Other injectable medications are covered under the Other Outpatient Services Benefit of the health plan;

12. Appetite suppressants or for purposes of weight loss;

13. Smoking cessation drugs, except to the extent that smoking cessation drugs which require a Prescription Order are specifically listed as covered under the "Drugs" definition in this benefit description;

14. Contraceptive devices (except diaphragms), injections and implants;

15. Replacement of lost, stolen or destroyed Prescription Drugs;

16. Herbal remedies;

17. Vitamins;

18. Drugs prescribed in connection with the treatment of a dental condition.

S. DIABETES CARE

1. Diabetic Equipment

Benefits are provided for the following devices and equipment for the management and treatment of diabetes when Medically Necessary and authorized by the Plan:

a. blood glucose monitors, including those designed to assist the visually impaired;

b. Insulin pumps and all related necessary supplies;

c. podiatric devices to prevent or treat diabetes-related complications, including extra-depth orthopedic shoes;

d. visual aids, excluding eyewear, designed to assist the visually impaired with proper dosing of Insulin (excluding video-assisted visual aids).

e. for coverage of diabetic testing supplies including blood and urine testing strips and test tablets, lancets and lancet puncture devices and pen delivery systems for the administration of insulin, refer to the Outpatient Prescription Drug benefits described in Section R. (These items are covered without a Prescription Order.)

2. Diabetes Self-Management Training

Diabetes outpatient self-management training, education and medical nutrition therapy that is Medically Necessary to enable a Member to properly use the diabetes-related devices and equipment and any additional treatment for these Services if directed or prescribed by the Member's Personal Physician and authorized by the Plan. These benefits shall include, but not be limited to, instruction that will enable diabetic patients and their families to gain an understanding of the diabetic disease process, and the daily management of diabetic therapy, in order to thereby avoid frequent hospitalizations and complications.

T. HOSPICE CARE

For Hospice Program Services rendered in California when the Member resides in or temporarily relocates to California and the

Hospice Program Services are received and authorized by a Participating Hospice Agency:

Benefits are provided for the following services through a Participating Hospice Agency when an eligible Member requests admission to and is formally admitted to an approved Hospice Program. The Member must have a Terminal Illness as determined by their Plan Provider's certification and the admission must receive prior approval from Blue Shield. Covered services are available on a 24-hour basis to the extent necessary to meet the needs of individuals for care that is reasonable and necessary for the palliation and management of Terminal Illness and related conditions. Members can continue to receive covered services that are not related to the palliation and management of the Terminal Illness from the appropriate Plan Provider. Member copayments when applicable are paid to the Participating Hospice Agency.

All of the services listed below must be received through the Participating Hospice Agency. **Note: Hospice services provided by a Non-Participating hospice agency are not covered except in certain circumstances in counties in California in which there are no Participating Hospice Agencies.** If Blue Shield prior authorizes Hospice Program Services from a non-contracted Hospice, the Member's copayment for these Services will be the same as the copayments for Hospice Program Services when received and authorized by a Participating Hospice Agency.

1. Interdisciplinary Team care with development and maintenance of an appropriate Plan of Care and management of Terminal Illness and related conditions.

2. Skilled Nursing Services, certified health aide services and homemaker services under the supervision of a qualified registered nurse.

3. Bereavement Services.

4. Social Services/Counseling Services with medical social services provided by a qualified social worker. Dietary counseling, by a qualified provider, shall also be provided when needed.

5. Medical Direction with the medical director being also responsible for meeting the general medical needs for the Terminal Illness of the Members to the extent that these needs are not met by the Personal Physician.

6. Volunteer Services.

7. Short-term inpatient care arrangements.

8. Pharmaceuticals, medical equipment and supplies that are reasonable and necessary for the palliation and management of Terminal Illness and related conditions.

9. Physical therapy, occupational therapy, and speech-language pathology services for purposes of symptom control, or to enable the enrollee to maintain activities of daily living and basic functional skills.

10. Nursing care services are covered on a continuous basis for as much as 24 hours a day during Periods Of Crisis as necessary to maintain a Member at home. Hospitalization is covered when the Interdisciplinary Team makes the determination that skilled nursing care is required at a level that can't be provided in the home. Either Homemaker Services or Home Health Aide Services or both may be covered on a 24 hour continuous basis during Periods Of Crisis but the care provided during these periods must be predominantly nursing care.

11. Respite Care Services are limited to an occasional basis and to no more than five consecutive days at a time.

Members are allowed to change their Participating Hospice Agency only once during each Period of Care. Members can receive care for two 90-day periods followed by an unlimited number of 60-day periods. The care continues through another Period of Care if the Plan Provider recertifies that the Member is Terminally ill.

DEFINITIONS:

BEREAVEMENT SERVICES – services available to the immediate surviving family members for a period of at least one year after the death of the Member. These services shall include an assessment of the needs of the bereaved family and the development of a care plan that meets these needs, both prior to, and following the death of the Member.

CONTINUOUS HOME CARE – home care provided during a Period of Crisis. A minimum of 8 hours of continuous care, during a 24-hour day, beginning and ending at midnight is required. This care could be 4 hours in the morning and another 4 hours in the evening. Nursing care must be provided for more than half of the period of care and must be provided by either a registered nurse or licensed practical nurse. Homemaker Services or Home Health Aide Services may be provided to supplement the nursing care. When fewer than 8 hours of nursing care are required, the services are covered as routine home care rather than Continuous Home Care.

HOME HEALTH AIDE SERVICES – services providing for the personal care of the Terminally Ill Member and the performance of related tasks in the Member's home in accordance with the Plan Of Care in order to increase the level of comfort and to maintain personal hygiene and a safe, healthy environment for the patient. Home Health Aide Services shall be provided by a person who is certified by the state Department of Health Services as a home health aide pursuant to Chapter 8 of Division 2 of the Health and Safety Code.

HOMEMAKER SERVICES – services that assist in the maintenance of a safe and healthy environment and services to enable the Member to carry out the treatment plan.

HOSPICE SERVICE OR HOSPICE PROGRAM – a specialized form of interdisciplinary health care that is designed to provide palliative care, alleviate the physical, emotional, social and spiritual discomforts of a Member who is experiencing the last phases of life due to the existence of a Terminal Disease, to provide supportive care to the primary caregiver and the family of the hospice patient, and which meets all of the following criteria:

a) Considers the Member and the Member's family in addition to the Member, as the unit of care.

b) Utilizes an Interdisciplinary Team to assess the physical, medical, psychological, social and spiritual needs of the Member and the Member's family.

c) Requires the interdisciplinary team to develop an overall Plan Of Care and to provide coordinated care which emphasizes supportive services, including, but not limited to, home care, pain control, and short-term inpatient services. Short-term inpatient services are intended to ensure both continuity of care and appropriateness of services for those Members who cannot be managed at home because of acute complications or the temporary absence of a capable primary caregiver.

d) Provides for the palliative medical treatment of pain and other symptoms associated with a Terminal Disease, but does not provide for efforts to cure the disease.

e) Provides for Bereavement Services following the Member's death to assist the family to cope with social and emotional needs associated with the death of the Member.

f) Actively utilizes volunteers in the delivery of hospice services.

g) Provides services in the Member's home or primary place of residence to the extent appropriate based on the medical needs of the Member.

h) Is provided through a Participating Hospice.

INTERDISCIPLINARY TEAM – the hospice care team that includes, but is not limited to, the Member and the Member's family, a physician and surgeon, a registered nurse, a social worker, a volunteer, and a spiritual caregiver.

MEDICAL DIRECTION – services provided by a licensed physician and surgeon who is charged with the responsibility of acting as a consultant to the Interdisciplinary Team, a consultant to the Member's Personal Physician, as requested, with regard to pain and symptom management, and liaison with physicians and surgeons in the community. For purposes of this section, the person providing these services shall be referred to as the "medical director".

PERIOD OF CARE – the time when the Personal Physician recertifies that the Member still needs and remains eligible for hospice care even if the Member lives longer than one year. A Period Of Care starts the day the Member begins to receive hospice care and ends when the 90 or 60 day period has ended.

PERIOD OF CRISIS – a period in which the Member requires continuous care to achieve palliation or management of acute medical symptoms.

PLAN OF CARE – a written plan developed by the attending physician and surgeon, the "medical director" (as defined under "Medical Direction") or physician and surgeon designee, and the Interdisciplinary Team that addresses the needs of a Member and family admitted to the Hospice Program. The Hospice shall retain overall responsibility for the development and maintenance of the Plan of Care and quality of services delivered.

RESPITE CARE SERVICES – short-term inpatient care provided to the Member only when necessary to relieve the family members or other persons caring for the Member.

SKILLED NURSING SERVICES – nursing services provided by or under the supervision of a registered nurse under a Plan of Care developed by the Interdisciplinary Team and the Member's Plan Provider to a Member and his family that pertain to the palliative, supportive services required by a Member with a Terminal Illness. Skilled Nursing Services include, but are not limited to, Member assessment, evaluation and case management of the medical nursing needs of the Member, the performance of prescribed medical treatment for pain and symptom control, the provision of emotional support to both the Member and his family, and the instruction of caregivers in providing personal care to the enrollee. Skilled Nursing Services provide for the continuity of services for the Member and his family and are available on a 24-hour on-call basis.

SOCIAL SERVICE/COUNSELING SERVICES – those counseling and spiritual services that assist the Member and his family

to minimize stresses and problems that arise from social, economic, psychological, or spiritual needs by utilizing appropriate community resources, and maximize positive aspects and opportunities for growth.

TERMINAL DISEASE OR TERMINAL ILLNESS – a medical condition resulting in a prognosis of life of one year or less, if the disease follows its natural course.

VOLUNTEER SERVICES – services provided by trained hospice volunteers who have agreed to provide service under the direction of a hospice staff member who has been designated by the Hospice to provide direction to hospice volunteers. Hospice volunteers may provide support and companionship to the Member and his family during the remaining days of the Member's life and to the surviving family following the Member's death.

For Hospice Care Services rendered in Mexico:

Benefits are provided by Access Baja Plan Providers for the following services for a Member who has a Terminal Illness as determined by his Personal Physician's certification. Covered Services are available on a 24 hour basis to the extent necessary to meet the needs of individuals for care that is reasonable and necessary for the palliation and management of Terminal Illness and related conditions.

All of the Hospice Care listed below must be received in Mexico.

1. Interdisciplinary Team care with development and maintenance of an appropriate Plan of Care and management of Terminal Illness and related conditions.
2. Home visits by a Mexican Registered Nurse to provide skilled services, for up to 24 hours a day.
3. Bereavement Services, for covered Access Baja Plan Members.
4. Social Services/Counseling Services provided by a certified mental health provider. Dietary counseling, by a qualified provider, shall also be provided when needed.
5. Medical Direction with the medical director also responsible for meeting the general medical needs for the Terminal Illness of the Member to the extent that these needs are not met by the Member's Plan Providers, and when available from community resources.
6. Short-term inpatient care arrangements.
7. Pharmaceuticals, medical equipment and supplies that are reasonable and necessary for the palliation and management of Terminal Illness and related conditions.
8. Physical therapy, occupational therapy, respiratory therapy and speech-language pathology services for purposes of symptom control, or to enable the enrollee to maintain activities of daily living and basic functional skills.
9. Nursing care services by Mexican Registered Nurses are covered on a continuous basis for as much as 24 hours a day during Periods Of Crisis as necessary to maintain a Member at home. Hospitalization is covered when the Interdisciplinary Team makes the determination that skilled nursing care is required at a level that cannot be provided in the home.

Members can receive Hospice Care for two 90-day periods followed by an unlimited

number of 60-day periods. The care continues through another Period of Care if the Personal Physician recertifies that the Member is Terminally ill.

DEFINITIONS:

BEREAVEMENT SERVICES – services available to the immediate surviving family members who are enrolled in the Access Baja Plan for a period of at least one year after the death of the Member. These services shall include an assessment of the needs of the family Members who are enrolled in the Access Baja Plan and the development of a care plan that meets these needs, both prior to, and following the death of the Member.

HOSPICE CARE – a specialized form of interdisciplinary health care that is designed to provide palliative care, alleviate the physical, emotional and social discomforts of a Member who is experiencing the last phases of life due to the existence of a Terminal Disease, to provide supportive care to the primary caregiver and the family of the hospice care patient, and which meets all of the following criteria:

a) Considers the Member and the Member's family in addition to the Member, as the unit of care.

b) Utilizes an Interdisciplinary Team to assess the physical, medical, psychological and social needs of the Member and the Member's family.

c) Requires the Interdisciplinary Team to develop an overall Plan Of Care and to provide coordinated care which emphasizes supportive services, including, but not limited to, home care, pain control, and short-term inpatient services. Short-term inpatient services are intended to ensure both continuity of care and appropriateness of services for those Members who cannot be managed at home because of acute complications or the temporary absence of a capable primary caregiver.

d) Provides for the palliative medical treatment of pain and other symptoms associated with a Terminal Disease, but does not provide for efforts to cure the disease.

e) Provides for Bereavement Services following the Member's death to assist the family members who are enrolled in the Access Baja Plan to cope with social and emotional needs associated with the death of the Member.

f) Provides services in the Member's home or primary place of residence to the extent appropriate based on the medical needs of the Member.

g) Services are provided in Mexico.

INTERDISCIPLINARY TEAM – the hospice care team that includes, but is not limited to, the Member and the Member's family, the Member's Personal Physician and a Mexican Registered Nurse.

MEDICAL DIRECTION – services provided by a licensed physician and surgeon who is charged with the responsibility of acting as a consultant to the Interdisciplinary Team, as requested, with regard to pain and symptom management, and liaison with physicians and surgeons in the community. For purposes of this section, the person providing these services shall be referred to as the "medical director".

PERIOD OF CARE – the time when the Personal Physician recertifies that the Member still needs and remains eligible for hospice care even if the Member lives longer than one year. A Period Of Care starts the day the Member begins to receive hospice

care and ends when the 90 or 60 day period has ended.

PERIOD OF CRISIS – a period in which the Member requires continuous care to achieve palliation or management of acute medical symptoms.

PLAN OF CARE – a written plan developed by the attending physician and surgeon, the "medical director" (as defined under "Medical Direction") or physician and surgeon designee, and the Interdisciplinary Team that addresses the needs of a Member and family receiving Hospice Care Services. The medical director shall retain overall responsibility for the development and maintenance of the Plan of Care and quality of services delivered.

SKILLED NURSING SERVICES – nursing services provided by a Mexican Registered Nurse under a Plan of Care developed by the Interdisciplinary Team and the Member's Personal Physician to a Member and his family that pertain to the palliative, supportive services required by a Member with a Terminal Illness. Skilled Nursing Services include, but are not limited to, Member assessment, evaluation and case management of the medical nursing needs of the Member, the performance of prescribed medical treatment for pain and symptom control, the provision of emotional support to both the Member and his family, and the instruction of caregivers in providing personal care to the enrollee. Skilled Nursing Services provide for the continuity of services for the Member and his family and are available on a 24-hour on-call basis.

SOCIAL SERVICE/COUNSELING SERVICES – those counseling services that assist the Member and his family to minimize stresses and problems that arise from social, economic or psychological needs by utilizing appropriate community resources, and maximize positive aspects and opportunities for growth.

TERMINAL DISEASE OR TERMINAL ILLNESS – a medical condition resulting in a prognosis of life of one year or less, if the disease follows its natural course.

U. CLINICAL TRIAL FOR CANCER

Benefits are provided for routine patient care for a Member whose Personal Physician has obtained prior authorization from the Plan and who has been accepted into an approved clinical trial for cancer provided that:

1. the clinical trial has a therapeutic intent and the Member's treating Physician determines that participation in the clinical trial has a meaningful potential to benefit the Member with a therapeutic intent; and

2. the Member's treating Physician recommends participation in the clinical trial; and

3. the Hospital and/or Physician conducting the clinical trial is a Plan Provider, unless the protocol for the trial is not available through a Plan Provider.

Services for routine patient care will be paid on the same basis and at the same benefit levels as other covered Services shown in the Summary of Benefits.

Routine patient care consists of those Services that would otherwise be covered by the Plan if those Services were not provided in connection with an approved clinical trial, but does not include:

1. Drugs or devices that have not been approved by the federal Food and Drug Administration (FDA);

2. Services other than health care services, such as travel, housing,

companion expenses and other non-clinical expenses;

3. Any item or service that is provided solely to satisfy data collection and analysis needs and that is not used in the clinical management of the patient;

4. Services that, except for the fact that they are being provided in a clinical trial, are specifically excluded under the Plan;

5. Services customarily provided by the research sponsor free of charge for any enrollee in the trial.

An approved clinical trial is limited to a trial that:

1. is approved by one of the following:

   a. one of the National Institutes of Health

   b. the federal food and Drug Administration, in the form of an investigational new drug application;

   c. the United States Department of Defense;

   d. the United States Veterans' Administration; or

2. involves a drug that is exempt under federal regulations from a new drug application.

Approved clinical trial services will be authorized by the Plan to be performed in California, if available, or elsewhere in the United States, if not available in California.

V. CLAIMS FOR EMERGENCY AND OUT-OF-AREA URGENT SERVICES

1. Emergency

If emergency services were received and expenses were incurred by the Member for services other than medical transportation, the Member must submit a complete claim with the emergency service record for payment to the Plan, within 1 year after the first provision of emergency services for which payment is requested. If the claim is not submitted within this period, the Plan will not pay for those emergency services, unless the claim was submitted as soon as reasonably possible as determined by the Plan. If the services are not preauthorized, the Plan will review the claim retrospectively for coverage. If the Plan determines that the services were received for a medical condition for which a reasonable person would not reasonably believe that an emergency medical condition existed and would not otherwise have been authorized by the Plan, and, therefore, are not covered, it will notify the Member of that determination. The Plan will notify the Member of its determination within 30 days from receipt of the claim. In the event covered medical transportation services are obtained in such an emergency situation, the Access Baja HMO shall pay the medical transportation provider directly.

2. Out-of-Area Urgent Services

If out-of-area urgent services were received from a non-participating BlueCard provider you must submit a complete claim with the urgent service record for payment to the Plan, within 1 year after the first provision of urgent services for which payment is requested. If the claim is not submitted within this period, the Plan will not pay for those urgent services, unless the claim was submitted as soon as reasonably possible as determined by the Plan. The services will be reviewed retrospectively by the Plan to determine whether the services were urgent services. If the Plan determines that the services would not have been authorized by the Plan, and therefore, are not covered, it will

notify the Member of that determination. The Plan will notify the Member of its determination within 30 days from receipt of the claim.

W. MEMBER MAXIMUM CALENDAR YEAR COPAYMENT

The Member Maximum Calendar Year Copayment responsibility for covered Services, excluding those specified, is listed in the Summary of Benefits. (Also, see the paragraphs under *Member Maximum Calendar Year Copayment* in Section IV. How to Use Your Health Plan.)

X. OTHER CHARGES

You are responsible for paying a minimum charge (Copayment) to the physician or provider of services at the time you receive services. The specific Copayments, as applicable, are listed in the Summary of Benefits. There are no deductibles to be met.

Y. PLAN CHANGES

No change in the Plan benefits nor waiver of any of its provisions shall be valid without the approval of the Plan and Blue Shield.

The benefits of this Plan are subject to change following at least 30 days' written notice by Blue Shield.

Benefits for services or supplies furnished on or after the effective date of any change in benefits will be provided based on the change. There is no vested right to obtain benefits. Benefits for services or supplies furnished on or after the effective date of any benefit modification shall be provided based on that modification.

VII. EXCLUSIONS AND LIMITATIONS

GENERAL EXCLUSIONS AND LIMITATIONS

Unless exceptions to the following exclusions are specifically made elsewhere in the contract, no benefits are provided for services which are:

1. **experimental or investigational in nature, except for Services for Members who have been accepted into an approved clinical trial for cancer as provided under Covered Services;**

2. **for or incident to services rendered in the home or hospitalization or confinement in a health facility primarily for custodial, maintenance or domiciliary care, except as provided in Section VI., T.; or rest;**

3. **for substance abuse treatment or rehabilitation on an inpatient, day-care or outpatient basis, except as specifically provided under Plan Benefits;**

4. **performed in a hospital by hospital officers, residents, interns and others in training;**

5. **for or incident to hospitalization or confinement in a pain management center to treat or cure chronic pain, except as may be provided in Section VI., T. and except as Medically Necessary;**

6. **for Cosmetic Surgery or any resulting complications, except that Medically Necessary services to treat complications of Cosmetic Surgery (e.g., infections or hemorrhages) will be a benefit, but only upon review and approval by a Blue Shield physician consultant;**

7. incident to an organ transplant; except as provided under Section VI, M.;

8. for convenience items such as telephones, TVs, guest trays, and personal hygiene items;

9. for or incident to intersex surgery (transsexual operations) or any resulting medical complications, except for treatment of medical complications that is Medically Necessary;

10. for any services related to the harvesting or stimulation of the human ovum, in vitro fertilization, Gamete Intrafallopian Transfer (G.I.F.T.) procedure, artificial insemination or any other form of assisted fertilization (including related medications, laboratory and radiology services), or services incident to or resulting from procedures for a surrogate mother who is otherwise not eligible for covered Pregnancy and Maternity Care under a Blue Shield of California health plan;

11. for or incident to the reversal of a vasectomy or tubal ligation, repeat vasectomy or tubal ligation;

12. for speech therapy, speech correction or speech pathology except as specifically provided in Sections VI., J. and K.;

13. for routine foot care including callus, corn paring or excision and toenail trimming (except as may be provided in Section VI., T.); treatment (other than surgery) of chronic conditions of the foot, including but not limited to weak or fallen arches, flat or pronated foot, pain or cramp of the foot, bunions, muscle trauma due to exertion or any type of massage procedure on the foot; for special footwear except as specifically listed as covered herein;

14. for eye refractions, surgery to correct refractive error (such as but not limited to radial keratotomy, refractive keratoplasty), lenses and frames for eye glasses, contact lenses (except as provided in Section VI., L.);

15. for hearing aids;

16. for dental care or services incident to the treatment, prevention or relief of pain or dysfunction of the Temporomandibular Joint and/or muscles of mastication, except as specifically provided under the Treatment of Teeth, Gums, Jaw Joints or Jaw Bones and Hospital Services Benefits;

17. for or incident to dental care and dental supplies including but not limited to diagnostic, preventive, periodontic and orthodontic services; dental implants; braces, crowns, dental orthoses and prostheses; except as specifically mentioned;

18. for or incident to reading, vocational, educational, recreational, art, dance or music therapy; weight control or exercise programs;

19. for learning disabilities, or behavioral problems;

20. for or incident to acupuncture;

21. for spinal manipulation and adjustment, except as specifically provided;

22. for or incident to any injury or disease arising out of, or in the course of, any employment for salary, wage or profit if such injury or disease is covered, by any workers' compensation

law, occupational disease law or similar legislation. However, if Blue Shield provides payment for such services it will be entitled to establish a lien upon such other benefits up to the reasonable cash value of benefits provided by Blue Shield for the treatment of the injury or disease as reflected by the providers' usual billed charges;

23. in connection with private duty nursing, except as provided in Section VI., F.1., Section VI., J. and Section VI., T.;

24. for testing for intelligence or learning disabilities;

25. for rehabilitative therapy services in excess of those provided in Section VI., K., or when services are the result of the following conditions: psychosocial speech delay including delayed language development, mental retardation or dyslexia, syndromes associated with diagnosed disorders attributed to perceptual and conceptual dysfunctions, and developmental articulation and language disorders;

26. for prescribed drugs and medicines for outpatient care, except when the Member is receiving Hospice Care as provided in Section VI., T., and except as may be provided under the Outpatient Prescription Drug Benefit;

27. for contraceptives and contraceptive devices, except that Physician office visits for diaphragm fittings are covered; oral contraceptives and diaphragms are excluded, except as may be provided under the Outpatient Prescription Drugs Benefit;

28. for transportation services other than provided under Ambulance Services in Section VI., P.;

29. for unauthorized non-emergency services;

30. not provided by, prescribed, referred, or authorized by a Personal Physician or the Access Baja HMO except for OB/GYN services provided by an obstetrician/gynecologist or family practice physician within the same Medical Group/IPA as the Personal Physician, Emergency Services or Urgent Services as provided under Section VI., O. and Q., when specific authorization has been obtained in writing for such Services from the Plan, or for Hospice Program Services received by a Participating Hospice Agency, when the Member resides in or temporarily relocates to California;

31. performed by a Close Relative or by a person who ordinarily resides in the Subscriber's or Dependent's home;

32. for orthopedic shoes, except as provided under Section VI., S., home testing devices, environmental control equipment, exercise equipment, self help/educational devices, prescription or non-prescription food and nutritional supplements, except as provided under the Home Health Care Services and PKU Related Formulas and Special Food Products benefit, or for any type of communicator, voice enhancer, voice prosthesis or any other language assistance devices, except as provided under Section VI., L., vitamins and comfort items;

33. for physical exams required for licensure, employment, or insurance unless the examination corresponds to the schedule of routine physical examinations provided in Section VI., A.1.;

34. for penile implant devices and surgery, and any related services except for any resulting complications and Medically Necessary services as provided under Reconstructive Surgery Benefits;

35. for home testing devices and monitoring equipment except for use of the peak flow monitor for self-management of asthma, the glucose monitor for self-management of diabetes and the apnea monitor for management of newborn's apnea when authorized as Home Medical Equipment;

36. for or incident to sexual dysfunctions and sexual inadequacies, except as provided for treatment of organically based conditions;

37. for disposable medical supplies for home use such as alcohol, peroxide or Phisohex solution, wipes/towelettes, thermometers, bandages, tape, elastic wraps, disposable underpads, standard batteries, shoe inserts, except as provided under Sections VI. S. and VI., T., face masks, gloves, etc., except as provided under Sections VI., J., VI., L. and VI., T.; diabetic testing supplies and insulin syringes and needles, except as may be provided under the Outpatient Prescription Drugs Benefit;

38. for Reconstructive Surgery and procedures: 1) where there is another more appropriate surgical procedure that is approved by a Blue Shield physician consultant, or 2) when the surgery or procedure offers only a minimal improvement in function or in the appearance of the enrollees, e.g., spider veins;

39. not specifically listed as a benefit.

MEDICAL NECESSITY EXCLUSION

All services must be Medically Necessary. The fact that a physician or other provider may prescribe, order, recommend, or approve a service or supply does not, in itself, make it Medically Necessary, even though it is not specifically listed as an exclusion or limitation. Blue Shield may limit or exclude benefits for services which are not Medically Necessary.

VIII. PLAN SERVICE AREA AND ELIGIBILITY

PLAN SERVICE AREA

The Plan Service Area of this Plan is identified geographically as the municipality of Tijuana, Baja California, Mexico and the area in California encompassed within a 50 mile radius from the U.S.-Mexico border crossing point at San Ysidro, CA, and those portions of the following Zip Codes that extend beyond that 50 mile radius: 91934, 92026, 92036, 92054, 92057, 92070 and 92082. You must live or work in this Plan Service Area to enroll in this Plan. The Plan Service Area is further defined by the below postal codes.

California:

CITY NAME	ZIP CODE
Alpine	91901
Bonita	91902
Alpine	91903
Boulevard	91905
Campo	91906
Bonita	91908
Chula Vista	91909-915
Descanso	91916
Dulzura	91917
Chula Vista	91921
Imperial Beach	91932-933
Jacumba	91934
Jamul	91935

La Mesa	91941-944
Lemon Grove	91945-946
National City	91947
Mount Laguna	91948
National City	91950-951
Pine Valley	91962
Potrero	91963
San Ysidro	91973
Spring Valley	91976-979
Tecate	91980
Tecate	91987
Potrero	91990
Cardiff by the Sea	92007
Carlsbad	92008-009
Carlsbad	92013
Del Mar	92014
Carlsbad	92018
El Cajon	92019-022
Encinitas	92023-024
Escondido	92025-027
Escondido	92029
Julian	92036
La Jolla	92037-039
Lakeside	92040
Escondido	92046
Oceanside	92049
Oceanside	92051-052
Oceanside	92054
Oceanside	92056-058
Poway	92064
Ramona	92065
Rancho Santa Fe	92067
San Marcos	92069
Santa Ysabel	92070
Santee	92071-072
Poway	92074
Solana Beach	92075
San Marcos	92078-079
Valley Center	92082
Vista	92083-085
El Cajon	92090
Rancho Santa Fe	92091
La Jolla	92092-093
San Marcos	92096
San Diego	92101-117
Coronado	92118
San Diego	92119-124
San Diego	92126-140
San Diego	92142-143
San Diego	92145
San Diego	92147
San Diego	92149-150
San Diego	92152-155
San Diego	92158-179
San Diego	92182
San Diego	92184
San Diego	92186-187
San Diego	92190-199

Baja California, Mexico

CITY NAME	MEXICAN ZIP CODE
Tijuana	22000-22698

ELIGIBILITY

If you are an Employee and reside or work in the Plan Service Area, you are eligible for coverage as a subscriber the day following the date you complete the applicable waiting period established by your employer. Your spouse and all your dependent children are eligible at the same time.

When you do not enroll yourself or your dependents during the initial enrollment period and later apply for coverage, you and your dependents will be considered to be Late Enrollees. When Late Enrollees decline coverage during the initial enrollment period, they will be eligible the earlier of, 12 months from the date of application for coverage or at the employer's next Open Enrollment Period. Blue Shield will not consider applications for earlier effective dates.

You and your Dependents will not be considered to be Late Enrollees if either you or your Dependents lose coverage under another employer health plan and you apply for coverage under this plan within 31 days of the date of loss of coverage. You will be required to furnish Blue Shield written proof of the loss of coverage.

Newborn infants of the employee will be eligible immediately after birth for the first 31 days. A child placed for adoption shall be eligible immediately from the date the subscriber or spouse has the right to control the child's health care. Enrollment requests for children who have been placed for adoption must be accompanied by evidence of the subscriber's or spouse's right to control the child's health care. Evidence of such control includes a health facility minor release report, a medical authorization form, or a relinquishment form. In either instance, in order to have coverage continue beyond the first 31 days without lapse, an application must be submitted to Blue Shield within 31 days of the birth or placement for adoption. Eligibility during the first 31 days includes coverage for treatment of injury or illness **only** but does not include well-baby care benefits unless the child is enrolled. **Well-baby care benefits are provided for enrolled children.**

You may add newly acquired Dependents and yourself to the contract by submitting an application within 31 days from the date of acquisition of the Dependent:

1. to continue coverage of a newborn or child placed for adoption;
2. to add a spouse after marriage;
3. to add yourself and spouse following the birth of a newborn or placement of a child for adoption;
4. to add yourself and spouse after marriage;
5. to add yourself and your newborn or child placed for adoption, following birth or placement for adoption.

Coverage is never automatic; an application is always required.

If a husband and wife are both eligible to be subscribers, children may be eligible and may be enrolled as Dependents of either parent, but not both parents.

Enrolled Dependent children who would normally lose their eligibility under this Plan solely because of age, but who are physically handicapped or mentally retarded, may have their eligibility extended under the following conditions: (1) the child must be chiefly dependent upon the employee for support and maintenance, and (2) the employee must submit a physician's written certification from the Member's Personal Physician of such mental retardation or physical handicap within 31 days of the request for such information by the employer or by Blue Shield. Proof of continuing disability and dependency must be submitted by the employee 6 months later and annually thereafter.

A Small Employer must meet specified Employer eligibility, participation and contribution requirements to be eligible for this group plan. See your Employer for further information.

EFFECTIVE DATE OF COVERAGE

Benefits of this Plan become effective for employees and dependents who enroll during the initial enrollment period at 12:01 a.m. Pacific Time on the eligibility date established by your employer. The group health service contract with your employer is for one year and automatically renews each year unless terminated as outlined in the contract.

If, during the initial enrollment period, you have included your eligible Dependents on your application to Blue Shield, their coverage will be effective on the same date as yours. If application is made for Dependent coverage within 31 days after you become eligible, their effective date of coverage will be the same as yours.

If you or your dependents are a Late Enrollee, your coverage will become effective the earlier of, 12 months from the date you made a written request for coverage or at the employer's next Open Enrollment Period. Blue Shield will not consider applications for earlier effective dates.

If you declined coverage for yourself and your Dependents during the initial enrollment period because you were covered under another employer health plan, and you subsequently lost coverage under that plan, you will not be considered a Late Enrollee. Coverage for you and your Dependents under this Plan will become effective on the date of loss of coverage, provided you enroll in this Plan within 31 days from the date of loss of coverage. You will be required to furnish Blue Shield written evidence of loss of coverage.

If you declined coverage for yourself and your Dependents during the initial enrollment period because your Dependents were covered under another employer health plan, and your Dependents subsequently lost coverage under that plan, you will not be considered a Late Enrollee. Coverage for you and your Dependents under this Plan becomes effective on the date of loss of coverage, provided you enroll in this Plan within 31 days from the date of loss of coverage. You will be required to furnish Blue Shield of California written evidence of loss of coverage.

If you declined enrollment during the initial enrollment period and subsequently acquire Dependents as a result of marriage, birth or placement for adoption, you may request enrollment for yourself and your Dependents within 31 days from the date of marriage, birth, or placement for adoption. The effective date of enrollment for both you and your Dependents will depend on how you acquire your Dependent(s):

1. For marriage, the effective date will be the first day of the first month following receipt of your request for enrollment;

2. For birth, the effective date will be the date of birth;

3. For a child placed for adoption, the effective date will be the date the Subscriber or Spouse has the right to control the child's health care.

Once each Calendar Year, for a time period designated by your employer, an annual Open Enrollment Period will occur. During that time period, you and your dependents may transfer from another health plan sponsored by your employer to the HMO. A completed enrollment form, which also indicates the choice of Personal Physician, must be forwarded to Blue Shield within the Open Enrollment Period. Enrollment becomes effective on the first day of the month following the annual Open Enrollment Period.

Any individual who becomes eligible at a time other than during the annual open enrollment (e.g., newborn, child placed for adoption, new spouse, newly hired, or newly transferred employees), must complete an enrollment form within 31 days of becoming eligible.

Coverage for a newborn child will become effective on the date of birth. Coverage for child placed for adoption will become effective from the date the subscriber or spouse has the right to control the child's health care. To have coverage continue beyond the first 31 days without lapse, a written application must follow within 31 days of the date of birth or placement for adoption of such dependent. Enrollment requests for children who have been placed for adoption must be accompanied by evidence of the subscriber's or spouse's right to control the child's health care. Such evidence includes a health facility minor release report, a medical authorization form,

or a relinquishment form. A dependent spouse becomes eligible on the date of marriage.

If a court has ordered that you provide coverage for your spouse or Dependent child, under your health benefit plan, their coverage will become effective within 30 days of presentation of a court order by the district attorney, or upon presentation of a court order or request by a custodial party, as described in subdivision (j) of Section 14124.93 or the Welfare and Institutions Code or Medi-Cal program.

Newly added dependents, newborns and children placed for adoption are subject to all other provisions of the contract.

If the Member is receiving inpatient care at a Non-Plan facility when coverage becomes effective, the Plan will provide benefits only for as long as the Member's medical condition prevents transfer to a Plan facility in the Member's Personal Physician Service Area, as approved by the Plan. Unauthorized continuing or follow-up care in a Non-Plan facility or by Non-Plan Providers is not a covered service.

If this Plan provides benefits within 60 days of the date of discontinuance of the previous group health plan that was in effect with your employer, you and all your dependents who were validly covered under the previous group health plan on the date of discontinuance, will be eligible under this Plan.

RENEWAL OF GROUP HEALTH SERVICE CONTRACT

Blue Shield of California will offer to renew the Group Health Service Contract except in the following instances:

1. non-payment of dues;
2. fraud, misrepresentations or omissions;
3. failure to comply with Blue Shield's applicable eligibility, participation or contribution rules;
4. termination of plan type by Blue Shield;
5. Employer moves out of the service area;
6. association membership ceases.

All groups will renew subject to the above.

PREPAYMENT FEE

The monthly dues for you and your dependents are indicated in your employer's group contract. The initial dues are payable on the effective date under the group contract, and subsequent dues are payable on the same date (called the transmittal date) of each succeeding month. Dues are payable in full on each transmittal date and must be made for all subscribers and dependents.

All dues required for coverage for you and your dependents will be handled through your employer, and must be paid to Blue Shield of California. Payment of dues will continue the benefits of this group contract up to the date immediately preceding the next transmittal date, but not thereafter.

The dues payable under this Plan may be changed from time to time, for example, to reflect new benefit levels. Your employer will receive notice from the Plan of any changes in dues at least 30 days prior to the change. Your employer will then notify you immediately.

The section on Prepayment Fee does not apply to a Member who is enrolled under a contract where monthly dues automatically increase, without notice, the first day of the month following an age change that moves the Member into the next higher age category. *(This paragraph applies only to Small Group Employers.)*

IX. DUPLICATE COVERAGE, THIRD PARTY LIABILITY AND COORDINATION OF BENEFITS

EXCLUSION FOR DUPLICATE COVERAGE

In the event that you are covered under the Plan and are also entitled to benefits under any of the conditions listed below, Blue Shield's liability for services (including room and board) provided to the Member for the treatment of any one illness or injury shall be reduced by the amount of benefits paid, or the reasonable value or the amount of Blue Shield's fee-for-service payment to the provider, whichever is less, of the services provided without any cost to you, because of your entitlement to such other benefits. This exclusion is applicable to benefits received from any of the following sources:

1. Benefits provided under Title 18 of the Social Security Act ("Medicare"). If a Member receives services to which he is entitled under Medicare and those services are also covered under this Plan, the Plan Provider may recover the amount paid for the services under Medicare. This exclusion for Medicare does not apply when the employer is subject to the Medicare Secondary Payer laws and the employer maintains:

   a. an employer group health plan that covers

      i. persons entitled to Medicare solely because of end-stage renal disease, and

      ii. active employees or spouses entitled to Medicare by reason of age, and/or

   b. a large group health plan as defined under the Medicare Secondary Payer laws that covers persons entitled to Medicare by reason of disability.

   This paragraph shall also apply to a subscriber or dependent who becomes eligible for Medicare on the date that he received notice from Blue Shield of his eligibility for such enrollment.

2. Benefits provided by any other federal or state governmental agency, or by any county or other political subdivision, except that this exclusion does not apply to Medi-Cal; or Subchapter 19 (commencing with Section 1396) of Chapter 7 of Title 42 of the United States Code; or for the reasonable costs of services provided to the person at a Veterans' Administration facility for a condition unrelated to military service or at a Department of Defense facility, provided the person is not on active duty.

EXCEPTION FOR OTHER COVERAGE

A Plan Provider may seek reimbursement from other third party payers for the balance of its reasonable charges for services rendered under this Plan.

CLAIMS AND SERVICES REVIEW

Blue Shield reserves the right to review all claims and services to determine if any exclusions or other limitations apply. Blue Shield may use the services of physician consultants, peer review committees of professional societies or hospitals and other consultants to evaluate claims.

THIRD PARTY LIABILITY

If a covered person is injured through the act or omission of another person (a "third party"), Blue Shield and the covered person's designated medical group, independent practice association and capitated hospital shall, with respect to services required as a result of that injury, provide the benefits of the plan only on the condition that the covered person:

1. Notifies Blue Shield in writing of any actual or potential claim or legal action which such covered person anticipates bringing or has brought against the third party arising from the alleged acts or omissions causing the injury or illness, not later than 30 days after submitting or filing a claim or legal action against the third party; and

2. Agrees in writing to reimburse Blue Shield and the covered person's designated medical group, independent practice association and capitated hospital, the reasonable costs of Benefits provided, calculated in accordance with California Civil Code section 3040, immediately upon collection of damages by the covered person, whether by action at law, settlement or arbitration unless otherwise prohibited by law, and

3. Agrees in writing to fully cooperate with Blue Shield and the covered person's designated medical group, independent practice association and capitated hospital to execute any forms or documents needed to permit the third party to make payments directly to the lienholder unless otherwise prohibited by law; and

4. Provides Blue Shield and the covered person's designated medical group, independent practice association and capitated hospital with a lien, in the amount of the reasonable costs of Benefits provided, calculated in accordance with California Civil Code section 3040. The lien may be filed with the third party, the third party's agent or the court unless otherwise prohibited by law.

COORDINATION OF BENEFITS

Coordination of benefits is designed to provide maximum coverage for medical and hospital services at the lowest cost by avoiding excessive payments.

When a person who is covered under this group Plan is also covered under another group plan, or selected group, or blanket disability insurance contract, or any other contractual arrangement or any portion of any such arrangement whereby the members of a group are entitled to payment of, or reimbursement for, hospital or medical expenses, such person will not be permitted to make a "profit" on a disability by collecting benefits in excess of actual value or cost during any Calendar Year.

Instead, payments will be coordinated between the plans in order to provide for "allowable expenses" (these are the expenses that are incurred for services and supplies covered under at least one of the plans involved) up to the maximum benefit value or amount payable by each plan separately.

If the covered person is also entitled to benefits under any of the conditions as outlined under the "Exclusion for Duplicate Coverage" provision, benefits received under any such condition will not be coordinated with the benefits of this Plan.

The following rules determine the order of benefit payments:

When the other plan does not have a coordination of benefits provision, it will always provide its benefits first. Otherwise, the plan covering the patient as an employee will provide its benefits before the plan covering the patient as a dependent.

Except for cases of claims for a dependent child whose parents are separated or divorced, the plan which covers the patient as a dependent of a person whose date of birth, (excluding year of birth), occurs earlier in a Calendar Year, shall determine its benefits before a plan which covers that person as a dependent of a person whose date of birth, (excluding year of birth), occurs later in a Calendar Year. If either plan does not have

the provisions of this paragraph regarding dependents, which results either in each plan determining its benefits before the other or in each plan determining its benefits after the other, the provisions of this paragraph shall not apply, and the rule set forth in the plan which does not have the provisions of this paragraph shall determine the order of benefits.

1. In the case of a claim involving expenses for a dependent child whose parents are separated or divorced, plans covering the child as a dependent shall determine their respective benefits in the following order: First, the plan of the parent with custody of the child; then, if that parent has remarried, the plan of the stepparent with custody of the child; and finally the plan(s) of the parent(s) without custody of the child.

2. Notwithstanding (1.) above, if there is a court decree which otherwise establishes financial responsibility for the medical, dental or other health care expenses of the child, then the plan which covers the child as a dependent of the parent with that financial responsibility shall determine its benefits before any other plan which covers the child as a dependent child.

3. If the above rules do not apply, the plan which has covered the patient for the longer period of time shall determine its benefits first, provided that:

   a. a plan covering a patient as a laid-off or retired employee, or as a dependent of such an employee, shall determine its benefits after any other plan covering that person as an employee, other than a laid-off or retired employee, or such dependent; and,

   b. if either plan does not have a provision regarding laid-off or retired employees, which results in each plan determining its benefits after the other, then the provisions of (a.) above shall not apply.

If this Plan is the primary carrier with respect to a covered person, then this Plan will provide its benefits without reduction because of benefits available from any other plan.

When this Plan is secondary in the order of payments, and Blue Shield is notified that there is a dispute as to which plan is primary, or that the primary plan has not paid within a reasonable period of time, this Plan will provide the benefits that would be due as if it were the primary plan, provided that the covered person (1) assigns to Blue Shield the right to receive benefits from the other plan to the extent of the difference between the value of the benefits which Blue Shield actually provides and the value of the benefits that Blue Shield would have been obligated to provide as the secondary plan, (2) agrees to cooperate fully with Blue Shield in obtaining payment of benefits from the other plan, and (3) allows Blue Shield to obtain confirmation from the other plan that the benefits which are claimed have not previously been paid.

X. INDIVIDUAL CONVERSION PLAN AND GROUP CONTINUATION COVERAGE

INDIVIDUAL CONVERSION PLAN

Regardless of age, physical condition or employment status, you may continue Blue Shield protection when you retire, leave the job or become ineligible for group coverage. If you have held group coverage for three or more consecutive months, you and your enrolled dependents may apply to transfer to an individual conversion health plan then

being issued by Blue Shield. Your employer is solely responsible for notifying you of the availability, terms and conditions of the individual conversion plan within 15 days of termination of the contract's coverage.

An application for the conversion plan must be received by Blue Shield within 31 days of the date of termination of your group coverage. However, if the group contract is replaced by your employer with another contract or if the contract is canceled, transfer to the individual conversion health plan will not be permitted. Nor will you be permitted to transfer to the individual conversion health plan under any of the following circumstances:

1. You failed to pay amounts due the Plan;
2. You were terminated by the Plan for good cause or for fraud or misrepresentation;
3. You knowingly furnished incorrect information or otherwise improperly obtained the benefits of the Plan;
4. You are covered or eligible for Medicare;
5. You are covered or eligible for hospital, medical or surgical benefits under state or federal law or under any arrangement of coverage for individuals in a group, whether insured or self-insured; and,
6. You are covered for similar benefits under an individual policy or contract.

Benefits or rates of an individual conversion health plan are different from those in your group plan.

An individual conversion health plan is also available to:

1. Dependents, if the subscriber dies;
2. Dependents who marry or exceed the maximum age for dependent coverage under the group plan;
3. Dependents, if the subscriber enters military service;
4. Spouse of a subscriber, if their marriage has terminated.
5. Dependents, when continuation of coverage under COBRA expires, or is terminated.

When a dependent reaches the limiting age for coverage as a dependent, or if a dependent becomes ineligible for any of the other reasons given above, it is your responsibility to inform Blue Shield. Upon receiving notification, Blue Shield will offer such dependent an individual conversion health plan for purposes of continuous coverage.

EXTENSION OF BENEFITS

If a person becomes Totally Disabled while validly covered under this Plan and continues to be Totally Disabled on the date the group contract terminates, Blue Shield will extend the benefits of this Plan, subject to all limitations and restrictions, for covered services and supplies directly related to the condition, illness or injury causing such Total Disability until the first to occur of the following: (1) the date the covered person is no longer Totally Disabled; (2) 12:00 a.m. on the day following a period of 12 months from the date the group contract terminated; (3) the date on which the covered person's maximum benefits are reached; (4) the date on which a replacement carrier provides coverage to the person without limitation as to the Totally Disabling condition.

Written certification of the Member's Total Disability should be submitted to Blue Shield by the Member's Personal Physician as soon as possible after the group health service contract terminates. Proof of continuing Total Disability must be furnished by the Member's Personal Physician at reasonable intervals determined by Blue Shield.

GROUP CONTINUATION COVERAGE

Applicable to Members when the Member's employer [Contractholder] is subject to either Title X. of the Consolidated Omnibus Budget Reconciliation Act [COBRA] as amended, or the California Continuation Benefits Replacement Act (Cal-COBRA). Please contact your Employer for further information.

In accordance with the Consolidated Omnibus Budget Reconciliation Act (COBRA) as amended, and the California Continuation Benefits Replacement Act (Cal-COBRA), a Member will be entitled to elect to continue group coverage under this Plan if he or she would lose coverage otherwise because of a Qualifying Event that occurs while the Contractholder is subject to the continuation of group coverage provisions of COBRA or Cal-COBRA.

The benefits under the group continuation of coverage will be identical to the benefits that would be provided to the Member if the Qualifying Event had not occurred (including any changes in such coverage).

Note: A Member will not be entitled to benefits under Cal-COBRA if at the time of the qualifying event such Member is entitled to benefits under Title XVIII of the Social Security Act ("Medicare"), or is covered under another group health plan that provides coverage without exclusions or limitations with respect to any pre-existing condition. Under COBRA, a Member is entitled to benefits if at the time of the qualifying event such Member is entitled to Medicare. However, if Medicare entitlement arises after COBRA coverage begins, it will cease.

QUALIFYING EVENT

A Qualifying Event is defined as a loss of coverage as a result of any one of the following occurrences.

1. With respect to the Member:
   a. the termination of employment (other than by reason of gross misconduct); or
   b. the reduction of hours of employment to less than the number of hours required for eligibility.
2. With respect to the dependent spouse and dependent children (children born to or placed for adoption with the Member during a COBRA or Cal-COBRA continuation period may be added as Dependents, provided the Contractholder is properly notified of the birth or placement for adoption, and such children are enrolled within 30 days of the birth or placement for adoption):
   a. the death of the Member; or
   b. the termination of the Member's employment (other than by reason of such Member's gross misconduct); or
   c. the reduction of the Member's hours of employment to less than the number of hours required for eligibility; or
   d. the divorce or legal separation of the Member from the dependent spouse; or

e. the Member's entitlement to benefits under Title XVIII of the Social Security Act ("Medicare"); or

f. a dependent child's loss of dependent status under this Plan.

3. With respect to a Member who is covered as a retiree, that retiree's dependent spouse and dependent children, when the employer files for reorganization under Title XI, United States Code, commencing on or after July 1, 1986.

4. With respect to any of the above, such other Qualifying Event as may be added to Title X of COBRA or the California Continuation Benefits Replacement Act (Cal-COBRA).

NOTIFICATION OF A QUALIFYING EVENT

1. With respect to COBRA enrollees

The Member is responsible for notifying the employer of divorce, legal separation or a child's loss of dependent status under this Plan, within 60 days of the date of the later of the Qualifying Event or the date on which coverage would otherwise terminate under this Plan because of a Qualifying Event.

The employer is responsible for notifying its COBRA administrator (or Plan administrator if the employer does not have a COBRA administrator) of the Member's death, termination or reduction of hours of employment, the Member's Medicare entitlement, or the employer's filing for reorganization under Title XI, United States Code.

When the COBRA administrator is notified that a Qualifying Event has occurred, the COBRA administrator will inform the Member within 14 days of the right to continue group coverage under this Plan.

The Member must then notify the COBRA administrator within 60 days of the later of (i) the date of the notice of his or her right to continue group coverage and (ii) the date coverage terminates due to the Qualifying Event.

If the Member does not notify the COBRA administrator within 60 days, coverage will terminate on the date the Member would have lost coverage because of the Qualifying Event.

2. With respect to Cal-COBRA enrollees

The Member is responsible for notifying Blue Shield in writing of the Subscriber's death or Medicare entitlement, of divorce, legal separation or a child's loss of Dependent status under this Plan. Such notice must be given within 60 days of the date of the later of the Qualifying Event or the date on which coverage would otherwise terminate under this plan because of a Qualifying Event. Failure to provide such notice within 60 days will disqualify the Member from receiving continuation coverage under Cal-COBRA.

The Employer is responsible for notifying Blue Shield in writing of the Subscriber's termination or reduction of hours of employment within 30 days of the Qualifying Event.

When Blue Shield is notified that a Qualifying Event has occurred, Blue Shield will inform the Member within 14 days of his or her right to continue group coverage under this plan. The Member must then notify Blue Shield in writing within 60 days of the later of (1) the date of the notice of his or her right to continue group coverage and (2) the date coverage terminates due to the Qualifying Event.

If the Member does not notify Blue Shield within 60 days, his or her

coverage will terminate on the date he or she would have lost coverage because of the Qualifying Event.

If this Plan replaces a previous group plan that was in effect with the Employer, and the Member had elected Cal-COBRA continuation coverage under the previous plan, the Member may choose to continue to be covered by this Plan for the balance of the period that the Member could have continued to be covered under the previous plan, provided that the Member notify Blue Shield within 30 days of receiving notice of the termination of the previous group plan.

DURATION AND EXTENSION OF CONTINUATION OF GROUP COVERAGE

The Member will be entitled to continue group coverage under this Plan up to a maximum of 36 months, except when the Member has lost coverage because of termination or reduction of work hours required for eligibility. For these Members, group coverage may only be continued for a maximum of 18 months. This 18-month period may be extended to 36 months if a second Qualifying Event such as death, divorce, legal separation or Medicare entitlement occurs during the first 18-month period.

The Member's 18-month period may also be extended to 29 months if the Member was disabled on or before the date of termination or reduction in hours of employment, or is determined to be disabled under the Social Security Act within the first 60 days of the initial Qualifying Event and before the end of the 18-month period (non-disabled eligible family members are also entitled to this 29-month extension).

For COBRA enrollees: The Employer must be notified of the Social Security Act determination within 60 days of the determination and before the end of the 18-month period. The Member is responsible for notifying the Employer within 30 days of any final determination affecting disability status.

For Cal-COBRA enrollees: Blue Shield must be notified of the Social Security Act determination within 60 days of the determination and before the end of the 18-month period. The Member is responsible for notifying Blue Shield within 30 days of any final determination that he or she is no longer disabled.

In no event will continuation of group coverage be extended for more than 3 years from the date the Qualifying Event has occurred which entitled the Member to continue group coverage under this Plan.

PAYMENT OF DUES

Dues for the Member continuing coverage shall be 102% of the applicable group dues rate if the Member is a COBRA enrollee, or 110% of the applicable group dues rate if the Member is a Cal-COBRA enrollee, except for the Member who is eligible to continue group coverage to 29 months because of a Social Security disability determination, in which case, the dues for months 19 through 29 shall not exceed 150% of the applicable group dues rate. If the Member is enrolled in COBRA and is contributing to the cost of coverage, the employer shall be responsible for collecting and submitting all dues contributions to Blue Shield in the manner and for the period established under this Plan.

Cal-COBRA enrollees must submit dues directly to Blue Shield of California. The initial dues must be paid within 45 days of the date the Member provided written notification to the Plan of the election to continue coverage. The dues payment must equal an amount sufficient to pay any required amounts that are due. Failure to submit the correct amount within the 45 day period will

disqualify the Member from continuation coverage.

EFFECTIVE DATE OF THE CONTINUATION OF COVERAGE

The continuation of coverage will begin on the date the Member's coverage under this Plan would otherwise terminate due to the occurrence of a Qualifying Event and it will continue for up to the applicable period, provided that coverage is timely elected and so long as dues are timely paid.

TERMINATION OF CONTINUATION OF GROUP COVERAGE

The continuation of group coverage will cease if any one of the following events occurs prior to the expiration of the applicable period of continuation of group coverage:

1. discontinuance of this group health service contract;

2. failure to timely and fully pay the amount of required dues to the COBRA administrator or the employer as applicable;

3. the Member becomes covered under another group health plan that does not include a Pre-existing Condition exclusion or limitation provision that applies to the Member;

4. the Member becomes entitled to Medicare;

5. the continuation of coverage was extended to 29 months and there has been a final determination that the Member is no longer disabled;

6. the Member no longer resides in Blue Shield's service area;

7. the Member commits fraud or deception in the use of the Services of this plan.

Continuation of group coverage in accordance with COBRA will not be terminated except as described in this provision.

CONTINUATION OF GROUP COVERAGE AFTER COBRA OR CAL-COBRA

Certain former Employees and their Dependent spouses (including a spouse who is divorced from the Employee and/or a spouse who was married to the Employee or former Employee at the time of that Employee's death) may be eligible to continue group coverage beyond the date their COBRA or Cal-COBRA coverage ends. Blue Shield will offer the extended coverage to former Employees of employers that are subject to the existing COBRA or Cal-COBRA, and to the former Employees' dependent spouses, including divorced or widowed spouses as defined above. This coverage is subject to the following conditions:

1. The former Employee worked for the employer for the prior 5 years and was 60 years of age or older on the date his/her employment ended.

2. The former Employee was eligible for and elected COBRA or Cal-COBRA for himself and his dependent spouse (a former spouse, i.e., a divorced or widowed spouse as defined above, is also eligible for continuation of group coverage after COBRA or Cal-COBRA. The former spouse must elect such coverage by notifying the plan in writing within 30 calendar days prior to the date that the Employee's initial COBRA or Cal-COBRA benefits are scheduled to end).

If elected, this coverage will begin after the COBRA or Cal-COBRA coverage ends and will be administered under the same terms and conditions as if COBRA or Cal-COBRA had remained in force.

Dues for this coverage shall be 213 percent of the applicable group dues rate, or 102 percent of the applicable age adjusted group dues rate for COBRA enrollees and 110 percent of the applicable age adjusted group dues rate for Cal-COBRA enrollees. Payment is due at the time the employer's payment is due.

NOTIFICATION REQUIREMENTS

The employer is solely responsible for notifying former Employees or Dependent spouses (including former spouses as defined above) of the availability of the coverage at least 90 calendar days before COBRA or Cal-COBRA is scheduled to end. To elect this coverage, the former Employee (and/or former spouse) must notify the plan in writing at least 30 calendar days before COBRA or Cal-COBRA is scheduled to end.

TERMINATION OF CONTINUATION COVERAGE AFTER COBRA OR CAL-COBRA

This coverage will end automatically on the earliest of the following dates:

1. the date the former Employee, spouse, or former spouse reaches 65;

2. the date the employer ceases to maintain any group health plan;

3. the date the former Employee, spouse, or former spouse transfers to another health plan, whether or not the benefits of the other health plan are less valuable than those of the health plan maintained by the employer;

4. the date the former Employee, spouse, or former spouse becomes entitled to Medicare;

5. for a spouse or former spouse, five years from the date the spouse's COBRA or Cal-COBRA coverage would end.

AVAILABILITY OF BLUE SHIELD INDIVIDUAL CONVERSION PLAN

Blue Shield's Individual Conversion Plan described at the beginning of this section will be available to Members whose continuation of group coverage is terminated or expires while covered under this group Plan.

XI. TERMINATION OF BENEFITS AND CANCELLATION PROVISIONS

TERMINATION OF BENEFITS

Coverage for you or your dependents terminates at 12:01 a.m. Pacific Time on the earliest of these dates: (1) the date the group contract is discontinued, (2) the last day of the month in which your status as an employee terminates, unless a different date on which you no longer meet the requirements for eligibility has been agreed to between Blue Shield and your employer, (3) the end of the period for which dues are paid, or (4) the date you or your dependents become ineligible. A spouse also becomes ineligible following entry of a final decree of divorce, annulment or dissolution of marriage from the Subscriber. See the "Definitions" provision.

Except as specifically provided under the Extension of Benefits and Group Continuation Coverage provisions, there is no right to receive benefits for services provided following termination of this group contract.

If you cease work because of retirement, disability, leave of absence, temporary layoff or termination, see the Individual Conversion Plan and Group Continuation Coverage provisions described in this booklet for information on continuation of coverage.

If your employer is subject to the California Family Rights Act of 1991 and/or the federal Family & Medical Leave Act of 1993, and the approved leave of absence is for family leave

under the terms of such Act(s), your payment of dues will keep your coverage in force for such period of time as specified in such Act(s). Your employer is solely responsible for notifying you of the availability and duration of family leaves.

If application is not made for a newborn or a child placed for adoption within the 31 days following that dependent's effective date of coverage, benefits under this Plan will be terminated on the 32nd day at 12:01 a.m. Pacific Time.

The Plan may terminate coverage of a Member for cause immediately upon written notice for the following:

1. Material information that is false or misrepresented information provided on the enrollment application or given to the group or the Plan;

2. Permitting a non-Member to use a Member identification card to obtain services and benefits;

3. Obtaining or attempting to obtain services or benefits under the contract by means of false, materially misleading, or fraudulent information, acts or omissions;

4. Disruptive behavior or threatening the life or well-being of the Plan personnel, providers of services and benefits or any Plan Member.

The Plan may terminate coverage of a Member for cause upon 31 days written notice for the following:

1. Inability to establish a satisfactory physician-patient relationship after following the procedures under *Relationship with Your Personal Physician* in Section III. Choice of Physicians and Providers;

2. Repeated and unreasonable demands for unnecessary medical services including medications when such demands are not in accordance with generally accepted professional standards;

3. Failure to pay any Copayment or supplemental charge.

NO VESTED RIGHTS

Very Important Information

No person has the right to receive the benefits of this Plan for services or supplies furnished following termination of coverage, except as specifically provided under the Extension of Benefits, Individual Conversion Plan or Group Continuation Coverage provisions in this booklet.

Benefits of this Plan are available only for services and supplies furnished during the term it is in effect and while the individual claiming benefits is actually covered by this group contract.

Benefits may be modified during the term of this Plan as specifically provided under the terms of the group contract or upon renewal. If benefits are modified, the revised benefits (including any reduction in benefits or the elimination of benefits) apply for services or supplies furnished on or after the effective date of modification. There is no vested right to receive the benefits of this Plan.

REINSTATEMENT

If you had been making contributions toward coverage for you and your dependents and voluntarily canceled such coverage, you may apply for reinstatement. You or your dependents must wait until the earlier of, 12 months from the date of application or the employer's next Open Enrollment Period to be reinstated. Blue Shield will not consider applications for earlier effective dates.

CANCELLATION

Blue Shield may cancel this group contract for non-payment of dues, after having given at least 15 days' written notice to your employer, stating when such cancellation will become effective.

No benefits will be provided for services rendered after the effective date of cancellation, except as specifically provided under the Extension of Benefits and Individual Conversion Plan and Group Continuation Coverage provisions in this booklet.

If you are hospitalized or undergoing treatment for an ongoing condition and the group contract is canceled for any reason, including non-payment of dues, no benefits will be provided unless you obtain an Extension of Benefits.

The group contract also may be canceled by your employer at any time provided written notice is given to Blue Shield to become effective upon receipt, or on a later date as may be specified on the notice.

Blue Shield may cancel the group contract for fraud or misrepresentation by your employer, or with respect to coverage of employees or dependents, for fraud or misrepresentation of the employee, dependent, or their representative.

Misrepresentations or omissions on an application or a health statement (if a health statement is required by the employer) may result in the cancellation or rescission of this plan. Cancellations are effective on receipt or on such later date as specified in the cancellation notice.

In the event the contract is rescinded or canceled, either by Blue Shield or your employer, it is your employer's responsibility to notify you of the rescission or cancellation.

RIGHT OF CANCELLATION

If you are making any contributions toward coverage for yourself or your dependents, you may cancel such coverage to be effective at the end of any period for which dues have been paid.

Any dues paid Blue Shield for a period extending beyond the cancellation date will be refunded to your employer. Your employer will be responsible to Blue Shield for unpaid dues prior to the date of cancellation.

Blue Shield will honor all claims for covered services provided prior to the effective date of cancellation.

If your employer does not meet the eligibility, participation and contribution requirements of the group contract, Blue Shield will cancel this plan after 30 days' written notice to your employer. *(This paragraph applies only to Small Group Employers.)*

XII. MEMBER SERVICES

If you have a question about services, providers, Benefits, how to use your plan, or concerns regarding the quality of care or access to care that you have experienced, you may call Blue Shield's Member Services Department at:

1-800-248-5451 from California, or

001-800-248-5451 from Mexico.

These phone numbers are staffed by representatives who speak Spanish.

You also may write to Blue Shield's Member Services Department as noted on the last page of this booklet.

Member Services can answer many questions over the telephone.

Note: Blue Shield of California has established a procedure for our Members to request an expedited decision. A Member, physician, or representative of a Member may request an expedited decision when the routine decision making process might seriously jeopardize the life or health of a Member, or when the Member is experiencing severe pain. Blue Shield shall make a decision and notify the Member and physician within 72 hours following the receipt of the request. An expedited decision may involve admissions, continued stay or other healthcare services. If you would like additional information regarding the expedited decision process, or if you believe your particular situation qualifies for an expedited decision, please contact our Member Services Department at 1-800-248-5451 from California or 001-800-248-5451 from Mexico.

XIII. GRIEVANCE AND APPEALS PROCESS

Blue Shield of California has established an appeals procedure for receiving, resolving and tracking Members' grievances with Blue Shield of California.

If you are not satisfied with the Member Services Department's response to your inquiry, you, your provider or representative may appeal by either: 1) calling or writing the Member Services Department as directed on the last page of this booklet and requesting that they review the initial response or, 2) submitting a completed "Grievance Form". You may request this form from your Member Services Department.

The completed form should be submitted to the Member Services Department at the address as noted on the last page of this booklet. Blue Shield will acknowledge receipt of a written grievance within 5 calendar days.

The grievance system allows Members to file grievances for at least 180 days following any incident or action that is the subject of the enrollee's dissatisfaction. Appeals are resolved within 30 days. See the previous Member Services section for information on the expedited decision process.

NOTE: If your employer's health plan is governed by the Employee Retirement Income Security Act ("ERISA"), you may have the right to bring a civil action under Section 502(a) of ERISA if all required reviews of your claim have been completed and your claim has not been approved.

EXTERNAL INDEPENDENT MEDICAL REVIEW

If your appeal involves a claim or services for which coverage was denied by Blue Shield or by a contracting provider in whole or in part on the grounds that the service is not medically necessary or is experimental /investigational (including the external review available under the Friedman-Knowles Experimental Treatment Act of 1996), you may choose to make a request to the Department of Managed Health Care to have the matter submitted to an independent agency for external review in accordance with California law. You normally must first request an appeal from Blue Shield and wait for at least 30 days before you request external review; however, if your matter would qualify for an expedited decision as described above or involves a determination that the requested service is experimental/investigational, you may immediately request an external review following receipt of notice of denial. You may initiate this review by completing an application for external review, a copy of which can be obtained by contacting Member Services. The Department of Managed Health Care will review the application and, if the request qualifies for external review, will select an external review agency and have

your records submitted to a qualified specialist for an independent determination of whether the care is Medically Necessary. You may choose to submit additional records to the external review agency for review. There is no cost to you for this external review. You and your physician will receive copies of the opinions of the external review agency. This external review will be conducted in accordance with the same normal and expedited appeal time frames stated above. The decision of the external review agency is binding on Blue Shield; if the external reviewer determines that the service is Medically Necessary, Blue Shield will promptly arrange for the service to be provided. This external review process is in addition to any other procedures or remedies available to you and is completely voluntary on your part; you are not obligated to request external review. However, failure to participate in external review may cause you to give up any statutory right to pursue legal action against Blue Shield regarding the disputed service. For more information regarding the external review process, or to request an application form, please contact Member Services.

XIV. OTHER PROVISIONS

DEPARTMENT OF MANAGED HEALTH CARE REVIEW

The California Department of Managed Health Care is responsible for regulating health care service plans. The Department has a toll-free telephone number **(1-888-HMO-2219)** to receive complaints regarding health plans. The hearing and speech impaired may use the California Relay Service's toll-free telephone numbers **(1-800-735-2929 (TTY) or 1-888-877-5378 (TTY))** to contact the department. The department's Internet website **(http://www.hmohelp.ca.gov)** has complaint forms and instructions online. If you have a grievance against your health plan, you should first telephone your plan **at the number listed on the last page of this booklet** and use the plan's grievance process before contacting the Department. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your plan, or a grievance that has remained unresolved for more than 30 days, you may call the Department for assistance. The plan's grievance process and the Department's complaint review process are in addition to any other dispute resolution procedures that may be available to you, and your failure to use these processes does not preclude your use of any other remedy provided by law.

In the event that Blue Shield should cancel or refuse to renew the enrollment for you or your Dependents and you feel that such action was due to health or utilization of benefits, you or your Dependents may request a review by the Department of Managed Health Care Director.

PUBLIC POLICY PARTICIPATION PROCEDURE

This procedure enables you to participate in establishing public policy of Blue Shield of California. It is not to be used as a substitute for the appeal procedure, complaints, inquiries or requests for information.

Public policy means acts performed by a plan or its employees and staff to assure the comfort, dignity, and convenience of patients who rely on the plan's facilities to provide health care services to them, their families, and the public (Health and Safety Code, Section 1369).

At least one third of the Board of Directors of Blue Shield is comprised of subscribers who are not employees, providers, subcontractors or group contract brokers and who do not have financial interests in Blue Shield. The

names of the members of the Board of Directors may be obtained from:

Director, Consumer Affairs
Blue Shield of California
50 Beale Street
San Francisco, CA 94105
Phone Number: 1-415-229-5104

Please follow the following procedure:

1. Your recommendations, suggestions or comments should be submitted in writing to the Director, Consumer Affairs, at the above address, who will acknowledge receipt of your letter;

2. Your name, address, phone number, subscriber number and group number should be included with each communication;

3. The policy issue should be stated so that it will be readily understood. Submit all relevant information and reasons for the policy issue with your letter;

4. Policy issues will be heard at least quarterly as agenda items for meetings of the Board of Directors. Minutes of Board meetings will reflect decisions on public policy issues that were considered. If you have initiated a policy issue, appropriate extracts of the minutes will be furnished to you within 10 business days after the minutes have been approved.

CONFIDENTIALITY OF PERSONAL AND HEALTH INFORMATION

Blue Shield of California protects the confidentiality of your personal and health information, including your medical records, claims and personal information. Blue Shield of California will not disclose your personal and health information without your consent, except as permitted by law.

A STATEMENT DESCRIBING BLUE SHIELD'S POLICIES AND PROCEDURES FOR PRESERVING THE CONFIDENTIALITY OF MEDICAL RECORDS IS AVAILABLE AND WILL BE FURNISHED TO YOU UPON REQUEST. To request a copy of this statement, call the Member Services Department at the number listed in the back of this booklet.

NON-ASSIGNABILITY

Benefits of this Plan are not assignable without the written consent of Blue Shield.

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

FACILITIES

The Plan has established a network of Physicians, Hospitals, Participating Hospice Agencies (California only) and Non-Physician Health Care Practitioners in your Personal Physician Service Area.

The Personal Physician(s) you and your dependents select will provide telephone access 24-hours-a-day, 7-days-a-week so that you can obtain assistance and prior approval of Medically Necessary care. The Hospitals in the Plan network provide access to 24-hour-a-day emergency services. The list of the Hospitals, Physicians and Participating Hospice Agencies (California only) in your Personal Physician Service Area indicates the location and phone numbers of these providers. Contact Member Services at the number listed in the back of this booklet for information on Plan Non-Physician Health Care Practitioners in your Personal Physician Service Area.

For urgent services when you are in the United States, but outside California, or

outside the U.S. or Mexico, you simply call toll-free 1-800-810 BLUE (2583) 24-hours-a-day, 7-days-a-week. We will identify the BlueCard participating provider closest to you. For urgent services when you are within California, but outside of your Personal Physician Service Area, you should contact your Personal Physician or Blue Shield Member Services at 1-800-248-5451 in accordance with Section IV., How to Use Your Health Plan. Urgent services when you are outside the U.S. or Mexico are available through the Blue Card Worldwide Network. For urgent services when you are within Mexico, but outside of your Personal Physician Service Area, you should contact your Personal Physician. For urgent services when you are within your Personal Physician Service Area, contact your Personal Physician to obtain urgent services which must be provided or authorized by your Personal Physician just like all other non-emergency services of the Plan.

INDEPENDENT CONTRACTORS

Plan Providers are neither agents nor employees of the Plan but are independent contractors. Blue Shield of California conducts a process of credentialing and certification of all physicians who participate in the Access Baja HMO Network. However, in no instance shall the Plan be liable for the negligence, wrongful acts or omissions of any person receiving or providing services, including any physician, hospital, or other provider or their employees.

PAYMENT OF PROVIDERS

Blue Shield generally contracts with groups of physicians to provide services to Members. A fixed, monthly fee is paid to the groups of physicians for each Member whose Personal Physician is in the group. This payment system, capitation, includes incentives to the groups of physicians to manage all services provided to Members in an appropriate manner consistent with the contract.

If you want to know more about this payment system, contact Member Services at the number listed in the back of this booklet or talk to your Plan Provider.

PLAN INTERPRETATION

Blue Shield shall have the power and discretionary authority to construe and interpret the provisions of the contract, to determine the benefits of the contract and determine eligibility to receive benefits under the contract. Blue Shield shall exercise this authority for the benefit of all persons entitled to receive benefits under the contract.

XV. DEFINITIONS

Accidental Injury — definite trauma resulting from a sudden unexpected and unplanned event, occurring by chance, caused by an independent external source.

Allowed Charges — the amount a Plan Provider agrees to accept as payment from Blue Shield or the billed amount for Non-Plan Providers.

Benefits (Covered Services) — those services which a Member is entitled to receive pursuant to the terms of the Group Health Service Contract.

Calendar Year — a period beginning at 12:01 a.m. on January 1 and ending at 12:01 a.m. January 1 of the following year.

Close Relative — the spouse, child, brother, sister or parent of a subscriber or dependent.

Copayment — the amount which a Member is required to pay for certain benefits.

Cosmetic Surgery — surgery that is performed to alter or reshape normal structures of the body to improve appearance.

Covered Services (Benefits) — those services which a Member is entitled to receive pursuant to the terms of the Group Health Service Contract.

Custodial or Maintenance Care — care furnished primarily to provide room and board or meet the activities of daily living (which may include nursing care, training in personal hygiene and other forms of self care or supervisory care by a physician); or care furnished to a Member who is mentally or physically disabled, and

1. who is not under specific medical, surgical or psychiatric treatment to reduce the disability to the extent necessary to enable the patient to live outside an institution providing such care; or,

2. when, despite such treatment, there is no reasonable likelihood that the disability will be so reduced.

Dental Care and Services — services or treatment on or to the teeth or gums whether or not caused by Accidental Injury, including any appliance or device applied to the teeth or gums.

Dependent —

1. a subscriber's legally married spouse who is:

   a. not covered for benefits as a subscriber;

   b. not legally separated from the subscriber; and

   c. not a member on active duty with the Armed Forces; or,

2. a subscriber's unmarried child (including any stepchild or child placed for adoption) who is not covered for benefits as a subscriber, is not a member on active duty with the Armed Forces, and who is:

   a. primarily dependent upon the subscriber for support and maintenance; or

   b. dependent upon the subscriber for medical support pursuant to a court order; and is

   c. less than 19 years of age; or

   d. is less than 25 years of age if enrolled as a full-time student and if proof of student status is submitted to Blue Shield (full-time student means enrolled in a college, university, vocational or technical school and for a minimum of 12 units as an undergraduate, or 6 units as a graduate student);

   and who has been enrolled and accepted by the Plan as a dependent and has maintained membership in accordance with the contract.

3. If coverage for a Dependent child would be terminated because of the attainment of age 19 (or age 25, if Dependent has been a full-time student), and the Dependent child is Totally Disabled (Physically Handicapped or Mentally Retarded), benefits for such Dependent will be continued upon the following conditions:

   a. the child must be chiefly dependent upon the Subscriber for support and maintenance;

b. the Subscriber submits to Blue Shield a Physician's written certification of Total Disability within 31 days from the date of the Employer's or Blue Shield's request; and

c. thereafter, certification of continuing disability and dependency from a Physician is submitted to Blue Shield on the following schedule:

(1) within 6 months after the month when the Dependent would otherwise have been terminated; and

(2) annually thereafter on the same month when certification was made in accordance with item (1) above. In no event will coverage be continued beyond the date when the Dependent child becomes ineligible for coverage under this plan for any reason other than attained age.

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

Dues — the monthly prepayment that is made to the Plan on behalf of each Member by the Contractholder.

Emergency Services — services provided for an unexpected medical condition, including a psychiatric emergency medical condition, manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in any of the following:

1. placing the Member's health in serious jeopardy;

2. serious impairment to bodily functions;

3. serious dysfunction of any bodily organ or part.

Employee — an individual who meets the eligibility requirements set forth in the Group Health Service Contract between Blue Shield of California and your employer.

Employer — any person, firm, proprietary or non-profit corporation, partnership, public agency or association that has at least 2 employees and that is actively engaged in business or service, in which a bona fide employer-employee relationship exists, in which the majority of employees were employed within this state, and which was not formed primarily for purposes of buying health care coverage or insurance.

Experimental or Investigational in Nature — any treatment, therapy, procedure, drug or drug usage, facility or facility usage, equipment or equipment usage, device or device usage, or supplies which are not recognized in accordance with the generally accepted professional medical standards as being safe and effective for use in the treatment of the illness, injury, or condition at issue. Services which require approval by the federal government or any agency thereof, or by any State government agency, prior to use and where such approval has not been granted at the time the services or supplies were rendered, shall be considered experimental or investigational in nature. Services or supplies which themselves are not approved or recognized in accordance with accepted professional medical standards, but nevertheless are authorized by law or by a government agency for use in testing, trials, or other studies on human patients, shall be considered experimental or investigational in nature.

Family – the Subscriber and all enrolled Dependents.

Group Health Service Contract (Contract) — the contract issued by the Plan to the Contractholder that establishes the services Members are entitled to receive from the Plan.

Home Medical Equipment — equipment designed for repeated use which is Medically Necessary to treat an illness or injury, to improve the functioning of a malformed body member, or to prevent further deterioration of the patient's medical condition. Home Medical Equipment includes wheelchairs, hospital beds, respirators, and other items that the Plan determines are Home Medical Equipment.

Hospice or Hospice Agency — an entity which provides Hospice Services to Terminally Ill persons and holds a license, currently in effect, as a Hospice pursuant to Health and Safety Code Section 1747, or a home health agency licensed pursuant to Health and Safety Code Sections 1726 and 1747.1 which has Medicare certification.

Hospital — for facilities in California, either 1., 2., 3. or 4. below; for facilities in Mexico, 5. below:

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

2. a psychiatric hospital licensed as a health facility accredited by the Joint Commission on Accreditation of Health Care Organizations; or

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

4. a "psychiatric health facility" as defined in Section 1250.2 of the Health and Safety Code;

5. a licensed and certified health facility which is primarily engaged in providing, for compensation from patients, medical, diagnostic and surgical facilities for the care and treatment of sick and injured Members on an inpatient basis, and which provides such facilities under the supervision of a staff of physicians and 24-hour-a-day nursing service by registered nurses. The licensing is performed under the laws of Mexico and Baja California. Certification is a governmental administered program that indicates that the facility has been reviewed by authorized evaluators from the Mexican National Health Council and found to be in compliance with the quality standards established by the Mexican National Commission on Hospital Certification.

Independent Practice Association (IPA) — a group of Physicians with individual offices who form an organization in Mexico in order to contract, manage and share financial responsibilities for providing benefits to Members.

Infertility — either (1) the presence of a demonstrated bodily malfunction recognized by a licensed Doctor of Medicine as a cause of Infertility, or (2) because of a demonstrated bodily

malfunction, the inability to conceive a pregnancy or to carry a pregnancy to a live birth after a year or more of regular sexual relations without contraception.

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

Late Enrollee — an eligible Employee or Dependent who has declined enrollment in this Plan at the time of the initial enrollment period, and who subsequently requests enrollment in this Plan; provided that the initial enrollment period shall be a period of at least 30 days. However, an eligible Employee or Dependent will not be considered a Late Enrollee if any of the conditions listed under (1.), (2.), (3.), (4.), (5.) or (6.) below is applicable:

1. The eligible Employee or Dependent meets all of the following requirements (a., b., c. and d.):

   a. The Employee or Dependent was covered under another employer health benefit plan at the time he was offered enrollment under this plan;

   b. The Employee or Dependent certified, at the time of the initial enrollment that coverage under another employer health benefit plan was the reason for declining enrollment provided that, if he was covered under another employer health plan, he was given the opportunity to make the certification required and was notified that failure to do so could result in later treatment as a Late Enrollee;

   c. The Employee or Dependent has lost or will lose coverage under another employer health benefit plan as a result of termination of his employment or of an individual through whom he was covered as a Dependent, change in his employment status or of an individual through whom he was covered as a Dependent, termination of the other plan's coverage, exhaustion of COBRA continuation coverage, cessation of an employer's contribution toward his coverage, death of an individual through whom he was covered as a Dependent, or legal separation or divorce; and

   d. The Employee or Dependent requests enrollment within 31 days after termination of coverage or employer contribution toward coverage provided under another employer health benefit plan; or

2. The employer offers multiple health benefit plans and the eligible employee elects this plan during an Open Enrollment Period; or

3. A court has ordered that coverage be provided for a spouse or minor child under a covered Employee's health benefit plan. The health plan shall enroll a dependent child within 31 days of presentation of a court order by the district attorney, or upon presentation of a court order or request by a custodial party, as described in subdivision (j) of Section 14124.93 of the Welfare and Institutions Code or Medi-Cal program; or

4. For eligible Employees or Dependents who fail to elect coverage in this plan during their initial enrollment period, the plan cannot produce a written statement from the employer stating that prior to

declining coverage, he or the individual through whom he was covered as a dependent, was provided with and signed acknowledgment of a Refusal of Personal Coverage specifying that failure to elect coverage during the initial enrollment period permits the plan to impose, at the time of his later decision to elect coverage, an exclusion from coverage for a period of 12 months, unless he or she meets the criteria specified in paragraphs (1.), (2.) or (3.) above; or

5. For eligible Dependents who have lost or will lose their no share-of-cost Medi-Cal coverage and who request enrollment within 31 days after notification of this loss of coverage.

6. For eligible Employees who decline coverage during the initial enrollment period and subsequently acquire Dependents through marriage, birth, or placement for adoption, and who enroll for coverage for themselves and their Dependents within 31 days from the date of marriage, birth or placement for adoption.

Medical Group — an organization of Physicians who are generally located in the same facility and provide benefits to Members.

Medically Necessary —

1. benefits are provided only for services which are Medically Necessary.

2. services which are Medically Necessary include only those which have been established as safe and effective and are furnished in accordance with generally accepted professional standards to treat an illness, injury or medical condition, and which, as determined by Blue Shield, are:

   a. consistent with Blue Shield Medical Policy; and,

   b. consistent with the symptoms or diagnosis; and,

   c. not furnished primarily for the convenience of the patient, the attending physician or other provider; and,

   d. furnished at the most appropriate level which can be provided safely and effectively to the patient.

3. hospital inpatient services which are Medically Necessary include only those services which satisfy the above requirements, require the acute bed-patient (overnight) setting, and which could not have been provided in a physician's office, the outpatient department of a hospital, or in another lesser facility without adversely affecting the patient's condition or the quality of medical care rendered.

   Inpatient services which are not Medically Necessary include hospitalization:

   a. for diagnostic studies that could have been provided on an outpatient basis;

   b. for medical observation or evaluation;

   c. in a pain management center to treat or cure chronic pain; or

   d. for inpatient rehabilitation that can be provided on an outpatient basis.

4. Blue Shield reserves the right to review all services to determine whether they are Medically Necessary.

Member — either a subscriber or dependent.

Mental Health Services— see definition for Psychiatric Care.

Mentally Retarded — only those Members, not psychotic, who are so mentally retarded from infancy or before reaching maturity that they are incapable of managing themselves and their affairs independently, with ordinary prudence, or of being taught to do so, and who require supervision, control and care for their own welfare or for the welfare of others or for the welfare of the community.

Non-Plan Provider — a provider who does not have an agreement with Blue Shield to participate in the Access Baja HMO Health Plan, and to provide Plan Benefits to Access Baja HMO Health Plan Members.

Occupational Therapy — treatment under the direction of a physician and provided by a certified occupational therapist, utilizing arts, crafts, or specific training in daily living skills, to improve and maintain a patient's ability to function.

Open Enrollment Period — that period of time set forth in the contract during which eligible individuals and their dependents may transfer from another health benefit plan sponsored by the Employer to the Access Baja HMO Plan.

Orthosis — an orthopedic appliance or apparatus used to support, align, prevent or correct deformities or to improve the function of movable body parts.

Outpatient — an individual receiving services under the direction of a Plan Provider, but not as an inpatient.

Outpatient Facility — a licensed facility, not a physician's office, or a hospital that provides medical and/or surgical services on an outpatient basis.

Participating Hospice or Participating Hospice Agency — an entity which: 1) provides Hospice Services to Terminally Ill Members and holds a license, currently in effect, as a Hospice pursuant to Health and Safety Code Section 1747, or a home health agency licensed pursuant to Health and Safety Code Sections 1726 and 1747.1 which has Medicare certification and 2) has either contracted with Blue Shield of California or has received prior approval from Blue Shield of California to provide Hospice Service benefits pursuant to the California Health and Safety Code Section 1368.2.

Personal Physician — a general practitioner, board-certified family practitioner, internist or pediatrician who is licensed in Mexico and has contracted with the Plan as a Personal Physician to provide primary care to Members and to refer, authorize, supervise and coordinate the provision of all benefits to Members in accordance with the contract.

Personal Physician Service Area — that geographic area served by your Personal Physician's Medical Group or IPA.

Physical Handicap — a physical or mental impairment that results in anatomical, physiological, or psychological abnormalities which are demonstrable by medically acceptable clinical or laboratory diagnostic techniques and which are expected to last for a continuous period of time not less than 12 months in duration.

Physical Therapy — treatment under the direction of a physician and provided by a registered physical therapist, certified occupational therapist or licensed doctor of podiatric medicine, utilizing physical agents, such as ultrasound, heat and massage, to improve a patient's musculoskeletal, neuromuscular and respiratory systems.

Physician — an individual licensed and authorized to engage in the practice of medicine or osteopathic medicine.

Plan — the Access Baja HMO Health Plan.

Plan Hospital — a hospital licensed under applicable state law contracting specifically with Blue Shield to provide benefits to Members under the Plan.

Plan Non-Physician Health Care Practitioner — a health care professional who is not a physician and has an agreement with one of the contracted Independent Practice Associations, Medical Groups, Plan Hospitals or Blue Shield to provide covered services to Members when referred by a Personal Physician.

Plan Provider — a provider who has an agreement with Blue Shield to participate in the Access Baja HMO Health Plan, and to provide Plan Benefits to Access Baja HMO Health Plan Members.

Plan Service Area — that geographic area served by the Access Baja HMO product as described in Part VIII.

Plan Specialist — a physician other than a Personal Physician, psychologist, licensed clinical social worker, or licensed marriage and family therapist who has an agreement with Blue Shield to provide covered services to Members either according to an authorized referral by a Personal Physician, or for OB/GYN physician services.

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

Psychiatric Care (Mental Health Care Services) — psychoanalysis, psychotherapy, counseling, medical management or other services provided by a psychiatrist, psychologist, licensed clinical social worker, or licensed marriage and family therapist, for diagnosis or treatment of a mental or emotional disorder, or the mental or emotional problems associated with an illness, injury or any other condition.

Reconstructive Surgery — surgery to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors or disease to do either of the following: 1) to improve function, or 2) to create a normal appearance to the extent possible.

Rehabilitation — care furnished primarily to restore an individual's ability to function as normally as possible after a disabling illness or injury. Rehabilitation services may consist of the combined use of medical, social, educational, occupational/vocational treatment modalities, and are provided in response to a written treatment plan.

Respiratory Therapy — treatment, under the direction of a physician and provided by a trained and certified respiratory therapist, to preserve or improve a patient's pulmonary function.

Serious Emotional Disturbances of a Child — refers to individuals who are minors under the age of 18 years who:

1. have one or more mental disorders in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders **(other than a primary substance use disorder or developmental disorder),** that results in behavior inappropriate for the child's age according to expected developmental norms, and
2. meet the criteria in paragraph (2) of subdivision (a) of Section 5600.3 of the

Welfare and Institutions Code. This section states that members of this population shall meet one or more of the following criteria:

a. As a result of the mental disorder the child has substantial impairment in at least two of the following areas: self-care, school functioning, family relationships, or ability to function in the community; and either of the following has occurred: the child is at risk of removal from home or has already been removed from the home or the mental disorder and impairments have been present for more than 6 months or are likely to continue for more than 1 year without treatment;

b. The child displays one of the following: psychotic features, risk of suicide or risk of violence due to a mental disorder.

Services — includes Medically Necessary health care services and Medically Necessary supplies furnished incident to those services.

Severe Mental Illnesses — conditions with the following diagnoses: schizophrenia, schizo affective disorder, bipolar disorder (manic depressive illness), major depressive disorders, panic disorder, obsessive-compulsive disorder, pervasive developmental disorder or autism, anorexia nervosa, bulimia nervosa.

Skilled Nursing Facility — a facility licensed by the California Department of Health Services as a "skilled nursing facility" or any similar institution licensed under the laws of any other state, territory, or foreign country.

Special Food Products — a food product which is both of the following:

1. Prescribed by a Physician or nurse practitioner for the treatment of phenylketonuria (PKU) and is consistent with the recommendations and best practices of qualified health professionals with expertise germane to, and experience in the treatment and care of, phenylketonuria (PKU). It does not include a food that is naturally low in protein, but may include a food product that is specially formulated to have less than one gram of protein per serving;

2. Used in place of normal food products, such as grocery store foods, used by the general population.

Speech Therapy — treatment under the direction of a physician and provided by a licensed speech pathologist or speech therapist, to improve or retrain a patient's vocal skills which have been impaired by illness or injury.

Subacute Care — skilled nursing or skilled rehabilitative care provided in a hospital or skilled nursing facility to patients who require skilled care such as nursing services, physical, occupational or speech therapy, a coordinated program of multiple therapies or who have medical needs that require daily Registered Nurse monitoring. A facility which is primarily a rest home, convalescent facility or home for the aged is not included.

Subscriber — an individual who satisfies the eligibility requirements of the contract, and who is enrolled and accepted by the Plan as a subscriber, and has maintained Plan membership in accord with this contract.

Total Disability —

1. in the case of an employee or Member otherwise eligible for coverage as an employee, a disability which prevents the individual from working with reasonable continuity in the individual's customary employment or in any other employment in which the individual reasonably might be expected to engage, in view of the individual's station in life and physical and mental capacity.

2. in the case of a dependent, a disability which prevents the individual from engaging with normal or reasonable continuity in the individual's customary activities or in those in which the individual otherwise reasonably might be expected to engage, in view of the individual's station in life and physical and mental capacity.

Urgent Services — those covered services (other than Emergency Services) which are medically necessary to prevent serious deterioration of a Member's health, alleviate severe pain, or treat an unforeseen illness, injury or medical condition with respect to which treatment can not reasonably be delayed until the Member returns to the Plan's service area.

This Evidence of Coverage should be retained for your future reference as a Member of the Access Baja HMO Plan.

Should you have any questions, please call the Member Services Department at 1-800-248-5451 from California or 001-800-248-5451 from Mexico. These phone numbers are staffed by representatives who speak Spanish.

Blue Shield of California
50 Beale Street
San Francisco, CA 94105

NOTES

NOTES

Handy Numbers

If your family has more than one Access Baja HMO Personal Physician, list each family member's name with the name of his or her Physician.

*Family Member*_____

*Personal Physician*_____

*Phone Number*_____

*Family Member*_____

*Personal Physician*_____

*Phone Number*_____

*Family Member*_____

*Personal Physician*_____

*Phone Number*_____

Important Numbers:

*Hospital*_____

*Pharmacy*_____

*Police Department*_____

*Ambulance*_____

*Poison Control Center*_____

*Fire Department*_____

General Emergency ***911***

Member Services Department ***1-800-248-5451 from California or001-800-248-5451 from Mexico***.

Member Services

Contacting Blue Shield of California

By Phone:

Call Member Services at **1-800-248-5451** from California or **001-800-248-5451** from Mexico**.** These phone numbers are staffed by representatives who speak Spanish.

By Mail:

For answers to your questions, please write to Blue Shield at:

Blue Shield of California
P.O. Box 272540
Chico, CA 95927-2540

BJA-00008-GOL (7/02)

TEXAS STATE LAWS

Provision in State Law	Summary	Questions/Further Research
Texas Insurance Code, Article 21.52	Defines providers. Most of the definitions define the provider as certified or licensed by a Texas State board.	Most Mexican providers will not meet the requirements of these definitions.
Texas Insurance Code, Article 3.70-2 (B)	Defines Doctor of Medicine, Doctor of Osteopathy, Doctor of Dentistry, and various other providers as certified or licensed by a Texas board. Requires that if an insurer stipulates that services be performed by specific types of physicians or providers, the insurer must use the definitions as written in the statute.	Most Mexican providers will not meet the requirements of these definitions.
Texas Insurance Code, Article 3.20 through 3.27-4; Article 21.43-21.44	Various requirements for alien and foreign insurance companies. Establishes guidelines necessary to conduct the business of insurance in Texas.	Would allow a Mexican insurer, but not an HMO, to offer insurance in Texas.
Texas Insurance Code, Article 21.42	States that any contract of insurance which is payable to a citizen or inhabitant of this state, shall be held to be a contract of Texas.	If a Mexican HMO or insurer enters into a contract with a Texas employer, would the contract be subject to Texas laws?
Texas Insurance Code, Article 21.55, 20A.18B, 3.70-3C, 20A.09 (j)	Requirements related to prompt payment of claims	Clean claims are defined in terms of CMS claim forms. If Mexican physicians and providers use other types of forms, how would the law apply?
Texas Insurance Code, Article 3.77	Texas Health Insurance Risk Pool requirements	Benefits of the Risk Pool are not available to non-U.S. citizens, except for HIPAA-eligible persons.

TEXAS STATE LAWS

Provision in State Law	Summary	Questions/Further Research
Texas Insurance Code, Article 20A.02	Defines physicians and providers as those licensed to practice in this state.	Most Mexican physicians and providers will not meet this definition
Texas Insurance Code, Article 20A.06(7)	Allows HMOs to receive payment from government agencies for services provided or arranged by the HMO	Is there any problem with Mexican HMOs receiving U.S. or Texas government funding for Mexican health care services?
Article 20A.10	Requires certain financial statement and information to be filed annually.	If a South-to-North model is enacted, will require alteration of TDI processes to allow for different currency.
Article 20A.12B(b)	Provides mechanism for investigating consumer complaint.	TDI will need to provide a bilingual process for consumer complaints.
Article 20A.14	Truth in advertising, fairness in re-enrollment and other issues.	How would TDI monitor advertising in Mexico?
Article 20A.13C.	Built in protections to guarantee solvency of organization.	If a South-to-North model is enacted, will require alteration of TDI processes to allow for different currency.
Article 20A.17	Establishes triennial financial and quality of care examinations.	Will it be possible to conduct any kind of examination in Mexico? Or will this even be necessary if carrier/company/HMO has a home office in Texas?

Witness List
Interim Committee on Binational Health Benefit Plan Coverage

August 13, 2002--Austin, Texas

Ronald Dutton, Ph.D., Director of Border Health, Texas Department of Health

Rod Bordelon, Public Counsel, Office of Public Insurance Counsel

Karen Pederson, President/CEO, Valley Baptist Health Plan

Mike Pollard, Executive Director, Texas Association of Life & Health Insurers

Maria Alen, M.D., Adjunct Professor and Clinical Consultant, South Texas Center for Rural Public Health, Texas A&M University System

Lisa McGiffert, Senior Policy Analyst, Consumers Union

David Warner, Ph.D., Professor, LBJ School of Public Affairs, University of Texas

September 9, 2002--Harlingen, Texas

Mannti Cummins, Consultant, Gonzalez, Kieschnick, Cross & Farias, LLP

Bill Adams, Senior Vice President, Valley Baptist Medical Center

Christopher Knight, Chief Financial Officer, South Texas Health System

Ron Tupper, Chairman of the Board, El Milagro Clinic

Ramiro Casso, M.D., Clinical Consultant, Texas A&M University Health Science Center

Jose Peralez, D.D.S., Rio Grande Valley District Dental Society

Jose Cassares, D.D.S., Rio Grande Valley District Dental Society

Tammy DeGannes, Program Administrator, Dentists Who Care

Susan Hanafin, CNM, Coalition of Nurses of Advanced Practice

Juan M. Campos, M.D., President, Hidalgo-Starr Medical Society (written testimony)

October 15, 2002--El Paso, Texas

The Honorable Eliot Shapleigh State Senator, El Paso, Texas

Jeannette Skinner, RN, Director of Case Management, Del Sol Medical Center

Jorge Magaña, M.D., Director, El Paso County Health and Environmental District

Brooke Ward, Sierra Providence Health Network

Manuel Feliberti, Director, Del Sol Medical Center

Luis Acosta, M.D., President-Elect, El Paso County Medical Society

Richard Fleager, Vice President, Southern Union Gas Company (written testimony)
David Rodriguez, President/CEO, El Paso First Health Plan (written testimony)

AN ACT

relating to a study of binational health care plan coverage.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF TEXAS:

SECTION 1. LEGISLATIVE FINDINGS. (a) The legislature finds that it is in the best interest of the state to find a cost-effective manner of delivering health care services through affordable health care plans to citizens residing on both sides of the Texas-Mexico border.

(b) The legislature further finds that the provision of health care coverage in the border area is not conducive to preventive care or prenatal care, or to the provision of a medical home for binational families.

SECTION 2. INTERIM COMMITTEE. (a) An interim committee is established to study the provision of binational health benefit plan coverage. The interim committee is composed of seven members as follows:

(1) the commissioner of insurance;

(2) the commissioner of health and human services;

(3) one member of the Texas House of Representatives from a border community, appointed by the speaker of the house;

(4) one member of the Texas Senate from a border community, appointed by the lieutenant governor;

(5) one member who represents health maintenance organizations, appointed by the governor;

(6) one member who represents hospitals, appointed by the governor; and

(7) one member who is a medical practitioner, appointed by the governor.

(b) The committee members shall be appointed not later than August 1, 2001. The members of the house and senate who serve on the committee shall act as joint presiding officers of the committee.

SECTION 3. COMMITTEE DUTIES. The interim committee appointed under this Act shall hold hearings in the border areas of the state to:

(1) determine the need for binational health benefit plan coverage;

(2) assess the health care needs of the border area and how those needs can be served by various types of providers; and

(3) assess the affordability, cost-effectiveness, economic impact, and improved health status achievable through binational health benefit plan coverage.

SECTION 4. COMMITTEE REPORT. Not later than October 1, 2002, the interim committee appointed under this Act shall issue a report of findings and recommendations for administrative action and legislation during the next session of the legislature. The report shall be filed with the governor, lieutenant governor, and the speaker of the house of representatives.

SECTION 5. EXPIRATION. This Act expires December 31, 2002.

SECTION 6. EFFECTIVE DATE. This Act takes effect

immediately if it receives a vote of two-thirds of all the members elected to each house, as provided by Section 39, Article III, Texas Constitution. If this Act does not receive the vote necessary for immediate effect, this Act takes effect September 1, 2001.

H.B. No. 2498

President of the Senate

Speaker of the House

I certify that H.B. No. 2498 was passed by the House on May 4, 2001, by a non-record vote; and that the House concurred in Senate amendments to H.B. No. 2498 on May 25, 2001, by a non-record vote.

Chief Clerk of the House

I certify that H.B. No. 2498 was passed by the Senate, with amendments, on May 22, 2001, by a viva-voce vote.

Secretary of the Senate

APPROVED: 6.14.01

Date

Governor

FILED IN THE OFFICE OF THE SECRETARY OF STATE
4:15 p.m. O'CLOCK

JUN 14 2001

Secretary of State

AN ACT

relating to a study of barriers to providing binational health benefit plan coverage.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF TEXAS:

SECTION 1. (a) The Texas Department of Insurance and the Texas Department of Health shall jointly study the provision in this state of health benefit plan coverage to individuals who are not residents of this state or another state of the United States. The study must:

(1) identify legal and practical impediments to providing binational health benefit plan coverage; and

(2) include recommendations to facilitate provision of binational health benefit plan coverage.

(b) The Commissioner of Insurance and the Texas Board of Health may jointly appoint an advisory committee under Chapter 2110, Government Code, to assist the departments in conducting the study required by this Act.

(c) Not later than November 1, 2002, the Texas Department of Health and the Texas Department of Insurance shall jointly issue a report describing the departments' recommendations, including proposals for legislation. The departments shall file the report with the governor, lieutenant governor, and the speaker of the house of representatives.

SECTION 2. This Act expires December 31, 2002.

SECTION 3. This Act takes effect immediately if it receives

a vote of two-thirds of all the members elected to each house, as provided by Section 39, Article III, Texas Constitution. If this Act does not receive the vote necessary for immediate effect, this Act takes effect September 1, 2001.

S.B. No. 496

President of the Senate

Speaker of the House

I hereby certify that S.B. No. 496 passed the Senate on March 22, 2001, by the following vote: Yeas 30, Nays 0, one present, not voting.

Secretary of the Senate

I hereby certify that S.B. No. 496 passed the House on May 23, 2001, by the following vote: Yeas 145, Nays 0, two present, not voting.

Chief Clerk of the House

Approved:

6.17.01

Date

Governor

FILED IN THE OFFICE OF THE SECRETARY OF STATE
11:30 A.M. O'CLOCK
JUN 1 2001
Secretary of State