Attachment A-2

SCHEDULE OF BENEFITS

Chiropractic/Acupuncture Expanded Benefit

Your Employer Group has contracted with Landmark Healthplan of California, Inc. (Landmark) to provide you with a combined chiropractic and acupuncture benefit that requires the use of Participating Chiropractors and Acupuncturists. You can obtain a directory of Participating Chiropractors and Acupuncturists through your employer, plan administrator, or Landmark, or you can access a continuously updated directory on Landmark's Web site at www.LHP-CA.com under the "Member" option. You may also call Landmark's Customer Service Department at **1-800-298-4875** for referrals to Participating Practitioners in your area.

FREE LANGUAGE ASSISTANCE IS AVAILABLE

If you need help in understanding your Landmark chiropractic or acupuncture benefits or need help to handle an issue about your benefits, please contact Landmark's Customer Service Department at 1-800-298-4875 between 5:30 AM and 5 PM, Monday through Friday, for free help. We can also help you in languages other than English.

If you or your dependents would like Landmark and your doctor to use a specific language when speaking or writing to you, please go to https://www.LHP-CA.com/Survey.aspx on the Internet and complete Landmark's brief language preference survey. The survey only takes about 3 minutes to complete and your answers will be strictly confidential. If you prefer to complete a paper copy of this survey, you may request one by writing to us at:

Landmark Healthplan of California, Inc.
Attn: QM Dept. - SURVEY
2629 Townsgate Rd, Suite 235
Westlake Village, CA 91361

Benefits and Co-payments	
Office Visit	**$15** co-payment
Maximum Annual Visits	**20** visits
X-ray Services*	$75 annual maximum benefit
Discount for non-covered services	25% for chiropractic; 20% for acupuncture
Durable Medical Equipment Purchase or Rental**	$50 annual maximum benefit
Acupuncture Herbal Therapies***	$5 co-payment per bottle / $500 annual max benefit

**X-ray Services must be prescribed by a Participating Chiropractor.*
***Durable Medical Equipment must be prescribed by a Participating Chiropractor.*
****Herbal therapies must be prescribed by a Participating Acupuncturist.*

A. Covered Services

1. Chiropractic Treatment

Covered Chiropractic Services are those within the scope of chiropractic care that are supportive or necessary to help Members achieve the physical state enjoyed before an injury or illness. In addition, services for preventive, maintenance, and wellness care for any mechanical neuromusculoskeletal condition are also covered. Services need not be pre-authorized, will not be reviewed for Medical Necessity, and include the following:

- Examinations
- Manipulation
- Conjunctive Physiotherapy
- X-rays
- Emergency Services

2. Acupuncture Treatment

Covered Acupuncture Services are those within the scope of acupuncture care for the treatment of neuromusculoskeletal pain resulting from an injury or illness. In addition, coverage is provided for preventive, maintenance and wellness care for any mechanical neuromusculoskeletal condition, uncomplicated asthma (that which is not effected by another condition or disease), allergies, post-operative or chemo-therapy nausea and vomiting, nausea of pregnancy,

post-operative (including dental) pain, fibromyalgia, headaches and low-back pain. Services need not be pre-authorized, will not be reviewed for Medical

Necessity, and include the following:

- Acupuncture
- Electro-acupuncture
- Moxibustion
- Cupping
- Acupressure

[*3. Acupuncture Herbal Therapies - Optional*

Herbal therapies are for oral ingestion or external application of naturally occurring botanical, animal, or mineral substances, to support normal structure and function of the human body according to the principles of traditional Oriental Medicine. These therapies are covered up to the annual maximum benefit amount when they are prescribed by a Participating Acupuncturist and do not include substances banned by the Food and Drug Administration and/or the Food and Drug Branch of the California Department of Health Services.**]**

4. Emergency Services

Emergency Services are covered for the sudden and unexpected onset of an acute illness, extreme neuromusculoskeletal pain or accidental injury to the nervous, musculoskeletal and/or skeletal body systems, that, in the reasonable judgment of the Member, requires immediate care, the delay of which could decrease the likelihood of maximum recovery, and for which the Member seeks to secure chiropractic or acupuncture services immediately after the onset, or as soon thereafter as practicable. Emergency Services do not require pre-authorization; however, Emergency Services rendered by a Non-Participating Practitioner are subject to Landmark's determination that the Member would reasonably have considered that Emergency Services were required.

Emergency Services rendered by a Non-Participating Practitioner are covered only when the practitioner rendering services can show that the services were for a neuromusculoskeletal condition and/or illness and were provided to reduce the severity of the condition including pain until a Participating Practitioner could safely assume treatment. Similarly, Emergency Services received outside of Landmark's Service Area will be covered only when the Non-Participating Practitioner rendering services can show that the services were for a neuromusculoskeletal condition and/or illness and were provided to reduce the severity of the condition including pain until a Participating Practitioner could safely assume treatment. Under the Landmark Plan, emergency care must be transferred to a Participating Practitioner as soon as such transfer would not create an unreasonable risk to the Member's health.

B. Second Opinions and Referrals

1. Second opinions

On occasion, a Participating Practitioner may require a second opinion, which is for consultation only, from another practitioner. Landmark does not require an authorization for any second opinion. Second opinions initiated by your Participating Practitioner will not count against your maximum annual visits and will not require a Member office visit co-payment. Second opinions initiated by Members will count against the maximum annual visits and will require a Member office visit co-payment.

2. Referrals to non-chiropractic and/or non-acupuncture practitioners

For referrals to non-chiropractic and/or non-acupuncture practitioners, Members or enrollees of full-service plans or HMOs will be referred to the plan or HMO practitioner network for non-neuromusculoskeletal conditions, conditions not improving with chiropractic and/or acupuncture care, and other such services that cannot be provided by another Participating Practitioner.

C. Limitations and Exclusions

Circumstances Causing Services to be Excluded or Limited

1. Services provided by a Non-Participating Practitioner, except for emergencies
2. Services provided outside of Landmark's Service Area, except for emergencies
3. Services incurred prior to the beginning or after the end of coverage
4. Services that exceed the combined maximum covered visits for the benefit year
5. Charges incurred for missed appointments
6. Educational programs
7. Pre-employment, school entrance, or athletic physical exams
8. Services for conditions arising out of employment, including self-employment or covered under any workers' compensation act or law
9. Services for any bodily injury arising from or sustained in an automobile accident that is covered under an automobile insurance policy
10. Charges for which the Member is not legally required to pay
11. Services rendered by a person who ordinarily

resides in the Member's home or who is related to the Member by marriage or blood.

Specific Services that are Excluded or Limited

1. Experimental or investigational services
2. Vocational, stroke, or long-term rehabilitation
3. Hypnotherapy, behavior training, sleep therapy, or biofeedback
4. Rental or purchase of Durable Medical Equipment (DME)
5. Treatment primarily for purposes of weight control
6. Lab services
7. Thermography, hair analysis, heavy metal screening, or mineral studies
8. Transportation costs, including ambulance charges
9. Inpatient services
10. Advanced diagnostic services, such as MRI, CT, EMG, SEMG, and NCV

Chiropractic Only Limitations/Exclusions

1. Drugs, vitamins, nutritional supplements, or herbs
2. Massage or soft-tissue techniques
3. Manipulation under anesthesia
4. Services related to diagnosis and treatment of jaw joint or TMJ disorders
5. Treatment of non-neuromusculoskeletal disorders
6. X-ray services that exceed the annual maximum benefit

Acupuncture Only Limitations/Exclusions

1. Drugs, vitamins, nutritional supplements, or herbs, except as specified in the Schedule of Benefits
2. Massage or soft-tissue techniques other than acupressure as defined in your Evidence of Coverage
3. X-rays of any kind
4. Services related to menstrual cramps
5. Services related to addiction, including smoking cessation
6. Treatment of non-neuromusculoskeletal disorders except for those described under "Acupuncture Treatment" above

Landmark Healthplan of California Member Handbook
Chiropractic/Acupuncture Expanded Benefit
Combined Evidence of Coverage and Disclosure Form

Landmark Healthplan of California, Inc.

Your employer group has contracted with Landmark Healthplan of California, Inc. to provide you with the expanded combined chiropractic and acupuncture benefits described in this Combined Evidence of Coverage and Disclosure Form ("Evidence of Coverage"), which discloses the terms and conditions of coverage. You have the right to view the Evidence of Coverage prior to your enrollment. These chiropractic and acupuncture services are provided through chiropractors and acupuncturists who have entered into a service agreement with Landmark or other approved practitioners, providers or organizations to provide services pursuant to an agreement with Landmark Healthplan of California, Inc. (hereinafter referred to as "Landmark").

Combined Evidence of Coverage and Disclosure Form

This Combined Evidence of Coverage and Disclosure Form constitutes only a summary of the Plan and describes in simplified terms the provisions of the formal plan contract, or Group Agreement, between Landmark and your employer group or plan administrator. The specimen of the plan contract will be furnished on request and must be consulted to determine the exact terms and conditions of coverage. This Evidence of Coverage also describes Landmark's requirements for how to use the plan.

Please read this handbook completely including the sections on "Definitions," "Covered Services and Conditions of Coverage," "Enrollment and Eligibility," "Limitation of Benefits," "Third-Party Liability," "Non-Duplication and Coordination of Benefits," "Termination of Coverage," and "Member Grievance Resolution." If you have special health care needs, please read carefully those sections that apply to them. Consult the "Schedule of Benefits" included herein for a summary of the services and the co-payments, as well as Limitations and Exclusions, applicable to your Employer Group. For a comparison of health plan benefits offered to you, please review the "Benefits and Coverage Matrix" provided with this Evidence of Coverage. If you would like more information regarding the Plan's benefits, please contact our Customer Service Department at (800) 298-4875.

New Member Information

We look forward to arranging for your chiropractic and acupuncture needs. Please review this member handbook thoroughly to ensure an understanding of your combined chiropractic and acupuncture benefit. Understanding and following the procedures described in this booklet will help you maximize your chiropractic and acupuncture benefit. If you have any questions, see your employer and/or plan administrator or contact Landmark's Customer Service Department at (800) 298-4875.

Choice of Practitioners

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

One of the most important steps in receiving chiropractic and/or acupuncture services under this plan is to ensure that you select a Landmark Participating Chiropractor or Acupuncturist, based on the services you require. When a need for chiropractic services arises, select a Participating Chiropractor using the appropriate Landmark Practitioner Directory, which is distributed during the open enrollment process. Updated directory information is also available to you through your employer, plan administrator, or Landmark, and on Landmark's Web site at www.LHP-CA.com under the "Member" option. For acupuncture services, you must select from the listing of Participating Acupuncturists. Once you have selected a practitioner from the appropriate directory, make sure to verify that he/she is still a Landmark Participating Practitioner prior to receiving chiropractic or acupuncture services. You may do this by calling the practitioner's office or by contacting Landmark's Customer Service Department at (800) 298-4875. You may change your Participating Practitioner at any time. If you need help choosing or changing a current Participating Practitioner, or if you would like help to receive services from a practitioner of specific ethnicity, language, training or practice specialty, you may receive such assistance through the Customer Service Department.

Liability of Subscriber or Enrollee for Payment
The Subscriber or Enrollee will be responsible for payment of all services (except for Emergency Services) provided by Non-Participating Practitioners.

Reimbursement Provisions
The selected Participating Practitioner is responsible for verifying benefits and coordinating care for chiropractic or acupuncture services. Your Participating Practitioner is also responsible for submitting claims to Landmark for Covered Chiropractic or Acupuncture Services, as applicable, and cannot balance-bill Members for such services; that is, Participating Practitioners may not bill Members for any portion of Covered Chiropractic or Acupuncture Services except for the Co-payment.
If you receive Emergency Services from a Non-Participating Practitioner, you may submit a claim for reimbursement to Landmark by following these guidelines:

1. Submit a fully itemized bill with progress notes including:
   - Chiropractor's or Acupuncturist's name, Tax ID, and address
   - Date of service
   - Diagnosis
   - CPT Codes and/or description of procedures
   - Billed amount
2. Indicate on the claim whether you have paid the Non-Participating Practitioner's bill in full. If the claim is determined to be a Covered Chiropractic or Acupuncture Service, Landmark will reimburse you, less any applicable Co-payment and other charges that are your responsibility (see **Other Charges**, below). If you have not paid the bill in full and wish Landmark to pay the Non-Participating Practitioner directly, please include a signed statement instructing Landmark to do so.
3. All claims must be submitted within one-hundred-eighty (180) days of the date of service. Please include your name, address, Member number, and daytime phone number on your claim, and mail or deliver it to:

Landmark Healthplan of California, Inc.
ATTN: Claims Department
2629 Townsgate Rd, Suite 235
Westlake Village, CA 91361

Please Note: Landmark reimburses your Participating Practitioner with an agreed fee for Covered Services delivered to you. Landmark does not offer bonuses or incentive payments for the performance of individual practitioners. For more information concerning how your Participating Practitioner is paid, you may contact Landmark or your Participating Practitioner.

Definitions
The following terms are used in the Group Agreement and this handbook, including the Schedule of Benefits:
Acupressure — This is a massage technique utilizing pressure applied to acupuncture points.
Acupuncture — The insertion and removal of fine-gauge, solid, metallic needles into the human body to stimulate a point or points according to the principles of traditional Oriental Medicine.
Acute Condition — This is a medical condition that involves a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention and that has a limited duration.
Aggravation — A new incident or injury in the same area where a previous injury occurred.
Allergy — An antibody-mediated reversible inflammatory reaction, manifested cutaneously as uticaria, as bronchospasm in the respiratory system, and in the nose, as congestion of the nasal mucosa, or rhinorrhea.
Asthma — Expiratory wheezing caused by aeroallergens, oral allergens, or endogenous and exogenous factors which effect a decrease in bronchial diameter and the forced expiratory volume in one (1) second by more than twenty (20) percent; and may also be associated with a dry cough, and sometimes mucus production.
Binding Arbitration — Resolution of disputes between Landmark and a Member and/or Employer Group will be subject to binding arbitration rather than a court of law before a jury, pursuant to the terms of the Group Agreement. Arbitration is a process by which an arbitrator, a person with the power to decide a dispute, will conduct a hearing and make a final determination regarding the dispute between the parties. The involved parties are bound by the decision of the arbitrator. Such arbitration hearing will be in accordance with the rules of procedure and decision of Judicial Arbitration and Mediation Services, Inc.
Conjunctive Physiotherapy — The use of therapeutic procedures or modalities to assist in Member's treatment and promote healing, that include but are not limited to hot packs, electrical muscle stimulation, or ultrasound.

Coordination of Benefits — A contractual provision that applies when a Member is covered under more than one health insurance program. Such provision requires that payment of benefits be coordinated by all programs to eliminate overinsurance or duplication of benefits.
Co-payment — A fee, as set forth in the Schedule of Benefits, payable by the Member for certain services and benefits. Such fee is to be paid directly to the Participating Practitioner at the time of service. Such payment is in addition to and separate from the Plan premiums paid by the Employer Group.
Coverage — Chiropractic and acupuncture coverage under the Group Agreement pertaining to a Member.

Coverage Decision — The approval or denial of health care services by a Plan, or by one of its contracting entities, substantially based on the finding that the provision of a particular service is included or excluded as a covered benefit under the terms and conditions of the Group Agreement.
Covered Acupuncture Services — Those services within the scope of acupuncture care for the treatment of neuromusculoskeletal pain resulting from an injury or illness. In addition, coverage is provided for preventive, maintenance, and wellness care for any mechanical neuromusculoskeletal condition, uncomplicated asthma (that which is not effected by another condition or disease), allergies, post-operative or chemotherapy nausea and vomiting, nausea of pregnancy, post-operative (including dental) pain, fibromyalgia, headaches and low-back pain. Services need not be pre-authorized, will not be reviewed for Medical Necessity, and include the following:
 Acupuncture
 Electro-acupuncture
 Moxibustion
 Cupping
 Acupressure
Covered Chiropractic Services — Those services within the scope of chiropractic care that are supportive or necessary to help Members achieve the physical state enjoyed before an injury or illness. In addition, services for preventive, maintenance, and wellness care for any mechanical neuromusculoskeletal condition are also covered. Services need not be pre-authorized, will not be reviewed for Medical Necessity, and include the following:
 Examinations
 Manipulation
 Conjunctive Physiotherapy
 X-rays
 Emergency Services
Cupping — The production of a vacuum by means of heating a cup or cups that are then applied to the surface of the body to produce a therapeutic effect.
Dependent — The spouse, registered domestic partner, or child (including a stepchild or legally adopted child) of a Subscriber who is enrolled under the Subscriber's Plan, who meets all the eligibility requirements set forth by the Subscriber's Employer Group and Landmark and for whom applicable premiums are received by Landmark.

Disputed Health Care Service — Any health care service eligible for coverage and payment under a health care service plan contract that has been denied, modified or delayed by a decision of the Plan, or by one of its contracting providers, in whole or in part due to a finding that the service is not Medically Necessary.
Electro-acupuncture — The application of a low-voltage electric current (less than 9 volts) to previously inserted acupuncture needles for the purpose of stimulating a point or points according to the principles of traditional Oriental Medicine.

Emergency Medical Condition — A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that the absence of immediate medical attention could reasonably be expected to result in any of the following:

1) Placing the patient's health in serious jeopardy.
2) Serious impairment to bodily functions.
3) Serious dysfunction of any bodily organ or part.

Emergency Services — Services rendered for the sudden and unexpected onset of an acute illness, extreme neuromusculoskeletal pain or accidental injury to the nervous, musculoskeletal and/or skeletal body systems, that, in the reasonable judgment of the Member, requires immediate care, the delay of which could decrease the likelihood of maximum recovery, and for which the Member seeks to secure chiropractic or acupuncture services immediately after the onset, or as soon thereafter as practicable.

Emergency Services and Care — Medical screening, examination, and evaluation by a physician or, to the extent permitted by applicable law, by other appropriate personnel under the supervision of a physician, to determine if an emergency medical condition or active labor exists, and if it does, the care, treatment, and surgery by a

physician necessary to relieve or eliminate the emergency medical condition within the capability of the facility. Emergency Services and Care also means an additional screening, examination, and evaluation by a physician, or other personnel to the extent permitted by applicable law and within the scope of their licensure and clinical privileges, to determine if a psychiatric emergency medical condition exists, and the care and treatment necessary to relieve or eliminate the psychiatric emergency medical condition, within the capability of the facility.

Employer Group — The employer, group or other entity that contracts with Landmark to arrange for the provision of chiropractic and acupuncture services.

ERISA – The Employee Retirement Income Security Act of 1974, as amended.

Exacerbation — A flare-up of an existing illness or injury.

Examination — A systematic physical evaluation of the Member's complaints including the performance of evaluative measures to determine Member's state of health, which may include height, weight, blood pressure, pulse, temperature, and physique evaluations. Chiropractic examination also includes biomechanical evaluation of the spine and related joints.

Exclusion — Specific conditions or circumstances set forth in the Group Agreement and Evidence of Coverage for which the Plan will not provide coverage or remit payment for services.

Expanded Benefit — Provides coverage for chiropractic and acupuncture services for the treatment of neuromusculoskeletal pain resulting from an injury or illness. In addition, preventive, maintenance, and wellness care for any mechanical neuromusculoskeletal condition is covered under both chiropractic and acupuncture services, and is covered under acupuncture services for uncomplicated asthma (that which is not effected by another condition or disease), allergies, post-operative or chemotherapy nausea and vomiting, nausea of pregnancy, post-operative (including dental) pain, fibromyalgia, headaches and low-back pain. Services need not be pre-authorized and will not be reviewed for Medical Necessity.

Experimental or Investigational Chiropractic or Acupuncture Care — Chiropractic or acupuncture care that is essentially investigatory or an unproven procedure or treatment regimen that does not meet the generally accepted standards of practice.

Group Agreement — The formal agreement between the Employer Group and Landmark Healthplan of California, Inc., the Plan, for the provision of chiropractic and acupuncture services.

Herbal Therapy — The oral ingestion or external application of naturally occurring botanical, animal, or mineral substances to support normal structure and function of the human body according to principles of traditional Oriental Medicine.

Life-Threatening — Conditions that are either or both of the following:

1) diseases or conditions where the likelihood of death is high unless the course of the disease is interrupted.
2) diseases or conditions with potentially fatal outcomes, where the end-point of clinical intervention is survival.

Limitation — Any provision other than an Exclusion that restricts coverage under the Group Agreement and Evidence of Coverage.

Maintenance Care — Chiropractic or acupuncture care in the form of maintenance therapy and/or ongoing chiropractic adjustments or acupuncture treatments for a patient whose condition has resolved itself or whose symptoms have disappeared.

Manipulation — Passive dynamic thrust applied by a Participating Chiropractor to a joint in an attempt to restore proper motion and function.

Maximum Annual Visits — The maximum number of visits to Participating Chiropractors and Acupuncturists for which the Plan will provide coverage on an annual basis.

Medically Necessary — Chiropractic or Acupuncture Services that are:

a) Necessary for the treatment or diagnosis of neuromusculoskeletal disorders or other acupuncture services as described under "Covered Acupuncture Services";
b) Established as safe and effective and furnished in accordance with generally accepted chiropractic or acupuncture standards to treat neuromusculoskeletal disorders in the most economically efficient manner that may be provided safely and effectively to the Member, and not furnished primarily for the convenience of the Member, the Participating Chiropractor or Acupuncturist, or other provider of service; and
c) Appropriate for the symptoms, consistent with the diagnosis, and otherwise in accordance with generally accepted chiropractic or acupuncture practice and professionally recognized standards.

Member — The Subscriber or family member. A family member includes the Subscriber's spouse or retistered domestic partner and children who meet eligibility requirements specified by the Employer Group and Landmark, and who are enrolled in the Plan.

Moxibustion — The stimulation of an acupuncture point or points by means of burning artemesia vulgaris, with or without the addition of herbs, near but not in direct contact with the skin.
Neuromusculoskeletal — Conditions that display symptoms of and/or signs related to the nervous, muscular and/or skeletal body systems.
Non-Participating Practitioner — A chiropractor or acupuncturist who is not under contract to provide Covered Chiropractic or Acupuncture Services to Landmark Members.
Outside Service Area — All geographic areas beyond the identified Service Area of Landmark as approved by the Director of the California Department of Managed Health Care.
Participating Acupuncturist — An acupuncturist under contract to provide Covered Acupuncture Services to Landmark Members.
Participating Chiropractor — A chiropractor under contract to provide Covered Chiropractic Services to Landmark Members.
Participating Practitioner — A chiropractor or acupuncturist under contract to provide Covered Chiropractic Services or Covered Acupuncture Services, respectively, to Landmark Members.
Plan — A California corporation licensed as a health care service plan by the California Department of Managed Health Care under the Knox-Keene Health Care Service Plan Act of 1975. The name of the Plan is Landmark Healthplan of California, Inc., and it is organized to provide chiropractic and acupuncture health care services. Remember, Landmark Healthplan of California, Inc. is the *Plan,* not a chiropractic or acupuncture practitioner.
Prevailing Rates — Rates generally prevailing in the Service Area for chiropractic, acupuncture and related services.
Preventive Care — Procedures considered necessary by professionally recognized standards of practice to prevent the development of clinical manifestations of illness. In other words, the implementation of a treatment protocol with the anticipation of avoiding the onset of clinical manifestation of disease (conditions, illness or symptoms). This includes any services on an asymptomatic patient or a patient who has reached a point of maximum chiropractic or acupuncture benefit, that is, a point where additional chiropractic or acupuncture services provide little or no additional improvement in the patient's condition. This definition encompasses educational materials, training, and back support programs provided by Participating Practitioners during their normal treatment process.
Qualified Beneficiary — Any individual who, on the day before an event that triggers the Federal COBRA group coverage continuation provisions, is covered under the Plan as the spouse or dependent child of the Subscriber. Such term shall also include a child who is born to or placed for adoption with the Subscriber during the period of continuation coverage under COBRA.
Serious Chronic Condition — This is a medical condition due to a disease, illness, or other medical problem or medical disorder that is serious in nature and that persists without full cure or worsens over an extended period of time or requires ongoing treatment to maintain remission or prevent deterioration.
Seriously Debilitating — Diseases or conditions that cause major irreversible morbidity.
Service Area — The geographic area designated by Landmark and approved by the Director of California Department of Managed Health Care within which Landmark shall provide Covered Chiropractic and Acupuncture Services.
Subscriber — An employee of the Employer Group that has contracted with Landmark for the provision of chiropractic and acupuncture health care services. Such employee meets all of the eligibility requirements specified by the Employer Group and Landmark and is enrolled in the Plan.
Terminated Practitioner — This is a Practitioner, previously contracted with Landmark to provide Covered Services to Landmark members, whose participation in Landmark's network of Participating Practitioners has been terminated or non-renewed.
Voluntary Mediation — A provision by which a Member and/or Employer Group and Landmark can request and voluntarily agree to resolve a grievance or appeal, other than a quality of care complaint, through the process of mediation. Mediation is a process whereby an intermediary agent intervenes between the conflicting parties to promote reconciliation, settlement or a compromise. Expenses for mediation are borne equally by the conflicting parties.
Wellness Care — A periodic lifestyle assessment designed to attain optimum performance and behavior to improve health status. This kind of care is performance-specific rather than condition- or symptom-specific; that is, it emphasizes quality of life aspects.
X-rays — A test using a low dose of ionizing radiation to produce an image of the Member's skeleton to assist the Participating Chiropractor in the evaluation of the Member's complaints.

Covered Services and Conditions of Coverage

Subject to all terms, conditions, exclusions and limitations set forth in this Evidence of Coverage and the Group Agreement, including receipt by Landmark of applicable monthly premiums, you are entitled to receive Covered Chiropractic and Acupuncture Services as set forth in this section and in the Schedule of Benefits. The Schedule of Benefits is an important part of this Evidence of Coverage, and it lists the specific benefits, number of visits, and Co-payments applicable to your Employer Group.

Coverage shall commence on the date the Plan accepts a Member's enrollment form and verifies the Member's eligibility through the eligibility roster provided by the Employer Group. The Plan's acceptance of the Member's enrollment form is contingent upon receipt of the applicable health plan premium payment. For further information regarding initial open enrollment, periodic open enrollment, and effective dates of coverage at a time other than during open enrollment, please consult your employer and/or Group Agreement.

Covered Chiropractic Services **—** Covered Chiropractic Services are those within the scope of chiropractic care that are supportive or necessary to help Members achieve the physical state enjoyed before an injury or illness. In addition, services for preventive, maintenance, and wellness care for any mechanical neuromusculoskeletal condition are also covered. Services need not be pre-authorized, will not be reviewed for Medical Necessity, and include the following:

- Examinations
- Manipulation
- Conjunctive Physiotherapy
- X-rays

Covered Acupuncture Services — Those services within the scope of acupuncture care for the treatment of neuromusculoskeletal pain resulting from an injury or illness. In addition, coverage is provided for preventive, maintenance, and wellness care for any mechanical neuromusculoskeletal condition, uncomplicated asthma (that which is not effected by another condition or disease), allergies, post-operative or chemotherapy nausea and vomiting, nausea of pregnancy, post-operative (including dental) pain, fibromyalgia, headaches and low-back pain. Services need not be pre-authorized, will not be reviewed for Medical Necessity, and include the following:

- Acupuncture
- Electro-acupuncture
- Moxibustion
- Cupping
- Acupressure

Herbal Therapies **—** Herbal therapies are covered up to the annual maximum benefit amount when they are prescribed by a Participating Acupuncturist and do not include substances banned by the Food and Drug Administration and/or the Food and Drug Branch of the California Department of Health Services. Herbal therapies may or may not be a covered service, depending upon the Group Agreement. Covered services are listed on the Schedule of Benefits, which members should read to determine coverage.

Emergency Services **—** Emergency Services are covered for the sudden and unexpected onset of an acute illness, extreme neuromusculoskeletal pain or accidental injury to the nervous, musculoskeletal and/or skeletal body systems, that, in the reasonable judgment of the Member, requires immediate care, the delay of which could decrease the likelihood of maximum recovery, and for which the Member seeks to secure chiropractic or acupuncture services immediately after the onset, or as soon thereafter as practicable. Emergency Services do not require pre-authorization; however, Emergency Services rendered by a Non-Participating Practitioner are subject to Landmark's determination that the Member would reasonably have considered that Emergency Services were required.

Emergency Services rendered by a Non-Participating Practitioner are covered only when the practitioner rendering services can show that the services were for a neuromusculoskeletal condition and/or illness and were provided to reduce the severity of the condition including pain until a Participating Practitioner could safely assume treatment. Similarly, Emergency Services received outside of Landmark's Service Area will be covered only when the Non-Participating Practitioner rendering services can show that the services were for a neuromusculoskeletal condition and/or illness and were provided to reduce the severity of the condition including pain until a Participating Practitioner could safely assume treatment. Under the Landmark Plan, emergency care must be transferred to a Participating Practitioner as soon as such transfer would not create an unreasonable risk to the Member's health.

Except for Emergency Services, Landmark will not pay for charges incurred by a Member for services from any practitioner other than a Participating Chiropractor or Participating Acupuncturist unless authorized by Landmark. Whenever the determination of whether a Member is entitled to a benefit is based on the need for Emergency Services, Landmark shall have final authority governing such determination as well as all other benefit deter-

minations, provided that such determinations are consistent with professional standards of practice and all terms and conditions of coverage of this Evidence of Coverage.

Second Opinions and Referrals

Second opinions **—** On occasion, a Participating Practitioner may require a second opinion, which is for consultation only, from another practitioner. Landmark does not require an authorization for any second opinion. Second opinions initiated by your Participating Practitioner will not count against your maximum annual visits and will not require a Member office visit co-payment. Second opinions initiated by Members will count against the maximum annual visits and will require a Member office visit co-payment.

Referrals to non-chiropractic and/or non-acupuncture practitioners **—** For referrals to non-chiropractic and/or non-acupuncture practitioners, Members or enrollees of full-service plans or HMOs will be referred to the plan or HMO practitioner network for non-neuromusculoskeletal conditions, conditions not improving with chiropractic and/or acupuncture care, and other such services that cannot be provided by another Participating Practitioner.

Your Obligations

After completing and submitting your enrollment form, you agree to notify Landmark or Employer Group of any changes impacting your enrollment in the Plan. In addition, you agree to use a Participating Practitioner when seeking chiropractic or acupuncture services, agree to cooperate with your Participating Practitioner by providing medical information necessary for Landmark's evaluation of chiropractic or acupuncture services, and agree to meet with Landmark or your Participating Practitioner, if necessary. Such cooperation is necessary to ensure that Covered Chiropractic and Acupuncture Services are effective and appropriate.

Whenever you see your Participating Practitioner, be sure you understand what you are told about your healthstatus. If the information or instructions given are not clear, do not hesitate to ask for further explanation. It is important that you fully understand and follow instructions carefully to maintain or regain your optimum health status.

Enrollment and Eligibility

Landmark will provide you, and other members of your family, Covered Chiropractic and Acupuncture Services in accordance with the Group Agreement when you and/or your family are properly enrolled and listed on the eligibility roster provided by your employer. Coverage will begin on the date Landmark accepts your enrollment form and verifies your eligibility through the eligibility roster provided by your employer.

Eligibility requirements for membership are as follows:

a) The Subscriber and any enrolled dependents must permanently reside within Landmark's Service Area.
b) The Subscriber must meet any eligibility requirements of Employer Group for membership in the Plan.
c) Dependents' eligibility for enrollment is contingent upon Subscriber's eligibility for enrollment in the Plan.
d) Coverage for newborn children of Subscribers begins at birth. For coverage to continue past thirty-one (31) calendar days from the date of birth, an enrollment form for the Dependent must be submitted to the Employer Group within thirty-one (31) calendar days of the date of birth. Newborn care is not a covered benefit at any time if the mother of the newborn is a Dependent child of the Subscriber.
e) Coverage for adopted children of Subscribers begins from the date physical custody of the child is obtained by Subscriber. For coverage to continue past thirty-one (31) calendar days from the date physical custody is obtained, an enrollment form for the Dependent must be submitted to the Employer Group within thirty-one (31) calendar days of the date the physical custody was obtained.
f) Dependent children are eligible up to the age of twenty-six (26) years.
g) Dependent unmarried children over the age of twenty-six (26) years who are incapable of self-sustaining employment by reason of mental retardation or physical handicap and who are dependent upon the Subscriber for support and maintenance are eligible for continuing membership in the Subscriber's Plan. Proof of such incapacity and dependency must be provided to Landmark within thirty (30) calendar days of the child's attainment of the limiting age specified in section f) above. Proof of continued incapacity and dependency of the Dependent may be required periodically; however, such requests will not occur more frequently than annually.
h) Addition of a Dependent spouse due to marriage must occur within thirty (30) calendar days of the date of marriage. Addition of a registered domestic partner must occur within thirty (30) calendar days of the date a valid Declaration of Domestic Partnership is filed with the California Secretary of State, or an equivalent document is issued by a local agency of California, another state, or a local agency of another state under which the partnership was created.

For further information regarding eligibility, please contact the Landmark Customer Service Department or consult your employer and/or Group Agreement.

Prepayment Fee

A monthly subscription fee for each Member shall be remitted to the Plan the first business day of each month for which membership is effective. The initial monthly fee schedule shall remain in effect for the initial term of the Group Agreement. Thereafter, the monthly subscription fee schedule shall be subject to change from year to year. If additional benefits are included in the future under your agreement, Landmark reserves the right to increase the subscription fee upon thirty (30) calendar days' prior written notice for an individual contract and upon renewal date for a group contract, and only upon providing thirty (30) calendar days' prior written notice of the group contract renewal date. For confirmation of the full premium charge and for information regarding sums, if any, to be withheld from the subscriber's salary or to be paid by the Member to the employer or group contract holder, please consult your employer and/or Group Agreement.

Other Charges

You are required to pay for all co-payments, non-covered services, services rendered due to Member fraud or deception, Emergency Services when it is determined that such services were not an emergency, and services provided by Non-Participating Practitioners.

Facilities

Please consult the Landmark Practitioner Directory for the locations of facilities and Participating Practitioners. All Subscribers will receive a copy of the Practitioner Directory. Additionally, updated directory information is available through your employer or plan administrator. You may also contact Landmark's Customer Service Department at (800) 298-4875 for assistance.

Limitation of Benefits

1. *Acts Beyond Landmark's Control* — In accordance with the Group Agreement, Landmark shall not be responsible for the provision of services or have any liability for acts of Participating Practitioners beyond Landmark's control.
2. *Inability to Provide Covered Chiropractic or Acupuncture Services* — In the event Landmark, for any reason beyond its control, is unable to provide Covered Chiropractic or Acupuncture Services, then Landmark shall be liable for the reimbursement of expenses necessarily incurred by the Member in procuring the services through Non-Participating Practitioners, to the extent required by the Director of the California Department of Managed Health Care.

Continuity of Care

If you have been receiving care from a Non-Participating Practitioner immediately before enrolling with Landmark, or from a Participating Practitioner who terminates or is terminated from participation in the Landmark network, you must contact Landmark in order to be considered eligible for completion of care. [**Please note:** for new Landmark members, if you could have chosen to move to, or elected to remain with, a plan that permitted treatment by your current practitioner who is not a Participating Practitioner on Landmark's panel, but you voluntarily chose coverage under Landmark, then you are not eligible for continuity of care.] You may contact Landmark's Customer Service Department at (800) 298-4875 to request a written copy of Landmark's continuity of care policy and for help to request that your care be continued with your current Practitioner. You may also download a Member Request for Continuity of Care form to fill out and mail in from Landmark's Web site at www.LHP-CA.com.

Your care will not be continued with a Non-Participating Practitioner or a Terminated Practitioner if the Practitioner does not accept payment at rates and methods of payment similar to those used by Landmark for Participating Practitioners providing similar services who are practicing in the same or a similar geographic area as your Practitioner. Also, Landmark is not required to cover services or provide benefits that are not otherwise covered under the terms and conditions of this Combined Evidence of Coverage and Disclosure Form, and specifically the Schedule of Benefits section of this document. You will still be responsible for co-payments during the period of completion of Covered Services with the Non-Participating or Terminated Practitioner.

If the conditions above are met, continuity of care will be provided on these terms:

1. For an Acute Condition (as defined above), completion of Covered Services shall be provided for the duration of the Acute Condition.
2. For a Serious Chronic Condition (as defined above), completion of Covered Services shall be provided for a period of time necessary to complete a course of treatment and to arrange for a safe transfer to a Participating Practitioner. Such period of time will not exceed 12 months from either your effective date of coverage or the Practitioner's termination date, as applicable.

3. For a newborn child between birth and age 36 months, completion of Covered Services shall be provided for up to 12 months from the child's effective date of coverage or the Practitioner's termination date, as applicable.

If you have further questions, you are encouraged to contact the Department of Managed Health Care, which protects HMO consumers, by telephone at its toll-free number, 1(888) HMO-2219, or at a TDD number for the hearing impaired at 1(877) 688-9891, or online at www.hmohelp.ca.gov.

Confidentiality

Landmark agrees to maintain and preserve the confidentiality of Member's medical records in accordance with state and federal laws. However, a Member authorizes the release of information and access to Member's medical records to Landmark, its agents and employees, Member's Participating Practitioner, and appropriate governmental agencies for purposes of utilization review, quality assurance, processing of any claim, financial audit, coordination of benefits, or for any other purpose reasonably related to the provision of benefits under the Group Agreement. When required by law, Landmark shall obtain Member's specific written authorization for the release of Member's medical records. Landmark shall not release any information to Employer Group that would directly or indirectly indicate to Employer Group that a Member is receiving or has received services under the Group Agreement, unless authorized to do so by the Member.

A STATEMENT DESCRIBING LANDMARK'S POLICIES AND PROCEDURES FOR PRESERVING THE CONFIDENTIALITY OF MEDICAL RECORDS IS AVAILABLE AND WILL BE FURNISHED TO YOU UPON REQUEST.

Individual Continuation of Benefits

Member and/or Member's family may have rights to convert to individual coverage as specified in the Group Agreement. Contact Landmark or Employer Group for information on conversion to individual coverage.

Continuation of Group Coverage

Federal Continuation Provisions "COBRA"

(Employers with 20 or more Employees)

In accordance with the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), a Subscriber or Qualified Beneficiary who loses coverage under his or her group benefit plan is entitled to continue group coverage, including this Chiropractic/Acupuncture benefit, provided the Employer Group is not exempted under COBRA. Generally, COBRA requires all employers of 20 or more employees to offer to continue group coverage for up to 18 months to Subscribers and their Qualified Beneficiaries who lose coverage due to termination of employment (except for gross misconduct) or reduction in hours worked, and for up to 36 months to Qualified Beneficiaries who lose coverage due the death of the employee, divorce or legal separation from the employee or to children who no longer qualify as covered Dependents. "Extended" coverage of up to 29 months is available to certain COBRA beneficiaries who are disabled at the time of their qualifying event and entitled to Social Security disability benefits. Continuation of group coverage rights under COBRA continues until either the exhaustion of the previously mentioned maximum continuation periods or a "terminating event" occurs (e.g., the Employer Group no longer offers any Chiropractic/Acupuncture group benefit, failure of the Subscriber or Qualified Beneficiary to pay monthly prepayment fees when due, the Subscriber or Qualified Beneficiary is or becomes covered under any other Chiropractic/Acupuncture benefit plan without limitation as to the Totally Disabling Condition, or the Subscriber or Qualified Beneficiary is or becomes entitled to Medicare coverage). Subscribers or Qualified Beneficiaries whose COBRA continuation coverage began on or after January 1, 2003 and who have exhausted their COBRA benefits may be eligible for California continuation coverage, or "Cal-COBRA," as described below. If applicable, a notice will be provided to you at the time your COBRA benefits will expire, allowing up to an additional 18 months of continuation coverage, but not to exceed 36 months from the date COBRA coverage first began.

Benefits of the continuation plan are identical to this group plan. The cost of the coverage will be 102% of the applicable group rate (including any portion previously paid by Employer Group) during the period of basic COBRA coverage and 150% of the applicable group rate during the period of "extended" coverage (i.e., 19th through 29th month for disabled beneficiaries).

UNDER COBRA, THE EMPLOYER GROUP IS SOLELY RESPONSIBLE FOR ALL NOTIFICATION, ADMINISTRATION, AND OTHER COMPLIANCE RESPONSIBILITIES. Please consult your Employer Group with your questions regarding continuation of group coverage. You should receive notice from your Employer Group's plan administrator of your eligibility for group continuation coverage if a qualifying event occurs. In the event of a Sub-

scriber's death, this notice should be sent to the Subscriber's Qualified Beneficiaries. Failure of a Subscriber or affected Qualified Beneficiary to notify the Employer Group within 60 days of divorce, legal separation or a Dependent child's loss of eligibility will result in loss of eligibility for group continuation coverage. The Employer Group must notify Landmark of the occurrence and related date of any qualifying event within 30 days of the incidence thereof. If the Subscriber or Qualified Beneficiary fails to provide such notice, then the Subscriber or Qualified Beneficiary shall not be entitled to elect continuation coverage under this benefit plan.

COBRA coverage will begin at the time group coverage ends if you apply and pay the required prepayment fees within 60 days after receiving notice of eligibility for continuation coverage or the date of loss of coverage, whichever is later. If you elect to continue, your coverage will be retroactively reinstated to the date you or your Qualified Beneficiaries were last covered under the Agreement. Any prepayment fees for retroactive coverage must be paid to Landmark no later than 45 days from the date you elect to continue coverage. You will be billed for current coverage on a monthly basis by your Employer Group. Your Employer Group shall pay prepayment fees to Landmark by the 20th day of each month prior to the month of coverage. Coverage will be canceled on midnight of the last day for which payment was last made if prepayment fees are not received within 30 days of the due date.

State Continuation Provisions "Cal-COBRA"

(Employers with fewer than 20 Employees)

The California CONTINUATION BENEFITS REPLACEMENT ACT, or Cal-COBRA, requires that Employer Groups with fewer than 20 eligible employees on at least 50% of its working days during the preceding calendar year, or, if the Employer Group was not in business during any part of the preceding calendar year, employed 2 to 19 eligible employees on at least 50% of its working days during the preceding calendar quarter, offer eligible employees and their Dependents the opportunity for a temporary extension of coverage (called "continuation of coverage") in certain instances where coverage under the plan would otherwise end.

Qualifying Events

A Subscriber who is an employee of an Employer Group with fewer than 20 employees and is enrolled in its Chiropractic/Acupuncture group benefit plan has a right to choose this continuation coverage if any of the following Qualifying Events occur:

1. The Subscriber loses coverage because of a reduction in hours of employment; or
2. The termination of employment (for reasons other than gross misconduct on the Subscriber's part).

Covered Dependents of an employee have the right to choose continuation coverage if any of the following Qualifying Events occur:

1. The death of the Subscriber;
2. The termination of the Subscriber's employment (for reasons other than gross misconduct) or reduction in the hours of employment;
3. Divorce, termination of domestic partnership, or legal separation from the Subscriber;
4. The Dependent child ceases to be a Dependent under the terms of this benefit plan; or
5. The Subscriber becomes entitled to Medicare.

Notification Requirement

A Subscriber or Dependent has the responsibility to inform Landmark of a Qualifying Event. This notification must be made in writing within 60 days of the date of the Qualifying Event and delivered to Landmark by first-class mail, or other reliable means of delivery, including personal delivery, express mail, or private courier. Such notification must also include the following information:

1. The name of the Member;
2. The date of the Qualifying Event and the type of Qualifying Event as listed above;
3. The name of the Employer Group and the group plan number; and
4. The name and address of the Subscriber and all qualified Dependents.

Failure to provide the required notification within 60 days will disqualify the individual from receiving continuation coverage.

Election and Enrollment

When Landmark is notified that one of these events has occurred, we will in turn notify the Member that he or she has the right to choose continuation coverage. If a Member wishes to choose continuation coverage, he or she must deliver a completed enrollment application within 60 days of the later of:

1. The date of receipt of notice from Landmark that the Member has the right to Cal-COBRA continuation coverage; or
2. The date the Member's coverage under the Employer Group plan terminated or will terminate.

If the Member elects continuation coverage, the coverage will be effective on the day after coverage would otherwise be terminated. Cal-COBRA continuation coverage will be the same as the coverage provided by the Employer to similarly situated employees and Dependents. Members do not have to show that they are insurable to choose continuation coverage; however, they will pay 110% of the applicable premium charged to similarly situated individuals under the Group Agreement. If they do not elect coverage and pay the appropriate premium, their benefit coverage will terminate in accordance with the provisions outlined in this Evidence of Coverage.

Premium Payments

The first premium payment must be submitted to Landmark by first-class mail, certified mail, or other reliable means of delivery, including personal delivery, express mail, or private courier company, within 45 days of delivering the completed enrollment form. The payment must cover the period from the last day of the prior coverage to the present. There can be no gap between prior coverage and Cal-COBRA continuation coverage. Failure to submit the correct premium within the 45-day period noted above will disqualify the Member from receiving continuation coverage. All subsequent payments are due on the first day of each coverage month. If prepayment fees are not received within 30 days of the due date, continuation coverage will be canceled on midnight of the last day for which payment was last made.

Termination of Cal-COBRA Coverage

Cal-COBRA continuation coverage will be terminated at the first to occur of the following:

1. 36 months from the date Cal-COBRA continuation coverage commenced;
2. The employer ceases to provide any Chiropractic/Acupuncture group benefit coverage to its employees;
3. Premium payments are not paid within 30 days of the due date; or, the Member fails to satisfy other terms and conditions of the plan contract and Evidence of Coverage;
4. Member becomes covered under any other Chiropractic/Acupuncture group benefit plan (as an employee or otherwise) that does not contain any exclusion or limitation with respect to any preexisting condition;
5. Member becomes covered, or is eligible for, federal COBRA coverage;
6. Member becomes entitled to Medicare benefits;
7. Member moves out of the Service Area; or
8. Member commits fraud or deception in the use of plan services.

A Member who is eligible for continuation coverage due to a loss of employment or reduction in hours worked, and determined, under Title II or XVI of the Social Security Act, to be disabled at any time during the first 60 days of continuation of coverage, and the Dependent who has elected coverage, is eligible for 36 months of Cal-COBRA coverage, beginning from the date the individual's benefits under the contract would otherwise have terminated because of a qualifying event. The qualified Member shall notify Landmark of the social security determination within 60 days of the date of the determination letter and prior to the end of the original 36-month continuation coverage period. Landmark will charge 150% of the applicable premium after the initial 18 months of continuation coverage. The qualified Member must notify Landmark within 30 days upon the determination that the qualified Member is no longer disabled under Title II or XVI of the Social Security Act.

A Member who is initially eligible for and elects continuation coverage due to a loss of employment or reduction in hours worked, but who has another Qualifying Event within 18 months of the date of the first Qualifying Event and notifies Landmark of the second Qualifying Event within 60 days of the date of the second Qualifying Event will be entitled to a total of 36 months of Cal-COBRA continuation coverage beginning on the date of the first Qualifying Event.

Early Termination of Group Contract

If the group contract between your employer and Landmark is terminated prior to the date your continuation coverage would terminate under Cal-COBRA, you may elect continuation coverage under the new group benefit plan, if any, for the remainder of the time period you would have been covered by Landmark. If there is a new group benefit plan, you must contact the new benefit plan for details on continuing coverage through the plan. Please note that continuation coverage will terminate if you fail to comply with the requirements pertaining to enrollment in, and payment of premiums to the new benefit plan within 30 days of receiving notice by Landmark of the termination of its group contract with your employer.

Cal-COBRA Continuation Coverage After COBRA

In the event a Subscriber or Qualified Beneficiary's COBRA coverage began on or after January 1, 2003 and those COBRA benefits have been exhausted as described above, the Subscriber or Qualified Beneficiary may be eligible to continue benefits under Cal-COBRA at 110 % of the premium charged for similarly situated eligible employees currently working at your former employment. A notice will be provided to you at the time your COBRA benefits will exhaust, allowing up to 18 more months, but not to exceed 36 months from the date COBRA benefits began.

Individuals Ineligible for Cal-COBRA

The following individuals are not eligible for Cal-COBRA continuation coverage:

1. Individuals who are entitled to Medicare benefits or become entitled to Medicare benefits pursuant to Title XVIII of the United States Social Security Act, as amended or superseded. Entitlement to Medicare Part A only constitutes entitlement to benefits under Medicare.
2. Individuals who have other hospital, medical, or surgical coverage or who are covered or become covered under another group benefit plan, including a self-insured employee welfare benefit plan, that provides coverage for individuals and that does not impose any exclusion or limitation with respect to any preexisting condition of the individual, other than a preexisting condition limitation or exclusion that does not apply to or is satisfied by the qualified beneficiary pursuant to Sections 1357 and 1357.06. A group conversion option under any group benefit plan shall not be considered as an arrangement under which an individual is or becomes covered.
3. Individuals who are covered, become covered, or are eligible for federal COBRA coverage pursuant to Section 4980B of the United States Internal Revenue Code or Chapter 18 of the Employee Retirement Income Security Act, 29 U.S.C. Section 1161 et seq.
4. Individuals who are covered, become covered, or are eligible for coverage pursuant to Chapter 6A of the Public Health Service Act, 42 U.S.C. Section 300bb-1 et seq.
5. Individuals who fail to meet the requirements of subdivision (b) of Section 1366.24 regarding notification of a qualifying event or election of continuation coverage within the specified time limits.
6. Individuals who fail to submit the correct premium amount required by subdivision (b) of Section 1366.24 and Section 1366.26, in accordance with the terms and conditions of the plan contract, or fail to satisfy other terms and conditions of the plan contract..

Third-Party Liability

In the case of injuries caused by any act or omission of a third party and any complications incident thereto, the benefits of the Group Agreement shall be furnished by Landmark to Member. Landmark does not delegate to providers Landmark's lien rights. Member agrees, however, to reimburse Landmark, or its nominee, for the cost of such services and benefits immediately upon obtaining a monetary recovery, whether due to settlement or judgment, on account of such injury. Member shall hold any such sum in trust for Landmark, but said sum shall not exceed the costs incurred in perfecting the lien and the lesser of (1) one-half of the total judgment or settlement, if the Member did not engage an attorney or (b) one-third of the total judgment or settlement, if the Member engaged an attorney; or (2) the amount actually paid by Landmark to the Provider.

a) Member agrees that Landmark's reimbursement under the Group Agreement is the first-priority claim against any third party. This means that Landmark shall be reimbursed from any recovery from a third party before payment of any other existing claims, including any claim by the Member for general damages. Landmark may collect from the proceeds of any settlement or judgment recovered by Member or his or her legal representative regardless of whether the Member has been fully compensated.
b) Member agrees to cooperate in protecting Landmark's interests under this provision. Member shall execute and deliver to Landmark or its nominee any and all liens, assignments or other documents which may be necessary or proper to fully and completely effectuate and protect Landmark's rights, or its nominee, including, but not limited to, the granting of a lien right in any claim or action made or filed on Member's behalf and the signing of documents evidencing the same.
c) Member shall not settle any claim, or release any person from liability, without Landmark's prior written consent if such release or settlement will extinguish or act as a bar to Landmark's rights of reimbursement.
d) In the event Landmark employs an attorney for the purpose of enforcing any part of this section against a Member based on such Member's failure to cooperate with Landmark, the prevailing party in any legal action or proceeding shall be entitled to reasonable attorney's fees.
e) In lieu of payment as indicated above, Landmark, at its option, may choose to be subrogated to the Member's rights to the extent of the benefits received under Landmark. Landmark's subrogation right shall include the right to bring suit in the Member's name. Member shall fully cooperate with Landmark when Landmark exercises its right of subrogation, and Member shall not take any action or refuse to take any action that would prejudice the rights of Landmark under the Group Agreement.

Non-Duplication of Benefits/ Coordination of Benefits

Workers' Compensation

Landmark shall not furnish benefits under the Group Agreement to any Member that duplicate the benefits to which such Member is entitled under any applicable workers' compensation law. The Member is responsible for taking whatever action is necessary to obtain payment under workers' compensation laws where payment under that system can be reasonably expected. Failure to take proper and timely action under such circumstances will preclude Landmark's responsibility for furnishing such benefits on behalf of such Member to the extent that payment of such benefits could have been reasonably expected under workers' compensation laws had action been taken.

a) In the event Landmark for any reason provides benefits that duplicate the benefits to which Member is entitled under workers' compensation laws, Member agrees to reimburse Landmark, or its nominee, for the cost of all such services and benefits provided by Landmark, at Prevailing Rates, immediately upon obtaining a monetary recovery, whether due to settlement or judgment. Member shall hold any sum collected as the result of a workers' compensation action in trust for Landmark. Such sum shall not exceed the lesser of the amount of the recovery obtained by the Member or the reasonable value of all services and benefits furnished to Member or on Member's behalf by Landmark on account of each incident.
b) Member agrees to cooperate in protecting Landmark's interests under this provision. Member must execute and deliver to Landmark or its nominee any and all liens, assignments or other documents which may be necessary or proper to fully and completely effectuate and protect Landmark's rights, or its nominee, including, but not limited to, the granting of a lien right in any claim or action made or filed on Member's behalf and the signing of documents evidencing such lien. Member's failure to cooperate reasonably with Landmark as provided in the Group Agreement may result in such Member's termination from Landmark.

Medicare Benefits

Member shall furnish information to Landmark concerning Member's eligibility for Medicare (Part B Coverage) upon request by Landmark. If a Member is eligible to enroll in Medicare Part B, Landmark shall furnish benefits under the Group Agreement on Member's behalf in accordance with federal law and regulation, regardless of whether Member has actually enrolled in Medicare. Should the cost of chiropractic and/or acupuncture services exceed the coverage of any applicable Medicare coverage, Landmark benefits shall be provided over and above such coverage.

If Landmark's payment duplicates the Medicare benefits available to Member, Landmark may seek reimbursement from the Medicare insurance carrier, practitioner or Member up to the amount Landmark has paid for benefits that duplicate Medicare coverage.

Automobile, Accident or Liability Coverage

Landmark shall not furnish benefits under the Group Agreement that duplicate the benefits to which a Member is entitled under any other automobile, accident or liability coverage. Member is responsible for taking whatever action is necessary to obtain the benefits of such coverage and shall notify Landmark of such coverage. If payment or services are provided by Landmark in duplication of the benefits available to Member under other automobile, accident or liability coverage, Landmark may seek reimbursement to the extent of the reasonable value of the benefits provided by Landmark from the insurance carrier, practitioner and Member.

Should the cost of chiropractic and/or acupuncture services exceed any other applicable coverage pursuant to the Group Agreement, Landmark benefits shall be provided over and above such coverage.

Coordination of Benefits

All of the benefits provided under Landmark are subject to coordination of benefits. Coordination of benefit rules shall be applied by Landmark in accordance with the coordination of benefits regulations and interpretive instructions promulgated by the California Department of Managed Health Care, as amended from time to time, which are incorporated in the Group Agreement.

Termination of Benefits

The rights of Members under the Group Agreement shall terminate upon occurrence of any of the following:

a) *Nonpayment of Landmark Premiums/Co-payments or Fees for Non-Covered Services* — Any Member for whom applicable Landmark premium payments, co-payments, or fees for non-covered services are not paid may be disenrolled from the Plan by Landmark within fifteen (15) calendar days after mailing written notice of termination for nonpayment to such Member. Such notice shall state that the receipt by Landmark of the applicable Landmark premiums, co-payments or fees for non-covered services within fifteen (15) calendar days shall cause Landmark to revoke the notice. The notice of termination shall be revoked and membership in the Plan shall continue without interruption upon the receipt of the applicable Landmark payments. The failure of any Member to reimburse Landmark for payments made in error by the Plan within fifteen (15) calendar days after the mailing of written notice of termination for nonpayment, or to reach reasonable accommodations with Landmark regarding repayment shall result in the termination of Member's enrollment in the Plan. To reinstate coverage, Member must submit a new enrollment form and comply with all applicable eligibility requirements.
b) *Termination of Agreement by Employer Group* — In the event Employer Group voluntarily terminates its Group Agreement, Member's enrollment in the Plan shall terminate at the end of the month for which the last Plan premium is received by Landmark from Employer Group on Member's behalf.
c) *Member Permanently Moves Out of Service Area* — Member's enrollment in the Plan shall terminate in the event either: (i) Member is absent from the Service Area for ninety (90) consecutive days, or (ii) Member moves from the Service Area without the intent to return. Member shall notify Landmark of his or her permanent move from the Service Area within thirty (30) calendar days. Termination shall be effective the last day of the month in which Member receives notice of termination from Landmark. Notice sent to Member's last known address shall be deemed effective notice.
d) *Member's Loss of Eligibility* — Member's enrollment in the Plan shall terminate on the last day of the month in which Member's eligibility ceases as specified in the Group Agreement.
e) *Member Fraud or Deception* — A Member's coverage under the Plan shall immediately terminate if such Member knowingly provides Landmark with fraudulent information upon which Landmark relies and which materially affects Member's eligibility for enrollment or benefits under the Plan. In such instances, Landmark shall mail a written notice of termination to the Member.
f) *Member Assists Another to Improperly Obtain Benefits* — A Member's enrollment in Landmark shall immediately terminate if such Member assists a person who is not a Member to obtain benefits from the Plan. In such instances, Landmark shall mail a written notice of termination to the Member.
g) *Disenrollment for Cause* — A Member may be disenrolled for cause if the Member's conduct is such as to be unduly disruptive or injurious to the Participating Practitioner/patient relationship, so that the Member's treatment suffers as a result. A disenrollment for cause shall be effective on the first (1st) day of the calendar month following the month in which notice of disenrollment is given to the Member.
h) *Voluntary Disenrollment by Member* — A Member may voluntarily disenroll by submitting a written request for disenrollment to Employer Group in a manner to be determined by Employer Group. Employer Group shall forward all such requests to Landmark for processing. Employer Group shall be responsible for any Member premiums through the last day of the month in which notice of disenrollment is received by Landmark.

Written Notice of Termination

When a written notice of termination is sent to the Member pursuant to the Group Agreement, it shall be dated and state:

a) The cause of termination with specific reference to the section of the Group Agreement giving rise to the right of termination;
b) That the cause for termination was not the Member's health status or requirements for health care services;
c) The effective date of termination; and
d) That notwithstanding the Member Grievance System set forth in the Group Agreement, Member may request a review before the Director of the Department of Managed Health Care for the state of California, if Member believes that his or her Plan membership has been terminated because of Member's health status or requirements for health care services.

Non-Liability After Termination

Upon termination of the Group Agreement for any reason, Landmark shall have no further liability to provide benefits to any Member, including, without limitation, those Members undergoing treatment for an ongoing condition. Member's right to receive benefits hereunder shall cease upon the effective date of termination.

Reinstatement of Benefits

A Member may re-enroll in the Plan if his or her coverage has terminated and the Member becomes eligible at a later date through an Employer Group.

Renewal Provisions

The Group Agreement is automatically renewed from year to year subject to termination provisions. Premium rates may be modified subject to (30) calendar days' written notice from Landmark to the Employer Group.

Parties Affected by this Agreement

Member Non-Liability

In the event Landmark fails to pay a Participating Practitioner for a covered service, Member shall not be liable to the Participating Practitioner for any sums owed by Landmark.

Participating Practitioners

Participating Practitioners providing chiropractic or acupuncture services pursuant to an agreement with Landmark are independent contractors. None of the Participating Practitioners or their employees or agents are employees or agents of Landmark and none of Landmark's employees or agents are employees or agents of any Participating Practitioner.

Relationship of Parties to this Agreement

Employer Group is not the agent or representative of Landmark, and shall not be liable for any acts or omissions of Landmark, its agents or employees, or independent contractors, or any other person or organization with which Landmark has made, or hereafter shall make, arrangements for the performance of services under Landmark. Member is not the agent or representative of Landmark and shall not be liable for any acts or omissions of Landmark, its agents or employees.

Landmark's Member Grievance Resolution

If you have a problem concerning your eligibility, coverage, denial of benefits, quality of care or any other matter relating to your chiropractic and acupuncture benefit plan, you are encouraged to call Landmark's Customer Service Department at (800) 298-4875. One of our Customer Service Representatives will make every effort to respond to your questions and address your concerns. If you are not satisfied with efforts to solve a problem, you may submit a formal grievance or quality of care complaint in person, by telephone, or in writing to Landmark. You have at least 180 calendar days to submit your grievance following any incident or action that is the subject of your dissatisfaction.

Landmark Healthplan of California, Inc.
ATTN: Quality Management Department
2629 Townsgate Rd, Suite 235
Westlake Village, CA 91361

(800) 298-4875

(888) 565-4236 (relay service for the hearing-impaired)
www.LHP-CA.com

Please include your name, address, telephone number, social security number and details of the problem. If you wish assistance in filing a complaint or would like a copy of Landmark's Grievance Form, our Customer Service Representatives and Quality Management Coordinators are available to help you. Large-print grievance materials and forms are available upon request for the visually impaired. In addition, if you prefer use of a language other than English, we can provide translated grievance materials and forms, and we have multilingual staff available and access to A T & T's Language Line interpreters to assist you through the filing process. Also, you may enter your grievance directly into an online form available at the web site given above, where you can preview and edit grievances before they are submitted. The information is transmitted directly to the Plan via the Plan's secure server.

We will then:

- Confirm in writing within five (5) calendar days that we received your complaint;
- Review your complaint and inform you of our decision in writing within thirty (30) days;

- Or, if your case involves an imminent and serious threat to your health, including but not limited to severe pain, the potential loss of life, limb, or major bodily function, we will expedite the process as an urgent grievance within three (3) days from receipt of your request.

REVIEW BY THE DEPARTMENT OF MANAGED HEALTH CARE (DMHC):

After completing Landmark's grievance process or participating in the process for at least thirty (30) days, you or your designee may submit the grievance to the DMHC for review. If the DMHC determines your case involves an imminent and serious threat to your health, including but not limited to severe pain, the potential loss of life, limb, or major bodily function as determined by the DMHC, or in any other case where the DMHC determines that an earlier review is warranted, you shall not be required to complete Landmark's initial grievance process or participate in the process for at least thirty (30) days before submitting a grievance to the DMHC. In reviewing the information submitted by you or your designee, the DMHC may ask for additional information and may hold an informal meeting with the involved parties. The DMHC shall send a written notice to you or your designee of the final disposition of the grievance and reason for decision within thirty (30) calendar days of receipt of the request for review unless the Director determines that additional time is reasonably necessary to fully and fairly evaluate the relevant grievance.

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at **(800) 298-4875** and use your health plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number **(1-888-HMO-2219)** and a **TDD line (1-877-688-9891)** for the hearing and speech impaired. The department's Internet Web site **http://www.hmohelp.ca.gov** has complaint forms, IMR application forms and instructions online.

VOLUNTARY MEDIATION OR BINDING ARBITRATION

If you are dissatisfied with the resolution of your grievance, either before or after submitting your grievance to the DMHC, you may submit or request that Landmark submit the appeal to voluntary mediation or binding arbitration before Judicial Arbitration and Mediation Services, Inc. (JAMS).

(i) Voluntary Mediation – In order to initiate mediation, you, or an agent acting on your behalf, may submit a written request for voluntary mediation. If the parties mutually agree to mediation, the mediation will be administered by JAMS in accordance with its Mediation Rules and Procedures, unless otherwise agreed to by the parties. Expenses for mediation shall be borne equally by the parties. The Department of Managed Health Care shall have no administrative or enforcement responsibilities in connection with the voluntary mediation process.

(ii) Binding Arbitration – Any and all disputes of any kind whatsoever, including, but not limited to, claims relating to the delivery of services under the Plan and claims of professional malpractice (that is, as to whether any professional services rendered under the health plan were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered), between you (including any heirs or assigns) and Landmark, except for claims arising under Section 502(a) of ERISA shall be submitted to binding arbitration. Any such dispute will not be resolved by a lawsuit or resort to court process, except as the Federal Arbitration Act provides for judicial review of arbitration proceedings. You and Landmark are both giving up your constitutional right to have any such dispute decided in a court of law before a jury, and are instead accepting the use of binding arbitration by a single arbitrator in accordance with the Comprehensive Rules of JAMS, and administration of the arbitration shall be performed by JAMS or such other

arbitration service to which the parties may agree in writing. The parties will mutually endeavor to agree to the appointment of the arbitrator, but if such agreement cannot be reached within thirty (30) days following the date demand for arbitration is made, the arbitrator appointment procedures in the Comprehensive Rules will be utilized.

Arbitration hearings shall be held in Sacramento County, California, or at such other location as the parties may agree to in writing. Civil discovery may be taken in such arbitration as provided by California law and civil procedure. The arbitrator selected shall have the power to control the timing, scope, and manner of the taking of discovery and shall further have the same powers to enforce the parties' respective duties concerning discovery as would a Superior Court of California including, but not limited to, the imposition of sanctions. The arbitrator shall have the power to grant all remedies provided by California law. The parties shall divide equally the expenses of JAMS and the arbitrator. In cases of extreme hardship, Landmark may assume all or part of your share of the fees and expenses of JAMS and the arbitrator, provided you submit a hardship application to JAMS. This application will be provided by JAMS upon your request to Landmark. The approval or denial of the hardship application will be determined solely by JAMS.

The arbitrator shall prepare in writing an award that includes the legal and factual reasons for the decision. The requirement of binding arbitration shall not preclude a party from seeking a temporary restraining order or preliminary injunction or other provisional remedies from a court with jurisdiction; however, any and all other claims or causes of action including, but not limited to, those seeking monetary damages, shall be subject to binding arbitration as provided herein. The Federal Arbitration Act, 9 U.S.C. §§ 1-16, shall also apply to the arbitration.

BY ENROLLING IN LANDMARK BOTH MEMBER (INCLUDING ANY HEIRS OR ASSIGNS) AND LANDMARK AGREE TO WAIVE THE CONSTITUTIONAL RIGHT TO A JURY TRIAL AND INSTEAD VOLUNTARILY AGREE TO THE USE OF BINDING ARBITRATION AS DESCRIBED IN THIS EVIDENCE OF COVERAGE.

INDEPENDENT MEDICAL REVIEW PROCESS FOR DISPUTED HEALTH CARE:

You may request an independent medical review ("IMR") of disputed health care services from the Department of Managed Health Care ("DMHC") if you believe that health care services have been improperly denied, modified, or delayed by Landmark or by one of its contracting providers. A "disputed health care service" is any health care service eligible for coverage and payment under your subscriber contract that has been denied, modified or delayed by Landmark or one of its contracting providers, in whole or in part because the service was not Medically Necessary.

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

Eligibility

Your application for IMR will be reviewed by the DMHC to confirm that:

1) A) Your provider has recommended a service as Medically Necessary, or
   B) You have received urgent care or emergency services that a provider determined was Medically Necessary, or
   C) You have been seen by an in-plan provider for the diagnosis of the medical condition for which you seek independent review.

2) The disputed service has been denied, modified, or delayed by Landmark based in whole or in part on a decision that the service is not Medically Necessary.

3) You have filed a grievance with Landmark or its contracting provider, and the disputed decision is upheld, or the grievance remains unresolved after thirty (30) days. If your grievance requires expedited review you may bring it immediately to the DMHC's attention. The DMHC may waive the requirement that you follow Landmark's grievance process in extraordinary or compelling cases.

If your case is eligible for IMR, the dispute will be submitted to a medical specialist who will make an independent determination of whether or not the care is Medically Necessary. You will receive a copy of the assessment made in your case. If the IMR determines that the service is Medically Necessary, Landmark will provide the health care service.

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

INDEPENDENT MEDICAL REVIEW PROCESS FOR EXPERIMENTAL AND INVESTIGATIONAL TREATMENT:

You may also request an IMR to re-examine a Landmark coverage decision based upon your request for experimental or investigational treatment. The IMR process for reviewing decisions regarding the denial, modification or delay of requested experimental and investigational treatment is similar to the IMR process previously described for disputed health care services, with the following exceptions:

Eligibility

In order for Landmark's coverage decision to be reviewed by the IMR process, you must meet all of the following criteria:

1) You must have a life-threatening or seriously debilitating condition.
   A) "Life-threatening" means either or both of the following:
      i) Diseases or conditions where the likelihood of death is high unless the course of the disease is interrupted.
      ii) Diseases or conditions with potentially fatal outcome, where the end-point of clinical intervention is survival.
   B) "Seriously debilitating" means diseases or condition that cause major irreversible morbidity.

2) Your practitioner must have certified your life-threatening or seriously debilitating condition for which standard therapies have not been effective in improving the condition, for which standard therapies would not be Medically Necessary or for which there is no more beneficial standard therapy covered by Landmark than the therapy proposed as specified in paragraph 3 below.

3) Either a) your Participating Practitioner has recommended a drug, device, procedure or other therapy that the Participating Practitioner certifies in writing is likely to be of more benefit to you than any available standard therapy, or b) you or your practitioner has requested a therapy that, based on two documents of medical and scientific evidence, is likely to be more beneficial for you than any available standard therapy.

4) Coverage for this drug, device, procedure or other therapy recommended or requested as outlined in paragraph 3 above has been denied by Landmark.

5) The specific drug, device, procedure or other therapy recommended or requested would be a Covered Service, except that it has been denied as experimental or investigational.

If you meet the criteria listed above, Landmark shall offer you the opportunity to have the requested therapy reviewed under the Independent Medical Review process and will notify you of such opportunity within five (5) business days of Landmark's decision to deny coverage. Included with this notice is an application and an addressed envelope that you may return to the DMHC to initiate the IMR process. This review is free of charge to you.

The analyses and recommendations of the experts on the IMR panel shall be in written form and state the reasons the requested therapy is or is not likely to be more beneficial for you than any available standard therapy, and the reasons the experts recommend that the therapy should or should not be provided by Landmark. This written response will be provided in writing to you, your Participating Practitioner and Landmark within thirty (30) days of the receipt of your request for review. If your Participating Practitioner determines that the proposed therapy would be significantly less effective if not promptly initiated, the analysis and recommendations of the experts

shall be rendered within seven (7) days of the request. The IMR panel experts may extend the deadline by up to three (3) days for any delay in providing the documents necessary for review. For urgent cases involving imminent and serious threat to your health, including, but not limited to, severe pain, the potential loss of life, limb, or major bodily function, or the immediate serious deterioration of your health, the IMR organization must provide its determination within three (3) business days.

For information about the IMR process, to request an application, or for assistance in completing the application, please call Landmark's Customer Service Department at (800) 298-4875.

Member Participation in Landmark Public Policy Standing Committee

Landmark has a Public Policy Standing Committee to make recommendations regarding the Plan's public policy. If a Member wants to participate in this committee or desires additional information regarding the development of the Plan's public policies, he or she should contact Landmark at (800) 298-4875.

Notices to Members

Notice of Coverage Changes/Termination

In the event of termination of the Group Agreement, Landmark will notify the Employer Group in writing of the cancellation. It is the responsibility of the Employer Group to notify all Members enrolled in the Plan of the termination of their coverage. The Employer Group shall provide such notice by delivering to each Member at the Member's last known address, a true, legible copy of the Notice of Termination sent from Landmark to the Employer Group. The Employer Group shall promptly provide Landmark with proof and the date of such mailing. In the event of an increase in co-payments or premiums, or a reduction in the benefits provided under the Group Agreement for any reason, the Employer Group shall provide notice to its Members of such benefit reduction or premium or co-payment increase within thirty (30) calendar days of the Employer Group's receipt of such notice from Landmark. Landmark shall have no responsibility to Members in the event the Employer Group fails to provide the notices as required.

Entirety of Contract and Subsequent Amendments

The Group Agreement, the Evidence of Coverage, group application form, enrollment form and any attachments constitute the entire contract between Landmark and Employer Group. Any changes to these heretofore mentioned documents must be approved by an officer of Landmark and be attached to the affected document to be valid. No other agent has the authority to change the document or waive any provisions.

Conformity with State Law

If any provision contained within the Evidence of Coverage and the Group Agreement be found not to be in conformance with the California Knox-Keene Service Plan Act of 1975 or other applicable state laws, all other provisions of the Evidence of Coverage and Group Agreement shall not be rendered invalid but shall be construed and applied as if they were in full compliance with the Act and other applicable laws.
If you need assistance or have questions call or write:

Landmark Healthplan of California, Inc.
ATTN: Customer Service Department
2629 Townsgate Rd, Suite 235
Westlake Village, CA 91361
(800) 298-4875
www.LHP-CA.com

Fraud Prevention

Landmark is committed to making the most of your healthcare dollar. Toward that end, we are working strenuously to prevent the sort of fraudulent practices that in some healthcare markets are estimated to represent over 10% of healthcare costs. If you know of any potentially fraudulent activity that you would like to report, you may call our Fraud and Abuse Hotline at 1-800-298-4871. You may do so anonymously if you wish.

LANDMARK HEALTHPLAN PRIVACY NOTICE

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

We are required by law to maintain the privacy of "protected health information." "Protected health information" includes individually identifiable health information, including demographic information, that relates to:

- the past, present, or future physical or mental health or condition of an individual;
- the provision of health care to an individual; or
- the past, present, or future payment for the provision of health care to an individual.

Beyond the requirements of law, we at Landmark understand and respect your right to the confidentiality of your protected health information, and we maintain numerous safeguards to protect your privacy.

As required by law, this notice provides you with information about your rights to access and control your protected health information, and our legal duties and privacy practices, including the types of uses and disclosures we will make of your protected health information.

We are required to abide by the terms of this notice, although we reserve the right to change the terms of this notice from time to time and to make the new notice provisions effective for all protected health information we maintain. You can always request a copy of our most current privacy notice by calling our Customer Service Department at (800) 298-4875, or you can access it on our web site at www.LHP-CA.com.

How We May Use and Disclose Protected Health Information About You

We are permitted by law to use or disclose your protected health information for purposes of **treatment, payment,** and **health care operations**.

For Treatment. This means the provision, coordination, or management of your health care and related services, including consultations between health care providers regarding your care, and referrals for health care from one health care provider to another. For example, one of your doctors may ask Landmark to supply copies of records in our possession pertaining to your treatment, or we may need to refer to your records in order to make a referral to an appropriate practitioner.

For Payment. This means activities we undertake to determine and provide the appropriate reimbursement to providers for the health care provided to you, including determinations of eligibility, coverage (including dual coverage), and appropriateness of care, and other utilization review activities. For example, prior to approving health care services, we may need to verify with your employer group or HMO the current eligibility status of you or of your dependents seeking care, and the exact level of benefits available to you through your plan.

For Health Care Operations. This means the support functions of Landmark related to **treatment** and **payment**, such as quality assurance activities, case management, provider reviews, compliance programs, audits, and business planning, development, management, and administrative activities. For example, we may use your protected health information to evaluate the performance of our providers in caring for you. We may also combine medical information about many patients to decide what additional services we should offer, what services are not needed, and whether certain new treatments are effective. If, to accomplish any of these purposes, we engage the services of a third-party "business associate", we will have a written contract with the business associate containing terms that will safeguard the privacy of your protected health information.
Additionally, we are permitted by law to make the following uses and disclosures of protected health information:

To Individuals Involved in Your Care or Payment for Your Care. Under certain circumstances, we may disclose protected health information about you to family members, friends, or any other persons identified by you when they are involved in your care or the payment for your care. We will only disclose the protected health information directly relevant to their involvement in your care or payment. We may also use or disclose your protected health information to notify, or assist in the notification of, a family member, a personal representative, or another person responsible for your care, of your location, general condition, or death. If you are available, we will give you an opportunity to object to these disclosures, and we will not make these disclosures if you object. If you are not available, we will determine whether a disclosure to your family or friends is in your best interest, and we will disclose only the protected health information that is directly relevant to their involvement in your care. We

will allow your family or friends to act on your behalf to pick up medical supplies, X-rays, or other similar forms of protected health information, when we determine, in our professional judgment, that it is in your best interest to make such disclosures.

When permitted by law, we may disclose protected health information about you to a public or private entity authorized by law or by its charter to assist in disaster relief efforts, to coordinate notification to your family of your location, general condition, or death.

As Required by Law. We may use or disclose protected health information when required by law, limiting this use or disclosure to the relevant requirements of such law.

For Public Health Activities. We may disclose protected health information for public health activities and purposes, which generally include the following:

- to prevent or control disease, injury, or disability;
- to report births and deaths;
- to report child abuse or neglect;
- to report reactions to medications or problems with products to persons under the jurisdiction of the Food and Drug Administration, for the purpose of activities related to the quality, safety, or effectiveness of such FDA-regulated products;
- to notify people of product recalls, repairs, or replacement;
- to notify a person who may have been exposed to a disease or may otherwise be at risk of contracting or spreading a disease or condition;
- to notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if the patient agrees or when required by law, or when authorized by law and the patient is incapacitated and thus unable to agree.

For Health Oversight Activities. We may disclose protected health information to a health oversight agency for such authorized activities as audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

For Legal Proceedings. We may disclose protected health information about you in response to a court or administrative order. We may also disclose protected health information about you in response to a subpoena, discovery request, or other lawful process, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

For Law Enforcement. We may disclose protected health information:

- in response to a court order, subpoena, warrant, summons, or similar process, or as otherwise required by law;
- in response to a law enforcement official's request, to identify or locate a suspect, fugitive, material witness, or missing person;
- in response to a law enforcement official's request for information about the victim of a crime, if, under certain limited circumstances, we are unable to obtain the individual's agreement;
- to alert law enforcement about a death that we believe may be the result of criminal conduct;
- to alert law enforcement about criminal conduct on our premises; and
- in an emergency, to alert law enforcement to the commission and nature of a crime; the location of the crime or victims; or the identity, description, and location of the person who committed the crime.

To Coroners, Medical Examiners, and Funeral Directors. We may disclose protected health information to a coroner or medical examiner in order, for example, to identify a deceased person or determine the cause of death. We may also disclose protected health information about patients to funeral directors as necessary to carry out their duties.

For Organ and Tissue Donation. For organ donors, we may disclose protected health information to organizations that handle organ, eye, or tissue procurement, banking, or transplantation, for the purpose of facilitating organ, eye, or tissue donation and transplantation.

For Research. Under certain circumstances, we may use and disclose protected health information for research purposes. For example, a research project may involve comparing the health and recovery of all patients who received one treatment to those who received another for the same condition. All research projects, however, are

subject to a special approval process. This process evaluates a proposed research project and its use of medical information, trying to balance the research needs with patients' need for privacy of their medical information. Before we use or disclose protected health information for research, the project will have been approved through this research approval process, but we may, however, disclose protected health information to people preparing to conduct a research project, for example, to help them look for patients with specific medical needs, so long as the protected health information they review does not leave our premises.

To Avert a Serious Threat to Health or Safety. We may use and disclose protected health information when necessary to prevent or lessen a serious and imminent threat to the health and safety of a person or the public. Any disclosure, however, would only be made to someone able to help prevent or lessen the threat.

With Regard to Armed Forces Personnel. We may use and disclose the protected health information of individuals who are Armed Forces personnel for activities deemed necessary by appropriate military command authorities. We may also use and disclose the protected health information of individuals who are foreign military personnel to the appropriate foreign military authority.

For National Security and Intelligence Activities; For Protective Services for the President and Others. We may disclose protected health information to authorized federal officials for the conduct of lawful intelligence, counter-intelligence, and other national security activities authorized by law; for the provision of protective services to the President or other authorized persons, or to foreign heads of state; or for the conduct of authorized investigations.

For Workers' Compensation. We may disclose protected health information about you as authorized by and to the extent necessary to comply with laws relating to workers' compensation or other similar programs established by law to provide benefits for work-related injuries or illness.

For Health-Related Benefits and Services. We may use and disclose protected health information to contact you to provide information about other health-related benefits or services that may be of interest to you.

To Your Group Health Plan Sponsor. We may disclose protected health information about you to the sponsor of your Group Health Plan, only upon receipt of a certification from the plan sponsor that the plan documents have been amended to provide, among other things, that the sponsor will not use or disclose the information for employment-related actions and decisions.

Other Uses and Disclosures

Except for the situations set forth above, we will not use or disclose your protected health information for any other purpose unless you provide written authorization. You may revoke that authorization at any time, provided that the revocation is in writing, except to the extent that we have already taken action in reliance on your authorization.

Your Rights Regarding Protected Health Information About You

Right to Request Restrictions. You have the right to request restrictions on our use or disclosure of protected health information about you for treatment, payment, or health care operations. You also have the right to request restrictions on the protected health information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend.
We are not required to agree to your request. If we do agree, we will not use or disclose protected health information about you in violation of such restriction, unless the information is needed to provide you emergency treatment.

To request restrictions, you must make your request in writing to our Privacy Officer at the address below. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure, or both; and (3) to whom you want the limits to apply.

Right to Request Confidential Communications. You have the right to request that we communicate protected health information to you in a certain way or at a certain location if disclosure of all or part of that information could endanger you. For example, you can ask that we only contact you at work or by mail.

To request confidential communications, you must make your request in writing to our Privacy Officer at the address below, including a statement that other disclosure could endanger you. Your request must specify where or how you wish to be contacted. We will accommodate all reasonable requests.

Right to Inspect and Copy. You have the right to inspect and obtain a copy of protected health information about you that may be used to make decisions about your care. Usually, this includes enrollment, payment, claims adjudication, and case management records. There are a few exceptions to the sorts of protected health information available to you, such as psychotherapy notes and information compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding.

To inspect and copy medical information that may be used to make decisions about you, you must make your request in writing to our Privacy Officer at the address below. If you request a copy of the information, we may charge a fee for the costs of copying, postage, and other supplies associated with your request.
In certain very limited circumstances, we may deny your request to inspect and copy, but in those cases, not including those types of exceptions noted above, you have the right to have the denial reviewed. A licensed health care professional who did not participate in the original decision to deny will be designated by Landmark to review the denial. We will comply with the outcome of the review.

Right to Amend. If you feel that protected health information we have about you is incorrect or incomplete, you may request that we amend the information. You have the right to request an amendment for as long as the information is kept.

To request an amendment, you must make your request in writing to our Privacy Officer at the address below. In addition, you must provide a reason that supports your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request to amend protected health information that:

- Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- Is not part of the protected health information kept by Landmark;
- Is not part of the information that you would be permitted to inspect and copy; or
- Is accurate and complete.

Right to an Accounting of Disclosures. You have the right to request an "accounting of disclosures." This is a list of the disclosures we have made of protected health information about you within the six years prior to the date on which you request the accounting, or such shorter time period as you request. There are some few exceptions to the disclosures we must account for. Examples include disclosures to carry out treatment, payment, and health care operations; those made to you; those made pursuant to an authorization by you; those made for national security or intelligence purposes; and those that occurred prior to April 14, 2003.

To request this list or accounting of disclosures, you must make your request in writing to our Privacy Officer at the address below. Your request should indicate in what form you want the list (for example, on paper, or electronically). The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved, and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. To obtain a paper copy of this notice, you must make your request in writing to our Privacy Officer at the address below.

Complaints

If you believe your privacy rights have been violated, you may file a complaint with Landmark or with the Secretary of the U.S. Department of Health and Human Services. You may contact the Secretary at:

U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201
Toll Free: (877) 696 – 6775
(202) 619 – 0257
HHSMail@hhs.gov

To file a complaint with Landmark, contact our Privacy Officer at the address below. All complaints must be submitted in writing.
You will not be penalized for filing a complaint.

Privacy Officer

Michael G. Polis
Landmark Healthplan of California, Inc.
2629 Townsgate Rd, Suite 235
Westlake Village, CA 91361

(916) 441-2430

Effective Date

This notice is effective April 14, 2003.

CALIFORNIA*CHOICE*

SUPPLEMENT TO

EVIDENCE OF COVERAGE

WELCOME TO CALIFORNIA*CHOICE*

Your Employer has chosen to offer health coverage to you and your fellow Employees through the California*Choice* Program. This Cal*Choice* Supplement is part of the Evidence of Coverage used by Landmark Healthplan ("Landmark" or "PLAN") into which this California*Choice* Program Supplement is inserted. This Cal*Choice* Supplement explains certain details specific to the California*Choice* Program and may duplicate what is already stated in that Evidence of Coverage. All of the provisions of that Evidence of Coverage are applicable to your coverage, except if this Supplement has a conflicting provision, in which case that Supplement provision will be the controlling provision.

WHAT IS THE CALIFORNIA*CHOICE* PROGRAM?

The California*Choice* Program is a mechanism that makes available to employers with fewer than 100 Full-Time and Full-Time Equivalent (FTE) employees a variety of substantially similar medical and specialized health care products ("California*Choice* Program Products") offered by a group of health care service plans and insurance carriers participating in the California*Choice* Program. Such Products include medical, dental, vision, and chiropractic/acupuncture care benefit plans. You as an Employee have the opportunity to select to receive your health benefits from one of these health plans or carriers through the California*Choice* Program. This gives you the sort of choice of health care coverage that previously has been enjoyed by only a few.

Your employer has selected Landmark Healthplan as the health care service plan from which you may receive your employer-designated chiropractic and/or acupuncture benefits. You and your eligible Dependents have chosen to become enrollees of Landmark Healthplan.

The California*Choice* Program is administered by California*Choice* Benefit Administrators.

IMPORTANT FEATURES OF THE CALIFORNIA*CHOICE* PROGRAM

Some of the important features of the California*Choice* Program which impact you as an enrollee in Landmark Healthplan (or "PLAN") are listed below.

1. Participation Requirements
   Your Employer must have medical coverage through though California*Choice* in order to elect to offer chiropractic/acupuncture coverage to its employees. (This medical coverage requirement, as well as the medical coverage eligibility requirement in Section 2 immediately below, shall cease to be in effect in the event that your Employer loses its medical coverage because of the operation of the Partial Payment Protocol described below in Section 7.)

At least, seventy percent (70%) of your fellow Employees will receive their medical and other coverage from one of the health plans or carriers participating in the California*Choice* Program. If there are only two Employees, both must participate in the Program.

One hundred percent (100%) of your fellow employees covered for medical coverage through the California*Choice* Program will receive their chiropractic or chiropractic/acupuncture coverage from Landmark Healthplan if your employer has selected these optional benefits.

2. Eligibility Requirements

Employee/dependents must be eligible to enroll in medical coverage in California*Choice* in order to be eligible for Chiropractic/Acupuncture coverage.

New Dependents

(i) New Dependent - Spouse

An individual who becomes a new Dependent by virtue of marriage is eligible for coverage hereunder at a time other than the Employer's annual open enrollment, provided the appropriate request form is submitted to the Employer within 45 days after such marriage, allowing the Employer sufficient time to submit the request to California*Choice* Benefit Administrators within 60 days after such marriage. If California*Choice* Benefit Administrators receives all required documentation before the 16th day of the month of marriage, Premiums are charged for the full month and coverage is effective as of the date of marriage. If California*Choice* Benefit Administrators receives all required documentation on or after the 16th day of the month of marriage, the new spouse will be enrolled as of the 1st of the month following the date of receipt. The Employee Enrollee requesting coverage for such new Dependent must provide a stamped copy of the marriage certificate. The Employee must agree to notify the California*Choice* Benefit Administrators immediately upon termination of marriage.

(ii) New Dependent – Birth/Adoption/Legal Guardian

An individual who becomes a new Dependent by virtue of birth, adoption or placement for adoption or legal guardianship is eligible for coverage at other than the Employer's annual open enrollment, provided the appropriate request is submitted to the Employer within 45 days after such birth, placement for adoption or effective date of a guardianship order, allowing the Employer sufficient time to submit the request to California*Choice* Benefit Administrators within 30 days after such birth, placement for adoption or legal guardianship, with coverage to be effective upon the date of the birth, adoption or placement for adoption or legal guardianship. The first 30 days of coverage for such new or adopted child is automatic, regardless of whether the child is enrolled or not after this 30-day period. If the birth, adoption or placement for adoption or legal guardianship effective date occurs between the 1st and the 15th day of the month, Premiums are charged for the full month. If the birth, placement for adoption or legal guardianship effective date occurs between the 16th day and the end of the month, no Premiums are charged (copy of legal documentation will be required).

(iii) New Dependent – Stepchild

A child who comes to be the stepchild of an Enrollee is eligible for coverage hereunder at a time other than the Employer's annual open enrollment, provided the appropriate request is submitted to the Employer within 45 days following marriage or establishment of a registered domestic partnership to the parent or legal guardian of the stepchild, allowing the Employer sufficient time to submit the request to California*Choice* Benefit Administrators within 60 days following the date of the Enrollee's marriage to or establishment of a registered domestic partnership with the parent or legal guardian of the stepchild (actual adoption by the stepparent Enrollee is not required, although a copy of the marriage certificate to, or a State-stamped copy of the Certificate of Registered Domestic Partnership with, the parent of the new stepchild may be required). If the marriage or creation of the domestic partnership occurs before the 16th day of the month, Premium is charged for the full month and coverage is effective as of the date of marriage or creation of the domestic partnership. If the marriage or creation of the domestic partnership occurs on or after the 16th day of the month, the stepchild will be enrolled effective as of the 1st of the month following the date of receipt.

(iv) New Dependent – Domestic Partner

In order for an Employee's domestic partner to be eligible for coverage hereunder, at the time of Employee eligibility for enrollment, the Employee and domestic partner must:

- .Not be married under either statutory or common law or part of another domestic partnership.
- Both be 18 years of age or older and of the same or different sex.
- If of opposite sexes one or the other must be over age 62, and one or both must meet the Social Security eligibility requirements referenced in California Family Code Section 297(b)(4)(B)
- If one is under 18 years of age meet the requirements and follow the procedures prescribed in California Family Code Section 297.1
- Share an intimate and committed relationship of mutual caring.
- Both be mentally competent and capable of consenting to the domestic partnership.
- Not related by blood to a degree of closeness that would prevent them from being married in this state.
- Agree to notify California*Choice* Benefit Administrators immediately upon termination of the domestic partnership.

The domestic partnership is deemed created on the date Declaration of Domestic Partnership is filed with the California Secretary of State and at the time of the filing both partners meet all of the requirements above.

An individual who becomes a new Dependent by virtue of becoming a registered domestic partner of the Employee is eligible for coverage hereunder at other than the Employer's annual open enrollment, provided the appropriate request form is submitted to the Employer within 45 days after such domestic partnership is created, allowing the Employer sufficient time to submit the request to California*Choice* Benefit Administrators within 60 days after such event. If California*Choice* Benefit Administrators receives all required documentation before the 16th days of the month in which the domestic partnership was established, Premium is charged for the full month and coverage is effective as of the date the event. If California*Choice* Benefit Administrators receives all required documentation the 16th day and the end of the month, the new domestic partner will be enrolled as of the 1st of the month following the creation of the domestic partnership. The Employee Enrollee requesting coverage for such new Dependent must provide a State-stamped copy of the Certificate of Registered Domestic Partnership within 45 days after such domestic partnership is created, allowing the Employer sufficient time to submit the request and Certificate to California*Choice* Benefit Administrators within 60 days of its issuance. For purposes of this provision only, the domestic partnership is deemed created on the date the Declaration of Domestic Partnership is filed with the California Secretary of State. The Employee must agree to notify California*Choice* immediately upon termination of the domestic partnership.

3. Special Enrollment

Employees who did not enroll during the initial enrollment period or at the Employer's annual open enrollment may add newly acquired Dependents and themselves to the contract by submitting an application within 60 days from the date of acquisition of the Dependent:

- to add Employee and spouse or domestic partner following the birth of a newborn, adoption, placement for adoption of a child or arrival at status of eligible dependent child, coverage effective on the date of such event:

- to add Employee and spouse or registered domestic partner after marriage or creation of a domestic partnership. Coverage for Employee and spouse or domestic partner will be effective on the first day of the month following the date of marriage or creation of the domestic partnership:

- to add Employee and Employee's newborn, eligible dependent child, or child placed for adoption, following birth, adoption, placement for adoption, or arrival at status of eligible dependent child, effective on effective date of such event;

- to add Employee and Employee's stepchild, coverage effective on the first of the month following the acquisition of the stepchild, which is defined as the date of the marriage or the creation of a domestic partnership between the Employee and a birth parent of the child.

If an Employee did not enroll himself or herself or a Dependent at initial enrollment or at the Employer's annual open enrollment because the Employee or Dependent had coverage under another employer health plan, please refer to PLAN's Evidence of Coverage for further information regarding rights to request enrollment at a later time.

4. Waiting Period

The waiting period for coverage hereunder, which shall be applicable for all Employees, is specified by your Employer.

5. Benefits

The benefits you have chosen to receive from Landmark Healthplan are described in the Evidence of Coverage to which this Cal*Choice* Supplement is attached. PLAN will make all benefit and coverage dispute determinations, although these determinations are subject to PLAN's grievance procedures. You may not change your benefit level within PLAN other than during your Group's open enrollment period unless you experience a qualifying event listed in Paragraph 3 above.

a. Cal-COBRA and COBRA

Landmark Healthplan has agreed to provide coverage for you if you are Cal-COBRA-eligible or COBRA-eligible, at rates which you can receive by requesting them from your Employer. Please examine your options carefully before declining this coverage.

b. Copayments

As noted in PLAN's Evidence of Coverage, certain covered services and benefits are subject to copayments which you will be required to make.

c. Plan Materials

Landmark will provide you with an identification card and its provider directory, along with the Evidence of Coverage and this Cal*Choice* Supplement. (In lieu of hard copies, Landmark may notify you of where to obtain electronic copies of its Evidence of Coverage and the Cal*Choice* Evidence of Coverage Supplement.)

6. Termination for Nonpayment of Premiums

A Notice of Consequences for Nonpayment of Premiums will be included in your Employer's aggregated premium billing. This notice shall contain the date the premiums are due and inform your Employer of the consequences for failure to pay the premium amounts by the due date. The notice shall also inform your Employer that coverage will continue during a 30-day grace period that begins on the first day after the last day of paid coverage and lasts at least 30 days. Premium

payments are due on or before the 20th day of the month prior to the month of coverage. If your Employer fails to pay the required Premiums when due, PLAN (or California*Choice* Benefit Administrators on behalf of PLAN) will mail your Employer a "Notice of Cancellation for Nonpayment of Premiums and Grace Period" stating that the Employer has until the final day of the month of unpaid coverage contract will take effect. This notice will provide information to your Employer regarding the reason for cancellation(s), the effective date of cancellation(s), the dollar amount(s) due to PLAN, the date of the last day of paid coverage, the date the grace period begins and expires, any obligations of your Employer during the grace period, consequences of your Employer's failure to pay the Premiums due within that timeframe, as well as the right of your Employer to request a review by the PLAN and/or the California Department of Managed Health Care if your Employer believes coverage has been or will be improperly cancelled.

The notice shall also inform your Employer that coverage will continue during a 30-day grace period that begins on the first day after the last day of paid coverage and lasts at least 30 days. If the Premium remains unpaid by the 14th day of the coverage month, California*Choice* Benefit Administrators on behalf of PLAN will send your Employer a "Second Notice of Cancellation" repeating the need to pay the Premium(s) and the consequences for not doing so. If Premium payment(s) is/are not received by the effective date of cancellation*, PLAN (or California*Choice* Benefit Administrators on behalf of PLAN) will cancel the Group Service Agreement ("Agreement") and coverage for you and all your Dependents will end on such date as is contained in the "Notice Confirming Cancellation of Coverage for Nonpayment of Premium" sent to your Employer (*The 30-day grace period begins the day after the last day of paid coverage and lasts at least 30 days. If the affected premium(s) is(are) not paid by the last day of the grace period, coverage under the Agreement will be terminated prospectively, which in most cases occurs on the last day of the coverage month. Since the month of February consists of only 28/29 days, Employers who do not pay February's premium(s) by the end of the 30-day grace period will have their coverage contract(s) terminated on the last day of March)..

PLAN (or California*Choice* Benefit Administrators on behalf of PLAN) will mail a separate Notice Confirming Cancellation of Coverage to its affected individual Members that includes the same information provided in the Notice Confirming Cancellation of Coverage for Nonpayment of Premium that is sent to your Employer. The Notice that is sent to your Employer would provide your Employer with the following information: (1) that the agreement for coverage has been cancelled for non-payment of premiums; (2) the specific date and time when the coverage ended; (3) how and when coverage may be reinstated; (4) the responsibility of the Employer to pay all Premiums due, including for coverage during the grace period provided; (5) the right of your Employer to request a review by the PLAN and/or the California Department of Managed Health Care if your Employer believes coverage has been improperly cancelled, and the right to reinstatement of the membership agreement if the Department rules in favor of the Employer in any such review; (6) the California*Choice* Benefit Administrators telephone number Members can call to obtain additional information, including whether your Employer obtained reinstatement of the Agreement; and (7) GROUP is responsible for notifying each affected individual Member of his or her right to purchase continuation coverage and that within one business day following the date of the transmission of the Notice Confirming Cancellation of Coverage to your Employer, you would be sent a similar Notice Confirming Cancellation, along with a "loss of coverage/termination certification" packet of materials, which would include a State-approved notice regarding the possibility that you could secure coverage either through the "Covered Cali-

fornia" State Exchange or in the State's Medi-Cal Program and also providing you toll-free contact telephone numbers and an Internet website where you could obtain additional information about these opportunities.

PLAN (or California*Choice* Benefit Administrators on behalf of PLAN) will send you a HIPAA certificate which will state the date on which your coverage terminated, the reason for the termination, and the number of months of creditable coverage that you have.

7. Partial Payment Protocol

If your Employer has subscribed to more than one health Plan or Carrier for your healthcare coverage through the California*Choice* Program and fails to make premium payments for every one of its coverage contracts, the application of such Partial Premium payment as is submitted will be made to specific coverage contracts according to a priority articulated in the Group Service Agreement Supplement that is part of your Employer's contract with each Plan. If the Partial Payment is adequate to cover all the Medical coverage contracts the Employer has, then they will be maintained in place and the remainder of the Partial Payment will be applied to any Specialty coverage contracts your Employer may have through the Program, in a priority that goes dental-vision-chiropractic/acupuncture-life until the Partial Payment funds run out. If your Employer's Partial Payment is insufficient to cover certain of the Specialty contract premiums then those contracts will terminate at the end of the grace period. If there is not sufficient Partial Payment to cover the Medical premiums due, then that coverage will terminate at the end of the grace period and the Partial Payment will be applied to any Specialty coverage contracts the Employer has through the Program, in the above priority until the Partial Payment funds run out. In either scenario, the premium-paid Specialty coverage contracts will terminate at the end of the contract period.

By way of illustration only, if a Group has two separate dental coverage options, Partial Payment shall be applied to the dental contract with the highest membership count first, unless the Partial Payment amount is insufficient to cover that dental contract's due premium. Whether it is sufficient to cover the first dental contract premium or not, Choice Administrators shall then apply the Partial Payment amount or the remainder of the Partial Payment amount to the dental contract premium with the next highest membership count. If at this point of application there remains a Partial Payment amount then that amount shall be applied to any remaining dental coverage contract premiums due, ranked by membership count. If after application to dental premiums due there remains a Partial Payment amount, then it shall be applied to the vision contract with the highest membership count, and any remaining Partial Payment amount shall then be applied to the premium due for the vision contract with the next highest membership. This progression of Partial Payment amount application shall continue down through the premiums due for additional vision coverage contracts, and then in similar fashion to premiums due for chiropractic/acupuncture coverage and then for life insurance coverage. If two contracts within the same line of coverage (e.g., dental) have the same membership count, Choice Administrators shall first apply available Partial Payment amounts to the coverage contract with the highest premium due.

Partial Payment Hierarchy:
10) All Medical contract(s) (all must be paid in full or all terminate)

11) Dental contract with highest membership count
12) Dental contract with next highest membership count (repeated through all dental contracts)
13) Vision contract with highest membership count
14) Vision contract with next highest membership count (repeated through all vision contracts)
15) Chiropractic/acupuncture contract with highest membership count
16) Chiropractic/acupuncture contract with next highest membership count (repeated through all chiropractic contracts)
17) Life contract with the highest membership count
18) Life contract with the next highest membership count (repeated through all life contracts)

Your Employer is required to inform you in the event it becomes involved in such a Partial Premium Payment situation so that you may plan for desired alternate coverage. If you have questions regarding this Partial Payment Protocol, you may contact your employer or the California*Choice* Program at 800-558-8003.

RENEWAL

If your Employer wishes to renew in Landmark Healthplan through the California*Choice* Program upon the anniversary date of its Group Service Agreement with Landmark Healthplan, your Employer must have a minimum of two (2) Eligible Employees (or such number as may come to be used in controlling statutes or regulations to define a Small Group Employer) and seventy percent (70%) of those not covered elsewhere by a plan sponsored by your Employer must be enrolled in a medical health care service plan or insurance program participating in the California*Choice* Program. If your Employer does not meet such renewal requirements, it may renew at such later date as it meets such renewal qualification requirements. If your Employer does not so renew, you will only be able to retain your current set of benefits if your Employer contracts with another health care service plan or insurance carrier participating in the California*Choice* Program for that level of benefits.

THE REST IS THE SAME!

This Cal*Choice* Supplement merely describes the particular features of your coverage from Landmark Healthplan because of Landmark Healthplan's participation in the California*Choice* Program. You should refer to the Evidence of Coverage to which this is merely a Supplement for all other details regarding your membership in and receipt of health care services from Landmark Healthplan

EXHIBIT B

CALIFORNIA CONTINUATION BENEFITS REPLACEMENT ACT ("CAL-COBRA")

Cal-COBRA mandates the inclusion of the following requirements in all Group Agreements issued, amended or renewed after July 1, 1998:

- Group is required to notify Landmark in writing of any Employee who has lost coverage due to termination of employment or reduction of hours of employment within thirty (30) days of the loss of coverage.

- Group is required to notify Landmark in writing, within thirty (30) days of the date when Group becomes subject to Section 4980B of the U.S. Internal Revenue Code or Chapter 18 of the Employee Retirement Income Security Act (i.e. subject to Federal COBRA requirements.)

- Group is required to notify qualified beneficiaries who are currently receiving continuation coverage, and whose continuation coverage will terminate under one group benefit plan prior to the end of the period the qualified beneficiary would have remained covered due to termination of the group contract with Group, of the qualified beneficiary's ability to continue coverage under a new group benefit plan for the balance of the period the qualified beneficiary would have remained covered under the prior group benefit plan. This notice shall be provided the later of either thirty (30) days prior to the termination of coverage or when all enrolled Employees are notified.

- Group is required to notify a successor plan in writing of the qualified beneficiaries currently receiving continuation coverage so that the successor plan, or contracting Group or Administrator, can provide qualified beneficiaries with appropriate enrollment materials.

- Within fifteen (15) days of any written request, Landmark shall furnish the Group that is replacing coverage provided by Landmark, or the Group's agent or representative, information in the possession of Landmark which is reasonably required by Group to administer the notification requirements noted above (e.g. addresses of beneficiaries).