

HEALTH PLAN HMO



CALIFORNIA

Combined Evidence of Coverage and Disclosure Form

PacifiCare[®]

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Welcome To PacifiCare of California

Since 1978, we've been providing health care coverage in the state. This publication will help you become more familiar with your health care benefits. It will also introduce you to our health care community.

PacifiCare provides health care coverage to Members who have properly enrolled in our plan and meet our eligibility requirements. To learn more about these requirements, see **Section Seven: Member Eligibility**.

What is this publication?

This publication is called a *Combined Evidence of Coverage and Disclosure Form*. It is a legal document that explains your health care plan and should answer many important questions about your benefits. Many of the words and terms are capitalized because they have special meanings. To better understand these terms, please see **Section Ten: Definitions**.

Whether you are the Subscriber of this coverage or enrolled as a Family Member, your *Combined Evidence of Coverage and Disclosure Form* is key to making the most of your membership. You'll learn about important topics like how to select a Primary Care Physician and what to do if you need hospitalization.

What else should I read to understand my benefits?

Along with reading this publication, be sure to review your *Schedule of Benefits* and any benefit materials. Your *Schedule of Benefits* provides the details of your particular health plan, including any Copayments that you may have to pay when using a health care service. Together, these documents explain your coverage.

What if I still need help?

After you become familiar with your benefits, you may still need assistance. Please don't hesitate to call our Customer Service department at **1-800-624-8822** or **1-800-442-8833 (TDHI)**. **NOTE:** Your *Combined Evidence of Coverage and Disclosure Form* and *Schedule of Benefits* provides the terms and conditions of your coverage with PacifiCare, and all applicants have a right to view these documents prior to enrollment. The *Combined Evidence of Coverage and Disclosure Form* should be read completely and carefully. Individuals with special health needs should pay special attention to those sections that apply to them.

You may correspond with PacifiCare at the following address:

PacifiCare of California
5701 Katella Avenue
P.O. Box 6006
Cypress, California 90630
PacifiCare's Web site: www.pacificare.com

Questions? Call the Customer Service Department at 1-800-624-8822.

Section One



Getting Started: Your Primary Care Physician

- *What Is a Primary Care Physician?*
- *What Is a Subscriber?*
- *What Is a Participating Medical Group?*
- *Your Provider Directory*
- *Choosing Your Primary Care Physician*
- *Continuity of Care*

One of the first things you do when joining PacifiCare is to select a Primary Care Physician. This is the doctor in charge of overseeing your care through PacifiCare. This section explains the role of the Primary Care Physician, as well as how to make your choice. You'll also learn about your Participating Medical Group and how to use your *Provider Directory*.

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

Introduction

Now that you're a PacifiCare Member, it's important to become familiar with the details of your coverage. Reading this publication will help you go a long way toward understanding your coverage and health care benefits. It's written for **all** our Members receiving this plan, whether you're the Subscriber or an enrolled Family Member.

Please read this *Combined Evidence of Coverage and Disclosure Form* along with any supplements you may have with this coverage. You should also read and become familiar with your *Schedule of Benefits*, which lists the benefits and costs unique to your plan.

What Is a Primary Care Physician?

When you become a Member of PacifiCare, one of the first things you do is choose a doctor to be your Primary Care Physician. This is a doctor who is contracted with PacifiCare and who is primarily responsible for the

coordination of your health care services. A Primary Care Physician is trained in internal medicine, general practice, family practice, pediatrics or obstetrics/gynecology.

Unless you need Emergency or Urgently Needed care, your Primary Care Physician is your first stop for using these medical benefits. Your Primary Care Physician will also seek authorization for any referrals, as well as initiate and coordinate any necessary hospital services. *All Members of PacifiCare are required to have a Primary Care Physician.* If you don't select one when you enroll, PacifiCare will choose one for you. Except in an urgent or emergency situation, if you see another health care Provider without the approval of either your Primary Care Physician, Participating Medical Group or PacifiCare, the costs for these services will not be covered.

What Is the Difference Between a Subscriber and an Enrolled Family Member?

While both are Members of PacifiCare, there's a difference between a Subscriber and an enrolled Family Member. A Subscriber is the Member who enrolls through his or her employment after meeting the eligibility requirements of the Employer Group and PacifiCare. A Subscriber may also contribute toward a portion of the premiums paid to PacifiCare for his or her health care coverage for him or herself and any enrolled Family Members. An enrolled Family Member is someone such as a Spouse or child whose dependent status with the Subscriber allows him or her to be a Member of PacifiCare. Why point out the difference? Because Subscribers often have special responsibilities, including sharing benefit updates with any enrolled Family Members. Subscribers also have special responsibilities that are noted throughout this publication. If you're a Subscriber, please pay attention to any instructions given specifically for you.

For a more detailed explanation of any terms, see the "Definitions" section of this publication.

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



Section One

Choosing a Primary Care Physician

When choosing a Primary Care Physician, you should always make certain your doctor meets the following criteria:

- Your doctor is selected from the list of Primary Care Physicians in PacifiCare's *Provider Directory*.
- Your doctor is located within a 30-mile radius of either your Primary Residence or Primary Workplace.

You'll find a list of our participating Primary Care Physicians in the *Provider Directory*. It's also a source for other valuable information. (NOTE: If you are pregnant, please read the section below, "If You Are Pregnant," to learn how to choose a Primary Care Physician for your newborn.)

What Is a Participating Medical Group?

When you select a Primary Care Physician, you are also selecting a Participating Medical Group. This is the group that's affiliated with both your doctor and PacifiCare. If you need a referral to a Specialist, you will generally be referred to a doctor or service within this group. Only if a Specialist or service is unavailable will you be referred to a health care Provider outside your medical group.

To learn more about a particular Participating Medical Group, look in your *Provider Directory*. Along with addresses and phone numbers, you'll find other important information, including hospital affiliations, additional services and any restrictions about the availability of Providers.

Your *Provider Directory* – Choice of Physicians and Hospitals (Facilities)

Along with listing our participating Physicians, your *Provider Directory* has detailed information about our Participating Medical Groups and other Providers. This includes a quality index for helping you become familiar with our Participating Medical Groups. Every Subscriber should receive a *Provider Directory*. If you need a copy or would like assistance picking your Primary Care Physician, please call our Customer Service department. You can also find an online version of the Directory at www.pacificare.com.

NOTE: If you are seeing a Participating Provider who is not a part of a Medical Group, your doctor will coordinate services directly with PacifiCare.

Choosing a Primary Care Physician for Each Enrolled Family Member

Every PacifiCare Member must have a Primary Care Physician; however, the Subscriber and any enrolled Family Members don't need to choose the same doctor. Each PacifiCare Member can choose his or her own Primary Care Physician, so long as the doctor is selected from PacifiCare's list of Primary Care Physicians, and the doctor is located within a 30-mile radius of either the Member's Primary Residence or Primary Workplace.

If a Family Member doesn't make a selection during enrollment, PacifiCare will choose the Member's Primary Care Physician. (NOTE: If an enrolled Family Member is pregnant, please read below to learn how to choose a Primary Care Physician for the newborn.)

Section One



What Is Continuity of Care?

Under certain circumstances, new Members of PacifiCare may be able to temporarily continue receiving services from a Non-Participating Provider. This short-term transition assistance is intended for new Members who are experiencing an acute episode of care while making the transition to PacifiCare. Typically, this condition requires prompt medical attention and is of limited duration. (Examples include: pregnancy in the third trimester; being in an acute hospital or scheduled to be in the hospital immediately after your PacifiCare coverage becomes effective; undergoing a course of chemotherapy, radiation therapy, or psychiatric counseling; being on a transplant list.)

If you're a new Member and believe you qualify for Continuity of Care, please call the Customer Service department and request the form "Continuity of Care for New Enrollees Request." Complete and return this form to PacifiCare as soon as possible. Upon receiving the completed form, a medical review will be completed in 3 business days. If you qualify, you will be notified by telephone of the decision and provided with the plan for your care. If you don't qualify, attempts will be made to notify you by telephone of the decision. You will be notified in writing within 3 business days of the completed review, and alternatives will be offered.

PLEASE NOTE: It's not enough to simply prefer receiving treatment from a former Physician or other Non-Participating Provider, even for a Chronic Condition. You should not continue care with a Non-Participating Provider without our formal approval. If you do not receive preauthorization by PacifiCare or your Participating Medical Group, payment for services performed by a Non-Participating Provider will be your responsibility.

If You Are Pregnant

Every Member of PacifiCare needs a Primary Care Physician, including your newborn. If you are pregnant, we encourage you to plan ahead and pick a Primary Care Physician for your baby. Newborns remain enrolled with the mother's Participating Medical Group from birth until discharge from the hospital. You may enroll your newborn with a different Primary Care Physician or Participating Medical Group following the newborn's discharge by calling PacifiCare's Customer Service department. If a Primary Care Physician isn't chosen for your child, the newborn will remain with the mother's Primary Care Physician or Participating Medical Group. If you call the Customer Service department by the 15th of the current month, your newborn's transfer will be effective on the first day of the following month. If the request for transfer is received after the 15th of the current month, your newborn's transfer will be effective the first day of the second succeeding month. For example, if you call PacifiCare on June 12th to request a new doctor for your newborn, the transfer will be effective on July 1st. If you call PacifiCare on June 16th, the transfer will be effective August 1st.

If your newborn has not been discharged from the hospital, is being followed by the Case Management or is receiving acute institutional or non-institutional care at the time of your request, a change in your newborn's Primary Care Physician or Participating Medical Group will not be effective until the first day of the second month following the newborn's discharge from the institution or termination of treatment. When PacifiCare's Case Management is involved, the Case Manager is also consulted about the effective date of your requested Physician change for your newborn.

You can learn more about changing Primary Care Physicians in **Section Four: Changing Your Doctor or Medical Group**. (For more about adding a newborn to your coverage, see **Section Seven: Member Eligibility**.)



Does Your Group or Hospital Restrict Any Reproductive Services?

Some hospitals and other Providers do not provide one or more of the following services that may be covered under your plan contract that you or your Family Member might need: family planning, contraceptive services, including emergency contraception; sterilization, including tubal ligation at the time of labor and delivery; infertility treatments; or abortion. You should obtain more information before you enroll. Call your prospective doctor, medical group, independent practice association, clinic or call the PacifiCare Health Plan Customer Service department at 1-800-624-8822 or 1-800-442-8833 (TDHI) to ensure that you can obtain the health care services that you need.

If you have chosen a Participating Medical Group that does not provide the family planning benefits you need, and these benefits have been purchased by your Employer Group, please call our Customer Service department.

Section Two



Seeing the Doctor

- *Scheduling Appointments*
- *Referrals To Specialists*
- *PacifiCare Express Referrals*
- *Seeing the OB/GYN*
- *Second Medical Opinions*
- *Prearranging Hospital Stays*

Now that you've chosen a Primary Care Physician, you have a doctor for your routine health care. Your Primary Care Physician will determine when you need a Specialist, arrange any necessary hospital care and oversee your health care needs.

This section will help you begin taking advantage of your health care coverage. It will also answer common questions about seeing a Specialist and receiving medical services that are not Emergency Services or Urgently Needed Services. (For information on "Emergency Services or Urgently Needed Services," please turn to **Section Three**.)

Seeing the Doctor: Scheduling Appointments

To visit your Primary Care Physician, simply make an appointment by calling your doctor's office. Your Primary Care Physician is your first stop for accessing care except when you need Emergency Services, or when you require Urgently Needed Services and you are outside of the area served by your Participating Medical Group, or when your Participating Medical Group is unavailable. Without an authorized referral from your Primary Care Physician or PacifiCare, no Physician or other health care services will be covered except for Emergency Services and Urgently Needed Services. (There is an exception if you wish to visit an obstetrical and gynecological Physician. See below, "OB/GYN: Getting Care Without a Referral.")

When you see your Primary Care Physician or use one of your health care benefits, you may be required to pay a charge for the visit. This charge is called a Copayment. The amount of a Copayment depends upon the health care service. Your Copayments are outlined in your *Schedule of Benefits*. More detailed information can also be found in **Section Six: Payment Responsibility**.

Referrals To Specialists and Nonphysician Health Care Practitioners

The Primary Care Physician you have selected will coordinate your health care needs.

If your Primary Care Physician determines you need to see a Specialist or Nonphysician Health Care Practitioner, he or she will make an appropriate referral. (There is an exception for visits to obstetrical and gynecological (OB/GYN) Physicians. This is explained in "OB/GYN: Getting Care without a Referral.")

(Your plan may not cover services provided by all Nonphysician Health Care Practitioners. Please refer to the Medical Benefits and Exclusions and Limitations section in this *Combined Evidence of Coverage and Disclosure Form* for further information regarding Nonphysician Health Care Practitioner services excluded from coverage or limited under this Health Plan.)

Your Primary Care Physician will determine the number of Specialist or Nonphysician Health Care Practitioner visits that you require and will provide you with any other special instructions.

This referral may also be reviewed by the Primary Care Physician's Utilization Review Committee. For more information regarding the role of the Utilization Review Committee, please refer to the definition of "Utilization Review Committee." A Utilization Review Committee meets on a regular basis as determined by membership needs, special requests or issues and the number of authorization or referral requests to be addressed. Decisions may be made outside of a formal committee meeting to assure a timely response to emergency or urgent requests.

PacifiCare Express Referrals®

PacifiCare's Express Referrals® program is available through a select network of Participating Medical Groups. With Express Referrals®, your Primary Care Physician decides when a Specialist or Nonphysician Health Care Practitioner should be consulted – no further authorization is required. For a list of Participating Medical Groups offering Express Referrals®, please contact PacifiCare's Customer Service department or refer to your *PacifiCare HMO Provider Directory* or visit our Web site at www.pacificare.com.



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Standing Referrals To Specialists

A standing referral is a referral by your Primary Care Physician that authorizes more than 1 visit to a participating Specialist. A standing referral may be provided if your Primary Care Physician, in consultation with you, the Specialist and your Participating Medical Group's Medical Director (or a PacifiCare Medical Director), determines that as part of a treatment plan you need continuing care from a Specialist. You may request a standing referral from your Primary Care Physician or PacifiCare. **PLEASE NOTE:** A standing referral and treatment plan is only allowed if approved by your Participating Medical Group or PacifiCare.

Your Primary Care Physician will specify how many Specialist visits are authorized. The treatment plan may limit your number of visits to the Specialist and the period for which visits are authorized. It may also require the Specialist to provide your Primary Care Physician with regular reports on your treatment and condition.

Extended Referral for Care By a Specialist

If you have a life-threatening, degenerative or disabling condition or disease that requires specialized medical care over a prolonged period, you may receive an "extended specialty referral." This is a referral to a participating Specialist or specialty care center, so the Specialist can oversee your health care. The Physician or center will have the necessary experience and skills for treating the condition or disease.

You may request an extended specialty referral by asking your Primary Care Physician or PacifiCare. Your Primary Care Physician must then determine if it is Medically Necessary. Your Primary Care Physician will do this in consultation with the Specialist or specialty care center, as well as your Participating Medical Group's Medical Director or a PacifiCare Medical Director.

If you require an extended specialty referral, the referral will be made according to a treatment plan approved by your Participating Medical Group's Medical Director or a PacifiCare Medical Director. This is done in consultation with your Primary Care Physician, the Specialist and you.

Once the extended specialty referral begins, the Specialist begins serving as the main coordinator of your care. The Specialist does this in accordance with your treatment plan.

OB/GYN: Getting Care Without a Referral

Women may receive obstetrical and gynecological (OB/GYN) Physician services directly from a Participating OB/GYN, family practice Physician, or surgeon identified by your Participating Medical Group as providing OB/GYN Physician services. This means you may receive these services without preauthorization or a referral from your Primary Care Physician. In all cases, however, the doctor must be affiliated with your Participating Medical Group.

PLEASE REMEMBER: If you visit an OB/GYN or family practice Physician not affiliated with your Participating Medical Group without preauthorization or a referral, you will be financially responsible for these services. All OB/GYN inpatient or hospital services, except Emergency or Urgently Needed Services, need to be authorized in advance by your Participating Medical Group or PacifiCare.

If you would like to receive OB/GYN Physician services, simply do the following:

- Call the telephone number on the front of your ID Card and request the names and telephone numbers of the OB/GYNs affiliated with your Participating Medical Group;
- Telephone and schedule an appointment with your selected Participating OB/GYN.

After your appointment, your OB/GYN will contact your Primary Care Physician about your condition, treatment and any needed follow-up care.

PacifiCare also covers important wellness services for our Members. For more information, see "Health Education Services" in **Section Five: Your Medical Benefits**.

Second Medical Opinions

A second medical opinion is a reevaluation of your condition or health care treatment by an appropriately qualified Provider. This Provider must be either a Primary Care Physician or a Specialist acting within his or her scope of practice, and must possess the clinical background necessary for examining the illness or condition associated with the request for a second medical opinion. Upon completing the examination, the Provider's opinion is included in a consultation report.

Either you or your treating Participating Provider may submit a request for a second medical opinion. Requests

Section Two



should be submitted to your Participating Medical Group; however in some cases, the request is submitted to PacifiCare. To find out how you should submit your request, talk to your Primary Care Physician.

Second medical opinions will be provided or authorized in the following circumstances:

- When you question the reasonableness or necessity of recommended surgical procedures;
- When you question a diagnosis or treatment plan for a condition that threatens loss of life, loss of limb, loss of bodily functions or substantial impairment (including, but not limited to, a Chronic Condition);
- When the clinical indications are not clear, or are complex and confusing;
- When a diagnosis is in doubt due to conflicting test results;
- When the treating Provider is unable to diagnose the condition;
- When the treatment plan in progress is not improving your medical condition within an appropriate period of time given the diagnosis, and you request a second opinion regarding the diagnosis or continuance of the treatment;
- When you have attempted to follow the treatment plan or consulted with the initial Provider and still have serious concerns about the diagnosis or treatment.

Either the Participating Medical Group or, if applicable, a PacifiCare Medical Director will approve or deny a request for a second medical opinion. The request will be approved or denied in a timely fashion appropriate to the nature of your condition. For circumstances other than an imminent or serious threat to your health, a second medical opinion request will be approved or denied within 5 business days after the request is received by the Participating Medical Group or PacifiCare.

When there is an imminent and serious threat to your health, a decision about your second opinion will be made within 72 hours after receipt of the request by your Participating Medical Group or PacifiCare. An imminent and serious threat includes the potential loss of life, limb or other major bodily function, or where a lack of timeliness would be detrimental to your ability to regain maximum function.

If you are requesting a second medical opinion about care given by your Primary Care Physician, the second medical opinion will be provided by an appropriately qualified health care professional of your choice within the same Participating Medical Group. (If your Primary Care Physician is independently contracted with PacifiCare and not affiliated with any Participating Medical Group, you may request a second opinion from a Primary Care Physician or Specialist listed in our *Provider Directory*.) If you request a second medical opinion about care received from a Specialist, the second medical opinion will be provided by any health care professional of your choice from any medical group within the PacifiCare Participating Provider network of the same or equivalent specialty.

The second medical opinion will be documented in a consultation report, which will be made available to you and your treating Participating Provider. It will include any recommended procedures or tests that the Provider giving the second opinion believes are appropriate. If this second medical opinion includes a recommendation for a particular treatment, diagnostic test or service covered by PacifiCare — and the recommendation is determined to be Medically Necessary by your Participating Medical Group or PacifiCare — the treatment, diagnostic test or service will be provided or arranged by your Participating Medical Group or PacifiCare.

PLEASE NOTE: The fact that an appropriately qualified Provider gives a second medical opinion and recommends a particular treatment, diagnostic test or service does not necessarily mean that the recommended action is Medically Necessary or a Covered Service. You will also remain responsible for paying any outpatient office Copayments to the Provider who gives your second medical opinion.

If your request for a second medical opinion is denied, PacifiCare will notify you in writing and provide the reasons for the denial. You may appeal the denial by following the procedures outlined in **Section Eight: Overseeing Your Health Care**. If you obtain a second medical opinion without preauthorization from your Participating Medical Group or PacifiCare, you will be financially responsible for the cost of the opinion.



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To receive a copy of the Second Medical Opinion timeline, you may call or write PacifiCare's Customer Service department at:

PacifiCare Customer Service Department
5701 Katella Avenue/P.O. Box 6006
Cypress, CA 90630
1-800-624-8822

What Is PacifiCare's Case Management Program?

PacifiCare has licensed registered nurses who, in collaboration with the Member, Member's family and the Member's Participating Medical Group, help arrange care for PacifiCare Members experiencing a major illness or recurring hospitalizations. Case Management is a collaborative process that assesses, plans, implements, coordinates, monitors and evaluates options to meet an individual's health care needs based on the health care benefits and available resources.

Prearranging Hospital Stays

Your Primary Care Physician will prearrange any Medically Necessary hospital or facility care, including inpatient Transitional Care or care provided in a Subacute/Skilled Nursing Facility. If you've been referred to a Specialist and the Specialist determines you need hospitalization, your Primary Care Physician and Specialist will work together to prearrange your hospital stay.

Your hospital costs, including semiprivate room, tests and office visits, will be covered, minus any required Copayments, as well as any deductibles. Under normal circumstances, your Primary Care Physician will coordinate your admission to a local PacifiCare Participating Hospital or facility; however, if your situation requires it, you could be transported to a regional medical center.

If Medically Necessary, your Primary Care Physician may discharge you from the hospital to a Subacute/Skilled Nursing Facility. He or she can also arrange for skilled home health care.

Section Three



Emergency and Urgently Needed Services

- *What Is an Emergency Medical Condition?*
- *What To Do When You Require Emergency Services*
- *What To Do When You Require Urgently Needed Services*
- *Post-Stabilization and Follow-Up Care*
- *Out-of-Area Services*
- *What To Do If You're Abroad*

Worldwide, wherever you are, PacifiCare provides coverage for Emergency Services and Urgently Needed Services. This section will explain how to obtain Emergency Services and Urgently Needed Services. It will also explain what you should do following receipt of these services.

IMPORTANT!

If you believe you are experiencing an Emergency Medical Condition, call 911 or go directly to the nearest hospital emergency room or other facility for treatment.

What Are Emergency Medical Services?

Emergency Services are Medically Necessary ambulance or ambulance transport services provided through the 911 emergency response system. It is also the medical screening, examination and evaluation by a Physician, or other personnel — to the extent provided by law — to determine if an Emergency Medical Condition or psychiatric emergency medical condition exists. If this condition exists, Emergency Services include the care, treatment and/or surgery by a Physician necessary to stabilize or eliminate the Emergency Medical Condition or psychiatric medical condition within the capabilities of the facility.

What Is an Emergency Medical Condition?

The state of California defines an Emergency Medical Condition as: a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected by the Member, as a Prudent Layperson, to result in any of the following:

- Placing the Member's health in serious jeopardy;
- Serious impairment to his or her bodily functions;
- A serious dysfunction of any bodily organ or part; or
- Active labor, meaning labor at a time that either of the following would occur:
 - There is inadequate time to effect a safe transfer to another hospital prior to delivery; or
 - A transfer poses a threat to the health and safety of the Member or unborn child.

What To Do When You Require Emergency Services

If you believe you are experiencing an Emergency Medical Condition, **call 911 or go directly to the nearest hospital emergency room or other facility for treatment.** You do not need to obtain preauthorization to seek treatment for an Emergency Medical Condition that could cause you harm. Ambulance transport services provided through the 911 emergency response system are covered if you reasonably believe that your medical condition requires emergency ambulance transport services. PacifiCare covers all Medically Necessary Emergency Services provided to Members in order to stabilize an Emergency Medical Condition.

You, or someone else on your behalf, must notify PacifiCare or your Primary Care Physician within 24 hours, or as soon as reasonably possible, following your receipt of Emergency Services so that your Primary Care Physician can coordinate your care and schedule any necessary follow-up treatment. When you call, please be prepared to give the name and location of the facility and a description of the Emergency Services that you received.



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Post-Stabilization and Follow-up Care

Following the stabilization of an Emergency Medical Condition, the treating health care Provider may believe that you require additional Medically Necessary Hospital (health care) Services prior to your being safely discharged. In such a situation, the medical facility (Hospital) will contact your Participating Medical Group, or PacifiCare, in order to obtain the timely authorization for these post-stabilization services. PacifiCare reserves the right, in certain circumstances, to transfer you to a Participating Hospital in lieu of authorizing post-stabilization services at the treating facility.

Following your discharge from the Hospital, any Medically Necessary follow-up medical or Hospital Services must be provided or authorized by your Primary Care Physician in order to be covered by PacifiCare. Regardless of where you are in the world, if you require additional follow-up medical or Hospital Services, please call your Primary Care Physician or PacifiCare's Out-of-Area unit to request authorization. PacifiCare's Out-of-Area unit can be reached during regular business hours (8 a.m. – 5 p.m. PST) at 1-800-762-8456.

Out-of-Area Services

PacifiCare arranges for the provision of Covered Services through its Participating Medical Groups and other Participating Providers. With the exception of Emergency Services, Urgently Needed Services, authorized Post-Stabilization Care or other specific services authorized by your Participating Medical Group or PacifiCare, when you are away from the geographic area served by your Participating Medical Group, you are not covered for any other medical or hospital services. If you do not know the area served by your Participating Medical Group, please call your Primary Care Physician or the Participating Medical Group's administrative office to inquire.

The out-of-area services that are not covered include, but are not limited to:

- Routine follow-up care to Emergency or Urgently Needed Services, such as treatments, procedures, X-rays, lab work and doctor visits, Rehabilitation Services, Skilled Nursing Care or home health care.

- Maintenance therapy and durable medical equipment, including, but not limited to, routine dialysis, routine oxygen, routine laboratory testing or a wheelchair to assist you while traveling outside the geographic area served by your Participating Medical Group.
- Medical care for a known or Chronic Condition without acute symptoms as defined under Emergency Services or Urgently Needed Services.
- Ambulance services are limited to transportation to the nearest facility with the expertise for treating your condition.

Your Participating Medical Group provides 24-hour access to request authorization for out-of-area care. You can also request authorization by calling the PacifiCare Out-of-Area Unit during regular business hours (8 a.m. – 5 p.m. PST) at **1-800-762-8456**.

What To Do When You Require Urgently Needed Services

If you need Urgently Needed Services when you are in the geographic area served by your Participating Medical Group, you should contact your Primary Care Physician or Participating Medical Group. The telephone numbers for your Primary Care Physician and/or Participating Medical Group are on the front of your PacifiCare ID card. Assistance is available 24 hours a day, 7 days a week. Identify yourself as a PacifiCare Member and ask to speak to a Physician. If you are calling during non-business hours and a Physician is not immediately available, ask to have the Physician-on-call paged. A Physician should call you back shortly. Explain your situation and follow any provided instructions. If your Primary Care Physician or Participating Medical Group is temporarily unavailable or inaccessible, you should seek Urgently Needed Services from a licensed medical professional wherever you are located.

You, or someone else on your behalf, must notify PacifiCare or your Participating Medical Group within 24 hours, or as soon as reasonably possible, after the initial receipt of Urgently Needed Services. When you call, please be prepared to give a description of the Urgently Needed Services that you received.

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Out-of-Area Urgently Needed Services

Urgently Needed Services are Medically Necessary health care services required to prevent the serious deterioration of a Member's health, resulting from an unforeseen illness or injury for which treatment cannot be delayed until the Member returns to the geographic area served by the Member's Participating Medical Group.

Urgently Needed Services are required in situations where a Member is temporarily outside the geographic area served by the Member's Participating Medical Group and the Member experiences a medical condition that, while less serious than an Emergency Medical Condition, could result in the serious deterioration of the Member's health if not treated before the Member returns to the geographic area served by his or her Participating Medical Group or contacts his or her Participating Medical Group.

When you are temporarily outside the geographic area served by your Participating Medical Group and you believe that you require Urgently Needed Services, you should, if possible, call (or have someone else call on your behalf) your Primary Care Physician or Participating Medical Group as described in "What To Do When You Require Urgently Needed Services." The telephone numbers for your Primary Care Physician and/or Participating Medical Group are on the front of your PacifiCare ID card. Assistance is available 24 hours a day, 7 days a week. Identify yourself as a PacifiCare Member and ask to speak to a Physician. If you are calling during non-business hours and a Physician is not immediately available, ask to have the Physician-on-call paged. A Physician should call you back shortly. Explain your situation and follow any provided instructions.

If you are unable to contact your Primary Care Physician or Participating Medical Group, you should seek Urgently Needed Services from a licensed medical professional wherever you are located.

You, or someone else on your behalf, must notify PacifiCare or your Participating Medical Group within 24 hours, or as soon as reasonably possible, after the initial receipt of Urgently Needed Services. When you call, please be prepared to give a description of the Urgently Needed Services that you received.

International Emergency and Urgently Needed Services

If you are out of the country and require Urgently Needed Services, you should still, if possible, call your Primary Care Physician or Participating Medical Group. Just follow the same instructions outlined above. If you are out of the country and experience an Emergency Medical Condition, either use the available emergency response system or go directly to the nearest hospital emergency room. Following receipt of Emergency Services, please notify your Primary Care Physician or Participating Medical Group within 24 hours, or as soon as reasonably possible, after initially receiving these services.

NOTE: Under certain circumstances, you may need to initially pay for your Emergency or Urgently Needed Services. If this is necessary, please pay for such services and then contact PacifiCare at the earliest opportunity. Be sure to keep all receipts and copies of relevant medical documentation. You will need these to be properly reimbursed. For more information on submitting claims to PacifiCare, please refer to **Section 6** in this *Combined Evidence of Coverage and Disclosure Form*.

Always Remember

Emergency Services: Following receipt of Emergency Services, you, or someone else on your behalf, must notify PacifiCare or your Primary Care Physician within 24 hours, or as soon as reasonably possible, after initially receiving these services.

Urgently Needed Services: When you require Urgently Needed Services, you should, if possible, call (or have someone else call on your behalf) your Primary Care Physician or Participating Medical Group. If you are unable to contact your Primary Care Physician or Participating Medical Group, and you receive medical or Hospital Services, you must notify PacifiCare or your Primary Care Physician within 24 hours, or as soon as reasonably possible of initially receiving these services.



Changing Your Doctor or Medical Group

- *How To Change Your Primary Care Physician*
- *How To Change Your Participating Medical Group*
- *When We Change Your Physician or Medical Group*
- *When Medical Groups or Doctors are Terminated by PacifiCare*

There may come a time when you want or need to change your Primary Care Physician or Participating Medical Group. This section explains how to make this change, as well as how we continue your care.

Changing Your Primary Care Physician

Whether you want to change doctors within your Participating Medical Group or transfer out of your Participating Medical Group entirely, you should contact our Customer Service department. PacifiCare will approve your request, if the Primary Care Physician you've selected is accepting new patients and meets the other criteria in **Section One: Getting Started**. This includes being located within a 30-mile radius of your Primary Residence or Primary Workplace.

In addition, you must meet the following criteria:

- You are not an inpatient in a hospital, a Skilled Nursing Facility or other medical institution;
- Your pregnancy is not high-risk or has not reached the third trimester; and
- The change isn't likely to adversely affect the quality of your health care.

PacifiCare reviews these requests on a case-by-case basis. If you meet these requirements and call us by the 15th of the current month, your transfer will be effective on the first day of the *following* month. If you meet the criteria but your request is received after the 15th of the current month, your transfer will be effective the first day of the *second succeeding month*. For example, if

you meet the above requirements and you call PacifiCare on June 12th to request a new doctor, the transfer will be effective on July 1st. If you meet the above requirements and you call PacifiCare on June 16th, the transfer will be effective August 1st.

If you are hospitalized, confined in a Skilled Nursing Facility, being followed by a Case Management program or receiving acute institutional or non-institutional care at the time of your request, a change in your Primary Care Physician or Participating Medical Group will not be effective until the first day of the second month following your discharge from the institution or termination of treatment. When PacifiCare's Case Management is involved, the Case Manager is also consulted about the effective date of your Physician change request.

If you are changing Participating Medical Groups, our Customer Service department may be able to help smooth the transition. At the time of your request, please let us know if you are currently under the care of a Specialist, receiving home health services or using durable medical equipment such as a wheelchair, walker, hospital bed or an oxygen delivery system.

When We Change Your Participating Medical Group

Under special circumstances, PacifiCare may require that a Member change his or her Participating Medical Group. Generally, this happens at the request of the Participating Medical Group after a material detrimental change in its relationship with a Member. If this occurs, we will notify the Member of the effective date of the change, and we will transfer the Member to another Participating Medical Group, provided he or she is medically able and there's an alternative Participating Medical Group within 30 miles of the Member's Primary Residence or Primary Workplace.

PacifiCare will also notify the Member in the event that the agreement terminates between PacifiCare and the Member's Participating Medical Group. If this occurs, PacifiCare will provide 30 days of notice of the termination. PacifiCare will also assign the Member a new Primary Care Physician. If the Member would like to select a different Primary Care Physician, he or she may do so by contacting Customer Service. Upon the effective date of transfer, the Member can begin receiving services from his or her new Primary Care Physician.

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PLEASE NOTE: Except for Emergency and Urgently Needed Services, once an effective date with your new Participating Medical Group has been established, a Member must use his or her new Primary Care Physician or Participating Medical Group to authorize all services and treatments. *Receiving services elsewhere will result in PacifiCare's denial of benefit coverage.*

Continuing Care With a Terminated Physician

You may be eligible to continue receiving care from a terminated Physician if the doctor didn't voluntarily end participation with PacifiCare or a Participating Medical Group. The care must be Medically Necessary, and the terminated Physician must agree to the previous terms and conditions of his or her contract with PacifiCare. The cause of termination by PacifiCare or your Participating Medical Group also has to be for a reason other than a medical disciplinary cause, fraud or any criminal activity.

Continued care from the terminated Physician may be provided for an acute or serious Chronic Condition for up to 90 days or a longer period, until you can be safely transferred to another Provider. Continued care from a terminated Physician may be provided if you have a high-risk pregnancy or a pregnancy in the third trimester. Care may be extended through completed treatment of pregnancy-related and postpartum conditions, or until your care can be safely provided by another Physician. If you are receiving treatment for any of these conditions, contact our Customer Service department. You can request permission to continue being treated by this Physician beyond the termination date.

PacifiCare must preauthorize or coordinate services for continued care. If you have any questions, want to appeal a denial, or would like a copy of PacifiCare's Continuity of Care Policy, call our Customer Service department. (To learn more about appealing a denial, see **Section Eight: Overseeing Your Health Care.**)

Continuity of Care for New Members

Under certain circumstances, new Members of PacifiCare may be able to temporarily continue receiving services from a Non-Participating Provider. This short-term coverage is intended for new Members who are experiencing an acute episode of care while making the transition to PacifiCare. For more detail, see **Section One: Getting Started.**

Continuity of Mental Health Care Services for New Members

New PacifiCare Members who are receiving mental health care services from a Non-Participating Mental Health Provider for an acute, serious or chronic mental health condition may receive services from the Non-Participating Mental Health Provider for a reasonable period of time in order to safely transition to a mental health care Participating Provider. Please refer to the "Medical Benefits," and the "Exclusions and Limitations" sections of the PacifiCare *Combined Evidence of Coverage and Disclosure Form*, and the *Schedule of Benefits* for supplemental mental health care coverage information, if any. For a description of coverage of mental health care services for the diagnosis and treatment of Severe Mental Illness (SMI) and Serious Emotional Disturbances of Children (SED) please refer to the behavioral health supplement to the *Combined Evidence of Coverage and Disclosure Form*. A Non-Participating Mental Health Provider means a psychiatrist, licensed psychologist, licensed marriage and family therapist or licensed clinical social worker who has not entered into a written agreement with the network of providers from whom the Member is entitled to receive Covered Services.

If a new Member is eligible to receive continuing services from a Non-Participating Mental Health Provider to facilitate continuity of care, mental health services will be provided on a timely, appropriate and Medically Necessary basis for a reasonable period, taking into account the severity of the Member's condition and the amount of time necessary to effect a safe transfer to a Participating Provider.

For a new Member to receive continuing mental health care services from a Non-Participating Mental Health Provider to facilitate continuity of care, the following conditions must be met:

1. Continuing services from a Non-Participating Mental Health Provider must be preauthorized by PacifiCare;
2. The requested treatment must be a covered benefit under this Plan;
3. The Non-Participating Mental Health Provider must agree in writing to meet the same contractual terms and conditions that are imposed upon PacifiCare's Participating Providers, including location within PacifiCare's Service Area, payment methodologies and rates of payment;



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4. The Member must be new to PacifiCare as a result of the Member's Employer Group changing health plans;
5. The Member must not have been offered an out-of-network option under which the Member would be able to obtain services from the Non-Participating Mental Health Provider;
6. The Member must not have had the option to continue with his or her previous health plan at the time of enrollment in PacifiCare.

If you meet the criteria outlined above and believe you qualify for continuing services from a Non-Participating Mental Health Provider, please call the Customer Service department and request the form "Mental Health Continuity of Care for New Enrollees". Complete and return this form to PacifiCare as soon as possible. The address is:

PacifiCare
Attention: Clinical Review Department
P.O. Box 6006
Cypress, CA 90630

Upon receiving the completed form, PacifiCare will complete a medical review of your request within 3 business days of the date PacifiCare receives your completed form. If you qualify you will be notified by telephone of the decision and provided with the plan for your care. If you do not qualify, you will be notified either by telephone or in writing within 3 business days. If you receive notice that PacifiCare has determined that you do not qualify for continuing benefits with a Non-Participating Mental Health Provider, you may appeal the decision. Please refer to the appeals process outlined in the *Combined Evidence of Coverage and Disclosure Form*.

PLEASE NOTE: If you do not receive preauthorization by PacifiCare and continue care with a Non-Participating Mental Health Provider, payment for these services will be your financial responsibility.

You may request a copy of the written "*Coordination of Mental Health Transition and Continuity of Care Services Associated with New Enrollees*" by contacting the Customer Service department.

Section Five



Your Medical Benefits

- *Inpatient Benefits*
- *Outpatient Benefits*
- *Exclusions and Limitations*
- *Other Terms of Your Medical Coverage*
- *Terms and Definitions*

This section explains your medical benefits, including what is and isn't covered by PacifiCare. You can find some helpful definitions in the back of this publication. For any Copayments that may be associated with a benefit, you should refer to your *Schedule of Benefits*, a copy of which is included with this document.

Your Medical Benefits

I. INPATIENT BENEFITS*

These benefits are provided when admitted or authorized by either the Member's Participating Medical Group or PacifiCare. All services must be Medically Necessary as defined in this *Combined Evidence of Coverage and Disclosure Form*.

With the exception of Emergency or Urgently Needed Services, a Member will only be admitted to acute care, subacute care, transitional inpatient care and Skilled Nursing Care Facilities that are authorized by the Member's Participating Medical Group under contract with PacifiCare.

1. **Alcohol, Drug or Other Substance Abuse Detoxification** – Detoxification is the medical treatment of withdrawal from alcohol, drug or other substance addiction. Treatment in an acute care setting is covered for the acute stage of alcohol, drug or other substance abuse withdrawal when medical complications occur or are highly probable. Detoxification is initially covered up to 48 hours and extended when Medically Necessary. Methadone treatment for detoxification is not covered. Rehabilitation for substance abuse or addiction is not covered. (Coverage for

rehabilitation of alcohol, drug or other substance abuse or addiction may be available if purchased by the Subscriber's employer as a supplemental benefit. If the Member's health plan includes a Behavioral Health supplemental benefit, a brochure describing it will be enclosed with these materials.)

2. **Blood and Blood Products** – Blood and blood products are covered. Autologous (self donated), donor-directed and donor-designated blood processing costs are limited to blood collected for a scheduled procedure, not to exceed \$120.00 per unit. Members will be financially responsible for the transportation and processing costs that exceed the \$120.00 per blood unit.
3. **Bloodless Surgery** – Surgical procedures performed without blood transfusions or blood products, including Rho(D) Immune Globulin, for Members who object to such transfusion on religious grounds, are covered only when available within the Member's Participating Medical Group.
4. **Bone Marrow and Stem Cell Transplants** – Non-Experimental/Non-Investigational autologous and allogeneic bone marrow and stem cell transplants are covered. The testing of immediate blood relatives to determine the compatibility of bone marrow and stem cells is limited to immediate blood relatives who are sisters, brothers, parents and natural children. The testing for compatible unrelated donors and costs for computerized national and international searches for unrelated allogeneic bone marrow or stem cell donors conducted through a registry, are covered when the Member is the intended recipient. Costs for such searches are covered up to a maximum of \$15,000. A PacifiCare Preferred Transplant Network Facility center approved by PacifiCare must conduct the computerized searches. There is no dollar limitation for Medically Necessary donor related clinical transplant services once a donor is identified.
5. **Cancer Clinical Trials** – All Routine Patient Care Costs related to an approved therapeutic clinical trial for cancer (Phases I, II, III and IV) are covered for a Member who is diagnosed with cancer and

* The benefits described in Section Five will not be Covered Services unless they are determined to be Medically Necessary by Member's Participating Medical Group or PacifiCare and are provided by Member's Primary Care Physician or authorized by Member's Participating Medical Group or PacifiCare.



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whose Participating Treating Physician recommends that the clinical trial has a meaningful potential to benefit the Member.

For the purposes of this benefit, Participating Treating Physician means a Physician who is treating a Member as a Participating Provider pursuant to an authorization or referral from the Member's Participating Medical Group or PacifiCare.

Routine Patient Care Costs are costs associated with the provision of health care services, including drugs, items, devices and services that would otherwise be covered by PacifiCare if those drugs, items, devices and services were not provided in connection with an approved clinical trial program, including:

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

For purposes of this benefit, Routine Patient Care Costs do not include the costs associated with the provision of any of the following, which are not covered by PacifiCare:

- Drugs or devices that have not been approved by the federal Food and Drug Administration and that are associated with the clinical trial.
- Services other than health care services, such as travel, transportation, housing, companion

expenses and other nonclinical expenses that the Member may require as a result of the treatment being provided for purposes of the clinical trial.

- Any item or service that is provided solely to satisfy data collection and analysis needs and that is not used in the clinical management of the Member's care.
- Health care services that, except for the fact that they are being provided in a clinical trial, are otherwise specifically excluded from coverage under PacifiCare.
- Health care services customarily provided by the research sponsor free of charge.

An approved clinical trial for cancer is one where the treatment either involves a drug that is exempt under federal regulations from a new drug application or is approved by one of the following:

- One of the National Institutes of Health.
- The Federal Food and Drug Administration, in the form of an investigational new drug application.
- The United States Department of Defense.
- The United States Veterans' Administration.

A clinical trial with endpoints defined exclusively to test toxicity is not an approved clinical trial.

All services must be preauthorized by PacifiCare's Medical Director or designee. Additionally, services must be provided by a PacifiCare Participating Provider in PacifiCare's Service Area. In the event a PacifiCare Participating Provider does not offer a clinical trial with the same protocol as the one the Member's Participating Treating Physician recommended, the Member may select a Provider performing a clinical trial with that protocol within the State of California. If there is no Provider offering the clinical trial with the same protocol as the one the Member's treating Participating Physician recommended in California, the Member may select a clinical trial outside the State of California but within the United States of America.

* The benefits described in Section Five will not be Covered Services unless they are determined to be Medically Necessary by Member's Participating Medical Group or PacifiCare and are provided by Member's Primary Care Physician or authorized by Member's Participating Medical Group or PacifiCare.

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PacifiCare is required to pay for the services covered under this benefit at the rate agreed upon by PacifiCare and a Participating Provider, minus any applicable Copayment, coinsurance or deductibles. In the event the Member participates in a clinical trial provided by a Non-Participating Provider that does not agree to perform these services at the rate PacifiCare negotiates with Participating Providers, the Member will be responsible for payment of the difference between the Non-Participating Provider's billed charges and the rate negotiated by PacifiCare with Participating Providers, in addition to any applicable Copayment, coinsurance or deductibles.

Any additional expenses the Member may have to pay beyond PacifiCare's negotiated rate as a result of using a Non-Participating Provider do not apply to the Member's annual Copayment maximum.

6. **Hospice Services** – Hospice Services are covered for Members with a terminal illness, defined as a medical condition resulting in a prognosis of life expectancy of 1 year or less, if the disease follows its natural course. Hospice Services are provided as determined by the plan of care developed by the Member's interdisciplinary team, which includes, but is not limited to, the Member, the Member's Primary Care Physician, a registered nurse, a social worker and a spiritual caregiver. Hospice Services are provided in an appropriately licensed hospice facility when the Member's interdisciplinary team has determined that the Member's care cannot be managed at home because of acute complications or the temporary absence of a capable primary caregiver.

Hospice Services include skilled nursing services, certified home health aid services and homemaker services under the supervision of a qualified registered nurse; bereavement services; social services/counseling services; medical direction; volunteer services; pharmaceuticals, medical equipment and supplies that are reasonable and necessary for the palliation and management of the terminal illness and related conditions; and physical and occupational therapy and speech-

language pathology services for purposes of symptom control, or to enable the Member to maintain activities of daily living and basic functional skills.

Inpatient Hospice Services are provided in an appropriately licensed hospice facility when the Member's interdisciplinary team has determined that the Member's care cannot be managed at home because of acute complications or when it is necessary to relieve the family members or other persons caring for the Member ("respite care"). Respite care is limited to an occasional basis and to no more than 5 consecutive days at a time.

7. **Inpatient Hospital Benefits/Acute Care** – Medically Necessary inpatient Hospital Services authorized by the Member's Participating Medical Group or PacifiCare are covered, including, but not limited to: semi-private room, nursing and other licensed health professionals, intensive care, operating room, recovery room, laboratory and professional charges by the hospital pathologist or radiologist and other miscellaneous hospital charges for Medically Necessary care and treatment.
8. **Inpatient Physician and Specialist Care** – Services from Physicians, including Specialists and other licensed health professionals within, or upon referral from, the Member's Participating Medical Group are covered while the Member is hospitalized as an inpatient. A Specialist is a licensed health care professional with advanced training in an area of medicine or surgery.
9. **Inpatient Rehabilitation Care** – Rehabilitation services that must be provided in an inpatient rehabilitation facility are covered. Inpatient rehabilitation consists of the combined and coordinated use of medical, social, educational and vocational measures for training or retraining individuals disabled by disease or injury. The goal of these services is for the disabled Member to obtain his or her highest level of functional ability. Rehabilitation services include, but are not limited to physical, occupational and speech therapy.
- This benefit does not include drug, alcohol or other substance abuse rehabilitation.

* The benefits described in Section Five will not be Covered Services unless they are determined to be Medically Necessary by Member's Participating Medical Group or PacifiCare and are provided by Member's Primary Care Physician or authorized by Member's Participating Medical Group or PacifiCare.



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10. Mastectomy, Breast Reconstruction after Mastectomy and Complications from Mastectomy – Medically Necessary mastectomy and lymph node dissection are covered, including prosthetic devices and/or reconstructive surgery to restore and achieve symmetry for the Member incident to the mastectomy. The length of a hospital stay is determined by the attending Physician and surgeon in consultation with the Member, consistent with sound clinical principles and processes. Coverage includes any initial and subsequent reconstructive surgeries or prosthetic devices for the diseased breast on which the mastectomy was performed. Coverage is provided for surgery and reconstruction of the other breast if, in the opinion of the attending surgeon, this surgery is necessary to achieve symmetrical appearance. Medical treatment for any complications from a mastectomy, including lymphedema, is covered.

11. Maternity Care – Prenatal and maternity care services are covered, including labor, delivery and recovery room charges, delivery by Cesarean section, treatment of miscarriage and complications of pregnancy or childbirth.

- Educational courses on lactation, childcare and/or prepared childbirth classes are not covered.
- Alternative birthing center services are covered when provided or arranged by a Participating Hospital affiliated with the Member's Participating Medical Group.
- Nurse midwife services are covered only when available within the Member's Participating Medical Group.
- Home deliveries are not covered.

A minimum 48-hour inpatient stay for normal vaginal delivery and a minimum 96-hour inpatient stay following delivery by Cesarean section are covered. Coverage for inpatient hospital care may be for a time period less than the minimum hours if the decision for an earlier discharge of the mother and newborn is made by the treating Physician in consultation with the mother.

In addition, if the mother and newborn are discharged prior to the 48- or 96- hour minimum time periods, a post-discharge follow-up visit for the mother and newborn will be provided within 48 hours of discharge, when prescribed by the treating Physician.

12. Newborn Care – Postnatal Hospital Services are covered, including circumcision (if desired and performed in the Hospital) and special care nursery.

13. Organ Transplant and Transplant Services – Non-Experimental and Non-Investigational organ transplants and transplant services are covered when the recipient is a Member and the transplant is performed at a Preferred Transplant Network facility. Listing of the Member at a second Preferred Transplant Network Center is excluded, unless the Regional Organ Procurement Agencies are different for the 2 facilities and the Member is accepted for listing by both facilities. In these cases, organ transplant listing is limited to 2 Preferred Transplant Network facilities. If the Member is dual listed, his or her coverage is limited to the actual transplant at the second facility. The Member will be responsible for any duplicated diagnostic costs incurred at the second facility. Covered Services for living donors are limited to Medically Necessary clinical services once a donor is identified. Transportation and other nonclinical expenses of the living donor are excluded and are the responsibility of the Member, who is the recipient of the transplant. (See the definition for "Preferred Transplant Network.")

14. Reconstructive Surgery – Reconstructive surgery is covered to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors or disease. The purpose of reconstructive surgery is to correct abnormal structures of the body to improve function or create a normal appearance to the extent possible. Reconstructive procedures require preauthorization by the Member's Participating Medical Group or PacifiCare in accordance with standards of care as practiced by Physicians specializing in reconstructive surgery.

* The benefits described in Section Five will not be Covered Services unless they are determined to be Medically Necessary by Member's Participating Medical Group or PacifiCare and are provided by Member's Primary Care Physician or authorized by Member's Participating Medical Group or PacifiCare.

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15. **Skilled Nursing/Subacute and Transitional Care** – Medically Necessary Skilled Nursing Care and Skilled Rehabilitation Care are covered. The Member's Participating Medical Group or PacifiCare will determine where the Skilled Nursing Care and Skilled Rehabilitation Care will be provided.

Skilled Nursing Facility room and board charges are covered up to 100 consecutive days per admission. Days spent out of a Skilled Nursing Facility when transferred to an acute hospital setting are not counted toward the 100 consecutive day room and board limitation when the Member is transferred back to a Skilled Nursing Facility. Such days spent in an acute hospital setting also do not count toward renewing the 100 consecutive day benefit. In order to renew the room and board coverage in a Skilled Nursing Facility, the Member must either be out of all Skilled Nursing Facilities for 60 consecutive days, or if the Member remains in a Skilled Nursing Facility, then the Member must not have received Skilled Nursing Care or Skilled Rehabilitation Care for 60 consecutive days.

16. **Voluntary Termination of Pregnancy** – Refer to the *Schedule of Benefits* for the terms of any coverage, if any.

II. OUTPATIENT BENEFITS*

The following benefits are available on an outpatient basis and must be provided by the Member's Primary Care Physician or authorized by the Member's Participating Medical Group or PacifiCare. All services must be Medically Necessary as defined in this *Combined Evidence of Coverage and Disclosure Form*.

1. **Alcohol, Drug or Other Substance Abuse Detoxification** – Detoxification is the medical treatment of withdrawal from alcohol, drug or other substance addiction. Medically Necessary detoxification is covered. Methadone treatment for detoxification is not covered. In most cases of alcohol, drug or other substance abuse or toxicity, outpatient treatment is appropriate unless another medical condition requires close inpatient monitoring. Rehabilitation for substance abuse or addiction is not covered.
2. **Allergy Testing** – Services and supplies are covered for the determination of the appropriate course of allergy treatment.
3. **Allergy Treatment** – Services for the treatment of allergies are covered according to an established treatment plan, with the exclusion of allergy serum. Unless otherwise noted in your *Schedule of Benefits*, allergy serum is not included in this benefit.
4. **Ambulance** – The use of an ambulance (land or air) is covered without preauthorization, when the Member, as a Prudent Layperson, reasonably believes that the medical or psychiatric condition requires Emergency Services, and an ambulance transport is necessary to receive these services. Such coverage includes, but is not limited to, ambulance or ambulance transport services provided through the 911 Emergency response system. Ambulance transportation is limited to the nearest available Emergency facility having the expertise to stabilize the Member's Emergency Medical Condition. Use of an ambulance for a non-Emergency Service is covered only when specifically authorized by the Member's Participating Medical Group or PacifiCare.
5. **Attention Deficit/Hyperactivity Disorder** – The medical management of Attention Deficit/Hyperactivity Disorder (ADHD) is covered, including the diagnostic evaluation and laboratory monitoring of prescribed drugs. Coverage for outpatient prescribed drugs is only available if the Subscriber's Employer Group has purchased the supplemental Outpatient Prescription Drug Benefit. This benefit does not include non-crisis mental health counseling or behavior modification programs.
6. **Blood and Blood Products** – Blood and blood products are covered. Autologous (self-donated), donor-directed and donor-designated blood processing costs are limited to blood collected for a scheduled procedure, not to exceed \$120.00 per unit. Members will be financially responsible for the transportation and processing costs that exceed the \$120.00 per blood unit.

* The benefits described in Section Five will not be Covered Services unless they are determined to be Medically Necessary by Member's Participating Medical Group or PacifiCare and are provided by Member's Primary Care Physician or authorized by Member's Participating Medical Group or PacifiCare.



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7. **Bloodless Surgery** – Please refer to the benefit described under Inpatient Benefits for Bloodless Surgery. Outpatient services Copayments and/or deductibles apply for any services received on an outpatient basis.
8. **Cancer Clinical Trials** – Please refer to the benefit described under Inpatient Cancer Clinical Trials. Outpatient services Copayments and/or deductibles apply for any Cancer Clinical Trials services received on an outpatient basis according to the Copayments for that specific outpatient service. PacifiCare is required to pay for the services covered under this benefit at the rate agreed upon by PacifiCare and a Participating Provider, minus any applicable Copayment, coinsurance or deductibles. In the event the Member participates in a clinical trial provided by a Non-Participating Provider that does not agree to perform these services at the rate PacifiCare negotiates with Participating Providers, the Member will be responsible for payment of the difference between the Non-Participating Provider's billed charges and the rate negotiated by PacifiCare with Participating Providers, in addition to any applicable Copayment, coinsurance or deductibles.

Any additional expenses the Member may have to pay beyond PacifiCare's negotiated rate as a result of using a Non-Participating Provider do not apply to the Member's annual Copayment maximum.

9. **Cochlear Implant Device** – An implantable cochlear device for bilateral, profoundly hearing impaired individuals who are not benefited from conventional amplification (hearing aids) is covered. Coverage is for Members at least 18 months of age who have profound bilateral sensory hearing loss or for prelingual Members with minimal speech perception under the best hearing aided condition. Please also refer to "Cochlear Implant Medical and Surgical Services."
10. **Cochlear Implant Medical and Surgical Services** – The implantation of a cochlear device for bilateral, profoundly hearing impaired or prelingual individuals who are not benefited from conventional amplification (hearing aids) is

covered. This benefit includes services needed to support the mapping and functional assessment of the cochlear device at the authorized Participating Provider. (For an explanation of speech therapy benefits, please refer to "Outpatient Medical Rehabilitation Therapy.")

11. **Dental Treatment Anesthesia** – See "Oral Surgery and Dental Services; Dental Treatment Anesthesia."
12. **Diabetic Management and Treatment** – Coverage includes outpatient self-management training, education and medical nutrition therapy services. The diabetes outpatient self-management training, education and medical nutrition therapy services covered under this benefit will be provided by appropriately licensed or registered health care professionals. These services must be provided under the direction of and prescribed by a Participating Provider.
13. **Diabetic Self-Management Items** – Equipment and supplies for the management and treatment of Type 1, Type 2 and gestational diabetes are covered, based upon the medical needs of the Member, including but not necessarily limited to: blood glucose monitors; blood glucose monitors designed to assist the visually impaired; strips; lancets and lancet puncture devices; pen delivery systems (for the administration of insulin); insulin pumps and all related necessary supplies; ketone urine testing strips; insulin syringes, podiatry services and devices to prevent or treat diabetes related complications. Members must have coverage under the Outpatient Prescription Drug Benefit for insulin, glucagon and other diabetic medications to be covered.

Visual aids are covered for Members who have a visual impairment that would prohibit the proper dosing of insulin. Visual aids do not include eyeglasses (frames and lenses) or contact lenses. The Member's Participating Provider will prescribe insulin syringes, lancets, glucose test strips and ketone urine test strips to be filled at a pharmacy that contracts with PacifiCare.

* The benefits described in Section Five will not be Covered Services unless they are determined to be Medically Necessary by Member's Participating Medical Group or PacifiCare and are provided by Member's Primary Care Physician or authorized by Member's Participating Medical Group or PacifiCare.

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14. **Dialysis** – Acute and chronic hemodialysis services and supplies are covered. For chronic hemodialysis, application for Medicare Part A and Part B coverage must be made. Chronic dialysis (peritoneal or hemodialysis) must be authorized by the Member's Participating Medical Group or PacifiCare and provided within the Member's Participating Medical Group.
15. **Durable Medical Equipment (Rental, Purchase or Repair)** – Durable Medical Equipment is covered when it is designed to assist in the treatment of an injury or illness of the Member and the equipment is primarily for use in the home. Durable Medical Equipment is medical equipment that can exist for a reasonable period of time without significant deterioration. Examples of covered Durable Medical Equipment include wheelchairs, hospital beds and standard oxygen delivery systems.

Replacements, repairs and adjustments to Durable Medical Equipment are limited to normal wear and tear or because of a significant change in the Member's physical condition. The Member's Participating Medical Group or PacifiCare has the option to repair or replace Durable Medical Equipment items. Replacement of lost or stolen Durable Medical Equipment is not covered. The following equipment and accessories are not covered: Non-Medically Necessary optional attachments and modifications to Durable Medical Equipment for the comfort or convenience of the Member, accessories for portability or travel, a second piece of equipment with or without additional accessories that is for the same or similar medical purpose as existing equipment and home and car remodeling.
16. **Family Planning** – Refer to the *Schedule of Benefits* for the specific terms of coverage under your Health Plan.
17. **Footwear** – Specialized footwear, including foot orthotics, custom-made or standard orthopedic shoes are covered for a Member with diabetic foot disease or when an orthopedic shoe is permanently attached to a Medically Necessary orthopedic brace.
18. **Health Education Services** – Benefits include wellness services, such as the Free & Clear® StopSmokingSM program. PacifiCare also makes health and wellness information available to Members. The Health Education Resources Directory lists wellness classes available through Participating Medical Groups in the Member's area. Many are free, informative programs on such subjects as asthma, diabetes and cardiovascular disease, as well as health screenings. For more information about the Free & Clear® StopSmokingSM program or any other wellness program, call the PacifiCare Customer Service department at 1-800-624-8822.

The Member's Participating Medical Group may offer additional community health programs. These programs are independent of health improvement programs offered by PacifiCare and are not covered. Fees charged will not apply to the Member's Copayment maximum.
19. **Home Health Care** – Part-time or intermittent services, consisting of Skilled Nursing Care and Skilled Rehabilitation Care, are covered in the home. Part-time intermittent skilled nursing services are services provided by (i) a registered nurse or licensed vocational nurse; (ii) part-time or intermittent home health aide services which provide supportive services in the home under the supervision of a registered nurse or a physical, speech or occupational therapist; (iii) physical, occupational or speech therapy; and (iv) drugs and medications and related pharmaceutical services, medical supplies, infusion therapy drugs and lab services prescribed by a physician to the extent such charges or costs would have been covered under the plan if the covered person had remained in the hospital. Drugs and medications and related pharmaceutical services are covered only if the Subscriber's Employer Group has purchased the Outpatient Prescription Drug Benefit. If the Member's Participating Medical Group determines that Skilled Nursing Care needs are more extensive than part-time or intermittent services, the Member will be transferred to a Skilled Nursing Facility to obtain coverage for this benefit. PacifiCare, in consultation with the

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Member's Participating Medical Group, will determine the appropriate setting for delivery of the Member's Skilled Nursing Care services.

20. **Hospice Services** – Hospice Services are covered for Members with a terminal illness, defined as a medical condition resulting in a prognosis of life expectancy of 1 year or less, if the disease follows its natural course. Hospice Services are provided pursuant to the plan of care developed by the Member's interdisciplinary team, which includes, but is not limited to, the Member, the Member's Primary Care Physician, a registered nurse, a social worker and a spiritual caregiver.

Hospice Services include skilled nursing services, certified home health aid services and homemaker services under the supervision of a qualified registered nurse; bereavement services; social services/counseling services; medical direction; volunteer services; pharmaceuticals, medical equipment and supplies that are reasonable and necessary for the palliation and management of the terminal illness and related conditions; physical and occupational therapy and speech-language pathology services for purposes of symptom control, or to enable the Member to maintain activities of daily living and basic functional skills.

Covered Hospice Services are available in the home on a 24-hour basis when Medically Necessary, during periods of crisis, when a Member requires continuous care to achieve palliation or management of acute medical symptoms. Inpatient Hospice Services are provided in an appropriately licensed hospice facility when the Member's interdisciplinary team has determined that the Member's care cannot be managed at home because of acute complications or when it is necessary to relieve the family members or other persons caring for the Member ("respite care"). Respite care is limited to an occasional basis and to no more than 5 consecutive days at a time.

21. **Immunizations** – Immunizations for children (through age 18 years) are covered consistent with the most current version of the Recommended Childhood Immunization Schedule/United States.¹ An exception is made if, within 45 days of the published date of the schedule, the State Department of Health Services determines that the schedule is not consistent with state law. Immunizations for adults are covered consistent with the most current recommendations of the Center for Disease Control (CDC) for routine adult immunizations as advised by the Advisory Committee on Immunization Practices. For children under 2 years of age, refer to "Periodic Health Evaluations – Well Baby."

Routine boosters and immunizations must be obtained through the Member's Participating Medical Group.

Travel and/or required work immunizations are not covered.

22. **Infertility Services** – Please refer to the *Schedule of Benefits* for coverage, if any. Coverage for Infertility Services is only available if purchased by the Subscriber's Employer Group as a supplemental benefit. If the Member's health plan includes an Infertility Services supplemental benefit, a supplement to the *Combined Evidence of Coverage and Disclosure Form* will be provided to the Member.
23. **Infusion Therapy** – Infusion therapy means the therapeutic use of drugs or other substances, prepared or compounded, and administered by a Participating Provider and given to a Member through a needle or catheter. Services must be provided in the Member's home or an institution that is not a hospital or is not primarily engaged in providing Skilled Nursing or Rehabilitation Services. (For example, board and care, custodial care facility and assisted living facility.) Infusion therapy is only covered as part of a treatment plan authorized by the Member's Participating Medical Group or PacifiCare.

¹ This is jointly adopted by the American Academy of Pediatrics, the Advisory Committee on Immunization Practices (ACIP), and the American Academy of Family Physicians.

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24. **Injectable Drugs (Outpatient Injectable Medications and Self-Injectable Medications)** – Outpatient injectable medications administered in the Physician’s office (except insulin) are covered when a part of the medical office visit. Self-injectable medications (except insulin) are covered when the Member is trained in the use of the medication and the medication has been prescribed by a Participating Provider, as authorized by the Member’s Participating Medical Group or PacifiCare.

Outpatient injectable medications, including self-injectables, must be obtained through a Participating Provider or through the Member’s Participating Medical Group and may require preauthorization. Insulin is covered as a pharmacy benefit if the Member is covered by an Outpatient Prescription Drug supplemental benefit. Pen devices for the delivery of medication, other than for insulin, are not covered.

25. **Laboratory Services** – Medically Necessary diagnostic and therapeutic laboratory services are covered.

26. **Maternity Care, Tests and Procedures** – Physician visits, laboratory services (including the California Department of Health Services’ expanded alpha fetoprotein (AFP) program) and radiology services are covered for prenatal and postpartum maternity care. Nurse midwife services are covered when available within and authorized by the Member’s Participating Medical Group.

Genetic Testing and Counseling are covered when authorized by the Member’s Participating Medical Group as part of an amniocentesis or chorionic villus sampling procedure.

27. **Medical Supplies and Materials** – Medical supplies and materials necessary to treat an illness or injury are covered when used or furnished while the Member is treated in the Participating Provider’s office, during the course of an illness or injury, or stabilization of an injury or illness, under the direct supervision of the Participating Provider. Examples of items commonly furnished in the Participating Provider’s office to treat the Member’s illness or injury are gauzes, ointments, bandages, slings and casts.

28. **Mental Health Services** – Only services to treat Severe Mental Illness for adults and children, and Serious Emotional Disturbances of a Child are covered. (See your Supplement to this *Combined Evidence of Coverage and Disclosure Form* for a description of this coverage.) Refer to the *Schedule of Benefits* for additional coverage of Mental Health Services, if any.

29. **OB/GYN Physician Care** – See “Physician OB/GYN Care.”

30. **Oral Surgery and Dental Services** – Emergency Services for stabilizing an acute injury to sound natural teeth, the jawbone or the surrounding structures are covered. Coverage is limited to treatment provided within 48 hours of injury. Other covered Oral Surgery and Dental Services include:

- Biopsy and excision of cysts or tumors of the jaw, treatment of malignant neoplastic disease and treatment of temporomandibular joint syndrome (“TMJ”);
- Tooth extraction prior to a major organ transplant or radiation therapy to the head or neck;
- Preventive fluoride treatment prior to an aggressive chemotherapeutic or radiation therapy protocol.

Dental Services beyond Emergency treatment to stabilize an acute injury – including, but not limited to, crowns, fillings, dental implants, caps, dentures, braces, dental appliances and orthodontic procedures – are not covered. Charges for the dental procedure(s) beyond emergency treatment to stabilize an acute injury including, but not limited to, professional fees of the dentist or oral surgeon, X-ray and laboratory fees or related dental supplies provided in connection with the care, treatment, filling, removal or replacement of teeth or structures directly supporting the teeth, are not covered except for services covered by PacifiCare under this outpatient benefit, “Oral Surgery and Dental Services.”

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31. **Oral Surgery and Dental Services: Dental Treatment Anesthesia** – Anesthesia and associated facility charges for dental procedures provided in a hospital or outpatient surgery center are covered when: (1) the Member's clinical status or underlying medical condition requires use of an outpatient surgery center or inpatient setting for the provision of the anesthesia for dental procedure(s) that ordinarily would not require anesthesia in a hospital or outpatient surgery center setting; and (2) one of the following criteria is met:

- The Member is under 7 years of age;
- The Member is developmentally disabled, regardless of age; or
- The Member's health is compromised and general anesthesia is Medically Necessary, regardless of age.

The Member's dentist must obtain preauthorization from the Member's Participating Medical Group or PacifiCare before the dental procedure is provided.

Dental Anesthesia in a dental office or dental clinic is not covered. Charges for the dental procedure(s) itself, including, but not limited to, professional fees of the dentist or oral surgeon, X-ray and laboratory fees or related dental supplies provided in connection with the care, treatment, filling, removal or replacement of teeth or structures directly supporting the teeth are not covered except for services covered by PacifiCare under the outpatient benefit, "Oral Surgery and Dental Services."

32. **Outpatient Medical Rehabilitation Therapy** – Services provided by a registered physical, speech or occupational therapist for the treatment of an illness, disease or injury are covered.
33. **Outpatient Surgery** – Short stay, same day or other similar outpatient surgery facilities are covered when provided as a substitute for inpatient care.
34. **Periodic Health Evaluation** – Periodic Health Evaluations are covered as recommended by PacifiCare's Preventive Health Guidelines and the

Member's Primary Care Physician. This may include, but is not limited to, the following screenings:

- **Breast Cancer Screening and Diagnosis** – Services are covered for the screening and diagnosis of breast cancer. Screening and diagnosis will be covered consistent with generally accepted medical practice and scientific evidence, upon referral by the Member's Primary Care Physician. Mammography for screening or diagnostic purposes is covered as authorized by the Member's participating nurse practitioner, participating certified nurse midwife or Participating Provider.
- **Hearing Screening** – Routine hearing screening by a participating health professional is covered to determine the need for hearing correction. Hearing aids are not covered, nor is their testing or adjustment. (Hearing Screenings are limited to Dependents under age 19.)
- **Prostate Screening** – Evaluations for the screening and diagnosis of prostate cancer is covered (including, but not limited to, prostate-specific antigen testing and digital rectal examination). These evaluations are provided when consistent with good professional practice.
- **Vision Screening** – Annual routine eye health assessment and screening by a Participating Provider are covered to determine the health of the Member's eyes and the possible need for vision correction. An annual retinal examination is covered for Members with diabetes.
- **Well-Baby Care** – Up to the age of 2, preventive health services are covered (including immunizations) when provided by the child's Participating Medical Group. An office Copayment applies when infants are ill at the time services are provided.
- **Well-Woman Care** – Medically Necessary services, including a Pap smear (cytology), are

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covered. The Member may receive obstetrical and gynecological Physician services directly from an OB/GYN or Family Practice Physician or surgeon (designated by the Member's Participating Medical Group as providing OB/GYN services) affiliated with Member's Participating Medical Group.

35. **Phenylketonuria ("PKU") Testing and**

Treatment – Testing for Phenylketonuria (PKU) is covered to prevent the development of serious physical or mental disabilities or to promote normal development or function as a consequence of PKU enzyme deficiency. PKU includes those formulas and special food products that are part of a diet prescribed by a Participating Physician and managed by a health care professional in consultation with a physician who specializes in the treatment of metabolic disease and who participates in or is authorized by PacifiCare, provided that the diet is deemed Medically Necessary to avert the development of serious physical or mental disabilities or to promote normal development or function as a consequence of PKU. Special food products do not include food that is naturally low in protein but may include a special low-protein formula specifically approved for PKU and special food products that are specially formulated to have less than 1 gram of protein per serving.

36. **Physician Care (Primary Care Physician and Specialist)** – Diagnostic, consultation and treatment services provided by the Member's Primary Care Physician are covered. Services of a Specialist are covered upon referral by Member's Participating Medical Group or PacifiCare. A Specialist is a licensed health care professional with advanced training in an area of medicine or surgery.

37. **Physician OB/GYN Care** – The Member may obtain obstetrical and gynecological Physician services directly from an OB/GYN, Family Practice Physician or surgeon (designated by the Member's Participating Medical Group as providing OB/GYN services) affiliated with the Member's Participating Medical Group.

38. **Prosthetics and Corrective Appliances**

Prosthetics (except for bionic or myoelectric as explained below) are covered when Medically Necessary as determined by the Member's Participating Medical Group or PacifiCare. Prosthetics are durable, custom-made devices designed to replace all or part of a permanently inoperative or malfunctioning body part or organ. Examples of covered prosthetics include initial contact lens in an eye following a surgical cataract extraction and removable, non-dental prosthetic devices such as a limb that does not require surgical connection to nerves, muscles or other tissue.

Custom-made or custom-fitted Corrective Appliances are covered when Medically Necessary as determined by the Member's Participating Medical Group or PacifiCare. Corrective Appliances are devices that are designed to support a weakened body part. These appliances are manufactured or custom-fitted to an individual Member.

- Bionic and myoelectric prosthetics are not covered. Bionic prosthetics are prosthetics that require surgical connection to nerves, muscles or other tissues. Myoelectric prosthetics are prosthetics which have electric motors to enhance motion.
- Replacements, repairs and adjustments to corrective appliances and prosthetics coverage are limited to normal wear and tear or because of a significant change in the Member's physical condition. Repair or replacement must be authorized by the Member's Participating Medical Group or PacifiCare.
- Refer to "Footwear" in Benefits Available on an Outpatient Basis.

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39. Radiation Therapy (Standard and Complex):

- Standard photon beam radiation therapy is covered.
- Complex radiation therapy is covered. This therapy requires specialized equipment, as well as specially trained or certified personnel to perform the therapy. Examples include, but are not limited to: brachytherapy (radioactive implants) and conformal photon beam radiation. (Gamma knife procedures and stereotactic procedures are covered as outpatient surgeries for the purpose of determining Copayments. (Please refer to your *Schedule of Benefits* for applicable Copayment, if any.)

40. Radiology Services: Including but not limited to Standard X-ray films (with or without oral, rectal, injected or infused contrast medium) for the diagnosis of an illness or injury are covered. Standard X-ray services are X-ray(s) of an extremity, abdomen, head, chest, back, mammograms, nuclear studies and barium studies. Also see Maternity and Periodic Health Evaluations.

- Specialized Scanning and Imaging Procedures, such as CT, SPECT, PET, IMRT, MRA and MRI (with or without contrast media), are covered.

41. Reconstructive Surgery – Reconstructive surgery is covered to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors or disease. The purpose of reconstructive surgery is to improve function or create a normal appearance to the extent possible. Reconstructive procedures require preauthorization by the Member's Participating Medical Group or PacifiCare in accordance with standards of care as practiced by Physicians specializing in reconstructive surgery.

42. Refractions – Routine testing every 12 months is covered to determine the need for corrective lenses (refractive error), including a written prescription for eyeglass lenses. (Coverage for frames and lenses may be available if the Member's health plan includes a supplemental vision benefit.)

III. EXCLUSIONS AND LIMITATIONS OF BENEFITS

Unless described as a Covered Service in an attached supplement, all services and benefits described below are excluded from coverage or limited under this Health Plan. Any supplement must be an attachment to this Combined Evidence of Coverage and Disclosure Form. (NOTE: Additional exclusions and limitations may be included with the explanation of your benefits in the additional materials.)

GENERAL EXCLUSIONS

Services that are not Medically Necessary, as defined in the Definitions section of this *Combined Evidence of Coverage and Disclosure Form*, are not covered.

Services not specifically included in this *Combined Evidence of Coverage and Disclosure Form*, or any supplement purchased by the Subscriber's Employer Group, are not covered.

1. Services that are rendered without authorization from the Member's Participating Medical Group or PacifiCare (except for Emergency Services or Urgently Needed Services described in this *Combined Evidence of Coverage and Disclosure Form* and for obstetrical and gynecological Physician services obtained directly from an OB/GYN, Family Practice Physician or surgeon designated by the Member's Participating Medical Group as providing OB/GYN services), are not covered.
2. Services obtained from Non-Participating Providers or Participating Providers who are not affiliated with the Member's Participating Medical Group, when such services were offered or authorized by the Member's Participating Medical Group and the Member refused to obtain the services as offered by the Member's Participating Medical Group, are not covered.
3. Services rendered prior to the Member's effective date of enrollment or after the effective date of disenrollment are not covered.
4. PacifiCare does not cover the cost of services provided in preparation for a noncovered Service where such services would not otherwise be

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Medically Necessary. Additionally, PacifiCare does not cover the cost of routine follow-up care for noncovered Services (as recognized by the organized medical community in the state of California). PacifiCare will cover Medically Necessary services directly related to noncovered Services when complications exceed routine follow-up care such as life-threatening complications of cosmetic surgery.

OTHER EXCLUSIONS AND LIMITATIONS

- 1. Acupuncture and Acupressure** – Acupuncture and acupressure are not covered. (Coverage for acupuncture and acupressure may be available if purchased by the Subscriber's employer as a supplemental benefit. If the Member's health plan includes an acupuncture and acupressure supplemental benefit, a brochure describing it will be enclosed with these materials.)
- 2. Air Conditioners, Air Purifiers and Other Environmental Equipment** – Air conditioners, air purifiers and other environmental equipment are not covered.
- 3. Alcoholism, Drug Addiction and Other Substance Abuse Rehabilitation** – Inpatient, outpatient and day treatment rehabilitation for chronic alcoholism, drug addiction or other substance abuse are not covered. Methadone treatment for detoxification is not covered. (Coverage for rehabilitation of alcohol, drug or other substance abuse or addiction may be available if purchased by the Subscriber's employer as a supplemental benefit. If the Member's health plan includes a Behavioral Health supplemental benefit, a brochure describing it will be enclosed with these materials.)
- 4. Behavior Modification and Noncrisis Mental Health Counseling and Treatment** – Behavior modification and non-crisis mental health counseling and treatment are not covered. Examples include, but are not limited to, art therapy, music therapy and play therapy.
- 5. Biofeedback** – Biofeedback services are not covered except for bladder rehabilitation as part of an authorized treatment plan.
- 6. Blood and Blood Products** – The costs of transportation and processing for autologous, donor-directed or donor-designated blood are not covered in excess of \$120.00 per unit for a scheduled procedure.
- 7. Bloodless Surgery Services** – Bloodless surgery services are only covered to the extent available within the Member's Participating Medical Group.
- 8. Bone Marrow and Stem Cell Transplants** – Autologous or allogeneic bone marrow or stem cell transplants are not covered when they are Experimental or Investigational unless required by an external, independent review panel as described in **Section Eight** of this *Combined Evidence of Coverage and Disclosure Form*, under the caption "Independent Medical Review Procedures." Unrelated Donor Computer Searches for Members who require a bone marrow or stem cell transplant are limited to \$15,000. Unrelated Donor Searches must be performed at a PacifiCare approved transplant center. (See "Preferred Transplant Network" in Definitions.)
- 9. Chiropractic Care** – Care and treatment provided by a chiropractor are not covered. (Coverage for Chiropractic Care may be available if purchased by the Subscriber's employer as a supplemental benefit. If your Health Plan includes a Chiropractic Care supplemental benefit, a brochure describing it will be enclosed with these materials.)
- 10. Communication Devices** – Computers, personal digital assistants and any speech-generating devices are not covered.
- 11. Complementary and Alternative Medicine** – Complementary and Alternative Medicine are not covered unless purchased by the Subscriber's employer group as a supplemental benefit. (See the definition for Complementary and Alternative Medicine.)
- 12. Cosmetic Services and Surgery** – Cosmetic surgery and cosmetic services are not covered. Cosmetic surgery and cosmetic services are defined as surgery and services performed to alter or reshape normal structures of the body in order to improve appearance. Drugs, devices and procedures related to cosmetic surgery or cosmetic services are not covered. Cosmetic surgeries or cosmetic services do not become reconstructive surgery because of a Member's psychological or psychiatric condition.



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13. **Custodial Care** – Custodial Care is not covered except for those services provided by an appropriately licensed Hospice agency or appropriately licensed hospice facility incident to a Member's terminal illness as described in the explanation of Hospice Services in the Medical Benefits Section of this *Combined Evidence of Coverage and Disclosure Form*.
14. **Dental Care, Dental Appliances and Orthodontics** – Except as otherwise provided under the outpatient benefit captioned "Oral Surgery and Dental Services," dental care, dental appliances and orthodontics are not covered. Dental Care means all services required for prevention and treatment of diseases and disorders of the teeth, including, but not limited to: oral exams, X-rays, routine fluoride treatment; plaque removal, tooth decay, routine tooth extraction, dental embryonal tissue disorders, periodontal disease, crowns, fillings, dental implants, caps, dentures, braces and orthodontic procedures. (Coverage for Dental Care may be available if purchased by the Subscriber's employer as a separate benefit. If your Health Plan includes a separate Dental Care benefit, a brochure describing it will be enclosed with these materials.)
15. **Dental Treatment Anesthesia** – Dental treatment anesthesia provided or administered in a dentist's office is not covered. Charges for the dental procedure(s) itself, including but not limited to professional fees of the dentist or oral surgeon, X-ray and laboratory fees or related dental supplies provided in connection with the care, treatment, filling, removal or replacement of teeth or structures directly supporting the teeth are not covered, except for services covered by PacifiCare under the outpatient benefit, "Oral Surgery and Dental Services."
16. **Dialysis** – Chronic dialysis (peritoneal or hemodialysis) is not covered outside of the Member's Participating Medical Group.
17. **Disabilities Connected to Military Services** – Treatment in a government facility for a disability connected to military service that the Member is legally entitled to receive through a federal governmental agency, and to which Member has reasonable access, is not covered.
18. **Drugs and Prescription Medication (Outpatient)** – Outpatient drugs and prescription medications are not covered; however, coverage for prescription medications may be available as a supplemental benefit. If your Health Plan includes a supplemental benefit, a brochure will be enclosed with these materials. Infusion drugs and infusion therapy are not considered outpatient drugs for the purposes of this exclusion. Refer to outpatient benefits, "Injectable Drugs" and "Infusion Therapy" for benefit coverage. Pen devices for the delivery of medication, other than insulin or as required by law, are not covered.
19. **Durable Medical Equipment** – Replacements, repairs and adjustments to Durable Medical Equipment are limited to normal wear and tear or because of a significant change in the Member's physical condition. Replacement of lost or stolen Durable Medical Equipment is not covered. The following equipment and accessories are not covered: Non-Medically Necessary optional attachments and modifications to Durable Medical Equipment for the comfort or convenience of the Member, accessories for portability or travel, a second piece of equipment with or without additional accessories that is for the same or similar medical purpose as existing equipment and home and car remodeling.
20. **Educational Services for Developmental Delays and Learning Disabilities** – Educational services to treat developmental delays or learning disabilities are not covered. A learning disability is a condition where there is a meaningful difference between a child's current academic level of function and the level that would be expected for a child of that age. Educational services include, but are not limited to, language and speech training, reading and psychological and visual integration training as defined by the American Academy of Pediatrics *Policy Statement – Learning Disabilities, Dyslexia and Vision: A Subject Review*.
21. **Elective Enhancements** – Procedures, services and supplies for elective, non-Medically Necessary enhancements to normal body parts (items, devices or services to improve appearance or performance) are not covered. This includes, but is not limited to, elective enhancements related to hair growth, athletic performance, cosmetic

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changes and anti-aging. Please refer to “Reconstructive Surgery” for a description of Reconstructive Surgery services covered by your Health Plan.

22. **Exercise Equipment and Services** – Exercise equipment or any charges for activities, instructions or facilities normally intended or used for developing or maintaining physical fitness are not covered. This includes, but is not limited to, charges for physical fitness instructors, health clubs or gyms or home exercise equipment or swimming pools, even if ordered by a health care professional.
23. **Experimental and/or Investigational Procedures, Items and Treatments** – Experimental and/or Investigational Procedures, Items and Treatments are not covered unless required by an external, independent review panel as described in **Section Eight** of this *Combined Evidence of Coverage and Disclosure Form* captioned “Eligibility for Independent Medical Review; Experimental or Investigational Treatment Decisions,” or as described under “Cancer Clinical Trials” in the “Inpatient Benefits” and “Outpatient Benefits” sections of this *Combined Evidence of Coverage and Disclosure Form*. Unless otherwise required by federal or state law, decisions as to whether a particular treatment is Experimental or Investigational and therefore not a covered benefit are determined by a PacifiCare Medical Director or his or her designee. For the purposes of this *Combined Evidence of Coverage and Disclosure Form*, procedures, studies, tests, drugs or equipment will be considered Experimental and/or Investigational if any of the following criteria/guidelines are met:
- It cannot lawfully be marketed without the approval of the Food and Drug Administration (FDA), and such approval has not been granted at the time of its use or proposed use.
 - It is a subject of a current investigation of new drug or new device (IND) application on file with the FDA.
 - It is the subject of an ongoing clinical trial (Phase I, II or the research arm of Phase III) as defined in regulations and other official publications issued by the FDA and Department of Health and Human Services (DHHS).
 - It is being provided pursuant to a written protocol that describes among its objectives the determination of safety, efficacy, toxicity, maximum tolerated dose or effectiveness in comparison to conventional treatments.
 - It is being delivered or should be delivered subject to approval and supervision of an Institutional Review Board (IRB) as required and defined by federal regulations or other official actions (especially those of the FDA or DHHS).
 - Other facilities studying substantially the same drug, device, medical treatment or procedures refer to it as experimental or as a research project, a study, an invention, a test, a trial or other words of similar effect.
 - The predominant opinion among experts as expressed in published, authoritative medical literature is that usage should be confined to research settings.
 - It is not Experimental or Investigational itself pursuant to the above criteria, but would not be Medically Necessary except for its use in conjunction with a drug, device or treatment that is Experimental or Investigational (e.g. lab tests or imaging ordered to evaluate the effectiveness of an Experimental therapy).
 - The sources of information to be relied upon by PacifiCare in determining whether a particular treatment is Experimental or Investigational, and therefore not a covered benefit under this plan, include but are not limited to the following:
 - The Member’s medical records;
 - The protocol(s) pursuant to which the drug, device, treatment or procedure is to be delivered;
 - Any informed consent document the Member, or his or her representative, has executed or will be asked to execute, in order to receive the drug, device, treatment or procedure;



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- The published authoritative medical and scientific literature regarding the drug, device, treatment or procedure;
- Expert medical opinion;
- Opinions of other agencies or review organizations (e.g. ECRI Health Technology Assessment Information Services, HAYES New Technology Summaries or MCMC Medical Ombudsman);
- Regulations and other official actions and publications issued by agencies such as the FDA, DHHS and Agency for Health Care Policy and Research (AHCPR);
- PacifiCare Technology Assessment Committee Guidelines.

A Member with a Life-Threatening or Seriously Debilitating condition may be entitled to an expedited external, independent review of PacifiCare's coverage determination regarding Experimental or Investigational therapies as described in **Section Eight: Overseeing Your Health Care**, "Experimental or Investigational Treatment Decisions."

24. **Eye Wear and Corrective Refractive Procedures** – Corrective lenses and frames, contact lenses and contact lens fitting and measurements are not covered (except for initial post-cataract extraction or corneal bandages and for the treatment of keratoconus and aphakia). Surgical and laser procedures to correct or improve refractive error are not covered. (Coverage for frames and lenses may be available if the Subscriber's employer purchased a vision supplemental benefit. If your Health Plan includes a vision supplemental benefit, a brochure describing it will be enclosed with these materials.) Routine screenings for glaucoma are limited to Members who meet the medical criteria.
25. **Family Planning** – Family planning benefits, other than those specifically listed in the *Schedule of Benefits* that accompanies this document, are not covered.
26. **Follow-Up Care: Emergency Services or Urgently Needed Services** – Services following discharge after receipt of Emergency Services or Urgently Needed Services, including, but not limited to, treatments, procedures, X-rays, lab work, Physician visits, rehabilitation and Skilled Nursing Care are not covered without the Participating Medical Group's or PacifiCare's authorization. The fact that the Member is outside the Service Area and that it is inconvenient for the Member to obtain the required services from the Participating Medical Group will not entitle the Member to coverage.
27. **Foot Care** – Except as Medically Necessary, routine foot care, including, but not limited to, removal or reduction of corns and calluses and clipping of toenails, is not covered.
28. **Foot Orthotics/Footwear** – Specialized footwear, including foot orthotics and custom-made or standard orthopedic shoes is not covered, except for Members with diabetic foot disease or when an orthopedic shoe is permanently attached to a Medically Necessary orthopedic brace.
29. **Genetic Testing and Counseling** – Genetic testing of non-Members is not covered. Genetic testing solely to determine the gender of a fetus is not covered. Genetic testing and counseling are not covered when done for nonmedical reasons or when a Member has no medical indication or family history of a genetic abnormality. General testing and counseling are not covered to screen newborns, children or adolescents to determine their carrier status for inheritable disorders when there would be no immediate medical benefit or when the test results would not be used to initiate medical interventions during childhood. Genetic testing and counseling are not covered except when determined by PacifiCare's Medical Director or designee to be Medically Necessary to treat the Member for an inheritable disease. Refer to Maternity Care Test and Procedures in the Outpatient Benefits section for coverage of amniocentesis and chorionic villus sampling.
30. **Government Services and Treatment** – Any services that the Member receives from a local, state or federal governmental agency are not covered, except when coverage under this Health Plan is expressly required by federal or state law.
31. **Hearing Aids and Hearing Devices** – Hearing aids and non-implantable hearing devices are not covered. Audiology services (other than screening

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for hearing acuity) are not covered. Hearing aid supplies are not covered. Implantable hearing devices are not covered except for cochlear devices for bilaterally, profoundly hearing-impaired individuals or for prelingual Members who have not benefited from conventional amplification (hearing aids).

32. **Immunizations** – Travel and/or required work-related immunizations are not covered.
33. **Infertility Reversal** – Reversals of sterilization procedures are not covered.
34. **Infertility Services** – Infertility Services are not covered unless purchased by the Subscriber's Employer Group. Please refer to your *Schedule of Benefits*. The following services are excluded under the PacifiCare health plan: Ovum transplants, ovum or ovum bank charges, sperm or sperm bank charges and the Medical or Hospital Services incurred by surrogate mothers who are not PacifiCare Members are not covered. Medical and Hospital Infertility Services for a Member whose fertility is impaired due to an elective sterilization, including surgery, medications and supplies, are not covered.
35. **Institutional Services and Supplies** – Except for Skilled Nursing Services provided in a Skilled Nursing Facility, any services or supplies furnished by a facility that is primarily a place of rest, a place for the aged, a nursing home or any similar institution, regardless of affiliation or denomination, are not covered. (Skilled Nursing Services are covered as described in this *Combined Evidence of Coverage and Disclosure Form* in the sections entitled "Inpatient Benefits" and "Outpatient Benefits.") Members residing in these facilities are eligible for Covered Services that are determined to be Medically Necessary by Member's Participating Medical Group or PacifiCare, and are provided by Member's Primary Care Physician or authorized by Member's Participating Medical Group or PacifiCare.
36. **Medicare Benefits for Medicare Eligible Members** – The amount payable by Medicare for Medicare covered services is not covered by PacifiCare for Medicare eligible Members, whether or not a Medicare eligible Member has enrolled in Medicare Part A and Medicare Part B.
37. **Mental Health and Nervous Disorders** – Mental Health Services are not covered except for diagnosis and treatment of Severe Mental Illness for adults and children, and for diagnosis and treatment of Serious Emotional Disturbances of Children. Please refer to the behavioral health supplement to this *Combined Evidence of Coverage and Disclosure Form* for a description of this coverage. Academic or educational testing, as well as educational counseling or remediation are not covered. Coverage for Crisis Intervention may also be available as an additional benefit. Please refer to the *Schedule of Benefits* for coverage, if any.
38. **Morbid Obesity** – Surgical treatment for morbid obesity and services related to this surgery are not covered unless criteria as recommended by the National Institutes of Health (NIH) are met. Please also see Weight Alteration Programs (Inpatient or Outpatient).
39. **Nonphysician Health Care Practitioners** – This Plan may not cover services of all Nonphysician Health Care Practitioners. Treatment by Nonphysician Health Care Practitioners such as acupuncturists, psychologists, chiropractors, licensed clinical social workers and marriage and family therapists may be available if purchased by your employer as a supplemental benefit. (For coverage of Severe Mental Illnesses (SMI) of adults and children, and for children, the treatment of Serious Emotional Disturbances (SED), refer to Outpatient Benefits "Mental Health Services.") If your Health Plan includes a supplemental acupuncturist, chiropractic and/or mental health benefit, a brochure describing it will be enclosed with these materials.
40. **Nurse Midwife Services** – Nurse midwife services are covered only when available within the Member's Participating Medical Group. Home deliveries at home are not covered.
41. **Nursing, Private Duty** – Private duty nursing is not covered.
42. **Nutritional Supplements or Formulas** – Formulas, food, vitamins, herbs and dietary supplements are not covered, except as described under the outpatient description of "Phenylketonuria (PKU) Testing and Treatment."



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43. **Off-Label Drug Use** – Off-Label Drug Use, which means the use of a drug for a purpose that is different from the use for which the drug has been approved for by the FDA, including off-label self-injectable drugs, is not covered except as follows. If the self-injectable drug is prescribed for Off-Label Use, the drug and its administration is covered only when the following criteria are met:

- The drug is approved by the FDA;
- The drug is prescribed by a Participating Provider for the treatment of a life-threatening condition or for a chronic and seriously debilitating condition;
- The drug is Medically Necessary to treat the condition;
- The drug has been recognized for treatment of the life-threatening or chronic and seriously debilitating condition by one of the following: The American Medical Association *Drug Evaluations*, The American Hospital Formulary Service *Drug Information*, The United States Pharmacopoeia *Dispensing Information, Volume 1*, or in two articles from major peer-reviewed medical journals that present data supporting the proposed Off-Label Drug Use or Uses as generally safe and effective;
- The drug is covered under the injectable drug benefit described in the outpatient benefits section of this *Combined Evidence of Coverage and Disclosure Form*.

Nothing in this section shall prohibit PacifiCare from use of a formulary, copayment, technology assessment panel or similar mechanism as a means for appropriately managing the utilization of a drug that is prescribed for a use that is different from the use for which that drug has been approved for marketing by the FDA.

44. **Oral Surgery and Dental Services** – Dental Services including, but not limited to, crowns, fillings, dental implants, caps, dentures, braces and orthodontic procedures, are not covered.
45. **Oral Surgery and Dental Services: Dental Treatment Anesthesia** – Dental anesthesia in a dental office or dental clinic is not covered. Professional fees of the dentist are not covered.

(Please see “Dental Care, Dental Appliances and Orthodontics” and “Dental Treatment Anesthesia.”)

46. **Organ Donor Services** – Medical and Hospital Services, as well as other costs of a donor or prospective donor, are only covered when the recipient is a Member. The testing of blood relatives to determine compatibility for donating organs is limited to sisters, brothers, parents and natural children. Computer searches of unrelated donors for Members who require a bone marrow or stem cell transplant are limited to \$15,000 per lifetime. Donor Searches are only covered when performed by a Provider included in the “Preferred Transplant Network Facility.”
47. **Organ Transplants** – All organ transplants must be preauthorized by PacifiCare and performed in a PacifiCare Preferred Transplant Network facility.
- Transportation is limited to the transportation of the Member and one escort to a Preferred Transplant Network facility greater than 60 miles from the Member’s Primary Residence as preauthorized by PacifiCare. Transportation and other nonclinical expenses of the living donor are excluded and are the responsibility of the Member who is the recipient of the transplant. (See the definition for “Preferred Transplant Network.”)
 - Food and housing is not covered unless the Preferred Transplant Network Center is located more than 60 miles from the Member’s Primary Residence, in which case food and housing is limited to \$125.00 a day to cover both the Member and escort, if any (excludes liquor and tobacco). Food and housing expenses are not covered for any day a Member is not receiving Medically Necessary transplant services.
 - Listing of the Member at a second Preferred Transplant Network Center is excluded, unless the Regional Organ Procurement Agencies are different for the 2 facilities and the Member is accepted for listing by both facilities. In these cases, organ transplant listing is limited to 2 Preferred Transplant Network facilities. If the Member is dual listed, his or her coverage is limited to the actual transplant at the second facility. The

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Member is responsible for any duplicated diagnostic costs incurred at the second facility. (See the definition for “Regional Organ Procurement Agency.”)

48. **Phenylketonuria (“PKU”) Testing and Treatment** – Food products naturally low in protein are not covered.
49. **Physical or Psychological Examinations** – Physical or psychological examinations for court hearings, travel, premarital, pre-adoption or other non-preventive health reasons are not covered.
50. **Private Rooms and Comfort Items** – Personal or comfort items, and non-Medically Necessary private rooms during inpatient hospitalization, are not covered.
51. **Prosthetics and Corrective Appliances** – Replacement of lost prosthetics or corrective appliances is not covered. Prosthetics that require surgical connection to nerves, muscles or other tissues (bionic) are not covered. Prosthetics that have electric motors to enhance motion (myoelectronic) are not covered.
52. **Reconstructive Surgery** – Reconstructive Surgeries are not covered under the following circumstances:
 - When there is another more appropriate surgical procedure that has been offered to the Member; or
 - When only a minimal improvement in the Member’s appearance is expected to be achieved.

Preauthorizations for proposed reconstructive surgeries will be reviewed by Physicians specializing in such reconstructive surgery who are competent to evaluate the specific clinical issues involved in the care requested.

53. **Recreational, Lifestyle, Educational or Hypnotic Therapy** – Recreational, lifestyle, educational or hypnotic therapy, and any related diagnostic testing, is not covered.
54. **Rehabilitation Services and Therapy** – Rehabilitation services and therapy are either limited or not covered, as follows:
 - Speech, occupational or physical therapy is not covered when medical documentation

does not support the Medical Necessity because of the Member’s inability to progress toward the treatment plan goals or when a Member has already met the treatment goals.

- Speech therapy is limited to Medically Necessary therapy to treat speech disorders caused by a defined illness, disease or surgery (for example, cleft palate repair).
 - Exercise programs are only covered when they require the direct supervision of a licensed Physical Therapist and are part of an authorized treatment plan.
 - Activities that are motivational in nature or that are primarily recreational, social or for general fitness, are not covered.
 - Aquatic/pool therapy is not covered unless conducted by a licensed Physical Therapist and part of an authorized treatment plan.
 - Massage therapy is not covered.
55. **Respite Care** – Respite care is not covered, unless part of an authorized Hospice plan and is necessary to relieve the primary caregiver in a Member’s residence. Respite care is covered only on an occasional basis, not to exceed 5 consecutive days at a time.
 56. **Third Party Liability** – Expenses incurred due to liable third parties are not covered, as described in the Section “PacifiCare’s Right To The Repayment Of A Debt As A Charge Against Recoveries From Third Parties Liable For A Member’s Health Care Expenses.”
 57. **Services in the Home** – Services in the home provided by relatives or other household members are not covered.
 58. **Services While Confined** – Services required for injuries or illnesses experienced while under arrest, detained, imprisoned, incarcerated or confined pursuant to federal, state or local laws are not covered. However, PacifiCare will reimburse Members their out-of-pocket expenses for services received while confined in a city or county jail or, if a juvenile, while detained in any facility, if the services were provided or authorized by your Primary Care Physician or Participating Medical Group in accordance with the terms of



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this Health Plan or were Emergency Services or Urgently Needed Services. This exclusion does not restrict PacifiCare's liability with respect to expenses for Covered Services solely because the expenses were incurred in a state hospital; however, PacifiCare's liability with respect to expenses for Covered Services provided in a state hospital is limited to the rate PacifiCare would pay for those Covered Services if provided by a Participating Hospital.

59. **Sex Transformations** – Procedures, services, medications and supplies related to sex transformations are not covered.
60. **Skilled Nursing Facility Care/Subacute and Transitional Care** – Skilled Nursing Facility room and board charges are excluded after 100 consecutive days per admission. Days spent out of the Skilled Nursing Facility when transferred to an acute hospital setting are not counted toward the 100 consecutive days when the Member is transferred back to a Skilled Nursing Facility, but the count resumes upon the Member's return to a Skilled Nursing Facility. Such days in an acute hospital setting also do not count toward renewing the 100 consecutive day benefit. In order to renew the room and board coverage in a Skilled Nursing Facility, a Member must either be out of all Skilled Nursing Facilities for 60 consecutive days or if the Member remains in a facility, then the Member may not have received Skilled Nursing Care or Skilled Rehabilitation Care for 60 days.
61. **Surrogacy** – Infertility and maternity services for non-members are not covered. PacifiCare may seek recovery of actual costs incurred by PacifiCare from a Member who is receiving reimbursement for medical expenses for maternity services while acting as a surrogate.
62. **Transportation** – Transportation is not a covered benefit except for Ambulance transportation as defined in this *Combined Evidence of Coverage and Disclosure Form*.
63. **Veterans Administration Services** – Except for Emergency or Urgently Needed Services, services received by a Member in a Veterans Administration facility are not covered.
64. **Vision Care** – See “Eye Wear and Corrective Refractive Procedures” listed in Exclusions and Limitations.
65. **Vision Training** – Vision therapy and ocular training programs (orthoptics) that are not part of an authorized treatment plan are not covered.
66. **Weight Alteration Programs (Inpatient or Outpatient)** – Weight loss or weight gain programs are not covered. These programs include, but are not limited to, dietary evaluations, counseling, exercise, behavioral modification, food and food supplements, vitamins and other nutritional supplements. Also excluded are surgery and laboratory tests associated with monitoring weight loss or weight gain, except as described under the Morbid Obesity exclusion. For the treatment of anorexia nervosa and bulimia nervosa, please refer to the behavioral health supplement of your *Combined Evidence of Coverage and Disclosure Form*.

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Payment Responsibility

- *Premiums and Copayments*
- *What To Do If You Receive a Bill*
- *Coordinating Benefits With Another Plan*
- *Medicare Eligibility*
- *Workers' Compensation Eligibility*
- *Other Benefit Coordination Issues*

One of the advantages of your health care coverage is that most out-of-pocket expenses are limited to Copayments. This section explains these and other health care expenses. It also explains your responsibilities when you're eligible for Medicare or Workers' Compensation coverage and when PacifiCare needs to coordinate your benefits with another plan.

What Are Premiums? (Prepayment Fees)

Premiums are fees an Employer Group pays to cover the basic costs of your health care package. An Employer Group usually pays these premiums on a monthly basis. Often the Subscriber shares the cost of these premiums with deductions from his or her salary.

If you are the Subscriber, you should already know if you're contributing to your premium payment; if you aren't sure, contact your Employer Group's health benefits representative. He or she will know if you're contributing to your premium, as well as the amount, method and frequency of this contribution.

What Are Copayments (Other Charges)?

Aside from the Premium, you may be responsible for paying a charge when you receive a Covered Service. This charge is called a Copayment and is outlined in your *Schedule of Benefits*. If you review your *Schedule of Benefits*, you'll see that the amount of the Copayment depends on the service, as well as the Provider from whom you choose to receive your care.

Annual Copayment Maximum

For certain Covered Services, a limit is placed on the total amount you pay for Copayments during a calendar year. This limit is called your Annual Copayment Maximum, and when you reach it, for the remainder of

the calendar year, you will not pay any additional Copayments for these Covered Services.

You can find your Annual Copayment Maximum in your *Schedule of Benefits*. If you've surpassed your Annual Copayment Maximum, submit all your health care Copayment receipts and a letter of explanation to:

PacifiCare of California
Customer Service Department
P.O. Box 6006
Cypress, CA 90630-6006

Remember, it's important to send us all Copayment receipts along with your letter. They confirm that you've reached your Annual Copayment Maximum. You will be reimbursed by PacifiCare for Copayments you make beyond your individual or family Annual Copayment Maximum. The Annual Copayment Maximum includes coverage for Severe Mental Illnesses (SMI) of adults and children and Serious Emotional Disturbances of a Child. **NOTE:** The calculation of your Annual Copayment Maximum will not include supplemental benefits that may be offered by your Employer Group (e.g. coverage for outpatient prescription drugs).

If You Get a Bill (Reimbursement Provisions)

If you are billed for a Covered Service provided or authorized by your Primary Care Physician or Participating Medical Group or if you receive a bill for Emergency or Urgently Needed Services, you should do the following:

1. Call the Provider, then let them know you have received a bill in error and you will be forwarding the bill to PacifiCare.
2. Give the Provider your PacifiCare Health Plan information, including your name and PacifiCare Member number.

Forward the bill to:

PacifiCare of California
Claims Department
P.O. Box 6006
Cypress, CA 90630-6006

Include your name, your PacifiCare ID number and a brief note that indicates you believe the bill is for a Covered Service. The note should also include the date of service, the nature of the service and the name of the Provider who authorized your care. No claim form is required. If you need additional assistance, call our Customer Service department.



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PLEASE NOTE: Your Provider will bill you for services that are not covered by PacifiCare or haven't been properly authorized. You may also receive a bill if you've exceeded PacifiCare's coverage limit for a benefit.

What Is a "Schedule of Benefits"?

Your *Schedule of Benefits* is printed separately from this document and lists the Covered Services unique to your plan. It also includes your Copayments, as well as the Annual Copayment Maximum and other important information. If you need assistance understanding your *Schedule of Benefits*, or need a new copy, please call our Customer Service department.

Bills From Non-Participating Providers

If you receive a bill for a Covered Service from a Physician who is not one of our Participating Providers and the service was preauthorized and you haven't exceeded any applicable benefit limits, PacifiCare will pay for the service less the applicable Copayment. (Preauthorization isn't required for Emergency Services and Urgently Needed Services. See **Section Three: Emergency and Urgently Needed Services.**) You may also submit a bill to us if a Non-Participating Provider has refused payment directly from PacifiCare.

You should file a claim within 90 days, or as soon as reasonably possible, of receiving any services and related supplies. Forward the bill to:

PacifiCare of California Claims Department
P.O. Box 6006
Cypress, CA 90630-6006

Include your name, PacifiCare ID number and a brief note that indicates your belief that you've been billed for a Covered Service. The note should also include the date of service, the nature of the service and the name of the Provider who authorized your care. No claim form is required.

PacifiCare will make a determination within 30 days from the date you submit a claim containing all information reasonably necessary to decide the claim. PacifiCare will not pay any claim that is filed more than 1 year from the date the services or supplies were provided. PacifiCare also will not pay for excluded services or supplies unless authorized by your Primary Care Physician, your Participating Medical Group or directly by PacifiCare.

Any payment assumes you have not exceeded your benefit limits. If you've reached or exceeded any applicable benefit limit, these bills will be your responsibility.

How To Avoid Unnecessary Bills

Always obtain your care under the direction of PacifiCare, your Participating Medical Group, or your Primary Care Physician. By doing this, you only will be responsible for paying any related Copayments and for charges in excess of your benefit limitations. Except for Emergency or Urgently Needed Services, if you receive services not authorized by PacifiCare or your Participating Medical Group, you may be responsible for payment. This is also true if you receive any services not covered by your plan. (Services not covered by your plan are included in **Section Five: Your Medical Benefits.**)

Your Billing Protection

All PacifiCare Members have rights that protect them from being charged for Covered Services in the event a Participating Medical Group does not pay a Provider, a Provider becomes insolvent or a Provider breaches its contract with PacifiCare. In none of these instances may the Participating Provider send you a bill, charge you, or have any other recourse against you for a Covered Service. However, this provision does not prohibit the collection of Copayment amounts as outlined in the *Schedule of Benefits.*)

In the event of a Provider's insolvency, PacifiCare will continue to arrange for your benefits. If for any reason PacifiCare is unable to pay for a Covered Service on your behalf (for instance, in the unlikely event of PacifiCare's insolvency or a natural disaster), you are not responsible for paying any bills as long as you received proper authorization from your PacifiCare Participating Provider. You may, however, be responsible for any properly authorized Covered Services from a Non-Participating Provider or Emergency or Urgently Needed Services from a Non-Participating Provider.

NOTE: If you receive a bill because a Non-Participating Provider refused to accept payment from PacifiCare, you may submit a claim for reimbursement. See "Bills from Non-Participating Providers."

Coordination of Benefits

Coordination of Benefits (COB) is a process, regulated by law, which determines the financial responsibility for payment when a person has group health care coverage under more than one plan. "Plan" is defined below.

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COB is designed to provide maximum coverage for medical and hospital services at the lowest cost by avoiding excessive or duplicate payments.

The objective of COB is to ensure that all group health plans that provide coverage to an individual will pay no more than 100% of the allowable expense for services that are received. This payment will not exceed total expenses incurred or the reasonable cash value of those services and supplies when the group health plan provides benefits in the form of services rather than cash payments.

PacifiCare's COB activities will not interfere with your medical care.

The order of benefit determination rules below determine which health plan will pay as the Primary Plan. The Primary Plan that pays first pays without regard to the possibility that another plan may cover some expenses. A Secondary Plan pays after the Primary Plan and may reduce the benefits it pays so that payment from all group plans do not exceed 100% of the total allowable expense. "Allowable Expense" is defined below.

Definitions

The following definitions only apply to coverage provided under this explanation of Coordination of Benefits.

- A. "Plan" is any of the following that provides benefits or services for medical or dental care or treatment.
 - (1) "Plan" includes: group insurance, closed panel (HMO, POS, PPO or EPO) coverage or other forms of group or group-type coverage (whether insured or uninsured); hospital indemnity benefits in excess of \$200.00 per day; medical care components of group long-term care contracts, such as Skilled Nursing Care; or other governmental benefits, as permitted by law (Medicare is not included as a "Plan" as defined here – however PacifiCare does coordinate benefits with Medicare.) Please refer to **Section 6: Important Rules for Medicare and Medicare Eligible Members**.
 - (2) "Plan" does not include: non-group coverage of any type, including, but not limited to, individual or family insurance; amounts of hospital indemnity insurance of \$200.00 or less per day; school accident-type coverage; benefits for nonmedical components of group

long-term care policies; Medicare supplement policies, a state-plan under Medicaid; and coverage under other governmental plans, unless permitted by law.

Each contract for coverage under (1) or above is a separate Plan. However, if the same carrier provides coverage to members of a group under more than one group contract each of which provide for different types of coverage (for example, one covering dental services and one covering medical services), the separate contracts are considered parts of the same plan, and there is no COB among those separate contracts. However, if a Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan.

- B. "Primary Plan or Secondary Plan" – The order of benefit determination rules determine whether this Plan is a "Primary Plan" or "Secondary Plan," when compared to another Plan covering the person.

When this Plan is primary, its benefits are determined before those of any other Plan and without considering any other Plan's benefits. When this Plan is secondary, its benefits are determined after those of another Plan and may be reduced because of the Primary Plan's benefits.

- C. "Allowable Expense" means a health care service or expense, including Deductibles and Copayments, that is covered at least in part by any of the Plans covering the person. When a plan provides benefits in the form of services, (for example, an HMO) the reasonable cash value of each service will be considered an Allowable Expense and a benefit paid. An expense or service that is not covered by any of the plans is not an Allowable Expense. The following are examples of expenses or services that are **not** Allowable Expenses:

- (1) If a covered person is confined in a private hospital room, the difference between the cost of a semi-private room in the hospital and the private room (unless the patient's stay in a private hospital room is Medically Necessary) is not an Allowable Expense.
- (2) If a person is covered by two or more Plans that compute their benefit payments on the basis of usual and customary fees, any amount in excess of the highest of the usual and customary fees for a specific benefit is not an Allowable Expense.



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- (3) If a person is covered by two or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable Expense.
 - (4) If a person is covered by one Plan that calculates its benefits or services on the basis of usual and customary fees and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary Plan's payment arrangements shall be the allowable expense for all plans.
 - (5) The amount a benefit is reduced by the Primary Plan because a covered person does not comply with the Plan provisions. Examples of these provisions are precertification of admissions and preferred provider arrangements.
- D. "Claim Determination Period" means a calendar year or that part of the calendar year during which a person is covered by this Plan.
- E. "Closed Panel Plan" is a plan that provides health benefits to covered persons primarily in the form of services through a panel of Providers that have contracted with or are employed by the Plan and that limits or excludes benefits for services provided by other Providers, except in cases of emergency or referral by a panel member.
- F. "Custodial Parent" means a parent awarded custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than one half of the calendar year without regard to any temporary visitation.

Order of Benefit Determination Rules

If the Member is covered by another group health plan, responsibility for payment of benefits is determined by the following rules. These rules indicate the order of payment responsibility among PacifiCare and other applicable group health plans by establishing which plan is primary, secondary and so on:

- A. The Primary Plan pays or provides its benefits as if the Secondary Plan or Plans did not exist.
- B. A Plan that does not contain a coordination of benefits provision is always primary. There is one exception: coverage that is obtained by virtue of membership in a group that is designed to

supplement a part of a basic package of benefits may provide that the supplementary coverage shall be excess to any other parts of the plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan Hospital and surgical benefits and insurance type coverages that are written in connection with a closed panel plan to provide out-of-network benefits.

- C. A Plan may consider the benefits paid or provided by another Plan in determining its benefits only when it is secondary to that other Plan.
 - D. The first of the following rules that describes which Plan pays its benefits before another Plan is the rule that will apply.
 - (1) Subscriber (Non-Dependent) or Dependent. The Plan that covers the person other than as a dependent; for example as an employee, Member, Subscriber or retiree is primary and the plan that covers the person as a dependent is secondary.
 - (2) Child Covered Under More Than One Plan. The order of benefits when a child is covered by more than one plan is:
 - (a) Birthday Rule. The Primary Plan is the Plan of the parent whose birthday is earlier in the year if:
 - The parents are married;
 - The parents are not separated (whether or not they ever have been married); or
 - A court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage.
- If both parents have the same birthday, the plan that covered either of the parents longer is primary.
- (b) If the specific terms of a court decree state that one of the parents is responsible for the child's health care expenses or health care coverage, that Plan is primary if the parent has enrolled the child in the Plan and provided the Plan with a copy of the court order as required in the Eligibility section of this *Combined Evidence of Coverage and*

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Disclosure Form. This rule applies to Claim Determination Periods or plan years, commencing after the Plan is given notice of the court decree.

- (c) If the parents are not married, and/or are separated (whether or not they ever have been married) or are divorced, the order of benefits is:
- The Plan of the Custodial Parent;
 - The Plan of the spouse of the Custodial Parent;
 - The Plan of the noncustodial parent; and then
 - The Plan of the spouse of the noncustodial parent.
- (3) Active or Inactive Employee. The Plan that covers a person as an employee who is neither laid off nor retired (or his or her dependent) is primary in relation to a Plan that covers the person as a laid off or retired employee (or his or her dependent). If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule is ignored. Coverage provided an individual by one Plan as a retired worker and by another Plan as a dependent of an actively working spouse will be determined under the rule labeled D(1).
- (4) COBRA Continuation Coverage. If a person whose coverage is provided under a right of continuation provided by federal (COBRA) or state law (similar to COBRA) also is covered under another Plan, the Plan covering the person as an employee, member, subscriber or retiree (or as that person's dependent) is primary, and the continuation coverage is secondary. If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule is ignored.
- (5) Longer or Shorter Length of Coverage. If the preceding rules do not determine the order or payment, the Plan that covered the person as an employee, member, subscriber or retiree for the longer period is primary.

Effect On the Benefits of This Plan

- A. When this Plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Plans during a Claim Determination Period are not more than 100% of total Allowable Expenses.
- B. If a covered person is enrolled in two or more Closed Panel Plans and if, for any reason, including the person's having received services from a non-panel provider, benefits are not payable by one Closed Panel Plan, COB shall not apply between that Plan and other Closed Panel Plans.

Right To Receive and Release Needed Information

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under this Plan and other Plans.

PacifiCare may obtain the facts it needs from, or give them to, other organizations or persons for the purpose of applying these rules and determining benefits payable under this Plan and other Plans covering the person claiming benefits. Each person claiming benefits under this Plan must give PacifiCare any facts it needs to apply those rules and determine benefits payable. PacifiCare may use and disclose a Member's protected health information for the purposes of carrying out treatment, payment or health care operations, including but not limited to, diagnoses payment of health care services rendered, billing, claims management or other administrative functions of PacifiCare, without obtaining the Member's consent, in accordance with state and federal law.

PacifiCare's Right To Pay Others

A "payment made" under another Plan may include an amount that should have been paid under this Plan. If this happens, PacifiCare may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under this Plan. PacifiCare will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means the reasonable cash value of the benefits provided in the form of services.



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Right of Recovery

If the “amount of the payments made” by PacifiCare is more than it should have paid under this COB provision, PacifiCare may recover the excess from one or more of the persons it has paid or for whom it has paid or for any other person or organization that may be responsible for the benefits or services provided for the covered person. The “amount of payments made” includes the reasonable cash value of any benefits provided in the form of services.

Important Rules for Medicare and Medicare Eligible Members

You must let PacifiCare know if you are enrolled, or eligible to enroll, in Medicare (Part A and/or Part B coverage). PacifiCare is typically primary (that is, PacifiCare’s benefits are determined before those of Medicare) to Medicare for some initial period of time, as determined by the Medicare regulations. After the initial period of time, PacifiCare will be secondary to Medicare (that is, the benefits under this Health Plan will be reduced to the extent they duplicate any benefits provided or available under Medicare, if the Member is enrolled or eligible to enroll in Medicare.)

If you are eligible for Medicare, but fail to enroll in Medicare, your PacifiCare coverage will be reduced by the amount you would have received from Medicare.

If you have questions about the coordination of Medicare benefits, contact your Employer Group or our Customer Service department. For questions regarding Medicare eligibility, contact your local Social Security office.

Workers’ Compensation

PacifiCare will not provide or arrange for benefits, services or supplies required as a result of a work-related injury or illness. This applies to injury or illness resulting from occupational accidents or sickness covered under any of the following: the California Workers’ Compensation Act, occupational disease laws, employer’s liability or federal, state or municipal law. To recover benefits for a work-related illness or injury, the Member must pursue his or her rights under the Workers’ Compensation Act or any other law that may apply to the illness or injury. This includes filing an appeal with the Workers’ Compensation Appeals Board, if necessary.

If for any reason PacifiCare provides or arranges for benefits, services or supplies that are otherwise covered under the Workers’ Compensation Act, the Member is required to reimburse PacifiCare for the benefits, services or supplies provided or arranged for, at Prevailing Rates, immediately after receiving a monetary award, whether by settlement or judgment. The Member must also hold any settlement or judgment collected as a result of a workers’ compensation action in trust for PacifiCare. This award will be the lesser of the amount the Member recovers or the reasonable value of all services and benefits furnished to him or her or on his or her behalf by PacifiCare for each incident. If the Member receives a settlement from workers’ compensation coverage that includes payment of future medical costs, the Member must reimburse PacifiCare for any future medical expenses associated with this judgment if PacifiCare covers those services.

When a legitimate dispute exists as to whether an injury or illness is work-related, PacifiCare will provide or arrange for benefits until such dispute is resolved if the Member signs an agreement to reimburse PacifiCare for 100% of the benefits provided.

PacifiCare will not provide or arrange for benefits or services for a work-related illness or injury when the Member fails to file a claim within the filing period allowed by law or fails to comply with other applicable provision of law under the Workers’ Compensation Act. Benefits will not be denied to a Member whose employer has not complied with the laws and regulations governing Workers’ Compensation Insurance, provided that such Member has sought and received Medically Necessary Covered Services under this Health Plan.

Third Party Liability — Expenses Incurred Due To Liable Third Parties Are Not Covered

Health care expenses incurred by a Member for which a third party or parties or a third party’s (parties’) insurance company (collectively, “liable third party”) is liable or legally responsible by reason of negligence, a wrongful intentional act or the breach of any legal obligation on the part of such third party, are expressly excluded from coverage under this Health Plan. However, in all cases, PacifiCare will pay for the arrangement or provision of health care services for a Member that would have been Covered Services except that they

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were required due to a liable third party, in exchange for the agreement as expressly set forth in the Section of the *Combined Evidence of Coverage and Disclosure Form* captioned “PacifiCare’s Right To the Repayment of a Debt As a Charge Against Recoveries From Third Parties Liable for a Member’s Health Care Expenses.”

PacifiCare’s Right To the Repayment of a Debt As a Charge Against Recoveries From Third Parties Liable for a Member’s Health Care Expenses

Expenses incurred by a Member for which a third party or parties or a third party’s (parties’) insurance company (collectively, “liable third party”) is liable or legally responsible by reason of negligence, a wrongful intentional act or the breach of any legal obligation on the part of such third party, are expressly excluded from coverage under this Health Plan. However, in all cases, PacifiCare will pay for the arrangement or provision of health care services for a Member that would have been Covered Services except that they were required due to a liable third party, in exchange for the following agreement:

If a Member is injured by a liable third party, the Member agrees to give PacifiCare, or its representative, agent or delegate, a security interest in any money the Member actually recovers from the liable third party by way of any final judgment, compromise, settlement or agreement, even if such money becomes available at some future time.

If the Member does not pursue, or fails to recover (either because no judgment is entered or because no judgment can be collected from the liable third party), a formal, informal, direct or indirect claim against the liable third party, then the Member will have no obligation to repay the Member’s debt to PacifiCare, which debt shall include the cost of arranging or providing otherwise covered health care services to the Member for the care and treatment that was necessary because of a liable third party.

The security interest the Member grants to PacifiCare, its representative, agent or delegate applies only to the actual proceeds, in any form, that stem from any final judgment, compromise, settlement or agreement relating to the arrangement or provision of the Member’s health care services for injuries caused by a liable third party.

Non-Duplication of Benefits With Automobile, Accident or Liability Coverage

If you are receiving benefits as a result of automobile, accident or liability coverage, PacifiCare will not duplicate those benefits. It is your responsibility to take whatever action is necessary to receive payment under automobile, accident or liability coverage when such payments can reasonably be expected, and to notify PacifiCare of such coverage when available. PacifiCare will provide Covered Services over and above your automobile, accident or liability coverage, if the cost of your health care services exceeds such coverage.



Member Eligibility

- *Membership Requirements*
- *Adding Family Members*
- *Late Enrollment*
- *Updating Your Enrollment Information*
- *Termination of Enrollment*
- *Coverage Options Following Termination*

This section describes how you become a PacifiCare Member, as well as how you can add Family Members to your coverage. It will also answer other questions about eligibility, such as when late enrollment is permitted. In addition, you will learn ways you may be able to extend your PacifiCare coverage when it would otherwise terminate.

Who Is a PacifiCare Member?

There are 2 kinds of PacifiCare Members: Subscribers and enrolled Family Members (also called Dependents). The Subscriber is the person who enrolls through his or her employer-sponsored health benefit plan. The Employer Group, in turn, has signed a Group Agreement with PacifiCare.

The following Family Members are eligible to enroll in PacifiCare:

1. The Subscriber's Spouse;
2. The unmarried biological children of the Subscriber or the Subscriber's Spouse (step-children) who are under the Limiting Age established by the employer (for an explanation of "Limiting Age" see Definitions);
3. Children who are legally adopted or placed for adoption with the Subscriber or the Subscriber's Spouse who are under the Limiting Age established by the employer;
4. Children for whom the Subscriber or the Subscriber's Spouse has assumed permanent legal guardianship. Legal evidence of the guardianship, such as a certified copy of a court order, must be furnished to PacifiCare upon request; and
5. Children for whom the Subscriber or the Subscriber's Spouse is required to provide health

insurance coverage pursuant to a Qualified Medical Child Support Order assignment order or medical support order, in this section.

Your Dependent children cannot be denied enrollment and eligibility due to the following:

- Was born to a single person or unmarried couple;
- Is not claimed as a Dependent on a Federal Income Tax Return;
- Does not reside with the Subscriber or within the PacifiCare Service Area.

Eligibility

All Members must meet all eligibility requirements established by the Employer Group and PacifiCare. PacifiCare's eligibility requirements are:

- Have a Primary Residence within California;
- Select a Primary Care Physician within a 30-mile radius of his or her Primary Residence or Primary Workplace (except children enrolled as a result of a Qualified Medical Child Support Order);
- Meet any other eligibility requirements established by the Employer Group, such as exhaustion of a waiting period before an employee can enroll in PacifiCare. Employers will also establish the "Limiting Age," the age limit for providing coverage to unmarried children.

Eligible Family Members must enroll in PacifiCare at the same time as the Subscriber or risk not being eligible to enroll until the employer's next Open Enrollment Period, as explained below. Circumstances which allow for enrollment outside the Open Enrollment Period are also explained below. All applicants for coverage must complete and submit to PacifiCare all applications, medical review questionnaires or other forms or statements that PacifiCare may reasonably request.

Enrollment is the completion of a PacifiCare enrollment form (or a non-standard enrollment form approved by PacifiCare) by the Subscriber on his or her own behalf or on the behalf of any eligible Family Member. Enrollment is conditional upon acceptance by PacifiCare; the existence of a valid Employer Group Agreement; and the timely payment of applicable Health Plan Premiums. PacifiCare may in its discretion and subject to specific protocols, accept enrollment data through an electronic submission.

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Your effective date of enrollment in PacifiCare will depend on when and how you enroll. These circumstances are explained below. (**Please Note:** PacifiCare enrolls applicants in the order that they become eligible and up to our capacity for accepting new Members.)

What Is a Service Area?

PacifiCare is licensed by the California Department of Managed Health Care to arrange for medical and hospital services in certain geographic areas of California. These service areas are defined by ZIP codes. Please call our Customer Service department for information about PacifiCare's Service Area.

Open Enrollment

Most Members enroll in PacifiCare during the "Open Enrollment Period" established by the Employer Group. This is the period of time established by the employer when its Eligible Employees and their eligible Family Members may enroll in the employer's health benefit plan. An Open Enrollment Period usually occurs once a year, and enrollment is effective based on a date agreed upon by the employer and PacifiCare.

Adding Family Members To Your Coverage

The Subscriber's Spouse and eligible children may apply for coverage with PacifiCare during the employer's Open Enrollment Period. If you are declining enrollment for yourself or your dependents (including your Spouse) because of other health plan or insurance coverage, you may in the future be able to enroll yourself or your Dependents in PacifiCare, provided that you request enrollment within 30 days after your other coverage ends. In addition, if you have a new Dependent as a result of marriage, birth, adoption or placement for adoption, you may enroll yourself and your Dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption or placement for adoption. (Guardianship is not a qualifying event for other Family Members to enroll). Under the following circumstances, new Family Members may be added outside the Open Enrollment Period.

1. **Getting married.** When a new Spouse or child becomes an eligible Family Member as a result of

marriage, coverage begins on the first day of the month following the date of marriage. An application to enroll a Spouse or child eligible as a result of marriage must be made within 30 days of the marriage.

2. **Having a baby.** Newborns are covered for the first 30 days of life. In order for coverage to continue beyond the first 30 days of life, the Subscriber must submit a Change Request Form to PacifiCare prior to the expiration of the 30-day period for coverage to continue beyond the first 30 days of life.
3. **Adoption or Placement for Adoption.** Receive an adoptive placement from a recognized county or private agency, or adopted as documented by a health facility minor release form, a medical authorization form or a relinquishment form, granting you or your Spouse the right to control the health care for the adoptive child or absent such a document, on the date there exists evidence of the Subscriber's or Spouse's right to control the health care of the child placed for adoption. For adopted children, coverage is effective on the date of adoption or placement for adoption. An application must be received within 30 days of the adoption placement.
4. **Guardianship.** To enroll a Dependent child for whom the Subscriber has assumed legal guardianship, the Subscriber must submit a Change Request Form to PacifiCare along with a certified copy of a court order granting guardianship within 30 days of when the Subscriber assumed legal guardianship. Coverage will be retroactively effective to the date the Subscriber assumed legal guardianship.

Qualified Medical Child Support Order

A Member (or a person otherwise eligible to enroll in PacifiCare) may enroll a child who is eligible to enroll in PacifiCare upon presentation of a request by a District Attorney, State Department of Health Services or a court order to provide medical support for such a dependent child without regard to any enrollment period restrictions.

A person having legal custody of a child or a custodial parent who is not a PacifiCare Member may ask about obtaining dependent coverage as required by a court or administrative order, including a Qualified Medical Child Support Order, by calling PacifiCare's Customer Service department. A copy of the court or



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administrative order must be included with the enrollment application. Information including, but not limited to, the ID card, *Combined Evidence of Coverage and Disclosure Form* or other available information, including notice of termination, will be provided to the custodial parent, caretaker and/or District Attorney. Coverage will begin on the first of the month following receipt by PacifiCare of an enrollment form with the court or administrative order attached.

Except for Emergency and Urgently Needed Services, to receive coverage, all care must be provided or arranged in the PacifiCare Service Area by the designated Participating Medical Group, as selected by the custodial parent or person having legal custody.

Continuing Coverage for Student and Disabled Dependents

Certain Dependents who would otherwise lose coverage under the Health Plan due to their attainment of the Limiting Age established by the Employer Group may extend their coverage under the following circumstances:

Continuing Coverage for Student Dependents

An unmarried Dependent who is registered on a full-time basis (at least 12 semester units or the equivalent as determined by PacifiCare) at an accredited school or college may continue as an Eligible Dependent through the Limiting Age established by the employer for full-time students, if proof of such status is provided to PacifiCare on a periodic basis, as requested by us. If the Dependent student resides outside of the Service Area, the student must maintain a permanent address inside the Service Area with the Subscriber, and the student must select a Participating Medical Group within 30 miles of that address. All health care coverage must be provided or arranged for in the Service Area by the designated Participating Medical Group, except for Emergency and Urgently Needed Services.

Continuing Coverage for Certain Disabled Dependents

Unmarried enrolled Dependents, who attain the Limiting Age established by the employer, may continue enrollment in the Health Plan beyond the Limiting Age if the unmarried Dependent meets all of the following:

1. The unmarried Dependent resides within the Service Area with the Subscriber or the Subscriber's separated or divorced Spouse;
2. The unmarried Dependent is incapable of self-sustaining employment by reason of mental retardation or physical handicap;
3. The unmarried Dependent is chiefly dependent upon the Subscriber for support and maintenance; and
4. The mental or physical condition existed continuously prior to reaching the Limiting Age.

In order to continue coverage under this section for qualifying disabled Dependents, proof of such disability and dependency must be provided to PacifiCare by the Member within 31 days of the onset of the disability, attainment of the Limiting Age or at the time of the Subscriber's initial enrollment in PacifiCare.

PacifiCare may require ongoing proof of a Dependent's disability and dependency, but not more frequently than annually after the 2-year period following the Dependent's attainment of the Limiting Age. This proof may include supporting documentation from a state or federal agency or a written statement by a licensed psychologist, psychiatrist or other Physician to the effect that such disabled Dependent is incapable of self-sustaining employment by reason of mental retardation or physical handicap.

Late Enrollment

In addition to a special enrollment period due to the addition of a new Spouse or child, there are certain circumstances when employees and their eligible Family Members may enroll outside of the employer's Open Enrollment Period. These circumstances include:

1. The eligible employee (on his or her own behalf, or on behalf of any eligible Family Members) declined in writing to enroll in PacifiCare when they were first eligible because they had other health care coverage; and
2. PacifiCare cannot produce a written declination statement from the Employer Group or eligible employee stating that the eligible employee (on his or her own behalf, or on behalf of any eligible Family Members) was provided with and a signed acknowledgment of explicit written notice in boldface type specifying that failure to elect coverage with PacifiCare during the initial

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enrollment period permits the plan to impose an exclusion of coverage under the Health Plan for a period of 12 months from the date of election of coverage under the Health Plan, unless the eligible employee or Family Member can demonstrate that he or she meets the requirements for late enrollment.

3. The other health care coverage is no longer available due to:
 - i. The employee or eligible Family Member has exhausted COBRA continuation coverage under another group health plan; or
 - ii. The termination of employment or reduction in work hours of a person through whom the employee or eligible Family Member was covered; or
 - iii. The termination of the other health plan coverage; or
 - iv. The cessation of an employer's contribution toward the employee or eligible Family Member coverage; or
 - v. The death, divorce or legal separation of a person through whom the employee or eligible Family Member was covered.
4. The Court has ordered health care coverage be provided for your Spouse or minor child.

If the employee or an eligible Family Member meets these conditions, the employee must request enrollment with PacifiCare no later than 30 days following the termination of the other health plan coverage. PacifiCare may require proof of loss of the other coverage. Enrollment will be effective the first day of the calendar month following receipt by PacifiCare of a completed request for enrollment.

Notifying You of Changes In Your Plan

Amendments, modifications or termination of the Group Agreement by either the Employer Group or PacifiCare do not require the consent of a Member. PacifiCare may amend or modify the Health Plan, including the applicable Premiums, at any time space after sending written notice to the Employer Group 30 days prior to the effective date of any amendment or modification. Your Employer Group may also change your Health Plan benefits during the contract year. In accordance with PacifiCare's Group Agreement, the Employer Group is

obliged to notify employees who are PacifiCare Members of any such amendment or modification.

Updating Your Enrollment Information

Please notify your employer of any changes to the information you provided on the enrollment application within 31 days of the change. This includes changes to your name, address, telephone number, marital status or the status of any enrolled Family Members. For reporting changes in marital and/or Dependent status, please see "Adding Family Members to Your Coverage." If you wish to change your Primary Care Physician or Participating Medical Group, you may contact PacifiCare's Customer Service department at 1-800-624-8822 or 1-800-442-8833 (TDHI).

About Your PacifiCare Identification (ID) Card

Your PacifiCare ID card is important for identifying you as a Member of PacifiCare. Possession of this card does not entitle a Member to services or benefits under this Health Plan. A Member should show this card each time he or she visits a Primary Care Physician or, upon referral, any other Participating Provider.

IMPORTANT NOTE: Any person using this card to receive benefits or services for which he or she is not entitled will be charged for such benefits or services. If any Member permits the use of his or her identification card by any other person, PacifiCare may immediately terminate that Member's membership.

Renewal and Reinstatement (Renewal Provisions)

Your Employer Group's Group Agreement with PacifiCare renews automatically, on a yearly basis, subject to all terms of the Group Agreement. PacifiCare or your Employer Group may change your health plan benefits and premium at renewal. If the Group Agreement is terminated by PacifiCare, reinstatement is subject to all terms and conditions of the Group Agreement. In accordance with PacifiCare's Group Subscriber Agreement, the Employer Group is required to notify employees who are PacifiCare Members of any such amendment or modification.



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Ending Coverage (Termination of Benefits)

Usually, your enrollment in PacifiCare terminates when the Subscriber or enrolled Family Member is no longer eligible for coverage under the employer's health benefit plan. In most instances, your Employer Group determines the date in which coverage will terminate. Coverage can be terminated, however, because of other circumstances as well, which are described below.

Continuing coverage under this Health Plan is subject to the terms and conditions of the employer's Group Agreement with PacifiCare.

When the Group Agreement between the Employer Group and PacifiCare is terminated, all Members covered under the Group Agreement become ineligible for coverage on the date of termination. If the Group Agreement is terminated by PacifiCare for non-payment of Premiums, coverage for all Members covered under the Group Agreement will be terminated effective the last day for which Premiums were received. According to the terms of the Group Agreement, the Employer Group is responsible for notifying you if and when the Group Agreement is terminated for any reason, including the nonpayment of Health Plan Premiums. PacifiCare is not obligated to notify you that you are no longer eligible or that your coverage has been terminated.

In addition to terminating the Group Agreement, PacifiCare may terminate a Member's coverage for any of the following reasons:

- The Member no longer meets the eligibility requirements established by the Group Employer and/or PacifiCare.
- The Member establishes his or her Primary Residence outside the State of California.
- The Member establishes his or her Primary Residence outside the PacifiCare Service Area and does not work inside the PacifiCare Service Area (except for a child subject to a qualified child medical support order, for more information refer to "Qualified Medical Child Support Order" in this section).

Termination for Good Cause

PacifiCare has the right to terminate your coverage under this Health Plan in the following situations:

- **Failure to Pay.** Your coverage may be terminated if you fail to pay any required Copayments, coinsurance or charges owed to a Provider or PacifiCare for Covered Services. To be subject to termination under this provision, you must have been billed by the Provider for 2 different billing cycles and have failed to pay or make appropriate payment arrangements with the Provider. PacifiCare will send you written notice, and you will be subject to termination if you do not pay or make appropriate payment arrangements within the 30 day notice period.
- **Fraud or Misrepresentation.** Your coverage may be terminated if you knowingly provide false information (or misrepresent a meaningful fact) on your enrollment form or fraudulently or deceptively use services or facilities of PacifiCare, its Participating Medical Group or other health care Providers (or knowingly allow another person to do the same), including altering a prescription. Termination is effective immediately on the date PacifiCare mails the notice of termination, unless PacifiCare has specified a later date in that notice.
- **Disruptive Behavior.** Your coverage may be terminated if you threaten the safety of Plan employees, Providers, Members or other patients, or your repeated behavior has substantially impaired PacifiCare's ability to furnish or arrange services for you or other Members, or substantially impaired Provider(s) ability to provide services to other patients. Termination is effective 15 days after the notice is mailed to the Subscriber.

If coverage is terminated for any of the above reasons, you forfeit all rights to enroll in the PacifiCare conversion plan (discussed below) or COBRA Plan and lose the right to re-enroll in PacifiCare in the future. **Under no circumstances will a Member be terminated due to health status or the need for health care services.** If a Member is Totally Disabled when the Group's coverage ends, coverage for the Totally Disabling condition may be extended (please refer below to "Total Disability"). Any Member who believes his or her enrollment has been terminated due to the Member's health status or requirements for health care services may request a review of the termination by the California Department of Managed Health Care. For more information contact our Customer Service department.

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NOTE: If a Group Agreement is terminated by PacifiCare, reinstatement with PacifiCare is subject to all terms and conditions of the Group Agreement between PacifiCare and the employer.

Ending Coverage - Special Circumstances for

Enrolled Family Members: Enrolled Family Members terminate on the same date of termination as the Subscriber. If there's a divorce, the Spouse loses eligibility at the end of the month in which a final judgment or decree of dissolution of marriage is entered. Dependent children lose their eligibility if they marry or reach the Limiting Age established by the employer and do not qualify for extended coverage as a student Dependent or as a disabled dependent. Please refer to the section "Continuing Coverage for Certain Disabled Dependents." It may also end when a qualified student reaches the Limiting Age. Please refer to "Extending Your Coverage" for additional coverage which may be available to you.

Total Disability

If the Group Agreement providing the Subscriber coverage is terminated, and the Subscriber or any enrolled Family Members are Totally Disabled on the date the Group Agreement is terminated, federal law may require the Group's succeeding carrier to provide coverage for the treatment of the condition causing Total Disability. However, in the event that the Subscriber's Group does not contract with a succeeding carrier for health coverage, or in the event that federal law would allow a succeeding carrier to exclude coverage of the condition causing the Total Disability for a period of time, PacifiCare will continue to provide benefits to the Subscriber or any enrolled Family Member for Covered Services directly relating to the condition causing Total Disability existing at the time of termination, for a period of up to 12 successive months after the termination. The extension of benefits may be terminated by PacifiCare at such time the Member is no longer Totally Disabled, or at such time as a succeeding carrier is required by law to provide replacement coverage to the Totally Disabled Member without limitation as to the disabling condition.

Coverage Options Following Termination (Individual Continuation of Benefits)

If your coverage through this *Combined Evidence of Coverage and Disclosure Form* ends, you and your enrolled Family Members may be eligible for additional continuation coverage.

Federal COBRA Continuation Coverage

If the Subscriber's Employer Group is subject to the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended (COBRA), you may be entitled to temporarily extend your coverage under the Health Plan at group rates, plus an administration fee, in certain instances where your coverage under the Health Plan would otherwise end. This discussion is intended to inform you, in a summary fashion, of your rights and obligations under COBRA. However, your Employer Group is legally responsible for informing you of your specific rights under COBRA. Therefore, please consult with your Employer Group regarding the availability and duration of COBRA continuation coverage.

If you are a Subscriber covered by this Health Plan, you have a right to choose COBRA continuation coverage if you lose your group health coverage because the termination of your employment (for reasons other than gross misconduct on your part) or the reduction of hours of employment to less than the number of hours required for eligibility.

If you are the Spouse of a Subscriber covered by this Health Plan, you have the right to choose COBRA continuation coverage for yourself if you lose group health coverage under this Health Plan for any of the following four reasons:

1. The death of your Spouse;
2. A termination of your Spouse's employment (for reasons other than gross misconduct) or reduction in your Spouse's hours of employment to less than the number of hours required for eligibility;
3. Divorce or legal separation from your Spouse; or
4. Your Spouse becomes entitled to Medicare.



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In the case of a Dependent child of a Subscriber enrolled in this Health Plan, he or she has the right to continuation coverage if group health coverage under this Health Plan is lost for any of the following five reasons:

1. The death of the Subscriber;
2. A termination of the Subscriber's employment (for reasons other than gross misconduct) or reduction in the Subscriber's hours of employment to less than the number of hours required for eligibility;
3. The Subscriber's divorce or legal separation;
4. The Subscriber becomes entitled to Medicare; or
5. The Dependent child ceases to be a Dependent eligible for coverage under this Health Plan.

Under COBRA, the Subscriber or enrolled Family Member has the responsibility to inform the Employer Group (or, if applicable, its COBRA administrator) of a divorce, legal separation or a child losing Dependent status under the Health Plan within 60 days of the date of the event. Your Employer Group has the responsibility to notify its COBRA administrator of the Subscriber's death, termination, reduction in hours of employment or Medicare entitlement. Similar rights may apply to certain retirees, spouses and dependent children if your employer commences a bankruptcy proceeding and these individuals lose coverage.

When the COBRA administrator is notified that one of these events has happened, the COBRA administrator will in turn notify you that you have the right to choose continuation coverage. Under the law, you have at least 60 days from the date you would lose coverage because of one of the events described above to inform the COBRA administrator that you want continuation coverage.

If you do not choose continuation coverage on a timely basis, your group health insurance coverage under this Health Plan will end.

If you choose continuation coverage, your Employer Group is required to give you coverage which, as of the time coverage is being provided, is identical to the coverage provided under the plan to similarly situated employees or family members. COBRA permits you to maintain continuation coverage for 36 months, unless you lost group health coverage because of a termination of employment or reduction in hours. In that case, the

required continuation coverage period is 18 months. This initial 18-month period may be extended for affected individuals up to 36 months from termination of employment if other events (such as a death, divorce, legal separation or Medicare entitlement) occur during that initial 18-month period. In addition, the initial 18-month period may be extended up to 29 months if you are determined by the Social Security Administration to be disabled at any time during the first 60 days of COBRA continuation coverage. Please contact your Employer Group or its COBRA administrator for more information regarding the applicable length of COBRA continuation coverage available.

A child who is born to or placed for adoption with the Subscriber during a period of COBRA continuation coverage will be eligible to enroll as a COBRA qualified beneficiary. These COBRA qualified beneficiaries can be added to COBRA continuation coverage upon proper notification to the Employer Group or COBRA administrator of the birth or adoption.

However, under COBRA, the continuation coverage may be cut short for any of the following five reasons:

1. Your Employer Group no longer provides group health coverage to any of its employees;
2. The premium for continuation coverage is not paid on time;
3. The qualified beneficiary becomes covered after the date he or she elects COBRA continuation coverage under another group health plan that does not contain any exclusion or limitation with respect to any pre-existing condition he or she may have;
4. The qualified beneficiary becomes entitled to Medicare after the date he or she elects COBRA continuation coverage; or
5. The qualified beneficiary extends coverage for up to 29 months due to disability and there has been a final determination that the individual is no longer disabled.

Under the law, you may have to pay all of the premium for your continuation coverage. Premiums for COBRA continuation coverage is generally 102% of the applicable Health Plan Premium. However, if you are on a disability extension, your cost will be 150% of the applicable Premium. You are responsible for the timely submission of the COBRA premium to the Employer

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Group or COBRA administrator. Your Employer Group or COBRA administrator is responsible for the timely submission of Premium to PacifiCare. At the end of the 18-month, 29-month or 36-month continuation coverage period, qualified beneficiaries will be allowed to enroll in a PacifiCare individual conversion Health Plan (See the explanation under “Extending Your Coverage: Converting to an Individual Plan”).

If you have any questions about COBRA, please contact your Employer Group.

California Continuation Coverage After COBRA

California law provides that certain former employees and their dependent Spouses (including a Spouse who is divorced from the employee and/or a Spouse who was married to the employee at the time of that employee’s death) may be eligible to continue group coverage beyond the date their COBRA coverage is exhausted. PacifiCare will offer the extended coverage to employees and dependent Spouses of employers that are subject to the existing COBRA laws and to the former employees’ dependent Spouses, including divorced or widowed Spouses as defined above. This coverage is subject to the following conditions:

1. The former employee worked for the employer for the prior 5 years and was 60 years of age or older on the date his/her employment ended; and
2. The former employee was eligible for and elected COBRA for himself and his dependent Spouse; or
3. A former Spouse, (i.e. a divorced or widowed Spouse as defined above), is also eligible for continuation of group coverage after exhaustion of COBRA. The former Spouse must elect such coverage by notifying PacifiCare in writing within 30 calendar days prior to the date that the initial COBRA benefits are scheduled to end. A former spouse or surviving spouse may continue Continuation COBRA for up to 5 continuous years upon their exhaustion of COBRA, regardless of the age or length of employment of the Subscriber.

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

Premiums for this coverage will be 213% of the current applicable group rate. Your premium may be increased every time the Employer’s Group’s benefit package renews or changes. Payment is due at the time the Employer Group’s payment is due.

Notification Requirements

The Employer Group is solely responsible for notifying former employees or dependent Spouses (including former Spouses as defined above) of the availability of the coverage at least 90 calendar days before COBRA is scheduled to end. **To elect this coverage, the former employee or Spouse must notify PacifiCare in writing at least 30 calendar days before COBRA is scheduled to end.**

Termination of Continuation Coverage After COBRA

This coverage will end automatically on the earlier of:

1. The date the former employee, Spouse or former Spouse reaches 65;
2. The date in which the Employer Group terminates its Group Agreement contract with PacifiCare and ceases to provide coverage for any active employees through PacifiCare;
3. The date the former employee, Spouse or former Spouse transfers to another health plan;
4. The date the former employee, Spouse or former Spouse becomes eligible for Medicare;
5. For a Spouse or former Spouse, 5 years from the date the Spouse’s COBRA coverage would end;
6. The date the former employee, Spouse or former Spouse fails to pay timely premium as billed by PacifiCare.

Extending Your Coverage: Converting To an Individual Conversion Plan

If you have been enrolled in this Health Plan for 3 or more consecutive months, you and your enrolled Family Members may apply for the individual conversion plan issued by PacifiCare. The Employer Group is solely responsible for notifying you of the availability, terms and conditions of the individual conversion plan within 15 days of the termination of your group coverage.



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An application for the conversion plan must be received by PacifiCare within 31 days of the date of termination of your group coverage. However, if the Employer Group terminates its Group Agreement with PacifiCare or replaces the PacifiCare group coverage with another carrier, transfer to the individual conversion health plan is not permitted. You also will not be permitted to transfer to the individual conversion health plan under any of the following circumstances:

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

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

An individual conversion health plan is also available to:

1. Dependents, if the Subscriber dies;
2. Dependents who marry or exceed the maximum age for dependent coverage under the group plan;
3. Dependents, if the Subscriber enters military service;
4. Spouse of the Subscriber, if their marriage has terminated.

Written applications for all conversions must be received by PacifiCare within 30 days of the loss of group coverage. For more details, please contact our Customer Service department.

Certificate of Creditable Coverage

According to the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), a Certificate of Creditable Coverage will be provided to the Subscriber by either PacifiCare or the Employer Group when the Subscriber or a Dependent ceases to be eligible for benefits under the employer’s health benefit plan. A Certificate of Creditable Coverage may be used to reduce or eliminate a preexisting condition exclusion period imposed by a subsequent health plan. Creditable coverage information for Dependents will be included on the Subscriber’s Certificate, unless the Dependent’s address of record or coverage information is substantially different from the Subscriber’s. Please contact the PacifiCare Customer Service department if you need a duplicate Certificate of Creditable Coverage. If you meet HIPAA eligibility requirements, you may be able to obtain individual coverage using your Certificate of Creditable Coverage.

Uniformed Services Employment and Reemployment Rights Act

Continuation of Benefits under USERRA. Continuation coverage under this Health Plan may be available to you through your employer under the Uniform Services Employment and Reemployment Rights Act of 1994, as amended (USERRA). The continuation coverage is equal to, and subject to the same limitations as, the benefits provided to other Members regularly enrolled in this Health Plan. These benefits may be available to you if you are absent from employment by reason of service in the United States uniformed services, up to the maximum 18-month period if you meet the USERRA requirements. USERRA benefits run concurrently with any benefits that may be available through the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985, as amended. Your employer will provide written notice to you for USERRA continuation coverage.

If you are called to active military duty and are stationed outside of the Service Area, you or your eligible Dependents must still maintain a permanent address inside the Service Area and must select a Participating Medical Group within 30 miles of that address. To obtain coverage, all care must be provided or arranged in the Service Area by the designated Participating Medical Group, except for Emergency and Urgently Needed Services.

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The Health Plan Premium for USERRA Continuation of benefits is the same as the Health Plan Premium for other PacifiCare Members enrolled through your employer plus a 2% additional surcharge or administrative fee, not to exceed 102% of your employer's active group premium. Your employer is responsible for billing and collecting Health Plan Premiums from you or your Dependents and will forward your Health Plan Premiums to PacifiCare along with your employer's Health Plan Premiums otherwise due under this Agreement. Additionally, your employer is responsible to maintain accurate records regarding USERRA Continuation Member Health Plan Premium, qualifying events, terminating events and any other information that may be necessary for PacifiCare to administer this continuation benefit.



Section Eight

Overseeing Your Health Care

- *How PacifiCare Makes Important Decisions*
- *New Treatments and Technologies*
- *What To Do If You Have a Problem*
- *Quality of Care Review*
- *Appeals and Grievances*
- *Independent Medical Reviews*

This section explains how PacifiCare authorizes or makes changes to your health care services, how we evaluate new health care technologies and how we reach decisions about your coverage.

You will also find out what to do if you're having a problem with your health care plan, including how to appeal a health care decision by PacifiCare or one of our Participating Providers. You'll learn the process that's available for filing a formal grievance, as well as how to request an expedited decision when your condition requires a quicker review.

HOW PACIFICARE MAKES IMPORTANT HEALTH CARE DECISIONS

Authorization, Modification and Denial of Health Care Services

PacifiCare and its Participating Medical Groups use processes to review, approve, modify or deny, based on Medical Necessity, requests by providers for authorization of the provision of health care services to Members.

PacifiCare and Participating Medical Groups may also use criteria or guidelines to determine whether to approve, modify or deny, based on Medical Necessity, requests by providers of health care services for Members. The criteria used to modify or deny requested health care services in specific cases will be provided free of charge to the provider, the Member and the public upon request.

Decisions to deny or modify requests for authorization of health care services for a Member, based on Medical Necessity, are made only by licensed physicians or other appropriately licensed health care professionals.

Member agrees that their Provider will be their "authorized representative" (pursuant to ERISA) regarding receipt of approvals of requests for health

care services for purposes of medical management.

PacifiCare and Participating Medical Groups make these decisions within at least the following timeframes required by state law:

Decisions to approve, modify or deny requests for authorization of health care services, based on Medical Necessity, will be made in a timely fashion appropriate for the nature of the Member's condition, not to exceed 5 business days from PacifiCare's or the Participating Medical Group's receipt of the information reasonably necessary and requested to make the decision.

If the Member's condition poses an imminent and serious threat to their health, including, but not limited to, potential loss of life, limb or other major bodily function, or if lack of timeliness would be detrimental in regaining maximum function or to the Member's life or health, the decision will be rendered in a timely fashion appropriate for the nature of the Member's condition, not to exceed 72 hours after PacifiCare's or the Participating Medical Group's receipt of the information reasonably necessary and requested by PacifiCare or the Participating Medical Group to make the determination (an "Urgent Request").

If the decision cannot be made within these timeframes because (i) PacifiCare or the Participating Medical Group is not in receipt of all of the information reasonably necessary and requested or (ii) PacifiCare or the Participating Medical Group requires consultation by an expert reviewer or (iii) PacifiCare or the Participating Medical Group has asked that an additional examination or test be performed upon the Member, provided the examination or test is reasonable and consistent with good medical practice, PacifiCare or the Participating Medical Group will notify the provider and the Member, in writing, upon the earlier of the expiration of the required timeframes above or as soon as the plan becomes aware that it will not be able to meet the required timeframes.

The notification will specify the information requested but not received or the additional examinations or tests required and the anticipated date on which a decision may be rendered following receipt of all reasonably necessary requested information. Upon receipt of all information reasonably necessary and requested by PacifiCare or the Participating Medical Group, PacifiCare or the Participating Medical Group shall approve, modify or deny the request for authorization within the timeframes specified above as applicable.

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PacifiCare and Participating Medical Groups notify requesting providers of decisions to approve, modify or deny requests for authorization of health care services for Members within 24 hours of the decision. Members are notified of decisions to deny, delay or modify requested health care services, in writing, within 2 business days of the decision. The written decision will include the specific reason or reasons for the decision the clinical reason or reasons for modifications or denials based on a lack of Medical Necessity and information about how to file an appeal of the decision with PacifiCare. In addition, the internal criteria or benefit interpretation policy, if any, relied upon in making this decision will be made available upon request by the Member. PacifiCare's Appeals Process is outlined in the "General Information" section of this *Combined Evidence of Coverage and Disclosure Form*.

If the Member requests an extension of a previously authorized and currently ongoing course of treatment, and the request is an "Urgent Request" as defined above PacifiCare or its Participating Medical Group will approve, modify or deny the request as soon as possible, taking into account the Member's medical condition, and will notify the Member of the decision within 24 hours of the request, provided the Member made the request to PacifiCare (or its Participating Medical Group) at least 24 hours prior to the expiration of the previously authorized course of treatment. If the concurrent care request is not an Urgent Request as defined above, PacifiCare will treat the request as a new request for a Covered Service under the Health Plan and will follow the timeframe for nonurgent requests as discussed above.

If you would like a copy of PacifiCare's policy and procedure, a description of the processes utilized for the authorization, modification or denial of health care services, you may contact the PacifiCare Customer Service department at 1-800-624-8822.

PacifiCare's Utilization Management Policy

PacifiCare distributes its policy on financial incentives to all its Participating Providers, Members and employees. PacifiCare also requires that Participating Providers and staff who make utilization decisions and those who supervise them sign a document acknowledging receipt of this policy. The policy affirms that a utilization management decision is based solely on the appropriateness of a given treatment and service, as well as the existence of coverage. PacifiCare does not

specifically reward Participating Providers or other individuals conducting utilization review for issuing denials of coverage. Financial incentives for Utilization Management decision-makers do not encourage decisions that result in either the denial or modification of Medically Necessary Covered Services.

Assessment of New Technologies

PacifiCare regularly reviews new procedures, devices and drugs to determine whether or not they are safe and effective for our Members. The Technology Assessment and Guideline Committee — consisting of PacifiCare Medical Directors, Primary Care Physicians, pharmacists and Specialists — conducts careful reviews of case studies, clinical literature and opinions of review organizations, such as ECRI (formerly the Emergency Care Research Institute), the Health Technology Assessment Information Service, the HAYES New Technology Summaries, the Agency for Health Care Policy and Research, Medicare and Federal Drug Administration decisions.

Utilization Criteria

When a Provider or Member requests preauthorization of a procedure/service requiring preauthorization, a licensed professional reviews the request. The licensed professional applies the applicable criteria, including, but not limited to:

- InterQual® Criteria (nationally published criteria for utilization management);
- HCIA-Sachs Length of Stay© Guidelines (average length of hospital stays by medical or surgical diagnoses);
- PacifiCare Technology Assessment Guidelines (TAG) and Benefit Interpretation Policies ("BIP").

Those cases that meet the criteria for coverage and level of service are approved as requested. Those not meeting the utilization criteria are referred for review to a Participating Medical Group's Medical Director or a PacifiCare Medical Director.

Denial, delay or modification of health care services based on Medical Necessity must be made by a licensed Physician or a licensed health care professional who is competent to evaluate the specific clinical issues involved in the health care services requested by the Provider.



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Denials may be made for administrative reasons that include, but are not limited to, the fact that the patient is not a PacifiCare Member or that the service being requested is not a benefit provided by the Member's plan.

Preauthorization determinations are made once the Member's Participating Medical Group Medical Director or designee receives all reasonably necessary medical information. PacifiCare makes timely and appropriate initial determinations based on the nature of the Member's medical condition in compliance with state and federal requirements.

What To Do If You Have a Problem

PacifiCare's top priority is meeting our Members' needs, but sometimes you may have an unexpected problem. When this happens, your first step should be to call our Customer Service department. We'll assist you and attempt to find a solution to your situation.

If you have a concern about your treatment or a decision regarding your medical care, you may be able to request a second medical opinion. You can read more about requesting, as well as the requirements for obtaining a second opinion, in **Section Two: Seeing the Doctor**.

If you feel that we haven't assisted you or that your situation requires additional action, you may also request a formal Appeal or Quality Review. To learn more about this, read the following section; "Appealing a Health Care Decision."

Appealing a Health Care Decision

Our appeals and quality of care review procedures are designed to deliver a timely response and resolution to your complaints. This is done through a process that includes a thorough and appropriate investigation, as well as an evaluation of the complaint. You may submit a formal appeal within 180 days of your receipt of an initial determination through our Appeals department. To initiate an appeal or quality of care review, call our Customer Service department or write the Appeals department at:

PacifiCare of California
Appeals Department
Mail Stop CY44-157
5701 Katella Avenue
P.O. Box 6006
Cypress, CA 90630

This written request will initiate the following Appeals Process except in the case of "expedited reviews" as discussed below. You may submit written comments, documents, records and any other information relating to your appeal regardless of whether this information was submitted or considered in the initial determination. You may obtain, upon request and free of charge, copies of all documents, records and other information relevant to your appeal. The appeal will be reviewed by an individual who is neither the individual who made the initial determination that is the subject of the appeal nor the subordinate of that person.

PacifiCare will review your appeal and if the appeal involves a clinical issue, the necessity of treatment or the type of treatment or level of care proposed or utilized, the determination will be made by a medical reviewer who has the education, training and relevant expertise in the field of medicine necessary to evaluate the specific clinical issues that serve as the basis of your appeal.

Quality of Care Review

All quality of care complaints requiring clinical review are reviewed by PacifiCare's Health Services Department. Complaints affecting your immediate condition are reviewed immediately. PacifiCare conducts this review by investigating the complaint and consulting with your Participating Medical Group, treating Providers and other PacifiCare departments. We also review medical records as necessary, and you may need to sign an authorization to release your medical records.

We will notify you in writing regarding your quality of care review within 30 days of receipt of your complaint. The results of the quality of care review are confidential and protected from legal discovery in accordance with California law. Please refer to "Expedited Review Appeals" for Appeals involving an imminent and serious threat to your health, including, but not limited to, severe pain or the potential loss of life, limb or major bodily function.

If a Member has asserted a claim for benefits or reimbursement as part of a quality of care complaint, the claims for benefits or reimbursement will be reviewed through the Appeals Process described below.

The Appeals Process

PacifiCare's Health Services department will review your appeal within a reasonable period of time appropriate to the medical circumstances and make a determination not

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later than 30 days of PacifiCare's receipt of the appeal. For appeals involving the delay, denial or modification of health care services, PacifiCare's written response will describe the criteria or guidelines used and the clinical reasons for its decision, including all criteria and clinical reasons related to Medical Necessity. For determinations delaying, denying or modifying health care services based on a finding that the services are not Covered Services, the response will specify the provisions in the *Combined Evidence of Coverage and Disclosure Form* that exclude that coverage. If the complaint is related to quality of care, the complaint will be reviewed through the procedure described in the section of this *Combined Evidence of Coverage and Disclosure Form* captioned "Quality Management Review."

Expedited Review Process

Appeals involving an imminent and serious threat to your health including, but not limited to, severe pain or the potential loss of life, limb or major bodily function will be immediately referred to PacifiCare's clinical review personnel. If your case does not meet the criteria for an expedited review, it will be reviewed under the standard appeal process. If your appeal requires expedited review, PacifiCare will immediately inform you in writing of your review status and your right to notify the Department of Managed Health Care of the grievance and provide you and the Department of Managed Health Care with a written statement of the disposition or pending status of the expedited review no later than 3 days from receipt of the grievance. The DMHC may waive the requirement that you complete the appeals process or participate in the appeals process for at least 30 days if the DMHC determines that an earlier review is necessary.

Voluntary Mediation and Binding Arbitration

If you are dissatisfied with PacifiCare's Appeal Process determination, you have 60 days to request that PacifiCare submit the appeal to voluntary mediation or binding arbitration before the Judicial Arbitration and Mediation Services (JAMS). However, if you have a legitimate health or other reason that prevents you from electing binding arbitration within 60 days, you will have as long as is reasonably necessary to accommodate your special needs to elect binding arbitration. Binding arbitration is determined through a single arbitrator. The Member may file a grievance with the Department of Managed Health Care, upon the earlier of completing mediation or participating in PacifiCare's grievance

process or voluntary mediation for 30 days. Such voluntary mediation or binding arbitration will be limited to claims that are not subject to the Employee Retirement Income Security Act of 1974 (ERISA).

Voluntary Mediation

In order to initiate voluntary mediation, either you or the agent acting on your behalf must submit a written request to PacifiCare. If all parties mutually agree to mediation, the mediation will be administered by JAMS in accordance with the JAMS Mediation Rules and Procedures, unless all parties otherwise agree. Expenses for mediation will be shared equally by the parties. The Department of Managed Health Care will have no administrative or enforcement responsibilities with the voluntary mediation process.

Binding Arbitration

Any and all disputes of any kind whatsoever, including, but not limited to, claims for medical malpractice (that is, as to whether any medical services rendered under the health plan were unnecessary or unauthorized or were improperly, negligently or incompetently rendered) between Member (including any heirs, successors or assigns of Member) and PacifiCare, except for claims subject to ERISA, shall be submitted to binding arbitration. Any such dispute will not be resolved by a lawsuit or resort to court process, except as California law provides for judicial review of arbitration proceedings. Member and PacifiCare are giving up their constitutional rights 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 as the parties may agree in writing. The parties will endeavor to mutually agree to the appointment of the arbitrator, but if such agreement cannot be reached within 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 Orange County, California, or at such other location as the parties may agree in writing. Civil discovery may be taken in such arbitration as provided by California law and the Code of 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



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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, PacifiCare may assume all or part of the Member's share of the fees and expenses of JAMS and the arbitrator, provided the Member submits a hardship application to JAMS. 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 Federal Arbitration Act, 9 U.S.C. Sections 1–16, shall also apply to the arbitration.

ALL PARTIES EXPRESSLY AGREE TO WAIVE THEIR CONSTITUTIONAL RIGHT TO HAVE DISPUTES BETWEEN THEM RESOLVED IN COURT BEFORE A JURY AND ARE INSTEAD ACCEPTING THE USE OF ARBITRATION.

Experimental or Investigational Treatment

A PacifiCare Medical Director may deny a treatment if he or she determines it is Experimental or Investigational, except as described in “Cancer Clinical Trials” under **Section Five: Your Medical Benefits**. If you have a Terminal Illness as defined below, you may request that PacifiCare hold a conference within 30 days of receiving your request to review the denial. For purposes of this paragraph, Terminal Illness means an incurable or irreversible condition that has a high probability of causing death within 1 year or less. The conference will be held within 5 days if the treating Physician determines, in consultation with the PacifiCare Medical Director and based on professionally recognized standards of practice, that the effectiveness of the proposed treatment or services would be materially reduced if not provided at the earliest possible date.

Independent Medical Review

IF YOU BELIEVE THAT A HEALTH CARE SERVICE INCLUDED IN YOUR COVERAGE HAS BEEN IMPROPERLY DENIED, MODIFIED OR DELAYED BY PACIFICARE OR ONE OF ITS PARTICIPATING PROVIDERS, YOU MAY REQUEST AN INDEPENDENT MEDICAL REVIEW (IMR) OF THE DECISION. IMR IS AVAILABLE FOR DENIALS, DELAYS OR MODIFICATIONS OF

HEALTH CARE SERVICES REQUESTED BY YOU OR YOUR PROVIDER BASED ON A FINDING THAT THE REQUESTED SERVICE IS EXPERIMENTAL OR INVESTIGATIONAL OR IS NOT MEDICALLY NECESSARY. YOUR CASE ALSO MUST MEET THE STATUTORY ELIGIBILITY CRITERIA AND PROCEDURAL REQUIREMENTS DISCUSSED BELOW. IF YOUR COMPLAINT OR APPEAL PERTAINS TO A DISPUTED HEALTH CARE SERVICE SUBJECT TO INDEPENDENT MEDICAL REVIEW (AS DISCUSSED BELOW), YOU SHOULD FILE YOUR COMPLAINT OR APPEAL WITHIN 180 DAYS OF RECEIVING A DENIAL NOTICE.

Eligibility for Independent Medical Review

Experimental or Investigational Treatment Decisions

If you suffer from a Life-Threatening or Seriously Debilitating condition, you may have the opportunity to seek IMR of PacifiCare's coverage decision regarding Experimental or Investigational therapies under California's Independent Medical Review System pursuant to Health and Safety Code Section 1370.4. Life-Threatening means either or both of the following: (a) diseases or conditions where the likelihood of death is high unless the course of the disease is interrupted; (b) diseases or conditions with potentially fatal outcomes, where the end point of clinical intervention is survival. Seriously Debilitating means diseases or conditions that cause major irreversible morbidity.

To be eligible for IMR of Experimental or Investigational treatment, your case must meet all of the following criteria:

1. Your Physician certifies that you have a Life-Threatening or Seriously Debilitating condition for which:
 - Standard therapies have not been effective in improving your condition; or
 - Standard therapies would not be medically appropriate for you; or
 - There is no more beneficial standard therapy covered by PacifiCare than the proposed Experimental or Investigational therapy proposed by your Physician under the following paragraph.

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2. Either (a) your PacifiCare Participating Physician has recommended a treatment, drug, device, procedure or other therapy that he or she certifies in writing is likely to be more beneficial to you than any available standard therapies, and he or she has included a statement of the evidence relied upon by the Physician in certifying his or her recommendation; or (b) you or your non-contracting Physician — who is a licensed, board-certified or board-eligible Physician qualified to practice in the specialty appropriate to treating your condition — has requested a therapy that, based on two documents of medical and scientific evidence identified in California Health and Safety Code Section 1370.4(d), is likely to be more beneficial than any available standard therapy. To satisfy this requirement, the Physician certification must include a statement detailing the evidence relied upon by the Physician in certifying his or her recommendation. (Please note that PacifiCare is not responsible for the payment of services rendered by non-contracting Physicians who are not otherwise covered under your PacifiCare benefits).
3. A PacifiCare Medical Director has denied your request for a treatment or therapy recommended or requested pursuant to the above paragraph.
4. The treatment or therapy recommended pursuant to Paragraph 2 above would be a Covered Service, except for PacifiCare's determination that the treatment, drug, device, procedure or other therapy is Experimental or Investigational.

If you have a Life-Threatening or Seriously Debilitating condition and PacifiCare denies your request for Experimental or Investigational therapy, PacifiCare will send a written notice of the denial within 5 business days of the decision. The notice will advise you of your right to request IMR, and include a Physician certification form and an application form with a pre-addressed envelope to be used to request IMR from the DMHC.

Disputed Health Care Services

You may also request IMR of a Disputed Health Care Service. A Disputed Health Care Service is any health care service eligible for coverage and payment under your Health Plan that has been denied, modified or delayed by PacifiCare or one of its Participating Providers, in whole or in part, due to a finding that the service is not Medically Necessary. (NOTE: Disputed Health Care Services do not encompass coverage

decisions. Coverage decisions are decisions that approve or deny health care services substantially based on whether or not a particular service is included or excluded as a covered benefit under the terms and conditions of your health care coverage.)

You are eligible to submit an application to the DMHC for IMR of a Disputed Health Care Service if you meet all of the following criteria:

1. Your Provider has recommended a health care service as Medically Necessary; or (b) you have received Urgently Needed Services or Emergency Services that a Provider determined were Medically Necessary; or (c) you have been seen by a Participating Provider for the diagnosis or treatment of the medical condition for which you seek IMR;
2. The health care service has been denied, modified or delayed by PacifiCare or one of its Participating Providers, based in whole or in part on a decision that the health care service is not Medically Necessary; and
3. You have filed an appeal with PacifiCare regarding the decision to deny, delay or modify health care services and the disputed decision is upheld or the appeal remains unresolved after 30 days (or 3 days in the case of an urgent appeal requiring expedited review). (NOTE: If there is an imminent and serious threat to your health, the DMHC may waive the requirement that you complete the appeals process or participate in the appeals process for at least 30 days if the DMHC determines that an earlier review is necessary in extraordinary and compelling cases if the DMHC finds that you have acted reasonably.)

You may apply to the DMHC for IMR of a Disputed Health Care Service within 6 months of any of the events or periods described above, or longer if the DMHC determines that the circumstances of your case warrant an IMR review. PacifiCare will provide you an IMR application form with any grievance disposition letter that denies, modifies or delays health care services based in whole or in part due to a finding that the service is not Medically Necessary. A decision not to participate in the IMR process may cause you to forfeit any statutory right to pursue legal action against PacifiCare regarding the Disputed Health Care Service. The IMR process is in addition to any other procedures or remedies that may be available to you.



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Independent Medical Review Procedures

Applying for Independent Medical Review

In the case of Experimental or Investigational coverage decisions, if you have a Life-Threatening or Seriously Debilitating condition, PacifiCare will include an application for IMR in its notice to you that the requested service has been denied and include a Physician certification form with a preaddressed envelope to the DMHC. Your Physician must provide the Physician certification and medical and scientific documentation required for Experimental and Investigational IMR, which may be included with your application, or mailed or faxed directly to the DMHC by your Physician. Either you or your Physician can provide the letter from PacifiCare or its Participating Provider denying the request for Experimental or Investigational treatment.

In the case of determinations that a Disputed Health Care Service is not Medically Necessary, PacifiCare will provide you with an IMR application form with any disposition letter resolving your appeal of the determination. Your application for IMR of a Disputed Health Care Service may include information or documentation regarding a Provider's recommendation that the service is Medically Necessary, medical information that a service received on an urgent care or Emergency basis was Medically Necessary, and any other information you received from or gave to PacifiCare or its Participating Providers that you believe is relevant in support of your position that the Disputed Health Care Service was Medically Necessary.

Completed applications for IMR should be submitted to the DMHC. You pay no fee to apply for IMR. You, your Physician, or another designated representative acting on your behalf may request IMR. If there is any additional information or evidence you or your Physician wish to submit to the DMHC that was not previously provided to PacifiCare, you may include this information with the application for IMR. The DMHC fax number is **1-916-229-0465**. You may also reach the DMHC by calling **1-888-HMO-2219**.

Accepted Applications for Independent Medical Review

Upon receiving your application for IMR, the DMHC will review your request and notify you whether your case has been accepted. If your case is eligible for IMR, the

dispute will be submitted to an independent medical review organization (IRO) contracted with the DMHC for review by one or more expert reviewers, independent of PacifiCare, who will make an independent determination of whether or not the care should be provided. The IRO selects an independent panel of medical professionals knowledgeable in the treatment of your condition, the proposed treatment and the guidelines and protocols in the area of treatment under review. Neither you nor PacifiCare will control the choice of expert reviewers.

PacifiCare must provide the following documents to the IRO within 3 business days of receiving notice from the DMHC that you have successfully applied for an IMR:

1. The relevant medical records in the possession of PacifiCare or its Participating Providers;
2. All information provided to you by PacifiCare and any of its Participating Providers concerning PacifiCare and Provider decisions regarding your condition and care (including a copy of PacifiCare's denial notice sent to you);
3. Any materials that you or your Provider submitted to PacifiCare and its Participating Providers in support of the request for the health care services;
4. Any other relevant documents or information used by PacifiCare or its Participating Providers in determining whether the health care service should have been provided and any statement by PacifiCare or its Participating Providers explaining the reasons for the decision. The Plan shall provide copies of these documents to you and your Provider unless any information in them is found by the DMHC to be privileged.

If there is an imminent and serious threat to your health, PacifiCare will deliver the necessary information and documents listed above to the IRO within 24 hours of approval of the request for IMR.

After submitting all of the required material to the IRO, PacifiCare will promptly issue you a notification that includes an annotated list of the documents submitted and offer you the opportunity to request copies of those documents from PacifiCare.

If there is any information or evidence you or your Provider wish to submit to the DMHC in support of IMR that was not previously provided to PacifiCare, you may

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include this information with your application to the DMHC. Also as required, you or your Provider must provide to the DMHC or the IRO copies of any relevant medical records and any newly developed or discovered relevant medical records after the initial documents are provided and respond to any requests for additional medical records or other relevant information from the expert reviewers.

The Independent Medical Review Decision

The independent review panel will render its analysis and recommendations on your IMR case in writing, and in layperson's terms to the maximum extent practical, within 30 days of receiving your request for IMR and supporting information. The time may be adjusted under any of the following circumstances:

- In the case of a review of an Experimental or Investigational determination, if your Physician determines that the proposed treatment or therapy would be significantly less effective if not promptly initiated. In this instance, the analysis and recommendations will be rendered within 7 days of the request for expedited review. The review period can be extended up to 3 days for a delay in providing required documents at the request of the expert.
- If the health care service has not been provided and your Provider or the DMHC certifies in writing that an imminent and serious threat to your health may exist, including, but not limited to, serious pain, the potential loss of life, limb or major bodily function or the immediate and serious deterioration of your health. In this instance, any analyses and recommendations of the experts must be expedited and rendered within 3 days of the receipt of your application and supporting information.
- If approved by the DMHC, the deadlines for the expert reviewers' analyses and recommendations involving both regular and expedited reviews may be extended for up to 3 days in extraordinary circumstances or for good cause.

The IRO will provide the DMHC, PacifiCare, you and your Physician with each of the experts' analyses and recommendations, and a description of the qualifications of each expert. The IRO will keep the names of the expert reviewers confidential, except in cases where the reviewer is called to testify and in

response to court orders. In the case of an Experimental or Investigational determination, the experts' analyses will state the reasons the requested Experimental or Investigational therapy is or is not likely to be more beneficial for you than any available standard therapy and the reasons for recommending why the therapy should or should not be provided by PacifiCare, citing your specific medical condition, the relevant documents provided and the relevant medical and scientific evidence supporting the expert's recommendation. In the case of a review of a Disputed Health Care Service denied as not Medically Necessary, the experts' analyses will state whether the Disputed Health Care Service is Medically Necessary and cite your medical condition, the relevant documents in the record and the reviewer's relevant findings.

The recommendation of the majority of the experts on the panel will prevail. If the experts on the panel are evenly divided as to whether the health care service should be provided, the panel's decision will be deemed to be in favor of coverage. If the majority of the experts on the panel does not recommend providing the health care service, PacifiCare will not be required to provide the service.

When a Decision Is Made

The DMHC will immediately adopt the decision of the IRO upon receipt and will promptly issue a written decision to the parties that will be binding on PacifiCare. PacifiCare will promptly implement the decision when received from the DMHC. In the case of an IRO determination requiring reimbursement for services already rendered, PacifiCare will reimburse either you or your Provider — whichever applies — within 5 working days. In the case of services not yet rendered to you, PacifiCare will authorize the services within 5 working days of receiving the written decision from the DMHC, or sooner if appropriate for the nature of your medical condition, and will inform you and your Physician of the authorization.

PacifiCare will promptly reimburse you for reasonable costs associated with Urgently Needed Services or Emergency Services outside of PacifiCare's Participating Provider network, if:

- The services are found by the IRO to have been Medically Necessary;
- The DMHC finds your decision to secure services outside of PacifiCare's Participating Provider



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network prior to completing the PacifiCare grievance process or seeking IMR was reasonable under the circumstances; and

- The DMHC finds that the Disputed Health Care Services were a covered benefit under the PacifiCare Subscriber contract.

Health care services required by IMR will be provided subject to the terms and conditions generally applicable to all other benefits under your PacifiCare Health Plan.

For more information regarding the IMR process, or to request an application, please call PacifiCare's Customer Service department.

Review By the Department of Managed Health Care

In addition to the appeals processes described above, you may contact the California Department of Managed Health Care. The California Department of Managed Health Care is responsible for regulating health care service plans. The department has a toll-free telephone number **(1-888-HMO-2219)** to receive complaints regarding health plans. The hearing and speech impaired may use the California Relay Service's toll-free telephone numbers **(1-800-735-2929** or **1-888-877-5378 (TTY))** to contact the Department. The Department's Internet Web site (**www.hmohelp.ca.gov**) has complaint forms and instructions online. If you have a grievance against PacifiCare, you should first telephone us at **(1-800-624-8822** or **1-800-442-8833 (TDHI))** and use our grievance process before contacting the Department. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by PacifiCare or a grievance that has remained unresolved for more than 30 days, you may call the Department for assistance. PacifiCare's grievance process and the Department's complaint review process are in addition to any other dispute resolution procedures that may be available to you, and your failure to use these processes does not preclude your use of any other remedy provided by law.

Complaints Against Participating Medical Groups, Providers, Physicians and Hospitals

Claims against a Participating Medical Group, the group's Physicians, or Providers, Physicians or Hospitals — other than claims for benefits under your coverage — are not governed by the terms of this plan. You may seek any appropriate legal action against such persons and entities deemed necessary.

In the event of a dispute between you and a Participating Medical Group (or one of its Participating Providers) for claims not involving benefits, PacifiCare agrees to make available the Member appeals process for resolution of such dispute. In such an instance, all parties must agree to this resolution process. Any decision reached through this resolution process will not be binding upon the parties except upon agreement between the parties. The grievance will not be subject to binding arbitration except upon agreement between the parties. Should the parties fail to resolve the grievance, you or the Participating Medical Group (or its Participating Provider) may seek any appropriate legal action deemed necessary. Member claims against PacifiCare will be handled as discussed above under "Appealing a Health Care Decision."

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General Information

- *How To Replace Your Card*
- *Translation Assistance*
- *Speech and Hearing Impaired Assistance*
- *Coverage In Extraordinary Situations*
- *Compensation for Providers*
- *Organ and Tissue Donation*
- *Public Policy Participation*

What follows are answers to some common and uncommon questions about your coverage. If you have any questions of your own that haven't been answered, please call our Customer Service department.

What Should I Do If I Lose or Misplace My Membership Card?

If you should lose your card, simply call our Customer Service department. Along with sending you a replacement card, they can make sure there is no interruption in your coverage.

Does PacifiCare Offer a Translation Service?

PacifiCare uses a telephone translation service for almost 140 languages and dialects. That's in addition to select Customer Service representatives who are fluent in Spanish.

Does PacifiCare Offer Hearing and Speech Impaired Telephone Lines?

PacifiCare has a dedicated telephone number for the hearing and speech impaired. This phone number is 1-800-442-8833.

How Is My Coverage Provided Under Extraordinary Circumstances?

In the unfortunate event of a major disaster, epidemic, war, riot, civil insurrection or complete or partial destruction of facilities, our Participating Medical Groups and Hospitals will do their best to provide the services you need. Under these extreme conditions, go to the nearest doctor or hospital for Emergency Services. PacifiCare will later provide appropriate reimbursement.

How Does PacifiCare Compensate Its Participating Providers?

PacifiCare itself is not a Provider of health care. PacifiCare typically contracts with independent medical groups to provide medical services to its Members and with hospitals to provide hospital services. Once they are contracted, they become PacifiCare Participating Providers.

Participating Medical Groups in turn employ or contract with individual Physicians. None of the Participating Medical Groups or Participating Hospitals or their Physicians or employees are employees or agents of PacifiCare. Likewise, neither PacifiCare nor any employee of PacifiCare is an employee or agent of any Participating Medical Group, Participating Hospital or any other Participating Provider.

Most of our Participating Medical Groups receive an agreed-upon monthly payment from PacifiCare to provide services to our Members. This monthly payment may be either a fixed dollar amount for each Member or a percentage of the monthly premium received by PacifiCare. The monthly payment typically covers professional services directly provided, or referred and authorized, by the Participating Medical Group.

Some of PacifiCare's Participating Hospitals receive similar monthly payments in return for providing hospital services for Members. Other Participating Hospitals are paid on a discounted fee-for-service or fixed charge per day of hospitalization. Most acute care, Subacute and Transitional Care and Skilled Nursing Facilities are paid on a fixed charge per day basis for inpatient care.

At the beginning of each year, PacifiCare and its Participating Medical Groups agree on a budget for the cost of services for all PacifiCare Members assigned to the Participating Medical Group. At the end of the year, the actual cost of services for the year is compared to the agreed-upon budget. If the actual cost of services is less than the agreed-upon budget, the Participating Medical Group shares in the savings.

The Participating Hospital and Participating Medical Group typically participate in programs for hospital services similar to what is described above.

Stop-loss insurance protects Participating Medical Groups and Participating Hospitals from large financial expenses for health care services. PacifiCare provides stop-loss protection to our Participating Medical Groups



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and Participating Hospitals that receive the monthly payments described above. If any Participating Hospital or Participating Medical Group does not obtain stop-loss protection from PacifiCare, it must obtain stop-loss insurance acceptable to PacifiCare.

PacifiCare arranges with additional Providers or their representatives for the provision of Covered Services that cannot be performed by your assigned Participating Medical Group or Participating Hospital. Such services include authorized Covered Services that require a Specialist not available through your Participating Medical Group or Participating Hospital or Emergency and Urgently Needed Services. PacifiCare or your Participating Medical Group pays these Providers at the lesser of the Provider's reasonable charges or agreed-to rates. Your responsibility for Covered Services received from these Providers is limited to payment of applicable Copayments. (For more about Copayments, see **Section Six: Payment Responsibility**.) You may obtain additional information on PacifiCare's compensation arrangements by contacting PacifiCare or your Participating Medical Group.

How Do I Become an Organ and Tissue Donor?

Transplantation has helped thousands of people suffering from organ failure or in need of corneas, skin, bone or other tissue. The need for donated organs and tissues continues to outpace the supply. At any given time, nearly 50,000 Americans may be waiting for organ transplants while hundreds of thousands more need tissue transplants. Organ and tissue donation provides each of us with a special opportunity to help others.

Almost anyone can be a donor. There is no age limit, and the number of donors age 50 or older has increased. If you have questions or concerns about organ donation, speak with your family, doctor or clergy. There are many resources that can provide the information you need to make a responsible decision.

If you do decide to become a donor, be sure to share your decision. Sharing your decision to be an organ and tissue donor with your family is as important as making the decision itself. Your organs and tissue will not be donated unless a family member gives consent at the time of your death – even if you've signed your driver's license or a donor card. A simple family conversation will prevent confusion or uncertainty about your wishes.

It is also helpful to document your decision by completing a donor card in the presence of your family

and having them sign as witnesses. The donor card serves as a reminder to your family and medical staff of your personal decision to be a donor. Carry it in your wallet or purse at all times.

How Can I Learn More About Being an Organ and Tissue Donor?

To get your donor card and information on organ and tissue donation call 1-800-355-SHARE or 1-800-633-6562. You can also request donor information from your local Department of Motor Vehicles (DMV).

On the Internet, contact:

- All About Transplantation and Donation (www.transweb.org)
- Department of Health and Human Services (www.organdonor.gov)
- Once you get a donor card, be sure to sign it in your family's presence. Have your family sign as witnesses and pledge to carry out your wishes, then keep the card with you at all times where it can be easily found.

Keep in mind that even if you've signed a donor card, you must tell your family, so they can act on your wishes.

How Can I Participate In PacifiCare's Public Policy Participation?

PacifiCare gives its Members the opportunity to participate in establishing the public policy of the Health Plan. One third of PacifiCare of California's Board of Directors is comprised of Health Plan Members. If you are interested in participating in the establishment of the Health Plan's public policy, please call or write our Customer Service department.

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Definitions

PacifiCare is dedicated to making its services easily accessible and understandable. To help you understand the precise meanings of many terms used to explain your benefits, we have provided the following definitions. These definitions apply to the capitalized terms used in your *Combined Evidence of Coverage and Disclosure Form*, as well as the *Schedule of Benefits*.

Annual Copayment Maximum The maximum amount of Copayments a Member is required to pay for certain Covered Services in a calendar year. (Please refer to your *Schedule of Benefits*.)

Case Management A collaborative process that assesses, plans, implements, coordinates, monitors and evaluates options to meet an individual's health care needs based on the health care benefits and available resources in order to promote a quality outcome for the individual Member.

Chronic Condition A medical condition that is continuous or persistent over an extended period of time and requires ongoing treatment for its management.

Claim Determination Period A calendar year.

Complementary and Alternative Medicine Defined by the National Center for Complementary and Alternative Medicine as the broad range of healing philosophies (schools of thought), approaches and therapies that Conventional Medicine does not commonly use, accept, study or make available. Generally defined, these treatments and health care practices are not taught widely in medical schools and not generally used in hospitals. These types of therapies used alone are often referred to as "alternative." When used in combination with other alternative therapies or in addition to conventional therapies, these therapies are often referred to as "complementary."

Conventional Medicine Defined by the National Center for Complementary and Alternative Medicine as medicine as practiced by holders of M.D. (medical doctor) or D.O. (doctor of osteopathy) degrees. Other terms for conventional medicine are allopathic, Western, regular and mainstream medicine.

Copayments The fee that a Member is obligated to pay, if any, at the time he or she receives a Covered Service.

Copayments may be a specific dollar amount or a percentage of the cost of the Covered Services.

Copayments are fees paid by the Member in addition to the Premium paid by an Employer Group and any payroll contributions required by the Member's Employer Group.

Covered Services Medically Necessary services or supplies provided under the terms of this *Combined Evidence of Coverage and Disclosure Form*, your *Schedule of Benefits* and supplemental benefit materials.

Custodial Care Care and services that assist an individual in the activities of daily living. Examples include: assistance in walking, getting in or out of bed, bathing, dressing, feeding and using the toilet; preparation of special diets; and supervision of medication that usually can be self-administered. Custodial Care includes all homemaker services, respite care, convalescent care or extended care not requiring skilled nursing. Custodial Care does not require the continuing attention of trained medical or paramedical personnel.

Dependent A Member of a Subscriber's family who is enrolled with PacifiCare after meeting all of the eligibility requirements of the Subscriber's Employer Group and PacifiCare and for whom applicable Health Plan Premiums have been received by PacifiCare.

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

- placing the Member's health in serious jeopardy;
- serious impairment to bodily functions;
- serious dysfunction of any bodily organ or part;
- active labor, meaning labor at a time that either of the following would occur:
 1. there is inadequate time to effect safe transfer to another hospital prior to delivery, or
 2. a transfer poses a threat to the health and safety of the Member or unborn child.

Emergency Services Medical screening, examination and evaluation by a Physician or other personnel — to the extent provided by law — to determine if an Emergency Medical Condition or psychiatric emergency



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medical condition exists. If this condition exists, Emergency Services include the care, treatment and/or surgery by a Physician necessary to relieve or eliminate the Emergency Medical Condition or psychiatric emergency medical condition within the capabilities of the facility. (For a detailed explanation of Emergency Services, see **Section Three: Emergency and Urgently Needed Services.**)

Employer Group The single employer, labor union, trust, organization or association through which you enrolled for coverage.

Experimental or Investigational Defined in the “Exclusions and Limitations of Benefits” section of this *Combined Evidence of Coverage and Disclosure Form*.

Family Member The Subscriber’s Spouse and any person related to the Subscriber or Spouse by blood, marriage, adoption or guardianship. An enrolled Family Member is a Family Member who is enrolled with PacifiCare, meets all the eligibility requirements of the Subscriber’s Employer Group and PacifiCare, and for whom premiums have been received by PacifiCare. An eligible Family Member is a Family Member who meets all the eligibility requirements of the Subscriber’s Employer Group and PacifiCare.

Group Agreement The Medical and Hospital Group Subscriber Agreement entered into between PacifiCare and the employer, labor union, trust, organization or association through which you enroll for coverage.

Health Plan Your benefit plan as described in this *Combined Evidence of Coverage and Disclosure Form*, *Schedule of Benefits* and supplemental benefit materials.

Hospice Specialized form of interdisciplinary health care for a Member with a life expectancy of a year or less due to a terminal illness. Hospice programs or services are designed to provide palliative care; alleviate the physical, emotional, social and spiritual discomforts of a Member who is experiencing the last phase of life due to the existence of a terminal disease; and provide supportive care to the primary care giver and family of the Member receiving Hospice Services.

Hospital Services Services and supplies performed or supplied by a licensed hospital on an inpatient or outpatient basis.

Infertility Either: 1) the inability to conceive a pregnancy or to carry a pregnancy to a live birth after a year or more of regular sexual relations without

contraception; or 2) the presence of a demonstrated condition recognized by a licensed Physician who is a Participating Provider as a cause of infertility.

Late Enrollee An employee who declined enrollment in the PacifiCare Health Plan when offered and who subsequently requests enrollment outside the designated Open Enrollment Period.

Limiting Age The age established by the Employer Group when a Dependent is no longer eligible to be an enrolled Family Member under the Subscriber’s coverage.

Medically Necessary (or Medical Necessity) refers to an intervention, if, as recommended by the treating Physician and determined by the Medical Director of PacifiCare or the Participating Medical Group, it is all of the following:

- a. A health intervention for the purpose of treating a medical condition;
- b. The most appropriate supply or level of service, considering potential benefits and harms to the Member;
- c. Known to be effective in improving health outcomes. For existing interventions, effectiveness is determined first by scientific evidence, then by professional standards, then by expert opinion. For new interventions, effectiveness is determined by scientific evidence; and
- d. If more than one health intervention meets the requirements of (a) through (c) above, furnished in the most cost-effective manner that may be provided safely and effectively to the Member. “Cost-effective” does not necessarily mean lowest price.

A service or item will be covered under the PacifiCare Health Plan if it is an intervention that is an otherwise covered category of service or item, not specifically excluded, and Medically Necessary. An intervention may be medically indicated yet not be a covered benefit or meet the definition of Medical Necessity.

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In applying the above definition of Medical Necessity, the following terms shall have the following meanings:

- (i) *Treating Physician* means a Physician who has personally evaluated the patient.
- (ii) *A health intervention* is an item or service delivered or undertaken primarily to treat (that is, prevent, diagnose, detect, treat or palliate) a medical condition or to maintain or restore functional ability. A *medical condition* is a disease, illness, injury, genetic or congenital defect, pregnancy or a biological or psychological condition that lies outside the range of normal, age-appropriate human variation. A health intervention is defined not only by the intervention itself but also by the medical condition and the patient indications for which it is being applied.
- (iii) *Effective* means that the intervention can reasonably be expected to produce the intended results and to have expected benefits that outweigh potential harmful effects.
- (iv) *Health outcomes* are outcomes that affect health status as measured by the length or quality (primarily as perceived by the patient) of a person's life.
- (v) *Scientific evidence* consists primarily of controlled clinical trials that either directly or indirectly demonstrate the effect of the intervention on health outcomes. If controlled clinical trials are not available, observational studies that suggest a causal relationship between the intervention and health outcomes can be used. Partially controlled observational studies and uncontrolled clinical series may be suggestive but do not by themselves demonstrate a causal relationship unless the magnitude of the effect observed exceeds anything that could be explained either by the natural history of the medical condition or potential Experimental biases. For existing interventions, the scientific evidence should be considered first and, to the greatest extent possible, should be the basis for determinations of Medical Necessity. If no scientific evidence is available, professional standards of care should be considered. If

professional standards of care do not exist or are outdated or contradictory, decisions about existing interventions should be based on expert opinion. Giving priority to scientific evidence does not mean that coverage of existing interventions should be denied in the absence of conclusive scientific evidence. Existing interventions can meet the definition of Medical Necessity in the absence of scientific evidence if there is a strong conviction of effectiveness and benefit expressed through up-to-date and consistent professional standards of care or, in the absence of such standards, convincing expert opinion.

- (vi) *A new intervention* is one that is not yet in widespread use for the medical condition and patient indications being considered. New interventions for which clinical trials have not been conducted because of epidemiological reasons (i.e., rare or new diseases or orphan populations) shall be evaluated on the basis of professional standards of care. If professional standards of care do not exist, or are outdated or contradictory, decisions about such new interventions should be based on convincing expert opinion.
- (vii) An intervention is considered *cost-effective* if the benefits and harms relative to costs represent an economically efficient use of resources for patients with this condition. In the application of this criterion to an individual case, the characteristics of the individual patient shall be determinative.

Medicare (Original Medicare) The Hospital Insurance Plan (Part A) and the supplementary Medical Insurance Plan (Part B) provided under Title XVIII of the Social Security Act, as amended.

Medicare Eligible Those Members who meet eligibility requirements under Title XVIII of the Social Security Act, as amended.

Member The Subscriber or any Dependent who is eligible, enrolled and covered by PacifiCare.

Non-Participating Providers A hospital or other health care entity, a Physician or other health care professional, or a health care vendor that has not entered into a written agreement to provide Covered Services to PacifiCare's Members.



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Nonphysician Health Care Practitioners Include but are not limited to: psychologists, acupuncturists, optometrists, podiatrists, chiropractors, licensed clinical social workers, marriage and family therapists and nurse midwives.

Open Enrollment Period The time period determined by PacifiCare and the Subscriber's Employer Group when all Eligible Employees and their eligible Family Members may enroll in PacifiCare.

Participating Hospital Any general acute care hospital licensed by the State of California that has entered into a written agreement with PacifiCare to provide Hospital Services to PacifiCare's Members.

Participating Medical Group An independent practice association (IPA) or medical group of Physicians that has entered into a written agreement with PacifiCare to provide Physician services to PacifiCare's Members. An IPA contracts with independent contractor Physicians who work at different office sites. A medical group employs Physicians who typically all work at one or several physical locations.

Under certain circumstances, PacifiCare may also serve as the Member's Participating Medical Group. This includes but is not limited to, when the Member's Primary Care Physician contracts directly with PacifiCare and there is no Participating Medical Group.

Participating Provider A hospital or other health care entity, a Physician or other health care professional or a health care vendor that has entered into a written agreement to provide Covered Services to PacifiCare's Members. A Participating Provider may contract directly with PacifiCare, with a Participating Medical Group or with another Participating Provider.

Physician Any licensed allopathic or osteopathic Physician.

Preferred Transplant Network A network of transplant facilities that are:

- Licensed in the State of California;
- Certified by Medicare as a transplant facility for a specific organ transplant;
- Designated by PacifiCare as a transplant facility for a specific organ program;
- Able to meet the reasonable access standards for organ transplantation based on the Regional Organ Procurement Agency statistics within the transplant

facility's geographic location. A Regional Organ Procurement Agency is a geographic area designated by a state-licensed organ procurement organization for transplants in the State of California.

Premiums The payments made to PacifiCare by an Employer Group on behalf of a Subscriber and any enrolled Family Members for providing and continuing enrollment in PacifiCare.

Prevailing Rates As determined by PacifiCare, the usual, customary and reasonable rates for a particular health care service in the Service Area.

Primary Care Physician A Participating Provider who is a Physician trained in internal medicine, general practice, family practice, pediatrics or obstetrics/gynecology and who has accepted primary responsibility for coordinating a Member's health care services.

Primary Residence The home or address where the Member actually lives most of the time. A residence will no longer be considered a Primary Residence if: (1) the Member moves without intent to return; (2) the Member is absent from the residence for 90 consecutive days; or (3) the Member is absent from the residence for more than 100 days in any 6-month period.

Primary Workplace The facility or location where the Member works most of the time and to which the Member regularly commutes. If the Member does not regularly commute to one location, then the Member does not have a Primary Workplace.

Provider A person, group, facility or other entity that is licensed or otherwise qualified to deliver any of the health care services described in this *Combined Evidence of Coverage and Disclosure Form* and supplemental benefit materials.

Prudent Layperson A person without medical training who reasonably draws on practical experience when making a decision regarding whether Emergency Services are needed.

Rehabilitation Services The combined and coordinated use of medical, social, educational and vocational measures for training or retraining individuals disabled by disease or injury.

Schedule of Benefits An important part of your *Combined Evidence of Coverage and Disclosure Form* that provides benefit information specific to your Health Plan, including Copayment information.

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Serious Emotional Disturbances of a Child A Serious Emotional Disturbance (SED) of a child is defined as a child who:

1. Has one or more mental disorders as defined by the Diagnostic and Statistical Manual (DSM-IV), other than a primary substance use disorder or developmental disorder, that results in behavior inappropriate to the child's age according to expected developmental norms;
2. Is under the age of 18 years old; and
3. Meets one or more of the following criteria:
 - a. As a result of the mental disorder, the child has substantial impairment in at least two of the following areas: self-care, school functioning; family relationships or ability to function in the community; and either of the following occur:
 - i. the child is at risk of removal from home or has already been removed from the home;
 - ii. the mental disorder and impairments have been present for more than 6 months or are likely to continue for more than 1 year without treatment; or
 - b. The child displays one of the following: psychotic features, risk of suicide or risk or violence due to a mental disorder; or
 - c. The child meets special education eligibility requirement under Chapter 26.5 commencing with Section 7570 of Division 7 of Title 1 of the California Government Code.

Severe Mental Illness Severe Mental Illness (SMI) includes the diagnosis and Medically Necessary treatment of the following conditions:

- Anorexia Nervosa
- Bipolar Disorder
- Bulimia Nervosa
- Major Depressive Disorder
- Obsessive-Compulsive Disorder
- Panic Disorder
- Pervasive Developmental Disorder or Autism
- Schizoaffective Disorder
- Schizophrenia

Service Area A geographic region in the state of California where PacifiCare is authorized by the California Department of Managed Health Care to provide Covered Services to Members.

Skilled Nursing Care The care provided directly by or under the direct supervision of licensed nursing personnel, including the supportive care of a home health aide.

Skilled Nursing Facility A comprehensive freestanding rehabilitation facility or a specially designed unit within a hospital licensed by the state of California to provide Skilled Nursing Care.

Skilled Rehabilitation Care The care provided directly by or under the direct supervision of licensed nursing personnel or a licensed physical, occupational or speech therapist.

Spouse The Subscriber's husband or wife who is legally recognized as a husband or wife under the laws of the State of California.

Subacute and Transitional Care Subacute and Transitional Care are levels of care needed by a Member who does not require hospital acute care but who requires more intensive licensed Skill Nursing Care than is provided to the majority of the patients in a Skilled Nursing Facility.

Subscriber The person enrolled in the Health Plan for whom the appropriate Premiums have been received by PacifiCare and whose employment or other status, except for family dependency, is the basis for enrollment eligibility.

Totally Disabled or Total Disability For Subscribers, the persistent inability to reliably engage in any substantially gainful activity by reason of any medically determinable physical or mental impairment resulting from an injury or illness. For Dependents, Totally Disabled is the persistent inability to perform activities essential to the daily living of a person of the same age and sex by reason of any medically determinable physical or mental impairment resulting from an injury or illness. Determination of Total Disability will be made by a Participating Medical Group Physician on the basis of a medical examination of the Member and upon concurrence by PacifiCare's Medical Director.

Transitional Care See "Subacute Care."



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Urgently Needed Services Covered Services that are provided when the Member's Participating Medical Group is temporarily unavailable or inaccessible. This includes when the Member is temporarily absent from the geographic area served by their Participating Medical Group. These services must be Medically Necessary and cannot be delayed because of an unforeseen illness, injury or condition.

Utilization Review Committee A committee used by PacifiCare or a Participating Medical Group to promote the efficient use of resources and maintain the quality of health care. If necessary, this committee will review and determine whether particular services are Covered Services.

NOTE: THIS COMBINED EVIDENCE OF COVERAGE AND DISCLOSURE FORM CONSTITUTES ONLY A SUMMARY OF THE PACIFICARE HEALTH PLAN. THE GROUP AGREEMENT BETWEEN PACIFICARE AND THE EMPLOYER GROUP MUST BE CONSULTED TO DETERMINE THE EXACT TERMS AND CONDITIONS OF COVERAGE. A COPY OF THE GROUP AGREEMENT WILL BE FURNISHED UPON REQUEST AND IS AVAILABLE AT PACIFICARE AND YOUR EMPLOYER GROUP'S PERSONNEL OFFICE.

Notes



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PacifiCare of California
P.O. Box 6006
Cypress, California 90630

Customer Service:
800-624-8822
800-442-8833 (TDHI)

Visit our Web site @ www.pacificare.com