

EVIDENCE OF COVERAGE & DISCLOSURE INFORMATION



Secure Horizons Medicare+Choice Plan

- Details of How the Plan Works
- Health Care Terms
- Your Rights and Responsibilities

PacifiCare[®]
Secure Horizons[®] *Retiree Plans*SM

Benefits Effective January 1, 2003
Through December 31, 2003

June 16, 2003

Addendum to the 2003 Secure Horizons Medicare+Choice Plan Evidence of Coverage and Disclosure Information

This is an Addendum to the 2003 Secure Horizons Medicare+Choice (M+C) Plan Evidence of Coverage and Disclosure Information. *(For spouses, dependents and early retirees who are not entitled to Medicare and who are enrolled in the PacifiCare Commercial Plan through your employer group's selection of the PacifiCare/Secure Horizons Group Retiree M+C Plan, please refer to the PacifiCare Evidence of Coverage.)* The combined Evidence of Coverage and Disclosure Information contains important information. This book, combined with your Retiree Benefits Summary Brochure and Retiree Benefits Summary Insert, which is mailed to you on your annual renewal date, constitutes your official contract with PacifiCare/Secure Horizons M+C Plan. Together, these documents explain the details of your health care coverage. Please read them carefully.

The following section titled "ERISA Requirements" is applicable to all Group Retiree Plan members:

I. ERISA Requirements

If your former employer is governed under the Employee Retirement Income Security Act ("ERISA"), the Summary Plan Description for this Plan is your former employer's booklet for their eligible population from which you retired. The Summary Plan Description also includes your Provider Directory and the 2003 Secure Horizons M+C Plan Evidence of Coverage and Disclosure Information.

For detailed information concerning ERISA special disclosures, which includes Retiree and dependent eligibility, enrollment, contributions, coverage terminations, and other general plan information, please refer to your former employer's Summary Plan Description or contact your former employer who is the plan administrator for assistance.

If your former employer is not governed by ERISA — generally if you retired from a religious organization or a governmental plan — ERISA may not apply to you, although your former employer may be subject to some of the requirements below that look like ERISA but are under the Public Health Service Act. Please feel free to contact your former employer for more information.

Qualified Medical Child Support Order

You may be able to enroll a child on your former employer's group health plan benefits 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 Secure Horizons Group Retiree M+C Plan Member may ask about obtaining dependent coverage as required by a court or administrative order, including a Qualified Medical Child Support Order.

Your Provider Directory – Choice of Physicians and Hospital (Facilities)

Along with listing the Contracting Providers, your Provider Directory has detailed information about Contracting Medical Groups and IPAs. This includes a Quality Index for helping you become familiar with the Contracting Medical Groups. You can also find an online version of the Directory at www.securehorizons.com for Secure Horizons Group Retiree M+C Plan Members and at www.pacificare.com for spouses and dependents.

Notifying You of Changes in Your Secure Horizons Group Retiree M+C Plan

Amendments, modifications or termination of the employer group agreement by either your former employer group or PacifiCare do not require the consent of a Member. PacifiCare may amend or modify the group health plan, including the applicable Health Plan Premiums, at any time after sending written notice to your former employer, up to 60 days prior to the effective date of any amendment or modification. Your former employer may also change your health plan benefits during the contract year. Your former employer is obligated to notify Retirees who are Secure Horizons Group Retiree M+C Plan Members of any such amendment or modification.

Federal COBRA Continuation Coverage

If your former employer group is subject to the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended ("COBRA"), you may be entitled to temporarily extend your Retiree coverage under the health plan at Retiree group rates, plus an administration fee, in certain instances where your coverage under the health plan would otherwise end. This disclosure is intended to inform you, in a summary fashion, of your rights and obligation under COBRA. However, your former employer group is legally responsible for informing you of your specific rights under COBRA. Therefore, please consult with your former employer group regarding the availability and duration of COBRA continuation coverage.

If you are a spouse of a Retiree covered by this health plan, you have the right to choose COBRA continuation coverage for yourself if you lose your Retiree group health coverage under this health plan for any of the following reasons:

1. The death of the Retiree;
2. Divorce or legal separation from your spouse.

In the case of a Dependent child of a Retiree eligible in a group health plan as a result of the Retiree's coverage, he or she has the right to continuation coverage if group health coverage is lost for any of the following reasons:

1. The death of the Retiree;
2. The Retiree's divorce or legal separation;
3. The dependent child ceases to be a Dependent eligible for coverage under the former employer's commercial group health plan, such as reaching the limiting age or marries.

Under COBRA, the Retiree or enrolled family member has the responsibility to inform the former employer group (or if applicable, its COBRA administrator) of the Retiree's death, divorce, legal separation or a child losing dependent status under the health plan within 60 days of the date of the event. Similar rights may apply to certain Retirees, spouses and dependent children if your former 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 and you will be financially responsible for all health care services you may receive after the terminating date.

If you choose continuation coverage, your former employer 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 up to 36 months, unless you lost group health coverage because of a termination of employment or reduction in hours. In that case required continuation coverage is 18 months. The 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 former 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 Retiree during a period of COBRA continuation coverage will be eligible to enroll as a COBRA qualified beneficiary to other commercial group health plan coverage your former employer may have available. These COBRA qualified beneficiaries can be added to COBRA continuation coverage upon proper notification to the former 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 former employer no longer provides group health coverage to any of its employees;
2. The premium for continuation coverage is not paid by you 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 the entire premium for your continuation coverage. Premiums for COBRA continuation coverage are 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 former employer group or COBRA administrator. Your former employer group or COBRA administrator is responsible for the timely submission of premium to Secure Horizons or the other group health plan. At the end of the 18-month, 29-month or 36-month continuation coverage period, qualified beneficiaries may be allowed to enroll in a conversion product through the other group health plan or, if you have Medicare, the Secure Horizons Individual Plan. If you have questions about COBRA, please contact your former employer group.

Newborn's And Mother's Rights Act

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. 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 treating Physician in consultation with the Member makes the decision for an earlier discharge of the mother and newborn. 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. Under the Secure Horizons Group Retiree M+C Plan coverage, newborns are not eligible dependents. Newborn care will be the financial responsibility of the Retiree. Please contact your former employer to arrange health plan benefits for your newborn dependent.

Women's Health And Cancer Rights Act

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 attending Physician and surgeon in consultation with the Member, consistent with sound clinical principles and processes, determine the length of a hospital stay. 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.

II. As a Secure Horizons Group Retiree M+C Plan Member, the following components of the enclosed Evidence of Coverage may not pertain to you:

Section 1 – Health Care Terms

The definition for **Election Form** refers to a **Benefit Plan Transfer Application**. The Benefit Plan Transfer Application process does not apply to Group Retiree Plan Members.

The definition for **Select and Standard Hospitals** does not apply to Group Retiree Plan Members. Group Retiree Plan Members have access to the entire provider network.

Section 2 – Eligibility, Enrollment Periods and Effective Date

The language in this section pertaining to enrollment eligibility and effective date of enrollment does not apply to Group Retiree Plan Members who enroll in an employer group plan when that plan is open for enrollment. For more information regarding your effective date, please contact your former employer or trust administrator.

Section 5 – Working With Your Contracting Medical Providers

The section titled **Provider-Specific Benefit Plans** does not apply to Group Retiree Plan Members. Group Retiree Plan Members are not enrolled in Provider-Specific Benefit plans. These plans pertain to members enrolled in the individual Secure Horizons M+C Plan.

The language under Choosing a New Primary Care Physician or Contracting Medical Group/IPA Who Is With A Different Benefit Plan refers to *Provider-Specific Benefit Plans* and these do not apply to Group Retiree Plan Members. If you want to choose a new Primary Care Physician, please contact Member Service for assistance.

Under **Hospitalization**, the language pertaining to *Select and Standard Hospitals* does not apply to Group Retiree Plan Members.

Included in this section is information related to PacifiCare's National Preferred Transplant Network, which becomes effective September 1, 2003. Members who have been evaluated for a transplant or are on a waiting list at a non-National Preferred Transplant Network facility will not be affected by this change and will continue with their current facility for the transplant process unless they choose a National Preferred Transplant Network facility.

Transportation will be provided for the Member and one person escort to a PacifiCare National Preferred Transplant Network facility, if the facility is greater than 60 miles from the Member's Primary Residence, or out of state regardless of mileage, as Prior Authorized by PacifiCare. Transportation for any day a Member is not receiving Medically Necessary transplant services is not covered. Food and housing will be provided for the Member and one escort and is limited to \$125 per day (excludes liquor and tobacco). Food and housing for any day a Member is not receiving Medically Necessary transplant services is not covered.

Section 7 – Premiums and Payments

Your former employer or trust administrator is responsible for making payment of any applicable Health Plan Premium directly to PacifiCare on behalf of its enrolled Group Retiree Plan Members and their eligible dependent(s). Your former employer or trust administrator determines any retiree subscriber contribution toward Health Plan Premiums.

The discussion regarding the Centers for Medicare & Medicaid Services' (CMS) approval of Health Plan Premium changes applies to individuals with Secure Horizons M+C Plan not Group Retiree Plan Members. For Group Retiree Plan Members your employer group or trust administrator is responsible for promptly notifying you of any premium changes or contribution changes before they become effective.

Changes in the level of health care coverage may occur at the beginning of each Calendar Year and/or your retiree group contract year. You will receive a written notice at least 30 days prior to the date when such change shall become effective.

Since you do not pay a plan premium directly to PacifiCare/Secure Horizons M+C Plan, disenrollment due to your failure to pay plan premiums discussed in this section does not apply to you. However, if your former employer or trust administrator does not pay the plan premium, then you will be transferred to the individual Secure Horizons M+C Plan. Monthly Health Plan Premiums and benefits for the individual Secure Horizons M+C Plan vary by the Member's county of residence.

Section 8 – Disenrollment From Secure Horizons Medicare+Choice Plan

In the event you choose to cancel your membership under the Group Retiree Plan, re-enrollment may not be permitted until your next Open Enrollment Period. You should consult with your benefits administrator regarding the availability of other coverage before canceling your Group Retiree Plan membership outside of your former employer's or trust administrator's Open Enrollment Period. Please note that Group Retiree Plan Members may enroll in the individual Secure Horizons M+C Plan. Please refer to Section 2 of the Secure Horizons M+C Plan Evidence of Coverage and Disclosure Information for further information regarding enrollment. As an individual member of Secure Horizons M+C Plan, you will receive the benefit package approved by CMS for your county of residence, which may cover less than the benefit package available through your former employer or trust administrator, and a Health Plan Premium may apply.

Please contact your benefits administrator regarding their disenrollment and move notification policies and the possible impact to your retiree health care coverage options and other retirement benefits. Additionally, please contact your former employer, trust administrator or PacifiCare for more information regarding your disenrollment effective date.

Section 12 – Optional Supplemental Benefits

Since your former employer or trust administrator may offer you additional supplemental or "buy-up" benefits, this section is not applicable to you. For information regarding your supplemental benefits, if applicable, please refer to the Retiree Benefits Summary Insert which was previously mailed to you **during Open Enrollment** or on your **employer's/trust administrator's** annual renewal date.

Section 13 – General Provisions

The section titled **Plan Premiums for Optional Supplemental Benefits** does not apply to Group Retiree Plan Members.

If you have any questions regarding this Addendum or the Secure Horizons M+C Plan Evidence of Coverage and Disclosure Information, please contact Member Service, Monday through Friday, 7:00 a.m. to 9:00 p.m., at 1-800-228-2144, or for the hearing impaired, TDHI 1-800-685-9355.

Reference Page

Please fill this out for your reference:

Your Secure Horizons Medicare+Choice Plan membership number (located on your membership card)

Your Effective Date of enrollment

Questions? Problems? Need help?

Call Member Service at 1-800-228-2144 or (TDHI) 1-800-685-9355, 7:00 a.m. to 9:00 p.m., Monday through Friday or

Write:

Member Service
P.O. Box 489
Cypress, CA, 90630

Visit the web site
at www.securehorizons.com

This Evidence of Coverage and Disclosure Information contains the terms and conditions of coverage and rights you have with Secure Horizons Medicare+Choice Plan, offered by PacifiCare. All applicants have a right to view this document prior to enrollment. This information should be read completely and carefully. Individuals with special needs should carefully read those sections that apply to them.

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

This document will be mailed to you annually. This document is effective January 1, 2003 through December 31, 2003.

Federal law mandates that PacifiCare comply with Title VI of the Civil Rights Act of 1964, the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, the Americans with Disabilities Act, and other laws applicable to recipients of federal funds, and all other applicable laws and rules. Specifically, PacifiCare does not discriminate both in the employment of staff and in the provision of health care services on the basis of race, disability, religion, sex, sexual orientation, health, ethnicity, creed, age or national origin.

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Please call Member Service at 1-800-228-2144 or (TDHI) 1-800-685-9355, 7:00 a.m. to 9:00 p.m., Monday through Friday, for more information.

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Please call Member Service at 1-800-228-2144 or (TDHI) 1-800-685-9355, 7:00 a.m. to 9:00 p.m., Monday through Friday, for more information.

Welcome To Secure Horizons Medicare+Choice (M+C) Plan

This document and the Schedule of Benefits are an explanation of your rights, benefits and responsibilities as a Member of the Secure Horizons Medicare+Choice Plan, offered by PacifiCare of California, a Health Maintenance Organization with a Medicare+Choice contract. These documents also explain PacifiCare's responsibilities to you. Your Member contract for Secure Horizons Medicare+Choice Plan consists of this Evidence of Coverage and Disclosure Information, the Schedule of Benefits, your Election Form and any current or future amendments.

This Evidence of Coverage and Disclosure Information and the Schedule of Benefits contain important information. These documents will be mailed to you annually and will replace all prior Evidence of Coverage and Disclosure Documents and Schedule of Benefits. Please read them carefully. Keep them in a safe place, available for quick reference.

Secure Horizons Medicare+Choice Plan is not an insurance policy which merely pays Medicare deductibles and coinsurance charges (commonly called a "Medigap" or "Medicare supplement" policy). Instead, PacifiCare has entered into a contract with the Centers for Medicare & Medicaid Services (CMS), the federal government agency that administers Medicare and is regulated by the Department of Managed Health Care. This contract authorizes PacifiCare to arrange for comprehensive health care services for individuals who are entitled to Medicare benefits and who choose to enroll in Secure Horizons Medicare+Choice Plan. When you join Secure Horizons Medicare+Choice Plan, you usually do not pay Medicare deductibles and coinsurance charges, but instead pay Health Plan Premiums, Copayments and Coinsurance. Secure Horizons Medicare+Choice Plan covers all services and supplies offered by Medicare, plus additional services and supplies not covered by Medicare.

PacifiCare has signed a contract with CMS agreeing to cover you for one full year at a time. Secure Horizons Medicare+Choice Plan costs and

benefits may change from year to year and PacifiCare will notify you before any changes are made. In addition, either CMS or PacifiCare may choose not to renew all or a portion of the contract. If the contract is not renewed, your Medicare coverage will be switched to Original Medicare unless you decided to switch to another Medicare managed care plan. If either CMS or PacifiCare decides not to renew the contract at the end of the year, you will receive a letter at least ninety (90) days before the end of the contract. If CMS ends the contract in the middle of the year, you will receive a letter at least thirty (30) days before the end of the contract. In either situation the letter would explain your options for health care coverage in your area and provide information about your right to obtain Medicare supplemental insurance coverage.

By enrolling in Secure Horizons Medicare+Choice Plan, you have agreed to receive your health care services from Contracting Medical Providers and facilities. You are required to follow all plan rules, such as obtaining Referrals and Prior Authorization when required.

If you need Emergency Services (anywhere in the world), or Urgently Needed Services (generally, outside the area served under the Secure Horizons Medicare+Choice Plan), those services will be covered. However, if you receive services from Non-Contracting Medical Providers without Prior Authorization, except for Emergency Services, Urgently Needed Services or out-of-area renal dialysis services, neither PacifiCare nor Medicare will pay for those services.

Call Member Service Whenever You Need Information

In addition to arranging health care services, PacifiCare strives to provide the information you need about your Secure Horizons Medicare+Choice Plan when you need it.

Please call Member Service at 1-800-228-2144 or (TDHI) 1-800-685-9355, 7:00 a.m. to 9:00 p.m., Monday through Friday, for more information.

PacifiCare has specially trained Member Service Representatives who can answer your questions about:

- Covered Services
- Making address or telephone number changes
- Primary Care Physician selection and changes
- Enrollment or Disenrollment
- Appeal and Grievance complaint rights
- Medical care when you are traveling
- The quality of care you are receiving
- Information concerning your physician
- Any other questions or concerns regarding your Secure Horizons Medicare+Choice Plan

Updating Your Membership Records

Your Secure Horizons Medicare+Choice Plan membership record contains information from your Election Form including your address and telephone number, as well as your specific benefit plan coverage, Primary Care Physician and the Contracting Medical Group/IPA you selected upon enrollment. These records are very important because they identify you as an eligible Secure Horizons Medicare+Choice Plan Member and determine where you are eligible to receive Covered Services.

Please report any changes in name, address or telephone number to Member Service immediately. You should also report any changes in health insurance coverage you have from your employer or your spouse's employer. Additionally, you should report any liability claims (such as claims against another driver in an auto accident) eligibility under Workers' Compensation and Medi-Cal or Medicaid.

PacifiCare Is Interested in Your Comments

PacifiCare's goal is to arrange the Covered Services you need to stay as healthy and active as you can. PacifiCare is interested in your comments. From

time to time, PacifiCare will ask your thoughts on the Secure Horizons Medicare+Choice Plan through Member satisfaction surveys. These surveys help PacifiCare measure the performance of the Contracting Medical Groups/IPAs and Secure Horizons Medicare+Choice Plan Contracting Medical Providers, as well as PacifiCare's ability to assist you with your health care coverage concerns.

How to Submit a Claim

All Covered Services prescribed by PacifiCare will be billed directly to the plan. However, if you receive a bill for a Covered Service or Emergency Service delivered by a Non-Contracting Medical Provider, please send the claim to:

PacifiCare Claims Department
P.O. Box 489
Cypress, CA, 90630

If your plan includes a Copayment, you are responsible for paying these directly to the Provider. If you have any questions about any claims, please call Member Service.

Section 1

Health Care Terms

The following definitions apply to this Evidence of Coverage and Disclosure Information.

Acute Care A pattern of health care in which a Member is treated for an acute (immediate and severe) episode of illness, for the subsequent treatment of injuries related to an accident or other trauma, or during recovery from surgery. Acute care is usually received in a Hospital from specialized personnel using complex and sophisticated technical equipment and materials. This pattern of care is often necessary for a short time, unlike chronic care, where no significant improvement can be expected.

Please call Member Service at 1-800-228-2144 or (TDHI) 1-800-685-9355, 7:00 a.m. to 9:00 p.m., Monday through Friday, for more information.

Appeal The type of complaint you make when you want a reconsideration of a decision (determination) that was made regarding a service or what PacifiCare will pay for a service. For example, if PacifiCare refuses to cover or pay for services you think PacifiCare should cover, you can file an Appeal. If PacifiCare or one of the Contracting Medical Providers refuses to give you a service you think should be covered, you can file an Appeal. If PacifiCare or one of the Contracting Medical Providers reduces or cuts back on services you have been receiving, you can file an Appeal. If you think that PacifiCare is stopping your coverage too soon, you can file an Appeal.

Basic Benefits All health care services that are covered under the Medicare Part A and Part B programs (except hospice services) which are covered by Secure Horizons Medicare+Choice Plan, additional services that PacifiCare uses Medicare funds to cover, and other services for which you may be required to pay a Health Plan Premium. All Members of Secure Horizons Medicare+Choice Plan receive all Basic Benefits.

Benefit Period A Benefit Period is a way of measuring your use of services under Medicare Part A. A Benefit Period begins with the first day of a Medicare-covered inpatient hospital stay and ends with the close of a period of sixty (60) consecutive days during which you were neither an inpatient of a Hospital or of a Skilled Nursing Facility. Inpatient Hospital Care Copayments are charged on a per admission basis. Original Medicare Hospital Benefit Periods do not apply. For Inpatient Hospital Care, you are covered for an unlimited number of days as long as the Hospital stay is Medically Necessary and authorized by PacifiCare or Contracting Medical Providers.

Calendar Year A twelve (12) month period that begins on January 1 and ends twelve (12) consecutive months later on December 31.

Center for Health Dispute Resolution (CHDR) An independent review entity under contract with CMS that reviews Appeals by

members of Medicare managed care plans, including Secure Horizons Medicare+Choice Plan.

Centers for Medicare & Medicaid Services (CMS) Federal Agency responsible for administering Medicare (formerly known as the Health Care Financing Administration (HCFA).

Coinsurance The percentage of the cost of a Covered Service a Member is required to pay. Coinsurance is based on the amount Medicare would have covered. This may not necessarily reflect the actual cost to PacifiCare. If there is no set Medicare amount for the service provided, the percentage will be based on PacifiCare's contractually negotiated rates.

Contracting Hospital A Hospital that has a contract with PacifiCare to provide services and/or supplies to Secure Horizons Medicare+Choice Plan Members.

Contracting Medical Group/Independent Physicians Association (IPA) – Contracting Medical Groups are physicians organized as a legal entity for the purpose of providing medical care. The Contracting Medical Group has an agreement with PacifiCare to provide medical services to Members. **Independent Physicians Associations (IPAs)** are organizations or affiliated groups of physicians that deliver or arrange for the delivery of health services and function as Contracting Medical Groups with physicians practicing out of their own independent medical offices.

Contracting Medical Provider A health professional, a supplier of health items, or a health care facility having an agreement with PacifiCare or a Contracting Medical Group/IPA to provide or coordinate medical services to Members. Contracting Medical Providers are independent contractors and are not the employees or agents of PacifiCare.

Copayment The fee you pay at the time of medical services in accordance with your Secure Horizons Medicare+Choice Plan.

Please call Member Service at 1-800-228-2144 or (TDHI) 1-800-685-9355, 7:00 a.m. to 9:00 p.m., Monday through Friday, for more information.

Covered Services Those benefits, services and supplies listed in the Schedule of Benefits which are:

- Services provided or furnished by Contracting Medical Providers or authorized by PacifiCare or Contracting Medical Providers
- Emergency Services and Urgently Needed Services, for which you do not need Prior Authorization and which may be provided by Non-Contracting Providers. (Please refer to Section 6 for more information about Emergency Services and Urgently Needed Services)
- Post-Stabilization services furnished by Non-Contracting Providers or Facilities that are Prior Authorized by PacifiCare or were not Prior Authorized because PacifiCare did not respond to a request for Prior Authorization for such services within one (1) hour of the request or because PacifiCare could not be contacted for Prior Authorization
- Renal Dialysis services provided while you are temporarily outside of the Service Area
- Any services for which PacifiCare provides Prior Authorization

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 the administration 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.

Disenroll or Disenrollment The process of ending your membership in Secure Horizons Medicare+Choice Plan. Disenrollment can be voluntary or involuntary.

Durable Medical Equipment (DME)

Equipment that can withstand repeated use; is primarily and usually used to serve a medical

purpose; is generally not useful to a person in the absence of illness or injury; and is appropriate for use in the home. To be covered, Durable Medical Equipment must be Medically Necessary and prescribed by a Contracting Medical Provider for use in your home, such as oxygen equipment, wheelchairs, hospital beds and other items that are determined Medically Necessary, in accordance with Medicare law, regulations and guidelines. Routine DME will not be covered when the Member has exhausted the one hundred (100) days Skilled Nursing Facility benefits and remains in an institution or distinct part of an institution meeting the basic requirements of a Hospital or Skilled Nursing Facility.

Effective Date The date your Secure Horizons Medicare+Choice Plan coverage begins. You receive written notification of your Effective Date from PacifiCare.

Election Form The enrollment form a Medicare beneficiary or legal representative must complete (with your signature and date) in order to be enrolled as a Member of Secure Horizons Medicare+Choice Plan. This form is submitted to CMS for approval. **A Benefit Plan Transfer Application** (also known as an Abbreviated Election Form or short enrollment form) is used by Members or beneficiary representatives to elect a different benefit plan offered by PacifiCare.

Emergency Services Covered Services that are 1) furnished by a provider qualified to furnish Emergency Services; and 2) needed to evaluate or stabilize a Medical Emergency.

Evidence of Coverage and Disclosure Information This document, which explains Covered Services and defines your rights and responsibilities as a Member and those of PacifiCare.

Exclusion or Excluded Items or services which are not covered under this Evidence of Coverage and Disclosure Information, which includes the Schedule of Benefits. Exclusions are disclosed in the Schedule of Benefits. (Exclusions

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applicable to the Group Retiree Secure Horizons Medicare+Choice Plan Members may be found in the Retiree Benefit Summary rather than the Schedule of Benefits.) You are responsible for paying for excluded items or services.

Experimental Procedures and Items Items and procedures determined by PacifiCare and Medicare not to be generally accepted by the medical community. When making a determination as to whether a service or item is experimental, PacifiCare will follow CMS guidance (via the Medicare Carriers Manual and Coverage Issues Manual) if applicable, or rely upon determinations already made by Medicare. Experimental Procedures and Items are not covered under this Evidence of Coverage.

Fee-for-Service Medicare A payment system by which doctors, Hospitals and other Providers are paid for each service performed (also known as traditional and/or Original Medicare).

Grievance The type of complaint you make if you have any other type of problem (other than an Appeal) with PacifiCare or a Contracting Medical Provider. For example, you would file a Grievance if you have a problem with things such as: the quality of your care; general dissatisfaction with the way the Secure Horizons Medicare+Choice Plan benefits are designed; waiting times for appointments or in the waiting room; the way your doctors or others behave; being able to reach someone by phone or obtain the information you need; or the cleanliness or condition of the doctor's office.

Group Retiree Members Medicare-eligible retired employees and their Medicare-eligible dependents who meet the eligibility requirements of their former employer, trust administrator for enrollment in the employer-sponsored group retiree health plan available through PacifiCare.

Health Plan Premium The monthly payment to PacifiCare, if applicable, along with the Medicare Part B Premiums and Medicare Part A Premiums, paid to Medicare if applicable, that

entitle you to the Covered Services outlined in this Evidence of Coverage.

Home Health Agency A Medicare-certified agency which provides intermittent Skilled Nursing Care and other therapeutic services in your home when Medically Necessary, when you are confined to your home and when authorized by your Primary Care Physician.

Hospice An organization or agency certified by Medicare that is primarily engaged in providing pain relief, symptom management and supportive services to terminally ill people and their families.

Hospital A Medicare-certified institution licensed by the State, which provides inpatient, outpatient, emergency, diagnostic and therapeutic services. The term "Hospital" does not include a convalescent nursing home, rest facility or facility for the aged which furnishes primarily Custodial Care, including training in routines of daily living.

Hospitalist When you are admitted for a Medically Necessary procedure or treatment at a Contracting Hospital, your health care may be coordinated by a physician who specializes in treating inpatients (patients in a Hospital). This allows your Primary Care Physician to continue to see other patients in his or her office while you are hospitalized.

Lock-In Feature An arrangement under which all Covered Services, with the exception of Emergency Services, Urgently Needed Services and out-of-area and routine travel renal dialysis services, must be provided or authorized by your Contracting Medical Provider or your Primary Care Physician. If you receive services from a Non-Contracting Medical Provider, Facility or a Contracting Medical Provider such as a Specialist without Prior Authorization from PacifiCare or your Contracting Medical Group/IPA, neither PacifiCare nor Medicare will pay for that care. There are very limited exceptions to this rule. See the Schedule of Benefits for specific limitations that apply.

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Medi-Cal or Medicaid A joint federal/State medical assistance program established by Title XIX of the Social Security Act. Some Medicare beneficiaries are also eligible for Medi-Cal. Medi-Cal, unlike Medicare, can cover long-term care, such as Custodial Care. Medi-Cal can cover all or part of your Medicare premiums and/or deductibles and coinsurance, if your income and resources are low enough. You may inquire about Medi-Cal and other related programs, Qualified Medicare Beneficiary, Special Low Income Medicare Beneficiary, Qualified Disabled Working Individual, Qualified Individual, at your local Department of Social Services.

Medical Director A licensed physician who is an employee of PacifiCare and is responsible for monitoring the quality of care to the Members.

Medical Emergency A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: 1) serious jeopardy to the health of the individual or, in the case of a pregnant woman, the health of the woman or her unborn child; 2) serious impairment to bodily functions; or 3) serious dysfunction of any bodily organ or part.

Medically Necessary or Medical Necessity

An intervention will be covered under the PacifiCare Health Plan if it is an otherwise covered category of service, 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*. An intervention is *Medically Necessary* if, as recommended by the treating physician and determined by the medical director of PacifiCare, 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 treating the medical condition. 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 which may be provided safely and effectively to the Member.

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

- (i) 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 condition that lies outside the range of normal, age-appropriate human variation. A health intervention is defined by the intervention itself, the medical condition and the patient indications for which it is being applied.
- (ii) **Effective** means that the intervention can reasonably be expected to produce the intended results and to have expected benefits that outweigh potential harmful effects.
- (iii) **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. Such studies do not by themselves demonstrate a causal relationship unless the magnitude of the effect observed exceeds anything that could

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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.

- (iv) A **new intervention** is one which 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.
- (v) 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.

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Medicare (Original Medicare) The federal government health insurance program established by Title XVIII of the Social Security

Act for people 65 years of age or older, certain younger people with disabilities and people with end-stage renal disease (ESRD).

Medicare Part A Hospital insurance benefits including inpatient Hospital care, Skilled Nursing Facility care, Home Health Agency care and Hospice care offered through Medicare.

Medicare Part A Premium Part A is financed by part of the Social Security payroll withholding tax paid by workers and their employers and by part of the Self-Employment Tax paid by self-employed persons. Generally, people age 65 and older can obtain premium-free Medicare Part A benefits based on their own or their spouse's employment. If you are under 65, you can obtain premium-free Medicare Part A benefits if you have been a disabled beneficiary under Social Security or the Railroad Retirement Board for more than twenty-four (24) months. If you do not qualify for premium-free Part A benefits, you may buy the coverage if you are at least 65 years old and meet certain requirements. Also, you may be able to buy Medicare Part A if you are disabled and lost your premium-free Part A because you are working.

Medicare Part B Supplementary medical insurance that is optional and requires a monthly premium. Part B covers physician services (in both Hospital and non-hospital settings) and services furnished by certain non-physician practitioners. Other Part B services include lab testing, Durable Medical Equipment, diagnostic tests, ambulance services, prescription drugs that cannot be self-administered, certain self-administered anti-cancer drugs, some other therapy services, certain other health services, and blood not covered under Part A.

Medicare Part B Premium A monthly premium paid to Medicare (usually deducted from your Social Security check) to cover Part B services. You must continue to pay this premium to Medicare to receive Covered Services whether a Medicare+Choice Plan or Medicare covers you.

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Medicare+Choice (M+C) Coordinated Care Plans These are Medicare+Choice Plans that use a network of providers that are under contract or arrangement with a Medicare+Choice Organization or its Contracting Medical Groups/IPAs to provide covered benefits. Secure Horizons Medicare+Choice Plan is a Coordinated Care Plan.

Medicare+Choice Organization (M+CO) A public or private entity organized and licensed by the State as a risk-bearing entity that is certified by CMS as meeting Medicare+Choice requirements. M+CO's can offer one or more Medicare+Choice Plans. PacifiCare is an M+CO.

Medicare+Choice (M+C) Plan A policy or benefit package offered by a Medicare+Choice Organization under which a specific set of health benefits are offered at a uniform premium and uniform level of cost-sharing to all Medicare beneficiaries residing in the Service Area covered by the Medicare+Choice Plan. A M+CO may offer more than one Medicare+Choice Plan in the same Service Area. Secure Horizons Medicare+Choice Plan is an M+C Plan.

Member You, the Medicare beneficiary entitled to receive Covered Services, who has voluntarily elected to enroll in Secure Horizons Medicare+Choice Plan and whose enrollment has been confirmed by CMS

Member Service A department dedicated to answering your questions concerning your membership, Covered Services, Grievances and Appeals.

Network Providers, facilities and hospitals contracted by PacifiCare to deliver the Covered Services provided for in this Evidence of Coverage and Disclosure Information and the Schedule of Benefits.

Non-Contracting Medical Provider or Facility Any professional person, organization, health facility, Hospital, or other person or institution licensed and/or certified by the State or Medicare to deliver or furnish health care

services; and who is neither employed, owned, operated by, nor under contract with PacifiCare to deliver Covered Services to you.

Office Visit A visit for Covered Services to your Primary Care Physician, Specialist, other Contracting Medical Provider or Non-Contracting Medical Provider upon Referral.

Optional Supplemental Benefits Non-Medicare covered benefits that can be purchased beyond the benefits included in the basic Secure Horizons Medicare+Choice Plan which may be elected at a Member's option. There is a Plan Premium associated with Optional Supplemental Benefits. Members of Secure Horizons Medicare+Choice Plan must voluntarily elect Optional Supplemental Benefits in order to receive them. (Optional Supplemental Benefits may not be available to Group Retiree Members.)

Outpatient Services Ambulatory medical services received by a Member while the Member is not admitted to a Hospital or Skilled Nursing Facility.

PacifiCare A State corporation that is organized and licensed by the State as a risk-bearing entity and is certified by CMS as meeting Medicare+Choice requirements. PacifiCare is a Medicare+Choice Organization that offers Secure Horizons Medicare+Choice Plans.

Prescription Unit The maximum amount (quantity) of medication that may be dispensed per prescription for a single Copayment. For most oral medications, the Prescription Unit represents a thirty (30) day supply of medication. The Prescription Unit for other medications will represent a single container, inhaler unit, package, or course of therapy. For drugs that could be habit-forming, the Prescription Unit is set at a smaller quantity for your protection and safety.

Primary Care Physician The Contracting Medical Provider you choose who is responsible for providing or authorizing Covered Services

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while you are a Member of Secure Horizons Medicare+Choice Plan. Primary Care Physicians are generally physicians specializing in Internal Medicine, Family Practice or General Practice. However, they may also be other provider types, based on your preference and health care needs.

Prior Authorization A system whereby a Provider must receive approval from PacifiCare or your Contracting Medical Group/IPA before you, the Member, receive certain Covered Services. All services rendered by Non-Contracting Medical Providers must have Prior Authorization unless provided during an Emergency or while you are temporarily out of the Service Area and need Urgent Care.

Provider Any professional person, organization, health facility, Hospital, or other person or institution licensed and/or certified by the State or Medicare to deliver or furnish health care services.

Quality Improvement Organization (QIO) (Formerly known as Peer Review Organization (PRO)) An independent contractor paid by CMS to review Medical Necessity, appropriateness and quality of medical care and services provided to Medicare beneficiaries. Upon request, the QIO also reviews Hospital discharges for appropriateness, and quality of care complaints.

Referral A formal recommendation by your Primary Care Physician for you to receive care from a Specialist, Contracting Medical Provider or Non-Contracting Medical Provider.

Schedule of Benefits The document which provides the details of your particular benefit plan, including any Copayments and Coinsurance that you should pay when receiving a Covered Services. Together with this Evidence of Coverage and Disclosure Information document, the Schedule of Benefits explains your health care coverage. (Group Retiree Members receive the Retiree Summary of Benefits.)

Secure Horizons Medicare+Choice Plan

A Medicare+Choice Plan offered by PacifiCare, a Medicare+Choice Organization.

Select and Standard Hospitals – Select

Hospitals are facilities that, within a specific geographic Service Area, provide services with favorable financial terms to PacifiCare and the Members. When Members receive Hospital care at a Select Hospital, they share in the savings the Select Hospital provides. **Standard Hospitals** are all network Hospitals within in a specific Service Area that are not designated as Select Hospitals. All Secure Horizons Medicare+Choice Plan Network Hospitals have met PacifiCare's credentialing standards. The contracting rates between PacifiCare and Hospitals depend on numerous factors. Select status does not reflect, either positively or negatively, the quality of the Hospital's service. Please see the Schedule of Benefits for more information.

Service Area A geographic area approved by CMS within which a Medicare+Choice eligible individual may enroll in a particular Medicare+Choice Plan offered by PacifiCare.

Skilled Nursing Care Medically Necessary services that can only be performed by, or under the supervision of, licensed nursing personnel.

Skilled Nursing Facility A facility which provides inpatient Skilled Nursing Care, rehabilitation services or other related health services and is State licensed and/or certified by Medicare. The term "Skilled Nursing Facility" does not include a convalescent nursing home, rest facility or facility for the aged which furnishes primarily Custodial Care, including training in routines of daily living.

Specialist Any duly licensed physician, osteopath, psychologist or other practitioner (as defined by Medicare) who provides health care services for a specific disease, condition or body part and that your Primary Care Physician/Contracting Medical Provider may refer you to. Also any duly licensed emergency room physician who provides Emergency Services to you.

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State The State of California, responsible for licensing and regulating PacifiCare.

Technology Assessment New procedures and technology must be proven medically effective and cost competitive before they are eligible to become a Covered Service. PacifiCare has a formal committee process involving multiple physicians at both the national and State level to review and approve new procedures and technologies, including those related to behavioral health care. When clinical necessity requires rapid determination, a PacifiCare Medical Director will make that determination using as appropriate, scientifically based medical literature and independent external expert opinion.

Time-Sensitive A situation in which waiting for a standard decision on an authorization, request for services or an Appeal could seriously jeopardize your life, health, or your ability to recover from an illness, injury or condition.

Urgently Needed Services Covered Services provided when you are temporarily absent from the Secure Horizons Medicare+Choice Plan Service Area (or, under unusual and extraordinary circumstances, provided when you are in the Service Area but your Primary Care Physician is temporarily unavailable or inaccessible) when such services are Medically Necessary and immediately required: 1) as a result of an unforeseen illness, injury, or condition; and 2) it is not reasonable given the circumstances to obtain the services through your Primary Care Physician.

Utilization Review A comprehensive, integrated process in which a team of health care professionals evaluates your treatment in an effort to promote the efficient use of resources and the quality of health care. Duties of the Utilization Review staff include Prior Authorization, concurrent and retrospective review of medical services. Prior Authorization is the process of obtaining prior approval as to the coverage and appropriateness of service, as

defined in Section 1 (Health Care Terms) and described in Section 4 (How Your Secure Horizons Medicare+Choice Plan Coverage Works). Concurrent and retrospective review is an assessment which determines Medical Necessity or appropriateness of services as they are being or have already been rendered, as applicable.

Section 2

Eligibility, Enrollment Periods and Effective Date

To enroll in Secure Horizons Medicare+Choice Plan you must:

1. Be entitled to Medicare Part A and enrolled in Medicare Part B.
2. Not currently have end-stage renal disease or receive routine kidney dialysis. However, if either of these conditions should apply to you, you may still enroll if you are a current Member of PacifiCare either through an employer group sponsored health plan or as an individual. If you develop end-stage renal disease while a Member of Secure Horizons Medicare+Choice Plan, you can continue your membership with Secure Horizons. Note: If you have received a transplant that has restored your kidney function and you no longer require a regular course of dialysis, you **are not** considered to have ESRD and you **are** eligible to enroll in Secure Horizons Medicare+Choice Plan. Note: Individuals with ESRD may re-enroll in another Medicare+Choice Plan under the following circumstance: The Medicare+Choice Plan in which the individual was enrolled was terminated after December 31, 1998.
3. Permanently reside in the Service Area as defined in Section 14.
4. Complete and sign an Election Form. If another person assists you in completing the Election

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Form, that person must also sign the form and state his or her relationship to you.

5. Agree to abide by Secure Horizons Medicare+Choice Plan rules.

If you meet the above eligibility requirements, you cannot be denied membership in Secure Horizons Medicare+Choice Plan on the basis of your health status, excluding end-stage renal disease as described above.

Enrollment

Eligible individuals can enroll in Secure Horizons Medicare+Choice Plan at the following times:

- **Continuous Open Enrollment** — Secure Horizons Medicare+Choice Plans may have continuous open enrollment. If you are eligible, you may submit a completed Election Form at any time. Note: With a thirty (30) day advance public notice, enrollment in Secure Horizons Medicare+Choice Plans may be closed to new enrollees (except for beneficiaries covered by an ICEP, AEP or SEP).
- **Initial Coverage Election Period (ICEP)** — You may elect to enroll in a Medicare+Choice (M+C) Plan when you first become entitled to both Part A and Part B of Medicare. The Initial Election Covered Period begins on the first day of the third month before the date on which you are entitled to both Part A and Part B and ends on the last day of the month before the date on which you become eligible for both Parts of Medicare.
- **Annual Election Period (AEP)** — The AEP occurs from November 15 through December 31 of every year. During this time, all Medicare+Choice Plans are required to accept enrollments-elections, effective the following January 1. Thus, at this time, you can change your enrollment from Secure Horizons

Medicare+Choice Plan to Medicare or to a different Medicare+Choice Plan. Beneficiaries enrolled in Medicare or another Medicare+Choice Plan may also change enrollment to any other Medicare+Choice Plan, or enroll in Secure Horizons Medicare+Choice Plan. You may not be enrolled in more than one (1) Medicare+Choice Plan at any given time. If you are already a member of a Medicare+Choice Plan when you enroll with a different Medicare+Choice Plan, membership in that plan will automatically be terminated on the effective date of your enrollment in the new Medicare+Choice Plan.

- **Special Election Period (SEP)** — Special periods of time in which an enrollee can discontinue enrollment in a Medicare+Choice Plan and change his or her enrollment to another Medicare+Choice Plan or return to Medicare. In the event of the following circumstances, a Special Election Period is warranted: the Medicare+Choice Plan in which the Member is enrolled is discontinued in the Service Area in which the Member lives; the enrollee moves out of the Service Area of the Medicare+Choice Plan; the Medicare+Choice Organization offering the plan violated a material provision of its contract with the Member; or, the Member meets such other material conditions as CMS may provide.

Your Enrollment Form

The Secure Horizons Medicare+Choice Plan enrollment form is also referred to as an Election Form. Once you complete and sign an Election Form, it is submitted to CMS for verification of eligibility in Secure Horizons Medicare+Choice Plan. If for any reason an Election Form is rejected by CMS, PacifiCare will contact you for additional information or provide instructions to follow regarding resubmission of the Election Form.

Please call Member Service at 1-800-228-2144 or (TDHI) 1-800-685-9355, 7:00 a.m. to 9:00 p.m., Monday through Friday, for more information.

When Your Secure Horizons Medicare+Choice Plan Coverage Begins

The Effective Date of enrollment in Secure Horizons Medicare+Choice Plan will depend on when PacifiCare receives your signed and completed Election Form. PacifiCare will send you a letter that informs you when your coverage begins. Generally, completed Election Forms received by the end of the month will be effective the 1st day of the following month.

From your Effective Date forward, you must receive all routine Covered Services from Contracting Medical Providers. Neither PacifiCare nor Medicare will pay for services received from Non-Contracting Medical Providers except for:

- Emergency Services anywhere in the world
- Urgently Needed Services that were not foreseeable when you left the Service Area
- Out-of-area renal dialysis services and routine travel dialysis
- Those services for which Secure Horizons Medicare+Choice Plan allows you to self-refer to Contracting Medical Providers
- Referrals that have received Prior Authorization

If you receive any medical services not covered by Medicare before your Secure Horizons Medicare+Choice Plan coverage takes effect, you are financially responsible for those services.

Liability of Secure Horizons Medicare+Choice Plan Upon Initial Enrollment

If your Effective Date occurs during an inpatient stay in a Hospital, PacifiCare is not responsible for the provisions or payment of any of the inpatient Hospital services under the Medicare Hospital Insurance Plan (Part A). PacifiCare must assume responsibility for payment or provision of inpatient Hospital services under the Medicare Hospital Insurance Plan (Part A) on the day after the day of discharge. PacifiCare is responsible for

the full scope of Part B services required by Medicare beginning on your Effective Date.

About your Medicare Supplement (Medigap) Policy

You may consider canceling any Medicare supplement (Medigap) policy you may have after PacifiCare has sent you written confirmation of your Effective Date. This is because premiums, Copayments, or other amounts that M+C Plans charge for Medicare-covered services will not be reimbursed by Medigap policies. However, if you Disenroll from Secure Horizons Medicare+Choice Plan, you may not be able to have your Medigap policy reinstated.

Note: In certain cases you can be guaranteed the issue (without medical underwriting or pre-existing condition exclusions) of a Medicare supplemental (Medigap) policy. Examples of these cases include the following:

- You Disenroll from Secure Horizons Medicare+Choice Plan for a reason that does not involve any fault on your part (e.g., you move out of the Secure Horizons Medicare+Choice Plan Service Area or PacifiCare's contract with CMS terminates or the Service Area in which you reside is discontinued)
- You enrolled in Secure Horizons Medicare+Choice Plan upon first reaching Medicare eligibility at age 65, but Disenroll from Secure Horizons Medicare+Choice Plan within twelve (12) months of your Effective Date
- Your supplemental coverage under an employee welfare benefit plan terminates
- Your enrollment in a Medigap policy ceases because of the bankruptcy or insolvency of the insurer issuing the policy, or because of other involuntary termination of coverage for which there is no State law provision relating to continuation of coverage
- You were previously enrolled under a Medigap policy and terminated your enrollment to participate, for the first time, in Secure Horizons

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Medicare+Choice Plan and you disenroll during the first twelve (12) months. You will be entitled to purchase the same Medigap policy you had before, if it is still available from the same insurer. If it is not available, you will be entitled to purchase any Medigap Plan “A”, “B”, “C”, or “F” sold in your state.

You must apply for a Medigap policy within sixty-three (63) days after your Secure Horizons Medicare+Choice Plan coverage terminates and submit evidence of the date of your loss of coverage. For additional information regarding guaranteed Medicare supplemental policies, please call 1-800-MEDICARE.

Should you choose to keep your Medicare supplement (Medigap) policy, you may not be reimbursed for services you receive from Non-Contracting Medical Providers. Most supplemental (Medigap) policies will not pay for any portion of such services because:

- Supplemental insurers (Medigap insurers) process their claims based on proof of an Original Medicare payment, usually in the form of an explanation of Medicare benefits (EOMB). However, as long as you are a Member of Secure Horizons Medicare+Choice Plan, Original Medicare will not process any claims for medical services that you receive.
- PacifiCare has the financial responsibility for all Medicare-covered health services you need as long as you follow Secure Horizons Medicare+Choice Plan procedures on how to receive medical services.

Additionally, if PacifiCare/Secure Horizons Medicare+Choice Plan reduces your benefits, increases your Copayments, Coinsurance, or Health Plan Premium, or terminates the contract with your Primary Care Physician, Specialist, or Contracting Medical Group/IPA, you may be eligible for enrollment in a Secure Horizons Medicare Supplement policy on a guaranteed issue basis. For more information or to enroll, please contact PacifiCare at 1-800-637-9284 or (TDHI) 1-800-647-6038, 7:00 a.m. to 7:00 p.m., Monday through Friday.

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Section 3

Secure Horizons Medicare+Choice Plan Member Rights and Responsibilities

As a member of PacifiCare/Secure Horizons Medicare+Choice Plan you have the right to receive information about, and make recommendations regarding, your rights and responsibilities.

You have the right to:

Timely, Quality Care

- Choose and seek care through a qualified contracting Primary Care Physician and Contracting Hospital. PacifiCare/Secure Horizons can advise you if a specific contracted Primary Care Physician is not accepting new patients at a particular time. Your contracting Primary Care Physician will discuss with you the Contracting Hospital that best fits your needs in the event you need Hospital services.
- Timely response to your requests for covered healthcare services; access to your contracting Primary Care Physician; and Referrals to contracted Specialists for Covered Services when Medically Necessary.
- Receive Emergency Services when you, as a prudent layperson acting reasonably, believe that a Medical Emergency exists. Payment will not be withheld in cases where you have acted as a prudent layperson with an average knowledge of health and medicine in seeking Emergency Services.
- Receive Urgently Needed Services when traveling outside the plan’s Service Area or in the plan’s Service Area when unusual or extenuating circumstances prevent you from obtaining care from your contracting Primary Care Physician.

- Discuss with your Contracting Medical Provider the full range of appropriate or Medically Necessary treatment options for your condition, regardless of cost or benefit coverage.
- Participate actively in decision-making regarding your health with your Contracting Medical Provider.
- Receive reasonable continuity of care, including information about continuing health care requirements following discharge from inpatient or outpatient facilities. And to know, in advance, the time and location of an appointment, as well as the physician providing care.
- Receive information about your medications — what they are, how to take them and possible side effects.
- Be advised if a physician proposes to engage in experimental or investigational procedures affecting your care or treatment. You have the right to refuse to participate in such research projects.

Treatment with Dignity and Respect

- Be treated with dignity and respect and have your right to privacy recognized.
- Exercise these rights regardless of your race, physical or mental disability, ethnicity, gender, sexual orientation, creed, age, religion, national origin, cultural or educational background, economic or health status, English proficiency, reading skills, or source of payment for your health care. Expect these rights to be upheld by PacifiCare/Secure Horizons and Contracting Medical Providers.
- Refuse any treatment or leave a medical facility, even against the advice of a physician. Your refusal in no way limits or otherwise precludes you from receiving other Medically Necessary Covered Services for which you consent.

- Complete an Advance Directive, living will or other directive and provide it to your contracting Primary Care Physician or medical provider to include in your medical record. Treatment decisions are not based on whether or not an individual has executed an Advance Directive.

Information About PacifiCare/Secure Horizons Medicare+Choice Plan and Their Contracting Medical Providers

- Receive information about PacifiCare/Secure Horizons Medicare+Choice Plan and the Covered Services under your plan.
- Receive information about your Contracting Practitioners and Providers involved in your medical treatment, including names and qualifications.
- Receive information from your Contracting Medical Providers about an illness, the course of treatment and prospects for recovery in a language that you can understand. This may include information about any proposed treatment or procedures necessary for you to give an informed consent or to refuse a course of treatment. Except in a case of an Emergency, this information shall include a description of the procedure or treatment, the medically significant risks involved, any alternate course of treatment or non-treatment and the risks involved in each, and the name of the person who will perform the procedure or treatment.
- Receive information regarding how medical treatment decisions are made by your contracting Primary Care Physician, medical group or PacifiCare/Secure Horizons, including payment structure.
- Receive and examine a billing explanation for non-covered services, regardless of payment source.
- Request information about PacifiCare/Secure Horizons Medicare+Choice Plan Quality Improvement Program, its goals, processes and/or outcomes.

Please call Member Service at 1-800-228-2144 or (TDHI) 1-800-685-9355, 7:00 a.m. to 9:00 p.m., Monday through Friday, for more information.

Timely Problem Resolution

- Submit complaints and request Appeals, without discrimination, about PacifiCare/Secure Horizons or care provided to you.
- Expect problems to be fairly examined and appropriately addressed within the timeframes set by the plan.
- Choose to have a service or treatment decision, if it meets certain criteria, reviewed by a physician or panel of physicians who are not affiliated with PacifiCare/Secure Horizons. This process is referred to as an independent external review.

Protection of Privacy in All Settings

- Know that PacifiCare/Secure Horizons protects the privacy and security of personal health information in all settings from unauthorized or inappropriate use via its policies and procedures and agreements with Contracting Providers.
- Know that when you or your legal representative sign your application/Election Form, you provide routine consent to PacifiCare/Secure Horizons. Routine consent covers the use of your personal health information needed for plan operations, such as: treatment, coordination of care, use of measurement and survey data to improve care and service, utilization review, billing or fraud detection.
- Know that PacifiCare/Secure Horizons does not disclose medical information related to your mental health, genetic testing results and drug and alcohol abuse treatment records, to third parties without your special consent/authorization or as required or permitted by law.
- Know that if you are unable to give consent, you may extend your rights to any person who has legal responsibility to make decisions on your behalf regarding your medical care or the release of personal health information.

- Review your medical records. If you would like to review, correct or copy your medical records, you should contact your contracting Primary Care Physician or other health care provider who created the medical record directly.
- Know that PacifiCare/Secure Horizons may accommodate employer requests for information by providing de-identified aggregated data. Only as permitted by law, PacifiCare may release information to self-funded employers where needed to administer the provisions of the plan. If required to supply this information to self-funded employers, they agree to protect the individual's data from internal disclosure that would affect the individual.

Your Responsibilities Are To:

- Review information regarding Covered Services, any exclusions, deductibles or Copayments, and policies and procedures as stated in your member materials or Evidence of Coverage.
- Provide PacifiCare/Secure Horizons, your physicians, other health care professionals and Contracting Medical Providers, to the degree possible, the information needed to provide care to you.
- Follow treatment plans and care instructions as agreed upon with your Contracting Medical Provider. Actively participate, to the degree possible, in understanding and improving your own medical and/or behavioral health condition and in developing mutually agreed upon treatment goals.
- Behave in a manner that supports the care provided to other patients and the general functioning of the facility.
- Accept your financial responsibility for Health Plan Premiums, any other charges owed, and any Copayment or Coinsurance associated with services received while under the care of a physician or while a patient in a facility.

Please call Member Service at 1-800-228-2144 or (TDHI) 1-800-685-9355, 7:00 a.m. to 9:00 p.m., Monday through Friday, for more information.

- Ask your Contracting Primary Care Physician or PacifiCare/Secure Horizons questions regarding your care. If you would like information about Contracting Medical Providers or have a suggestion, complaint or payment issue, please call Member Service.

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If you have questions or concerns about your rights, please call Member Service. You can also get free help and information from California Health Insurance Counseling and Advocacy Program your State Health Insurance Assistance Program or SHIP at 1-800-434-0222. In addition, the Medicare program has written a booklet called *Your Medicare Rights and Protection*. To get a free copy call 1-800-MEDICARE (1-800-633-4227) or TTY 1-877-486-2048). Or you can access the Medicare web site at www.Medicare.gov to order this booklet or print it directly from your computer.

Section 4

How Your Secure Horizons Medicare+Choice Plan Coverage Works

Your Secure Horizons Medicare+Choice Plan Membership Card

Your Secure Horizons Medicare+Choice Plan membership card provides you with information to assist you in receiving all your Secure Horizons Medicare+Choice Plan Covered Services. In nearly all instances, you will need to present your Secure Horizons Medicare+Choice Plan membership card to your Contracting Medical Provider to verify your coverage and/or obtain Covered Services.

Carry your Secure Horizons Medicare+Choice Plan membership card and your Medicare card with you at all times.

Although you never need to discard your Medicare card, **you must now use your Secure Horizons Medicare+Choice Plan membership card to receive Covered Services.**

Please call Member Service at 1-800-228-2144 or (TDHI) 1-800-685-9355, 7:00 a.m. to 9:00 p.m., Monday through Friday, for more information.

It is important for you to use only your Secure Horizons Medicare+Choice Plan membership card, **NOT** your Medicare card, for the following reasons:

1. To prevent you from receiving medical services from Non-Contracting Medical Providers in error
2. In the case of a Medical Emergency, to alert Hospital staff of the need to notify your Primary Care Physician or PacifiCare as soon as possible so that PacifiCare is involved in the management of your care
3. To prevent errors in billing. PacifiCare pays the bills on behalf of Medicare. Medicare will not pay the bills while you are a Member of Secure Horizons Medicare+Choice Plan

If you lose your Secure Horizons Medicare+Choice Plan membership card or move, please contact Member Service.

How the Lock-In Feature Works for You and PacifiCare

As a Secure Horizons Medicare+Choice Plan Member, all your medical benefits (except for Emergency Services and Urgently Needed Services) are provided or arranged by your Primary Care Physician, a personal physician you choose from PacifiCare's list of Contracting Medical Providers. You are "Locked-In" to this Provider who will provide and coordinate all your routine health care services.

The "Lock-In" feature enables PacifiCare to offer you Secure Horizons Medicare+Choice Plan because of PacifiCare's contract with CMS, the governmental agency that oversees Medicare. Under this contract, the federal government agrees to pay PacifiCare a fixed monthly dollar amount for each Member. PacifiCare uses the monthly amount received from the federal government to contract with physicians, Hospitals and other health care Providers to arrange care for you.

If you receive services without Prior Authorization, except for Emergency Services, Urgently Needed Services, out-of-area renal dialysis and routine travel dialysis, or services for which PacifiCare allows you to self-refer to Contracting Providers, neither PacifiCare nor Medicare will pay for those services.

Section 5

Working With Your Contracting Medical Providers

Your Primary Care Physician

Your relationship with your Primary Care Physician is an important one. PacifiCare strongly recommends that you choose a Primary Care Physician close to your home. Having your Primary Care Physician nearby makes receiving medical care and developing a trusting and open relationship easier.

If you need assistance in choosing your Primary Care Physician, please refer to the Secure Horizons Medicare+Choice Plan Provider Directory for a listing of Primary Care Physicians. For a copy of the most recent Provider Directory, or to seek additional assistance, please call Member Service or you may consult the online provider directory at: www.securehorizons.com.

To help promote a smooth transition of your health care when you first join Secure Horizons Medicare+Choice Plan, please inform PacifiCare if you are currently seeing a Specialist, receiving Home Health Agency services, or using Durable Medical Equipment. Contact Member Service so that PacifiCare can assist you with the transfer of care or equipment.

Once you have chosen your Primary Care Physician, PacifiCare recommends that you have all your medical records transferred to his or her office. This will provide your Primary Care Physician access to your medical history, and

make him or her aware of any existing health conditions you may have.

Always ask to see your Primary Care Physician when you make an appointment. Your Primary Care Physician is now responsible for all your routine health care services, so he or she should be the first one you call with any health concerns. **When you select a Primary Care Physician it is important to remember this limits you to the panel of Specialists who are affiliated with the Contracting Medical Group/IPA you have selected.**

Provider-Specific Benefit Plans

A Provider-Specific Benefit Plan is available for Members in Alameda, Contra Costa, Los Angeles and San Diego Counties. A Provider-Specific Benefit Plan means that Prior Authorized services are covered through certain Contracting Medical Groups/IPAs in the county that is specifically assigned to a benefit plan. Typically along with a different Health Plan Premium, the primary difference between a standard benefit plan and a Provider-Specific Benefit Plan is the availability of Contracting Medical Groups/IPAs and Hospitals. More information is available regarding the Provider-Specific Benefit Plan in the Summary of Benefits and the Schedule of Benefits.

Like standard benefit plans, you must use Contracting Medical Group/IPAs and Primary Care Physicians for the coordination of all your medical care. Your access to Specialists care is linked to the Contracting Medical Group/IPA with which your Primary Care Physician is affiliated. Please refer to the Summary of Benefits for specific information on the benefit plans offered.

Sometimes, your Primary Care Physician may be available through various Contracting Medical Groups/IPAs as part of a standard benefit plan or a Provider-Specific Benefit Plan. For this information you may consult the online provider directory at: www.securehorizons.com, your Primary Care Physician or call Member Service. When you select a Primary Care Physician it is

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important to remember this limits you to the network of Specialists who are affiliated with your Primary Care Physician's Contracting Medical Group/IPA.

Members enrolled in Standard Plan I in Alameda County, Contra Costa County and Los Angeles County or Members enrolled in Standard Plan I or Standard Plan III in San Diego County, are covered **only** through Contracting Medical Groups/IPAs that are a part of the benefit plan selected by the Member. The only exceptions are Emergency Services, Urgently Needed Services, or out-of-area and routine travel dialysis in the United States at a Medicare-certified facility or when authorized by the Medical Director of the Contracting Medical Group/IPA or PacifiCare. Please see the Schedule of Benefits for more information.

Changing Primary Care Physicians Within Your Contracting Medical Group/IPA

If you wish, you may request to change Primary Care Physicians within your Contracted Medical Group/IPA at any time. If the Primary Care Physician is accepting additional Secure Horizons Medicare+Choice Plan Members, the change will become effective the first day of the month following your request. You will receive a new Secure Horizons Medicare+Choice Plan membership card that shows this change. Call Member Service for assistance.

Choosing a New Primary Care Physician Who Is With a Different Contracting Medical Group/IPA

If you want to change to a Primary Care Physician who is affiliated with a different Medical Group/IPA, you must contact Member Service. If the Primary Care Physician is accepting additional Secure Horizons Medicare+Choice Plan Members, the change will become effective on the first day of the following month. You will receive a new Secure Horizons Medicare+Choice Plan membership card that shows this change.

Although PacifiCare won't deny your request, for continuity of care reasons it is recommended

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that you postpone a request to change your Primary Care Physician or Contracting Medical Group/IPA if you are an inpatient in a Hospital, a Skilled Nursing Facility or other medical institution at the time of your request.

If you change your Primary Care Physician to one who is in a different Contracting Medical Group/IPA, any Referrals to Specialists or Referrals for Covered Services that you previously received may no longer be valid. In this situation, you will need to ask your new Primary Care Physician for a new Referral, which may require further evaluation. In some cases, the request for a new Referral will need to have Prior Authorization from your Contracting Medical Group/IPA or PacifiCare.

Since your Primary Care Physician is responsible for the coordination of all of your health care needs, it is important that you notify him or her if you wish to continue to receive services or Specialist care from a Provider who was affiliated with your previous Primary Care Physician or Contracting Medical Group/IPA.

If you think that you need to continue to receive ongoing services or Specialist care from the prior Contracting Medical Group/IPA, then for continuity of care reasons you should discuss this with your Primary Care Physician prior to the determination to transfer to a different Primary Care Physician or Contracting Medical Group/IPA.

If you continue to receive services or Specialist care without a new Referral from your new Primary Care Physician, you may be financially responsible for the cost of those services. In certain circumstances, PacifiCare may authorize continued care.

Continuity of Care When You Change Your Contracting Medical Group/IPA

To help promote a smooth transition of your health care when you change your Contracting Medical Group/IPA, please let PacifiCare know if you are currently seeing a Specialist, receiving Home Health Agency services, or using Durable

Medical Equipment. Member Service can assist with the transfer of your care or equipment.

If Your Primary Care Physician Changes to a Different Contracting Medical Group/IPA

Sometimes a Primary Care Physician will change to a different Contracting Medical Group/IPA. In this situation you may need to ask him or her for new Referrals to Specialists or for Covered Services, which may require further evaluation. In some cases, this request for a new Referral will need to have Prior Authorization from your Contracting Medical Group/IPA or PacifiCare.

Because your Primary Care Physician is affiliated with a different group of Specialist, if you think that you need to continue to receive ongoing services or Specialist care from the prior Contracting Medical Group/IPA, then for continuity of care reasons you should discuss this with your Primary Care Physician. A new authorization may be needed for continued care from the prior Specialist.

If you continue to receive services or Specialist care without a new Referral from your new Primary Care Physician, you may be financially responsible for the cost of those services. In certain circumstances, PacifiCare may authorize continued care.

It is important to remember that your Primary Care Physician selection determines the network of Specialists who are affiliated with your Primary Care Physician's Contracting Medical Group/IPA.

Provider Terminations

It is PacifiCare's policy that each affected Member receives timely and consistent notice when his or her Primary Care Physician or Specialist no longer contracts with a PacifiCare Contracting Medical Group/IPA. It is PacifiCare's goal to make a good faith effort to notify you within thirty (30) days of the termination of any health care Provider that affects you. PacifiCare will assist you in

selecting a new Primary Care Physician or arranging access to all Covered Services.

Choosing a New Primary Care Physician or Contracting Medical Group/IPA Who Is With a Different Benefit Plan

A Provider-Specific Benefit Plan is available for Members in Alameda, Contra Costa, Los Angeles and San Diego Counties. If the Primary Care Physician you would like to choose is in a different benefit plan, you will need to complete and return a Benefit Plan Transfer Application to transfer to that benefit plan and receive Covered Services from that Primary Care Physician. Generally, completed Benefit Plan Transfer Applications received by the end of the month will be effective the 1st day of the following month. For example, if your Benefit Plan Transfer Application is received July 15th, your effective date of your new benefit plan will be August 1st. Until your Effective Date, you will remain with your previously selected benefit plan and Primary Care Physician and continue to receive the benefits that are a part of that benefit plan, as long as you have made any applicable Health Plan Premium payments. Benefit plans within a Service Area may offer different benefits, Health Plan Premiums, Copayment and Coinsurance amounts. Please contact Member Service for the Summary of Benefits for your Service Area, so that you may review and understand any differences.

If the Primary Care Physician you would like to choose is in a different Contracting Medical Group/IPA, any Referrals to a Specialist or Referrals for Covered Services that you previously received may no longer be valid. In this situation, you will need to ask your new Primary Care Physician for new Referrals, which may require further evaluation. In some cases, the request for a new Referral will need to have Prior Authorization from PacifiCare or your Contracting Medical Group/IPA.

Since your Primary Care Physician is responsible for the coordination of all of your health care needs, it is important that you

Please call Member Service at 1-800-228-2144 or (TDHI) 1-800-685-9355, 7:00 a.m. to 9:00 p.m., Monday through Friday, for more information.

notify him or her if you wish to continue to receive services or Specialist care from a Provider who was affiliated with your previous Contracting Medical Group/IPA.

If you think that you need to continue to receive ongoing services or Specialist care from the prior Contracting Medical Group/IPA, then you should discuss this with your Primary Care Physician prior to the determination to transfer.

If you continue to receive services or Specialist care without a new Referral from your new Primary Care Physician, you may be financially responsible for the cost of those services. In certain circumstances, PacifiCare may authorize continued care.

Sometimes, your Primary Care Physician may be available through various Contracting Medical Groups/IPAs as part of a standard benefit plan or a Provider-Specific Benefit Plan. For this information, you can consult the online provider directory at: www.securehorizons.com, your Primary Care Physician or call Member Service. When you select a Primary Care Physician it is important to remember this limits you to the network of Specialists who are affiliated with your Primary Care Physician's Contracting Medical Group/IPA.

How to Schedule an Appointment With Your Primary Care Physician

To schedule an appointment, call your Primary Care Physician's office. There are no special rules to follow. Appointments are scheduled according to the type of medical care you are requesting. Medical conditions requiring more immediate attention are scheduled sooner. If you have difficulty obtaining an appointment with your Primary Care Physician, please call Member Service.

The telephone number for your Primary Care Physician and/or Contracting Medical Group/IPA is listed on your Secure Horizons Medicare+Choice Plan membership card.

If at all possible, please call your Primary Care Physician twenty-four (24) hours in advance if you are unable to keep a scheduled appointment.

How to Receive Care After Hours

If you need to talk to or see your Primary Care Physician after the office has closed for the day, call your Primary Care Physician's office. When the physician on call returns your call he or she will advise you on how to proceed. See Section 6, Emergency and Urgently Needed Services, for what to do in cases of an emergency.

How to Receive Covered Services From a Specialist

Even though your Primary Care Physician is trained to handle the majority of common health care needs, there may be a time when he or she feels you need more specialized treatment. In that case, you may receive a Referral to an appropriate Specialist. In some cases, the request for a Referral will need to have Prior Authorization from PacifiCare or your Contracting Medical Group/IPA. When you select a Primary Care Physician it is important to remember this limits you to the network of Specialists who are affiliated with your Primary Care Physician's Contracting Medical Group/IPA.

Neither PacifiCare nor Medicare will pay for your care if you receive services from a Specialist without a Referral or Prior Authorization from your Primary Care Physician, Contracting Medical Group/IPA, or PacifiCare, except for Emergency or Urgently Needed services.

Occasionally, Specialists contracted with PacifiCare are involuntarily terminated. PacifiCare will make a good faith effort to inform you of your right to maintain your treatment with the Specialist through other avenues which may include joining a different Medicare+Choice Coordinated Care Plan or returning to Medicare. Please refer to the Provider Directory for a listing of Secure Horizons Medicare+Choice Plan Specialists available through your selected

Please call Member Service at 1-800-228-2144 or (TDHI) 1-800-685-9355, 7:00 a.m. to 9:00 p.m., Monday through Friday, for more information.

Contracting Medical Group/IPA. For a copy of the most recent Provider Directory, please call Member Service.

Standing Referrals to Specialists

You may receive a standing Referral to a Specialist, if your Primary Care Physician determines, in consultation with the Specialist and your Contracting Medical Group/IPA's Medical Director or a PacifiCare Medical Director, that you need continuing care from a Specialist.

A "standing Referral" means a Referral by your Primary Care Physician for more than one visit to a Specialist, as indicated in the treatment plan, without the Primary Care Physician having to provide a specific Referral for each visit. The standing Referral will be made according to a treatment plan approved by your Contracting Medical Group/IPA or a PacifiCare Medical Director, in consultation with your Primary Care Physician, the Specialist, and you, if you have a complex or serious medical condition or a treatment plan is otherwise considered necessary. The treatment plan may limit the number of visits to the Specialist or may limit the period of time the visits are authorized. The Specialist will provide your Primary Care Physician with regular reports on the health care provided to you. You may request a standing Referral from your Primary Care Physician or Specialist.

Extended Referral for Coordination of 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 of time, you may receive a Referral to a Specialist or specialty care center that has expertise in treating the condition or disease for the purpose of having the Specialist coordinate your health care with your Primary Care Physician. To receive an "extended specialty Referral", your Primary Care Physician must determine, in consultation with the Specialist or specialty care center and your Contracting

Medical Group's/IPA's Medical Director or a PacifiCare Medical Director, that this extended specialized medical care is Medically Necessary. The extended specialty Referral will be made according to a treatment plan approved by your Contracting Medical Group's/IPA's Medical Director or a PacifiCare Medical Director, in consultation with your Primary Care Physician, the Specialist, and you. After the extended specialty Referral is made, the Specialist will serve as the main coordinator of your care, subject to the approved treatment plan. You may request an extended specialty Referral by asking your Primary Care Physician or Specialist.

Access to OB/GYN Physician Services and Women's Routine and Preventive Health Care Services

You may self-refer to an obstetrical and gynecological (OB/GYN) Specialist within your Contracting Medical Group/IPA, for a routine pap smear, pelvic exam and breast exam annually. You may receive these Covered Services without Prior Authorization or a Referral from your Primary Care Physician. In all cases, however, you must receive Covered Services from an obstetrical and gynecological (OB/GYN) Specialist within your Contracting Medical Group/IPA.

If you visit an OB/GYN or family practice Specialist not affiliated with your Contracting Medical Group/IPA or without Prior Authorization or a Referral, you will be financially responsible for these services. Any OB/GYN inpatient or Hospital services, except Emergency or Urgently Needed Services, must be Prior Authorized by your Contracting Medical Group/IPA or PacifiCare.

To receive OB/GYN Specialist services:

- Select an OB/GYN Specialist within your Contracting Medical Group/IPA. You may select an OB/GYN Specialist from the Provider Directory, visit www.securehorizons.com for an on-line Provider Directory, or call Member Service for assistance in selecting an OB/GYN within your Contracting Medical Group/IPA.

Please call Member Service at 1-800-228-2144 or (TDHI) 1-800-685-9355, 7:00 a.m. to 9:00 p.m., Monday through Friday, for more information.

You may also obtain OB/GYN Covered Services from your Primary Care Physician.

- Telephone and schedule an appointment with your selected OB/GYN, or Contracting Primary Care Physician if applicable.

Continuity of Care for Members With Terminating Physicians

In the event your Contracting Medical Provider is terminated by PacifiCare or your Contracting Medical Group/IPA for reasons other than a medical disciplinary cause, fraud or other criminal activity, you may be eligible to continue receiving care from your physician following the termination, providing the terminated physician agrees to the terms and conditions of the contract. Continued care from the terminated physician may be provided for up to ninety (90) days, or a longer period if Medically Necessary, for chronic serious or acute conditions or through the post-partum period for pregnancy related conditions or until your care can safely be transferred to another physician. This does not apply to physicians who have voluntarily terminated their contract with PacifiCare or a Contracting Medical Group/IPA.

If you are receiving treatment for:

- an acute condition (such as open surgical wounds, or recent heart attack)
- serious chronic condition (such as chemotherapy or radiation therapy)
- a high-risk pregnancy (such as multiple babies where there is a high likelihood of complications)
- pregnancy in the second or third trimester

and your physician is terminated, you may request to continue receiving treatment from the terminated physician beyond the termination date by calling Member Service. Your Contracting Medical Group's/IPA's Medical Director in consultation with your terminated physician will determine the best way to manage your ongoing care. **PacifiCare must provide Prior**

Authorization of services for continued care. If you have any questions, or would like a copy of PacifiCare's Continuity of Care Policy, or would like to Appeal a denial of your request for continuation of services from your terminated physician, call Member Service.

If the contract with your Primary Care Physician, Specialist, or Contracting Medical Group/IPA is terminated by PacifiCare, you may be eligible for enrollment in a Secure Horizons Medicare Supplement policy on a guaranteed issue basis. For more information or to enroll, please contact PacifiCare at 1-800-637-9284 or (TDHI) 1-800-647-6038, 7:00 a.m. to 7:00 p.m., Monday through Friday.

Access to Your Medical Records and Files

You have the right to access to your medical records and files. PacifiCare must provide timely access to your records and any information that pertains to them. Please contact your Contracting Medical Provider directly for a copy of your medical records. Except as authorized by federal and State laws, PacifiCare must obtain written permission from you or your authorized representative before medical records can be made available to any person not directly concerned with your care or responsible for making payments for the cost of such care.

Utilization Review

PacifiCare and its Contracting Medical Groups/IPAs use processes to review, approve, modify, delay, or deny, based on Medical Necessity, requests by Providers for authorization of the provision of health care services to Members. This process of Utilization Review (or medical management) is a way to make sure that Members receive the right care, at the right place, by the right Provider.

PacifiCare and its Contracting Medical Groups/IPAs may also use Utilization Review criteria or guidelines to determine whether to approve, modify, delay, or deny, based on Medical Necessity, requests by providers of health care services for Members. The criteria used as the

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basis of a decision to modify, delay, or deny requested health care services in a specific case under review will be disclosed to the Provider and the Member in that specific case. The criteria or guidelines used to determine whether to authorize, modify, delay, or deny health care services are available to the public upon request, limited to the criteria or guidelines for the specific procedure or condition requested.

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

PacifiCare and its Contracting Medical Groups/IPAs make these decisions within at least the timeframes required by federal law or regulation. Please see Section 9 of this Evidence of Coverage and Disclosure Information for specific information regarding the timeframes by which PacifiCare must make a determination (decision) on your request for payment or the provision of health care services.

If you have questions regarding Utilization Review and/or would like a copy of PacifiCare's policies and procedures, a description of the processes utilized for authorization, modification, delay, or denial of health care services, or PacifiCare criteria or guidelines, please call Member Service.

Second Medical Opinions

You may request an authorization for a Second Medical Opinion regarding the advisability of a particular surgery, major nonsurgical procedure or therapeutic procedure from your Primary Care Physician. The request will be evaluated by the Contracting Medical Group/IPA, (or a PacifiCare Medical Director as applicable) based on Medical Necessity. In some instances, such as when you receive conflicting First and Second Medical Opinions, you may request an authorization for a Third Medical Opinion from your Primary Care Physician. All decisions regarding Second Medical Opinions will be rendered within the following time limits: emergency procedures

within twenty-four (24) hours; urgent procedures within seventy-two (72) hours; and elective procedures within fourteen (14) calendar days.

Second Medical Opinions can only be rendered by a physician qualified to review and treat the medical condition in question. Referrals to Non-Contracting Medical Providers or Facilities will be approved only when the services requested are not available within the Contracting Medical Provider's (or PacifiCare's as appropriate) network of Contracting Medical Providers. If the Provider giving the Second Medical Opinion recommends a particular treatment, diagnostic test or service covered by Secure Horizons Medicare+Choice Plan and if it is Medically Necessary, the treatment, diagnostic test or service will be provided or arranged by the Member's Contracting Medical Group/IPA. If you are denied a Second Medical Opinion, you may appeal the denial by following the procedures outlined in Section 9, the Appeals Process.

PacifiCare has approved procedures to identify, assess, and establish treatment plans (including direct access visits to Specialists) for Members with complex or serious medical conditions. In addition, PacifiCare maintains procedures to make sure that Members are informed of health care needs which require follow-up and receive training in self-care and other measures to promote their own health.

Prior Authorization

For a number of elective treatments, surgeries, and drug therapies, Prior Authorization is required. The Prior Authorization process is employed to make sure the requested procedure is a Covered Service and is necessary and appropriate for the individual Member's medical situation. The Member's Contracting Medical Group/IPA or PacifiCare medical personnel check to make sure the Member meets specific predetermined medical criteria, and either approve or deny the requested treatment based upon the assessment. While PacifiCare or the Member's Contracting Medical Group/IPA may

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determine the specific requested treatment is not necessary and a more appropriate therapy is available, nothing precludes the Member from seeking out and privately paying for the requested treatment. As a Member you have the right to file an Expedited Appeal or a Standard Appeal when a Provider denies a requested treatment. For further information on how to file an Appeal, please refer to Section 9, Organization Determination, Appeal and Grievance Procedures. It's important to note, the decision to deny coverage because a treatment is not Medically Necessary can only be made by a physician.

Neither PacifiCare nor Medicare will pay for services, procedures, treatments, surgeries, and/or drug therapies for which Prior Authorization is required but was not obtained from your Primary Care Physician, Specialist or Contracting Medical Group/IPA, except for Emergency or Urgently Needed services.

Hospitalization

If your Primary Care Physician or Specialist determines you require Hospitalization, Outpatient Services, Home Health Care or Skilled Nursing Care, he or she will arrange these Covered Services for you.

Coverage for Acute Care (referred to in the Member materials as "inpatient hospital benefits") consists of Medically Necessary inpatient Hospital services authorized by your Contracting Medical Provider, including Hospital room, intensive care, definitive observation, isolation, operating room, recovery room, labor and delivery room, laboratory, diagnostic and therapeutic radiology, nuclear medicine, pharmacy, inhalation therapy, dialysis, EKG, EEG, EMG, blood and blood plasma, anesthesia supplies, surgically implanted devices and implanted breast prosthesis post mastectomy, nursing services, and professional charges by the Hospital pathologist or radiologist, coordinated discharge planning and other miscellaneous Hospital charges for Medically Necessary care and treatment.

(For Members in Santa Clara, San Mateo, Stanislaus, Alameda, Contra Costa, Fresno and Madera Counties who are enrolled in Standard Plan I, authorized Inpatient Hospital Services are available at Select and Standard Hospitals. Select Hospitals are listed in the Schedule of Benefits and in the Summary of Benefits. Please call Member Service if you have questions regarding Select and Standard Hospitals.

If you are admitted to your Select Network Hospital, a Copayment will be due to the facility. If you are admitted to a Standard Network Hospital, a higher Copayment will be due to that facility. If you are admitted to a non-network Hospital on an emergency or authorized basis, a higher Copayment (the same as the Standard Network Hospital Copayment) will be due the facility. When you are admitted to an Inpatient Hospital and then subsequently transferred to another Inpatient Hospital, you pay the Copayment charged for the first Hospital admission. You do not pay a Copayment charged for the second Hospital admission; the second Copayment is waived. For example, if you are admitted to a Standard Hospital and then subsequently transferred to a Select Hospital, you pay the higher Copayment charged for the Standard Hospital admission.

Select Hospitals are facilities that, within a specific geographic Service Area, provide services with favorable financial terms to PacifiCare and the Members. When Members receive Hospital care at a Select Hospital, they share in savings that the Select Hospital provides. Standard Hospitals are all Network Hospitals within a specific Service Area that are not designated as Select Hospitals.

All Secure Horizons Medicare+Choice Plan Network Hospitals have met PacifiCare's credentialing standards. The contracting rates between PacifiCare and Hospitals depend on numerous factors. Select status does not reflect, either positively or negatively, the quality of the Hospital's service. Please see the Schedule of Benefits for more information.)

Please call Member Service at 1-800-228-2144 or (TDHI) 1-800-685-9355, 7:00 a.m. to 9:00 p.m., Monday through Friday, for more information.

Coverage for Acute Care and subacute care includes Medically Necessary inpatient services authorized by your Contracting Medical Provider provided in an Acute Care Hospital, a comprehensive, free-standing acute rehabilitation facility, or a specially designed unit within a Skilled Nursing Facility.

With the exception of Emergency or Urgently Needed Services, you will only be admitted to those Hospitals, Acute Care, subacute care, transitional inpatient care and Skilled Nursing Facilities that are Prior Authorized by your Contracting Medical Group/IPA and under contract with PacifiCare.

You may call Member Service to request a copy of Secure Horizons Medicare+Choice Plan's Utilization Review and Prior Authorization processes that apply to care provided in subacute care, transitional inpatient care and Skilled Nursing Facilities.

PacifiCare's Medical Director or designee determines the Hospital or outpatient services facility designated by PacifiCare for elective services. PacifiCare reserves the right to transfer patients who are stable for transfer to other facilities based upon factors which may include Contracting Medical Provider Hospital privileges, capabilities of the Hospital, and outcomes.

Please note: PacifiCare will not pay federal Hospitals, such as Veteran's Administration (VA) Hospital, for emergency and non-emergency items and services furnished to veterans, retired military personnel or eligible dependents. For Members who are not eligible for VA benefits, PacifiCare will cover emergency, urgent and post-stabilization care provided by a VA facility; these services are considered out-of-network.

Please refer to the Schedule of Benefits for further details. (Benefits and Exclusions applicable to Group Retiree Members may be found in the Retiree Benefit Summary rather than the Schedule of Benefits.)

Hospitalist

When you are admitted to a Hospital, a Hospitalist may coordinate your inpatient care. Hospitalists are physicians who are specially trained to care for patients who are acutely ill in the Hospital, and are responsible for coordinating all aspects of your Hospital care. They remain in the Hospital and are available to react should your condition change. This allows your Primary Care Physician to continue to see other patients in his or her office while you are hospitalized. Hospitalists collect and manage all information related to your condition and treatment, and communicate with you, your family, and your Primary Care Physician throughout your Hospital stay. Hospitalists work together with your Primary Care Physician during the course of your stay and to transition your care upon discharge. Upon discharge, your Primary Care Physician will again assume coordination of your care.

Skilled Nursing Facility (SNF) Care

Secure Horizons Medicare+Choice Plan covers inpatient Skilled Nursing Care and services in a Medicare-certified Skilled Nursing Facility under contract with PacifiCare. For a list of Skilled Nursing Facility services, please see the Schedule of Benefits. Skilled Nursing Care is covered if the Member requires Skilled Nursing Care services or skilled rehabilitation services on a daily basis and these skilled services can be provided only on an inpatient basis in a Skilled Nursing Facility. Inpatient stays solely to provide Custodial Care are not covered.

In some situations, you may be able to receive services in a Skilled Nursing Facility that is not under contract with PacifiCare. Generally, Members receive Skilled Nursing Care from Skilled Nursing Facilities that are under contract with PacifiCare. However, if certain conditions are met, Members may be able to receive Skilled Nursing Care from a Skilled Nursing Facility that is not under contract with PacifiCare. In order to access these services, the Skilled Nursing Facility that is not under contract with

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PacifiCare must be willing to accept PacifiCare's rates for payment. At a Member's request, PacifiCare may be able to arrange for a Member to receive Skilled Nursing Care from one of the following facilities (in these situations, the facility is called a "Home Skilled Nursing Facility"): A nursing home or continuing care retirement community where the Member was living prior to the Hospital admission (as long as the facility provides Skilled Nursing Care) or in a Skilled Nursing Facility where the Member's spouse resides at the time of the Member's Hospital discharge.

Ambulance

Secure Horizons Medicare+Choice Plan covers Medically Necessary ambulance services for Emergency or Urgently Needed Services or when authorized by PacifiCare or its designee, according to Medicare guidelines. Secure Horizons Medicare+Choice Plan will **not cover** ambulance services that are:

1. Member initiated for social or convenience reasons not primarily medical in nature, including, but not limited to, changing to a different Contracting Medical Group/IPA, moving to be closer to family, and transferring from one nursing facility to another, while inpatient in an acute, psychiatric or nursing facility.
2. From a contracting facility to another contracting facility unless the transfer is necessary to deliver medical services not available at the first facility or authorized by PacifiCare.

Home Health Care Services

If your Primary Care Physician or Specialist determines that you require Home Health Care, he or she will arrange these Covered Services for you. In order to qualify for home health benefits, an individual must be confined to his or her home, be under a plan of treatment reviewed and approved by a physician and require a Medically Necessary qualifying skilled service.

Covered Home Health Services for those who **qualify** may include: Part-time or intermittent skilled nursing and home health aide services, physical and occupational therapy and speech pathology services, medical social services, medical supplies, and Durable Medical Equipment (such as wheelchairs, hospital beds, oxygen, walkers).

When you qualify for coverage of Home Health Services, Secure Horizons Medicare+Choice Plan covers either part-time or intermittent skilled nursing and home health aide services. **Part-time** means any number of days per week up to thirty-five (35) hours per week of skilled nursing and home health aide services combined for less than eight (8) hours per day, based upon the reasonable need for such additional care.

Intermittent means up to thirty-five (35) hours per week of skilled nursing and home health aide services combined which are provided on a less than daily basis, based upon the reasonable need for such additional care; or up to and including full-time (i.e., eight (8) hours per day) skilled nursing and home health aide services combined which are provided and needed seven (7) days per week for temporary, but not indefinite, periods of time of up to twenty-one (21) days with allowances for extensions in exceptional circumstances where the need for care in excess of twenty-one (21) days is finite and predictable.

A homebound Member has restricted ability, due to an illness or injury, to leave home without assistance of another person or aid of a supportive device (such as crutches, a cane, a wheelchair or a walker), or if leaving the home is contraindicated. You do not have to be bedridden in order to be considered confined to the home. However, your condition should be such that there exists a normal inability to leave the home and, consequently, leaving the home would require a considerable and taxing effort. If you leave the home, you may be considered homebound if the absences from the home are infrequent or for periods of

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relatively short duration, or to receive medical treatment, including regular absences for the purpose of participating in therapeutic, psychosocial or medical treatment in an adult day-care program that is licensed or certified by the State, or to attend religious services. Home health services do not include the costs of housekeepers, food service arrangements, or full-time nursing care at home.

Hospice

Hospice provides palliative service. It is based on the philosophy that everyone has the right to spend his or her remaining days in peace and with dignity. Hospice focuses on comfort, dignity and pain control, responding to the symptoms, needs and goals of patients and families. Hospice is dedicated to helping the terminally ill live each day to the fullest throughout the dying process, and supporting them to be with their family and friends in a home setting if they wish.

In order to access Hospice care, Members must elect Hospice care under Medicare. Upon making this election, all care related to the terminal illness will be provided by the Medicare-certified Hospice, which is billed directly to Medicare. You may remain enrolled in Secure Horizons Medicare+Choice Plan even if you elect Medicare-certified Hospice coverage for your terminal condition. Secure Horizons Medicare+Choice Plan will continue to cover non-Hospice-related benefits that Medicare does not cover.

As a Secure Horizons Medicare+Choice Plan Member, you have the right to obtain information about all available Medicare-certified Hospice Providers. For more information regarding electing Hospice care, including those Hospice facilities that have an agreement with your Contracting Medical Group/IPA, please call Member Service.

Clinical Trials

If you participate as a patient in a clinical trial that meets Medicare requirements, Medicare

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covers routine costs of qualifying clinical trials. If you join a clinical trial, you will be responsible for any Coinsurance under Medicare.

When you enroll in a clinical trial, the providers are paid directly by Medicare for all the covered services you receive. The clinical trial Providers do not have to be Contracting Medical Providers.

This means you do not need to obtain a Referral to join a clinical trial. However, you should inform PacifiCare before you begin a clinical trial. This allows PacifiCare to continue to keep track of your health care services. You may remain enrolled in Secure Horizons Medicare+Choice Plan even if you elect to participate in a clinical trial. Your care unrelated to the clinical trial must continue to be arranged by PacifiCare.

Religious Non-medical Health Care Institutions (RNHCIs) Care

Services in Medicare certified Religious Non-medical Health Care Institutions (RNHCIs) are covered under Secure Horizons Medicare+Choice Plan.

In order to be eligible for care in RNHCI, an individual must have a condition that would allow him or her to receive inpatient Hospital or extended care services. In addition, the individual must make an election that he or she is conscientiously opposed to the acceptance of "Non-excepted" medical treatment. "Excepted" medical treatment is medical care or treatment received involuntarily or is required under Federal, State or local law. "Non-excepted" medical treatment is any other medical care or treatment.

Organ Transplants

1. Organ Transplant Definitions

- **Donor:** A person who undergoes a surgical procedure for the purpose of donating either a body organ or body tissue for transplant procedure.

- **Histocompatibility Testing:** Testing that involves matching or typing of the human leukocyte antigen in preparation for organ or tissue transplant.
- **PacifiCare National Preferred Transplant Network facility:** A network of transplant facilities that are licensed in the state in which they operate; certified by Medicare as a transplant facility for a specific organ transplant; and satisfies PacifiCare's quality of care standards to be designated by PacifiCare as a transplant facility for a specific organ program. PacifiCare National Preferred Transplant Network facilities may be located outside the Service Area based on a number of factors including quality, cost and outcomes.
- **Regional Organ Procurement Agency:** An organization designated by the federal government and responsible for the procurement of organs for transplantation and the promotion of organ donation.

- Cornea transplants (not part of Preferred Transplant Program)
- Allogenic bone marrow or stem cell transplant
- Autologous bone marrow or stem cell transplant

PacifiCare shall intermittently review new developments in medical technology based on scientific evidence to determine if the list of covered transplants should be revised.

Bone Marrow and Stem Cell Transplants: The testing of immediate blood relatives to determine compatibility of bone marrow and stem cells is limited to 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. An approved PacifiCare National Preferred Transplant Network facility must conduct the computerized searches. There is no dollar limitation for Medically Necessary donor related clinical transplant services once a donor is identified.

2. Transplant Services

Human organ and tissue transplants are limited to non-experimental/non-investigational procedures that are determined to be Medically Necessary. Coverage is provided for the medical, surgical and Hospital services required for pre-transplant, transplant and post-transplant. All transplant procedures must be performed by approved PacifiCare National Preferred Transplant Network facilities. Examples of covered transplant services include:

- Heart transplants
- Lung transplants
- Heart/lung transplants
- Liver transplants
- Kidney transplants
- Simultaneous pancreas/kidney transplants
- Pancreas transplant after kidney transplant
- Intestinal and multivisceral transplants

3. Organ Procurement, Transplant and Transplant Services

Coverage of services shall include:

- Pre-transplant testing and evaluation, including histocompatibility testing of transplant recipient and non-related or related donor.
- Organ procurement from cadaver or live donor and organ transportation. Covered Services for living donor are limited to Medically Necessary services once a donor is identified.
- Oral or dental examination performed on an inpatient basis as part of comprehensive evaluation work-up prior to transplant procedure.

Please call Member Service at 1-800-228-2144 or (TDHI) 1-800-685-9355, 7:00 a.m. to 9:00 p.m., Monday through Friday, for more information.

- When the transplant recipient is a Secure Horizons Medicare+Choice Plan Member, reasonable and necessary Hospital services of the donor solely for the transplant procedure are covered (the donor does not need to be a Secure Horizons Medicare+Choice Plan Member).
- Services and/or charges related to a national donor search.
- Outpatient, post-transplant, immunosuppressive drug therapy. (Please see your Schedule of Benefits.)
- Reasonable transportation and lodging for transplant recipient and one person escort determined by transplant facility and/or PacifiCare. Transportation and non-clinical expenses of the living donor are excluded and are the responsibility of the Member, who is the recipient of the transplant.

4. Prior Authorization

Coverage for transplant services must be authorized by PacifiCare prior to transplant evaluation and prior to listing and must be performed at a PacifiCare National Preferred Transplant Network facility, which may be located outside the Service Area based on a number of factors including quality, cost and outcomes. New Members, already listed at a non-PacifiCare National Preferred Transplant Network facility, will be evaluated for continuity of care. PacifiCare requires thirty (30) days to obtain and review relevant clinical information. Transplant benefits are available only where a facility designated by PacifiCare is utilized and the Member is a recipient of the transplant.

The PacifiCare National Preferred Transplant Network facilities that may be available to Secure Horizons Medicare+Choice Plan Members are the following:

Northern California

BMT Stanford University Medical Center,
Alta Bates Medical Center

Heart	Stanford University Medical Center, Sutter Memorial Hospital – Sacramento
Kidney	Stanford University Medical Center, Sutter Memorial Hospital – Sacramento, California Pacific Medical Center
Kidney/ Pancreas, Liver	Stanford University Medical Center, California Pacific Medical Center
Heart/ Lung	Stanford University Medical Center

Southern California

All transplants except Heart/ Lung	St Vincent Medical Center, USC Medical Center, UCLA Medical Center, Loma Linda University Medical Center
Heart/ Lung	Stanford University Medical Center

San Diego

All transplants except Heart/ Lung	UCSD Medical Center
Heart/ Lung	Stanford University Medical Center

Please note: PacifiCare evaluates each transplant case to determine the appropriate transplant facility for each Member. PacifiCare will select a transplant facility within the above National Preferred Transplant Network based on the medical needs of the Member in consultation with the Member's treating physician and PacifiCare's Transplant Medical Director. Notwithstanding the foregoing, PacifiCare reserves the right to utilize alternative transplant facilities as authorized by PacifiCare.

Please call Member Service at 1-800-228-2144 or (TDHI) 1-800-685-9355, 7:00 a.m. to 9:00 p.m., Monday through Friday, for more information.

5. Continuity and Coordination of Care

PacifiCare's Centralized Transplant Unit (CTU) will continually work closely with the Member, the Member's family, the Member's treating physicians and facilities to monitor the continuity and coordination of services during the pre-transplant evaluation, transplant hospitalization, and post-transplant follow care. This includes, but is not limited to, reviewing requests from Primary Care Physicians/treating physician for transplant services, facilitating placement on National Preferred Transplant Network (NPTN) Facility waiting lists, and coordinating post-transplant services.

Following a determination by PacifiCare's CTU and the NPTN facility that a Member is a candidate for a transplant, the Member will be placed on the transplant waiting list of the NPTN facility. For Members who receive transplant services from a NPTN facility outside of the Service Area, PacifiCare will work closely with the Member, the NPTN facility, and the Member's Primary Care Physician/treating physician to coordinate travel to the NPTN facility, as appropriate and at no expense to the Member.

Following transplant and the stabilization of the Member, PacifiCare's CTU will coordinate post-transplant services between the NPTN Facility and the Member's Primary Care Physician/treating physician. Depending on the NPTN facility, the Member may receive post-transplant services locally or the Member may be required to travel outside of the Service Area. If the Member is required to travel outside the Service Area, PacifiCare will coordinate travel as appropriate at no expense to the Member.

6. Wait List

Listing of the Member at a second PacifiCare National Preferred Transplant Network facility is excluded, unless the Regional Organ Procurement Agencies are different for the two facilities and the Member is accepted for listing by both facilities, when associated with

continuity of care. If the Member is dual listed his or her coverage is limited to the actual transplant facility. PacifiCare will collaborate with the Member to determine what transplant facility he or she should be referred to. Duplicated diagnostic costs at a second PacifiCare National Preferred Transplant Network facility when the Member has already been evaluated at a PacifiCare National Preferred Transplant Network Facility, will be determined on a case by case basis when associated with continuity of care, hardship or Medically Necessary as defined by PacifiCare transplant policy.

7. Case Management and Medical Management

PacifiCare shall establish and maintain review procedures and screening criteria based on scientific evidence. PacifiCare's Case Management program will serve the needs of all Members in terms of:

- Coordination of care
- Patient advocacy
- Liaison for accurate claims payment

Payment of all services will be contingent upon PacifiCare's Case Management review and prior-authorization process.

8. Exclusions and Limitations

- Equipment and medication that is experimental/investigational and/or not Medically Necessary unless required by an external Independent Review Panel (CHDR).
- Unauthorized or not prior-authorized organ procurement and transplant related services are not covered.
- Transplants performed in a non-PacifiCare National Preferred Transplant Network facility are not covered.
- Transplant services, including donor costs, when the transplant recipient is not a Member are not covered.

Please call Member Service at 1-800-228-2144 or (TDHI) 1-800-685-9355, 7:00 a.m. to 9:00 p.m., Monday through Friday, for more information.

- Artificial or non-human organs are not covered.
- Transportation of any potential donor for typing and matching are not covered.
- Storage costs for any organ or bone marrow are not covered unless authorized by the PacifiCare Transplant Medical Director.
- Services for which government funding or other insurance coverage is available are not covered.

Behavioral Health Services

PacifiCare Behavioral Health (PBH) — Provides Behavioral Health Care Services for PacifiCare

Secure Horizons Medicare+Choice Plan and PacifiCare Behavioral Health (PBH) provide you with the Covered Services you need for mental health and chemical dependency issues.

How to Access Your Behavioral Health Benefits

To directly access your behavioral health benefits, please call PacifiCare Behavioral Health (PBH) at 1-800-999-9585 (TDHI) 1-888-877-5378 twenty-four (24) hours a day, seven (7) days a week. When you call, you will speak with a representative who will check your eligibility and gather basic information about you and your situation. Depending on the help you need, a clinician may then talk with you about the problem you're experiencing and assess what Provider and treatment would be appropriate for your situation. If you are Referred to a behavioral health Provider, you will be authorized for a specific number of visits for a specified period of time. You may also ask your Primary Care Physician to contact PacifiCare Behavioral Health (PBH) and arrange a Referral on your behalf. You can also call to receive information about contracted practitioners, subspecialty care and obtaining care after normal office hours.

PacifiCare Behavioral Health (PBH) maintains confidentiality so that you can be assured that what you discuss with its staff is kept strictly confidential.

Is Prior Authorization always necessary to start a treatment program?

Yes, all benefits must be Prior Authorized by PacifiCare Behavioral Health (PBH), except in an emergency, in which case you should call PacifiCare Behavioral Health (PBH) within 48 hours of admission, or as soon as reasonably possible. Utilization Review criteria or guidelines for specific mental health and chemical dependency conditions are used to authorize treatment. Specific care and treatment may vary depending on individual needs and benefit plan. The criteria are available upon request by calling Member Service.

What do I do if I receive a claim?

All services authorized by PacifiCare Behavioral Health (PBH) will be billed directly to PacifiCare Behavioral Health (PBH). However, if you receive a bill for Emergency Services from a Non-Contracting Medical Provider, or for Covered Services from a Contracting Provider, please mail the bill to:

PacifiCare Claims Department
P. O. Box 489
Cypress, CA, 90630

If your plan includes a Copayment, you are responsible to pay these directly to the Provider.

Please call Member Service at 1-800-228-2144 or (TDHI) 1-800-685-9355, 7:00 a.m. to 9:00 p.m., Monday through Friday, for more information.

Section 6

Emergency and Urgently Needed Services

Emergency Services: Prior Authorization for treatment of Medical Emergencies is not required.

What To Do in an Emergency

In the event of a Medical Emergency, go to the closest emergency room or call 911 for assistance. PacifiCare will cover Emergency Services whether you are in or out of the Service Area. Ambulance services dispatched through 911 are only covered if transportation in any other vehicle could endanger your life. You need to have someone telephone your Primary Care Physician or PacifiCare at the number listed on your Secure Horizons Medicare+Choice Plan membership card as soon as reasonably possible. Secure Horizons Medicare+Choice Plan offers worldwide emergency coverage.

Emergency Services are covered inpatient or outpatient services that are:

- 1. furnished by a Provider qualified to furnish Emergency Services; and**
- 2. needed to evaluate or stabilize a Medical Emergency.**

A Medical Emergency is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

1. serious jeopardy to the health of the individual or, in the case of a pregnant woman, the health of the woman or her unborn child;
2. serious impairment to bodily functions; or

3. serious dysfunction of any bodily organ or part.

Emergency Services are covered whether or not a Contracting Medical Provider provides them. It is important to notify your Primary Care Physician or PacifiCare of a Medical Emergency so your Primary Care Physician or PacifiCare can be involved in the management of your health care and transfer can be arranged when your medical condition is stable (as determined by your treating physician). Please contact your Primary Care Physician or PacifiCare at the number located on your Secure Horizons Medicare+Choice Plan membership card within forty-eight (48) hours or as soon as reasonably possible.

If you have a Medical Emergency while out of the Service Area, PacifiCare prefers you return to the Service Area to receive follow-up care through your Primary Care Physician. However, after you have been treated for your condition, follow-up care will be covered out of the Service Area as long as the care required continues to meet the definition for either Emergency Services or Urgently Needed Services.

If you have a Medical Emergency within the Service Area, you should contact your Primary Care Physician after the emergency so he or she can arrange for your follow-up care.

Post-Stabilization Care

Medically Necessary, non-emergency services following receipt of emergency care to enable you to remain stabilized are covered: when PacifiCare or its Contracting Medical Providers provide Prior Authorization for such services; when PacifiCare or its Contracting Medical Providers do not respond within one (1) hour to a request for a Prior Authorization from a Non-Contracting Provider or Facility; or when PacifiCare or its Contracting Medical Providers could not be contacted for Prior Authorization.

Coverage for post-stabilization care provided by a Non-Contracting Provider continues to be effective until one of the following:

Please call Member Service at 1-800-228-2144 or (TDHI) 1-800-685-9355, 7:00 a.m. to 9:00 p.m., Monday through Friday, for more information.

- You are discharged
- A Contracting Medical Provider arrives and assumes responsibility for your care
- The Non-Contracting Provider and PacifiCare agree to other arrangements
- A Contracting Medical Provider assumes responsibility for your care through the transfer to a contracting facility

Urgently Needed Services

Secure Horizons Medicare+Choice Plan also covers Urgently Needed Services. **Urgently Needed Services are Covered Services provided when you are temporarily* absent from the area served by your Primary Care Physician or Contracting Medical Group/IPA (or, under unusual and extraordinary circumstances, you are in the Service Area but your Contracting Medical Group/IPA is temporarily unavailable or inaccessible) when such services are Medically Necessary and immediately required:**

- **as a result of an unforeseen illness, injury, or condition; and**
- **it is not reasonable given the circumstances to obtain the services through your Primary Care Physician.**

*A temporary absence is an absence from the Service Area lasting not more than six months and it is not a permanent move.

If such a medical need arises, PacifiCare requests that you, if possible, first telephone your Primary Care Physician or PacifiCare, then seek care from a local doctor. If this is not possible, you may seek care from a Hospital emergency room or other medical facility.

If you must visit a Provider or a Hospital emergency room for Urgently Needed Services when outside the Service Area, you should contact your Primary Care Physician or Contracting Medical Group/IPA or PacifiCare within forty-eight (48) hours or as soon as

reasonably possible, so that PacifiCare can be involved in the management of your care. While PacifiCare prefers you return to the Service Area and receive follow-up care through your Primary Care Physician, follow-up care will be covered out of the Service Area when the care required continues to meet the definition of Urgently Needed Services.

If you receive services without Prior Authorization, except for Emergency Services, Urgently Needed Services, out-of-area and routine travel renal dialysis, or services for which PacifiCare allows you to self-refer to plan Providers, neither PacifiCare nor Medicare will pay for those services.

When You Need Urgent Care and You Are in Your Service Area.

Many Contracting Medical Providers have on-site urgent care centers. Many of these centers have extended hours and do not require appointments. PacifiCare encourages you to take advantage of this convenience in an urgent medical situation.

If you need urgent medical care within your Service Area:

1. Call your Contracting Medical Group/IPA at the number listed on your Secure Horizons Medicare+Choice Plan membership card.
2. Identify yourself as a Secure Horizons Medicare+Choice Plan Member and let them know you feel you need immediate medical attention.
3. Follow any first aid instructions provided (you may be advised to go to your medical provider or to a nearby Hospital).

All Contracting Medical Groups/IPAs have a twenty-four (24) hour emergency number. If, for any reason, you are unable to reach your Contracting Medical Provider, follow the steps for out-of-area Urgently Needed Services as previously described. Follow-up medical care must be received or authorized by your Primary Care Physician or Contracting Medical Group/IPA.

Please call Member Service at 1-800-228-2144 or (TDHI) 1-800-685-9355, 7:00 a.m. to 9:00 p.m., Monday through Friday, for more information.

Reimbursement for Services Paid by You

Providers should submit bills to PacifiCare for payment. However, if you paid for any Emergency Services or Urgently Needed Services or emergency out-of-area and routine travel dialysis obtained from Non-Contracting Medical Providers, you should submit your bills to PacifiCare for a payment determination. Bills should be submitted to the following address:

PacifiCare Claims Department
P.O. Box 489
Cypress, CA 90630

If you have questions about any bills, contact Member Service.

Right to Appeal

PacifiCare provides you with a written notice if a service or payment is denied. If PacifiCare has denied payment for services you think should have been covered, or if PacifiCare refused to arrange for services that you believe are covered by Medicare, you have the right to appeal. If you think waiting for a decision about authorization for a service could seriously harm your health, you may request an Expedited Appeal. (Please see Section 9.)

Section 7

Premiums and Payments

As a Member of Secure Horizons Medicare+Choice Plan, you will be financially responsible for the Health Plan Premiums, Copayments and Coinsurance amounts that are listed in the Schedule of Benefits.

- **Secure Horizons Medicare+Choice Plan Premium** Is listed in the Schedule of Benefits and is due on the first of each month.
- **Medicare Part A Premium** Most Medicare beneficiaries are automatically entitled to Medicare Hospital Insurance (Part A). If you are not entitled to Medicare Part A, and you have

purchased Part A through Social Security, you must continue to pay your Medicare Part A Premium. If you would like to purchase Part A from Social Security, please call your local Social Security Office or call 1-800-772-1213 toll free. For the hearing impaired the toll-free number to reach Social Security is 1-800-325-0778.

- **Medicare Part B Premium** A monthly premium paid to Medicare to cover Supplemental Medical Insurance (Part B). As a Secure Horizons Medicare+Choice Plan Member, you must continue to pay your Medicare Part B Premium. If you receive a Social Security annuity check, this premium is usually automatically deducted from your check. Otherwise your Premium is paid directly to Medicare by you or someone on your behalf (such as Medicaid or Medi-Cal).
- **Secure Horizons Medicare+Choice Plan Part A “Equivalent” Benefit Health Plan Premium** If you have purchased a Part A Benefit from PacifiCare in the past, you must continue to pay this amount to continue your coverage with Secure Horizons Medicare+Choice Plan, provided your membership with PacifiCare started prior to January 1, 1999.

Note: If you are enrolled in Part B only and not entitled to Part A and you disenroll from Secure Horizons Medicare+Choice Plan, you will not be eligible to re-enroll in Secure Horizons Medicare+Choice Plan or any other Medicare+Choice Plan until you are eligible for Part A coverage and meet other eligibility criteria.

What Happens If You Don't Pay Your Health Plan Premiums?

PacifiCare has the right to Disenroll you from Secure Horizons Medicare+Choice Plan for failure to pay Health Plan Premiums (except for plan premiums which cover Optional Supplemental Benefits, see Section 12). However, prior to such action, PacifiCare will:

- (a) contact you within twenty (20) days after the date of the delinquent charges are due,

Please call Member Service at 1-800-228-2144 or (TDHI) 1-800-685-9355, 7:00 a.m. to 9:00 p.m., Monday through Friday, for more information.

- (b) advise you that failure to pay Health Plan Premiums within a ninety (90) day grace period will result in your disenrollment; and
- (c) include an explanation of your rights under the Grievance procedures.

Should you decide later to re-enroll in Secure Horizons Medicare+Choice Plan or to enroll in another plan offered by PacifiCare, you must pay any outstanding Health Plan Premiums due from your previous enrollment in Secure Horizons Medicare+Choice Plan.

If you have chosen to add extra benefits (Optional Supplemental Benefits) to your basic coverage and you do not pay your past due plan premiums within a ninety (90) day grace period, you will be returned to the Basic Benefit plan without any optional benefits.

Until you are notified of your Disenrollment, you will continue to be a Secure Horizons Medicare+Choice Plan Member and must continue to use Contracting Medical Providers.

For details on Disenrollment for non-payment of Health Plan Premiums, see Section 8.

Your Premium Payment Options

As a Secure Horizons Medicare+Choice Plan Member, you have two (2) options for paying your monthly Health Plan Premium, or any other premiums that may be associated with Optional Supplemental Benefits. Your options are the Easy Pay method and the Monthly Payment Booklet method.

With the convenient EasyPay method, you can have your plan premium(s) automatically deducted from your personal bank account and electronically transmitted for payment. You will have no more checks to write, and can enjoy peace of mind knowing that your plan premium payments are taken care of, even if you are traveling. If you do not elect the EasyPay method of payment, you will be automatically enrolled in the Monthly Payment Booklet method.

Using the Monthly Payment Booklet method is simple. As plan premiums become due, remove the appropriate payment slip from your payment booklet, complete a check or money order for the amount shown on the payment slip, and mail them to PacifiCare in the pre-addressed, envelope provided or at the address indicated on the payment slip.

If you have any questions regarding your plan premium payment choices, please call Member Service.

Changes in Health Plan Premiums

Increases in Health Plan Premiums and/or decreases in your level of coverage are only allowed at the beginning of each contract year (which is based on the Calendar Year). These changes must be approved by CMS. There will be no benefit changes during the contract year unless they are to your advantage. You will receive a written notice in the Fall of any changes for the new contract year.

If Secure Horizons Medicare+Choice Plan reduces your benefits, increases your Copayments, Coinsurance, or Health Plan Premium, you may be eligible for enrollment in a Secure Horizons Medicare Supplement policy on a guaranteed issue basis. For more information or to enroll, please contact PacifiCare at 1-800-637-9284 or (TDHI) 1-800-647-6038, 7:00 a.m. to 7:00 p.m., Monday through Friday.

(Please note: Rate changes and employer-sponsored benefit changes for Group Retiree Members enrolled through an employer group or trust administrator are subject to contractual arrangements between PacifiCare and your former employer or trust. Your former employer or trust administrator is responsible for notifying you of any Secure Horizons Medicare+Choice Plan premium changes, contribution changes, or employer-sponsored benefit changes thirty (30) days before they become effective.)

Please call Member Service at 1-800-228-2144 or (TDHI) 1-800-685-9355, 7:00 a.m. to 9:00 p.m., Monday through Friday, for more information.

Section 8

Disenrollment From Secure Horizons Medicare+Choice Plan

Voluntary Disenrollment

You may choose to end your membership in Secure Horizons Medicare+Choice Plan for any reason. If you wish to Disenroll, you may:

- **Complete a Disenrollment form or write a letter and send it to PacifiCare. Please make sure you sign and date your letter. If you have any questions about the letter or want to request a Disenrollment form, please contact Member Service.**
- **Call the national Medicare help line at 1-800-MEDICARE (1-800-633-4227) TTY/TDD access line 1-877-486-2048 to Disenroll via the phone; or**
- **You can contact your nearest Social Security office or, if you have Railroad Retirement benefits, you can contact the Railroad Retirement Board office.**

The Effective Date of Your Disenrollment

In most cases, a written Disenrollment request received by the end of the month will make your Disenrollment effective the 1st of the following month. For example, if your Disenrollment request is received on March 31, your Disenrollment from Secure Horizons Medicare+Choice Plan would be processed for an effective date of April 1. There is an exception to this general rule. The Disenrollment date for requests made in November can be effective January 1.

Until your membership ends, you will continue to be a Member of Secure Horizons Medicare+Choice Plan and must continue to receive all routine Covered Services from Contracting Medical Providers until the date your Disenrollment is effective. PacifiCare will send you a letter that informs you when your

Disenrollment is effective. Once your Disenrollment is effective, you can begin using your red, white, and blue Medicare card to obtain services under Medicare unless you have joined another Medicare+Choice Coordinated Care Plan. (Note: You can call Social Security at 1-800-772-1213 if you need a new Medicare card.)

Moves or an Extended Absence From the Service Area

If you are permanently moving out of the Service Area or plan an extended absence of more than six (6) months, it is important to notify PacifiCare of the move or extended absence before you leave the Service Area. If you move permanently out of PacifiCare's Service Area, or if you are away from PacifiCare's Service Area for more than six consecutive months, you will need to Disenroll from Secure Horizons Medicare+Choice Plan.

Failure to notify PacifiCare of a permanent move or an extended absence may result in your involuntary Disenrollment from Secure Horizons Medicare+Choice Plan, since PacifiCare is required to Disenroll you if you have moved out of the Service Area for more than six (6) months. If you remain enrolled after a move or extended absence (and have not been involuntarily Disenrolled as just described), you should be aware that services will not be covered unless they are received from Contracting Medical Providers (except for Emergency Services, Urgently Needed Services and Prior Authorized Referrals).

Secure Horizons Medicare+Choice Plans are currently offered in the following states: Arizona, California, Colorado, Nevada, Oklahoma, Oregon, Texas and Washington. If you are moving outside of your Service Area, you may be eligible to enroll in a Secure Horizons Medicare+Choice Plan in your new location. Health Plan Premiums, Copayments and Covered Services will vary from one area to another. Please contact Member Service for information and assistance in completing any necessary paperwork.

For information on other plans available in your area, you can call 1-800-MEDICARE (1-800-633-4227)

Please call Member Service at 1-800-228-2144 or (TDHI) 1-800-685-9355, 7:00 a.m. to 9:00 p.m., Monday through Friday, for more information.

or the hearing impaired TTY/TDD access line 1-877-486-2048, or visit the CMS web site at www.medicare.gov.

What Happens if Secure Horizons Medicare+Choice Plan Leaves the Medicare Program or Leaves the Service Area Where You Live?

If PacifiCare leaves the Medicare program or discontinues the Secure Horizons Medicare+Choice Plan in your Service Area, PacifiCare will notify you in writing. **If either of these situations occur, you will be allowed to change the way you receive Medicare coverage.** Your choices will always include Original Medicare, and they may also include joining another Medicare managed care plan or a Private Fee-For-Service plan if such plans are available in your area and are accepting new members.

PacifiCare of California has a contract with CMS. This contract renews each year. At the end of each year, the contract is reviewed, and either PacifiCare or CMS can decide to end it. It is also possible for PacifiCare's contract to end at some other time. If the contract is going to end, PacifiCare will generally notify you at least ninety (90) days in advance. Your advance notice may be as little as thirty (30) days or even fewer days if CMS ends PacifiCare's contract in the middle of the year.

Until PacifiCare notifies you in writing that you must leave Secure Horizons Medicare+Choice Plan and indicates the date when your membership ends, you will continue to be a Member of Secure Horizons Medicare+Choice Plan and you must continue to receive all Covered Services from Contracting Medical Providers until the date your Disenrollment is effective. All Covered Services and rules described in this document will continue until your membership ends.

Once PacifiCare has notified you in writing that PacifiCare is leaving the Medicare program or the area where you live, you may switch to another way of getting your Medicare benefits at any time. If you decide to switch from Secure Horizons Medicare+Choice Plan to Original Medicare, you

will have the right to buy a Medigap policy regardless of your health. This is called "guaranteed issue rights". You may contact California Health Insurance Counseling and Advocacy Program at 1-800-434-0222 about how and when to buy a Medigap policy if you need one.

Coverage That Ends During an Inpatient Hospital Stay

If your coverage under Secure Horizons Medicare+Choice Plan ends while you are an inpatient in a Hospital (or Hospital unit), PacifiCare may be responsible for the inpatient services until the date of your discharge. PacifiCare's Member Service Representatives can advise you if PacifiCare is responsible for your inpatient services. In this case, PacifiCare is not responsible for services, other than inpatient Hospital services, furnished on or after the effective date of your disenrollment.

Involuntary Disenrollment

PacifiCare must Disenroll you from Secure Horizons Medicare+Choice Plan under the conditions listed below. You will not be Disenrolled due to your health status.

- If you move out of the Service Area or live outside the Service Area for more than six (6) months at a time and do not voluntarily Disenroll.
- If you do **not** stay continuously enrolled in both Medicare Part A and Medicare Part B.

You may be Disenrolled from Secure Horizons Medicare+Choice Plan under the following conditions:

- If you provide information on your Election Form that is false or deliberately misleading, and it affects whether or not you can enroll in Secure Horizons Medicare+Choice Plan.
- If you behave in a way that is unruly, uncooperative, disruptive, or abusive, and this behavior seriously affects our ability to arrange Covered Services for you or for others who are Members of Secure Horizons Medicare+Choice

Please call Member Service at 1-800-228-2144 or (TDHI) 1-800-685-9355, 7:00 a.m. to 9:00 p.m., Monday through Friday, for more information.

Plan. Before PacifiCare can disenroll you for this reason, **PacifiCare must obtain permission** from CMS, the government agency that runs Medicare.

- If you allow someone else use your Secure Horizons Medicare+Choice Plan membership card to obtain Covered Services. Before PacifiCare will disenroll you for this reason, PacifiCare must refer your case to the Inspector General, which may result in criminal prosecution.
- If you do not pay the Health Plan Premiums. PacifiCare will inform you of a ninety (90) day grace period during which you can pay the Health Plan Premiums before you are required to disenroll from Secure Horizons Medicare+Choice Plan. Should you decide later to re-enroll in a Secure Horizons Medicare+Choice Plan, you must pay any outstanding Health Plan Premiums due from your previous enrollment.

You have the right to file a complaint if PacifiCare asks you to leave

If PacifiCare does ask you to leave Secure Horizons Medicare+Choice Plan, PacifiCare will inform you of the reasons in writing and explain how you can file a Grievance if you choose to.

Until PacifiCare notifies you in writing that you have been Disenrolled, you will continue to be a Secure Horizons Medicare+Choice Plan Member and must continue to obtain routine Covered Services from Contracting Medical Providers. Neither Secure Horizons nor Medicare will pay for services received except for: Urgently Needed Services; Emergency Services anywhere in the world; out-of-area renal dialysis services; services for which Secure Horizons Medicare+Choice Plan allows you to self-refer to Contracting Medical Providers; and Referrals that have received Prior Authorization.

PacifiCare cannot ask you to leave due to your health

You can only be asked to leave Secure Horizons Medicare+Choice Plan under certain special conditions that are described above. These conditions do not include asking you to leave due to your health. No member of any Medicare health plan can be asked to leave the plan for any health-related reasons.

If you ever feel you are being encouraged or asked to leave Secure Horizons Medicare+Choice Plan due to your health, you should call the national Medicare help line at 1-800-MEDICARE or 1-800-633-4227 or TTY/TDD access line 1-877-486-2048.

Review of Termination and Reinstatement

No Member shall be Disenrolled due to the Member's health status or requirements for health care services other than as stated within this Section. Any Member who believes he or she was Disenrolled by Secure Horizons Medicare+Choice Plan due to the Member's health status or requirements for health care services may request a review by the California Director of Managed Health Care pursuant to California Health and Safety Code, Section 1365, or call the national Medicare help line at 1-800-MEDICARE or 1-800-633-4227 or TTY/TDD access line 1-877-486-2048. In the event the Director determines the Disenrollment was contrary to Section 1365, the Member shall be reinstated retroactively to the date of the Disenrollment.

Section 9

Organization Determination, Appeal and Grievance Procedures

As a Secure Horizons Medicare+Choice Plan Member you are encouraged to let PacifiCare know if you have concerns or experience any problems with PacifiCare or Secure Horizons Medicare+Choice Plan. PacifiCare has representatives available to help you with your questions and concerns.

Please call Member Service at 1-800-228-2144 or (TDHI) 1-800-685-9355, 7:00 a.m. to 9:00 p.m., Monday through Friday, for more information.

The procedures described in this section may be used if you have an Appeal or Grievance you want PacifiCare to review.

Appeals are defined as the type of complaint you make when you want a reconsideration of a decision (determination) that was made regarding a service or what PacifiCare will pay for a service. For example, if PacifiCare refuses to cover or pay for services you think PacifiCare should cover, you can file an Appeal. If PacifiCare or one of the Contracting Medical Providers refuses to give you a service you think should be covered, you can file an Appeal. If PacifiCare or one of the Contracting Medical Providers reduces or cuts back on services you have been receiving, you can file an Appeal. If you think that PacifiCare is stopping your coverage too soon, you can file an Appeal.

Grievances are defined as the type of complaint you make if you have any other type of problem (other than an Appeal) with PacifiCare or a Contracting Medical Provider. For example, you would file a Grievance if you have a problem with things such as: the quality of your care; general dissatisfaction with the way the Secure Horizons Medicare+Choice Plan benefits are designed; waiting times for appointments or in the waiting room; the way your doctors or others behave; being able to reach someone by phone or obtain the information you need; or the cleanliness or condition of the doctor's office.

Organization Determinations

PacifiCare must make a determination (decision) on your request for the provision of services or payment of claims within the following timeframes:

- **Request for Services or Referrals.** If you request services or require Prior Authorization of a Referral, PacifiCare must make a decision as expeditiously as your health care requires, but no later than fourteen (14) calendar days after receiving your request for service. An extension up to fourteen (14) calendar days is

permitted, if you request the extension or if PacifiCare finds that additional information is needed that will benefit you (for example, if PacifiCare needs additional medical records from Non-Contracted Medical Providers that could change a denial decision). When PacifiCare takes an extension, you will be notified of the extension in writing.

- **Requests for Payment.** If you request payment for services already received, PacifiCare must make a decision on whether or not to pay the claim no later than sixty (60) calendar days from receiving your request.

PacifiCare must notify you in writing of any organization determination denial decision, (partial or complete) within the timeframes listed above. The notice must state the reasons for the denial, inform you of your right to a standard and expedited reconsideration (Appeal) process and the right to appoint a representative to file an Appeal on your behalf. You also have the right to submit additional information regarding the requested service in writing or in person. If you have not received such a notice within fourteen (14) calendar days of your request for services, or within sixty (60) calendar days of a request for payment, you may assume the decision is a denial, and you may file an Appeal.

Expedited/72-Hour Organization Determination Procedures

You have the right to request and receive expedited decisions affecting your medical treatment in "Time-Sensitive" situations. A Time-Sensitive situation is a situation where waiting for a decision to be made within the time frame of the standard decision-making process could seriously jeopardize your life or health, or your ability to regain maximum function. If PacifiCare, your Primary Care Physician or Contracting Medical Group/IPA decides, based on medical criteria, that your situation is Time-Sensitive, or if any physician calls or writes in support of your request for an expedited review,

Please call Member Service at 1-800-228-2144 or (TDHI) 1-800-685-9355, 7:00 a.m. to 9:00 p.m., Monday through Friday, for more information.

PacifiCare, your Primary Care Physician or Contracting Medical Group/IPA will issue a decision as expeditiously as possible, but no later than seventy-two (72) hours after receiving the request. PacifiCare, your Primary Care Physician or Contracting Medical Group/IPA may extend this time frame by up to fourteen (14) calendar days if you request the extension or if PacifiCare, your Primary Care Physician or Contracting Medical Group/IPA needs additional information, and the extension of time benefits you (for example, if PacifiCare, your Primary Care Physician or Contracting Medical Group/IPA needs additional medical records from Non-Contracted Medical Providers that could change a denial decision). If the time frame is extended, you will be notified of the reasons for the delay and informed of your right to file a Grievance should you disagree with an extension. You will be notified promptly of the organization determination, but no later than upon expiration of the extension.

If you believe you need a service and you believe it is a Time-Sensitive situation, you or any physician, including a physician with no connection to PacifiCare, may request that the decision be expedited. If PacifiCare, your Primary Care Physician or Contracting Medical Group/IPA decides that it is a Time-Sensitive situation or if any physician indicates that applying the standard timeframe for making a determination could seriously jeopardize your life or health or your ability to regain maximum function, PacifiCare, your Primary Care Physician or Contracting Medical Group/IPA will make a decision on your request for a service on an expedited seventy-two (72) hour basis (subject to extension as discussed below).

To request an expedited seventy-two (72) hour organization determination call PacifiCare, your Primary Care Physician or Contracting Medical Group/IPA at the phone number on your membership card. **Be sure to ask for an expedited seventy-two (72) hour review when you make your request.**

How Your Expedited/72-Hour Review Request Will Be Processed

1. Upon receiving your request, PacifiCare, your Primary Care Physician or Contracting Medical Group/IPA will determine if your request meets the definition of Time Sensitive.
 - If your request does not meet the definition of Time Sensitive, it will be handled within the standard review timeframes (fourteen (14) calendar days for organization determinations). You will be informed by telephone that your request for the expedited seventy-two (72) hour review has been denied and will also receive a written confirmation that the request will be processed within the standard review timeframe, within three (3) calendar days of the telephone call. If you disagree with PacifiCare's, your Primary Care Physician's or Contracting Medical Group's/IPA's decision to process your request within the standard timeframe, you may file a Grievance with PacifiCare. The written confirmation letter will include instructions on how to file a Grievance. If your request is Time-Sensitive, you will be notified of PacifiCare's, your Primary Care Physician's or Contracting Medical Group's/IPA's decision within seventy-two (72) hours. You will also receive a follow-up letter within three (3) calendar days of the phone call.
2. Your request must be processed within seventy-two (72) hours if any physician calls or writes in support of your request for an expedited seventy-two (72) hour review, and the physician indicates that applying the standard review timeframe could seriously jeopardize your life or health or your ability to regain maximum function.

If a Non-Contracted Medical Provider supports your request, PacifiCare, your Primary Care Physician or Contracting Medical Group/IPA will have seventy-two (72) hours from the time all the necessary medical information is received from that Provider to make a decision.

Please call Member Service at 1-800-228-2144 or (TDHI) 1-800-685-9355, 7:00 a.m. to 9:00 p.m., Monday through Friday, for more information.

3. PacifiCare, your Primary Care Physician or Contracting Medical Group/IPA will make a decision and notify you of it within seventy-two (72) hours of receipt of your request. If PacifiCare, your Primary Care Physician or Contracting Medical Group/IPA does not approve your request, you can Appeal to PacifiCare (see below):

There are four possible dispositions to a request for an expedited organization determination.

They are:

- Your request to expedite an organization determination decision is accepted, PacifiCare, your Primary Care Physician or Contracting Medical Group/IPA makes a decision in seventy-two (72) hours and notifies you that they will arrange or continue the service.
- Your request to expedite an organization determination decision is accepted, PacifiCare, your Primary Care Physician or Contracting Medical Group/IPA makes a decision in seventy-two (72) hours and notifies you that they will **not** arrange or continue the service, and you can Appeal to PacifiCare.
- Your request to expedite the organization determination is **not** accepted, and PacifiCare, your Primary Care Physician or Contracting Medical Group/IPA informs you that your request will be handled under the standard organization determination process.
- Your request to expedite an organization determination cannot be made in seventy-two (72) hours, and PacifiCare, your Primary Care Physician or Contracting Medical Group/IPA informs you that they will need up to an additional fourteen (14) calendar days to process your request.

If you have questions regarding these rights, please call Member Service.

General Information on Medicare Appeals Process

As a Secure Horizons Medicare+Choice Plan Member, you have the right to appeal any organization determination about PacifiCare's payment for, or failure to arrange or continue to arrange for, what you believe are Covered Services (including Optional Supplemental Benefits) under your Medicare+Choice Plan. These include the following:

- Payment for out-of-area renal dialysis and routine travel dialysis services, Emergency Services, Post-Stabilization Care, or Urgently Needed Services
- Payment for any other health services furnished by a Non-Contracted Medical Provider or Facility you believe are covered under Original Medicare or should have been arranged for, or reimbursed by PacifiCare
- Services you have not received, but you believe are the responsibility of PacifiCare to pay for or arrange
- Discontinuation of services you believe are Medically Necessary Covered Services
- Failure of PacifiCare to approve, furnish, arrange for or provide payment for health care service in a timely manner or to provide you with a timely notice of an adverse determination such that a delay would adversely affect your health

Use the Grievance Procedure for any complaints or other disputes that are not denied claims or denied services subject to organization determinations as explained above. If you have a question about which complaint process to use, please call Member Service. PacifiCare has a standard Appeal procedure and an expedited Appeal procedure.

Who May File an Appeal

1. You may file an Appeal.
2. Someone else may file the Appeal for you on your behalf. You may appoint an individual to

Please call Member Service at 1-800-228-2144 or (TDHI) 1-800-685-9355, 7:00 a.m. to 9:00 p.m., Monday through Friday, for more information.

act as your representative to file the Appeal for you by following the steps below:

- (a) Provide PacifiCare with your name, your Medicare number and a statement, which appoints an individual as your representative. (Note: you may appoint a physician or a Provider.) For example: “ I [your name] appoint [name of representative] to act as my representative in requesting an Appeal from PacifiCare and/or CMS regarding the denial or discontinuation of medical services.
 - (b) You must sign and date the statement.
 - (c) Your representative must also sign and date this statement unless he or she is an attorney.
 - (d) You must include this signed statement with your Appeal.
3. A Non-Contracted Medical Provider may file a standard Appeal of a denied claim if he or she completes a waiver of payment statement, which says he or she will not bill you regardless of the outcome of the Appeal.

Support for Your Appeal

You are not required to submit additional information to support your request for reconsideration (Appeal). PacifiCare is responsible for gathering all necessary medical information. However, it may be helpful to include additional information to clarify or support your request. For example, you may want to include in your Appeal request information such as medical records or physician opinions in support of your request. To obtain medical records, you may send a written request to your Primary Care Physician. If your medical records from a Specialist are not included in your medical records from your Primary Care Physician, you may need to submit a separate request to the Specialist who provided medical services to you.

Assistance With Appeals

Regardless whether you request a standard or expedited Appeal, you can have a friend, lawyer or someone else help you. There are lawyers who do not charge unless you win your Appeal. Groups such as lawyer referral services can help you find a lawyer. There are also groups, such as legal aid services, who will provide free legal services if you qualify.

Standard Appeal Procedures

If you decide to proceed with the Medicare Standard Appeals Procedure, the following steps will occur:

1. You must submit a written request for a reconsideration to the PacifiCare Appeals and Grievance Unit at 5757 Plaza Drive, Cypress, CA 90630. You may also request a reconsideration through the Social Security office (or, if you are a railroad retirement beneficiary, through a Railroad Retirement Benefits Office). You must submit your written request within sixty (60) calendar days of the date of the notice of the initial organization determination.

Note: The sixty (60) day limit may be extended for good cause. Include in your written request the reason why you could not file within the sixty (60) day timeframe.

2. PacifiCare will conduct a reconsideration and notify you in writing of the decision within thirty (30) days, if the Appeal is for a request for a denied service. Note that PacifiCare must notify you of the reconsideration decision as expeditiously as possible, but no later than thirty (30) calendar days from receipt of your request. PacifiCare may extend this timeframe by up to fourteen (14) calendar days if you request the extension or if PacifiCare finds that additional information is needed and the extension of time benefits you (for example, if PacifiCare needs additional medical records from Non-Contracted Medical Providers that could change a denial decision).

Please call Member Service at 1-800-228-2144 or (TDHI) 1-800-685-9355, 7:00 a.m. to 9:00 p.m., Monday through Friday, for more information.

If the Appeal is for a denied claim, PacifiCare must notify you of the reconsideration determination no later than sixty (60) days after receiving your request for a reconsideration determination.

PacifiCare's reconsideration decision will be made by a person(s) not involved in the initial decision. A physician must make all reconsiderations of adverse organization determinations based on Medical Necessity with expertise in the field of medicine that is appropriate for the service at issue. However, that physician need not be of the same specialty or subspecialty as the treating physician.

3. If PacifiCare decides to reverse the original adverse decision, PacifiCare must authorize or provide your service as expeditiously as your health requires, but no later than thirty (30) calendar days from the date PacifiCare received your request for an Appeal; or PacifiCare will pay your claim within sixty (60) calendar days of your request for an Appeal.
4. If PacifiCare decides to uphold the original adverse decision, either in whole or in part, or if PacifiCare fails to provide you with a decision on your reconsideration within the relevant time frame, PacifiCare will automatically forward the case to the Center for Health Dispute Resolution (CHDR) for a new and impartial review and you will be notified. CHDR is CMS's independent contractor for appeal reviews involving Medicare+Choice managed care plans, like Secure Horizons Medicare+Choice Plan. PacifiCare must send CHDR the file within thirty (30) days of a request for services and within sixty (60) days of a request for payment. CHDR will either uphold PacifiCare's decision or issue a new decision. If PacifiCare forwards the case to CHDR, PacifiCare still must notify you of the decision within the relevant timeframe discussed above.

5. For cases submitted to CHDR for review, CHDR will make a reconsideration decision and notify you in writing of their decision and the reasons for the decision. **If CHDR decides in your favor and reverses PacifiCare's decision, the following must occur:**

Request for Service: If CHDR decides in your favor, PacifiCare must authorize the service under dispute within seventy-two (72) hours from the date of receipt of CHDR's notice reversing PacifiCare's decision, or provide the service under dispute as expeditiously as your health condition requires, but no later than fourteen (14) calendar days from date of receipt of CHDR's notice.

Request for Payment: If CHDR decides in your favor, PacifiCare must pay for the service no later than thirty (30) calendar days from the date of CHDR's notice. If CHDR maintains PacifiCare's decision, their notice will inform you of your right to a hearing before an administrative law judge of the Social Security Administration.

6. You may request a hearing before an administrative law judge (ALJ) by submitting a written request to PacifiCare, CMS or the Social Security Administration within sixty (60) days of the date of CHDR's notice that the reconsideration decision was not in your favor. This sixty (60) day notice may be extended for good cause. A hearing can be held only if the amount in controversy is one hundred dollars (\$100) or more as determined by the administrative law judge. All hearing requests will be forwarded to CHDR. CHDR will then forward your request and your reconsideration file to the hearing office. PacifiCare will also be made a party to the Appeal at the ALJ level.
7. If the administrative law judge's decision is adverse, either you or PacifiCare may request a review by the Departmental Appeals Board (DAB) of the Social Security Administration,

Please call Member Service at 1-800-228-2144 or (TDHI) 1-800-685-9355, 7:00 a.m. to 9:00 p.m., Monday through Friday, for more information.

which may either review the decision or decline review.

8. If the amount involved is one thousand dollars (\$1,000) or more, either you or PacifiCare may request that a decision made by the DAB or the administrative law judge, if the DAB has declined review, be reviewed by a federal district court.
9. Any initial or reconsidered decision made by PacifiCare, CHDR, the administrative law judge or the Departmental Appeals Board can be reopened: (a) within twelve (12) months; (b) within four (4) years for just cause; or (c) at any time for clerical correction or in cases of fraud.
10. The reconsidered determination is final and binding upon PacifiCare. The binding arbitration clause in your Individual Election Form does not apply to disputes subject to CMS's appeals process.

Expedited/72-Hour Appeal Procedures

You have the right to request and receive an expedited seventy-two (72) hour reconsideration (Appeal), in situations where waiting for a reconsideration (Appeal) could seriously jeopardize your life or health, or your ability to regain maximum function. If PacifiCare decides, based on medical criteria, that your situation is Time-Sensitive or if any physician calls or writes in support of your request for an expedited reconsideration (Appeal) review, PacifiCare will issue a decision as expeditiously as possible, but no later than seventy-two (72) hours after receiving the request. PacifiCare may extend this time frame by up to fourteen (14) days if you request the extension or if PacifiCare needs additional information, and the extension of time benefits you (for example, if PacifiCare needs additional medical records from Non-Contracted Medical Providers that could change a denial decision). If the reconsideration (Appeal) time frame is extended, you will be notified of the reasons for the delay and informed of your right

to file a Grievance should you disagree with an extension. You will be notified promptly of PacifiCare's determination, but no later than upon expiration of the extension.

If you wish to request a reconsideration (Appeal) of a decision by PacifiCare to deny a service you requested or to discontinue a service you are receiving that you believe is a Medically Necessary Covered Service and you believe it is a Time-Sensitive situation, you or your authorized representative may request that the reconsideration (Appeal) be expedited. If a physician wishes to file an expedited Appeal for you, you must give him or her authorization to act on your behalf. If PacifiCare or any physician decides that it is a Time-Sensitive situation, PacifiCare will make a decision on your Appeal on an expedited seventy-two (72) hour basis. Examples of service decisions which you may appeal on an expedited basis, when you believe it is a Time-Sensitive situation, include the following:

- If you received a denial of a service you requested
- If you think you are being discharged from a Skilled Nursing Facility too soon
- If you think your Home Health care is being discontinued too soon
- If you think you are being discharged from a Hospital too soon and you have missed the deadline for a Quality Improvement Organization (QIO) review

The procedures for requesting and receiving an expedited Appeal are described in the following sections.

How to Request an Expedited Reconsideration

To request an expedited seventy-two (72) hour review, you or your authorized representative may call, write, fax or visit PacifiCare. **Be sure to ask for an expedited seventy-two (72) hour review when you make your request.**

Please call Member Service at 1-800-228-2144 or (TDHI) 1-800-685-9355, 7:00 a.m. to 9:00 p.m., Monday through Friday, for more information.

Call: 1-888-260-3786
Business Hours: 9:00 a.m. - 4:00 p.m.
Monday through Friday, PacifiCare will document your request in writing.

TDHI: 1-800-685-9355
Business Hours: 9:00 a.m. - 4:00 p.m.
Monday through Friday, PacifiCare will document your request in writing.

Write: PacifiCare Appeals and Grievance Unit
5757 Plaza Drive
Cypress, CA 90630

Fax: Attention: Appeals and Grievance Unit

Walk-in: PacifiCare Member Service Center
5757 Plaza Drive
Cypress, CA 90630
Business Hours: 9:00 a.m. - 5:00 p.m.
Monday through Friday

How Your Expedited/72-Hour Review Request Will Be Processed

1. Upon receiving your reconsideration request, PacifiCare will determine if your request meets the definition of Time-Sensitive.

- If your request does not meet the definition, it will be handled within the standard review timeframes (thirty (30) days for Appeals). You will be informed by telephone that your request for the expedited seventy-two (72) hour Appeal review has been denied and will also receive a written confirmation that the request will be processed within the standard review timeframe, within three (3) calendar days of the telephone call. If you disagree with PacifiCare's decision to process your request within the standard timeframe, you may file a Grievance with PacifiCare. The written confirmation letter will include instructions on how to file a Grievance. If your request is Time-Sensitive, you will be notified of PacifiCare's Appeal decision within seventy-two (72) hours. You will also receive a follow-up decision letter within three (3) calendar days of the telephone call.

- An extension up to fourteen (14) calendar days is permitted for a seventy-two (72) hour Appeal if the extension of time benefits you, for example, if you need time to provide PacifiCare with additional information or if PacifiCare needs to have additional diagnostic testing completed. PacifiCare will make a decision as expeditiously as your health requires, but no later than the end of any extension period. If the timeframe is extended, you will be notified of the reasons for the delay and informed of your right to file a Grievance should you disagree with an extension.

2. Your request must be processed within seventy-two (72) hours if any physician calls or writes in support of your request for an expedited seventy-two (72) hour review, and the physician indicates that applying the standard review timeframe could seriously jeopardize your life or health or your ability to regain maximum function.

If a Non-Contracted Medical Provider supports your request, PacifiCare may request a fourteen (14) day extension if obtaining necessary medical information from the provider will benefit you.

3. PacifiCare will make a decision on the Appeal and notify you of it within seventy-two (72) hours of receipt of your request. If PacifiCare decides to uphold the original adverse determination, either in whole or in part, PacifiCare will forward the entire file to CHDR for review no later than twenty-four (24) hours after PacifiCare's decision. CHDR will send you a letter with their decision within seventy-two (72) hours of receipt of your case from PacifiCare, or at the end of the fourteen (14) day extension.

Standard and expedited Appeals received for denials due to "lack of Medical Necessity" will be reconsidered by a physician with expertise in the medical field appropriate to the services under appeal.

Please call Member Service at 1-800-228-2144 or (TDHI) 1-800-685-9355, 7:00 a.m. to 9:00 p.m., Monday through Friday, for more information.

There are four possible dispositions to a request for expedited Appeals. They are:

- Your request to expedite an Appeal decision is accepted, PacifiCare makes a decision in seventy-two (72) hours and notifies you that the care will be arranged or continued.
- Your request to expedite an Appeal decision is accepted, PacifiCare makes a decision in seventy-two (72) hours and notifies you that that the care will **not** be arranged or continued, and the case will be sent to CHDR for determination within twenty-four (24) hours.
- Your request to expedite an Appeal decision is **not** accepted, and PacifiCare informs you that your request will be handled under the standard Appeal process.
- Your request to expedite an Appeal decision cannot be made in seventy-two (72) hours, and PacifiCare informs you that PacifiCare will need up to an additional fourteen (14) calendar days to process your request.

If you have questions regarding these rights, please call Member Service.

CHDR Reopening

A reopening is not an Appeal right. Any of the parties to a reconsideration determination may request a reopening, however, granting a reopening is solely at CHDR's discretion. The party requesting a reopening must clearly state in writing the basis on which the request is made.

All CHDR determinations advise the parties of the standards for reopening of the case by CHDR. Any party to the determination may request a reopening if the party believes one of the following grounds for reopening is applicable:

1. Error on the face of the evidence by CHDR in its review
2. Fraud
3. New and additional information that was not available at the time CHDR made its initial determination in the case

A Medicare+Choice Organization's request for a reopening does not relieve the Medicare+Choice Organization of the responsibility to comply with CHDR's decision within the required time frames.

Information You Should Receive During Your Hospital Stay

When you are admitted to the Hospital, someone at the Hospital should give you a notice called the Important Message from Medicare. This notice explains your rights under the law. When a doctor decides that you are ready to leave the Hospital (to "be discharged"), you should be given a copy of another notice that includes specific information about your Hospital discharge. This other notice is called the Notice of Discharge and Medicare Appeal Rights. It will tell you:

- Why you are being discharged.
- The date that we will stop covering your Hospital stay (stop paying our share of your Hospital costs).
- What you can do if you think you are being discharged too soon.
- Who to contact for help.

As a Member, you should receive this information about your discharge **before** you leave the Hospital. You (or someone you authorize) may be asked to sign and date this document, to show that you received the notice. Signing the notice does not mean that you agree that you are ready to leave the Hospital, it only means that you received the notice. If you do not receive the notice when you are being told about your discharge from the Hospital, be sure to ask for it immediately.

Review of your Hospital discharge by the Quality Improvement Organization

If you think that you are being discharged too soon, you have the right by law to ask for a review of your discharge date. As explained in the Notice of Discharge & Medicare Appeal Rights, if you act quickly, you can ask an outside agency called the Quality Improvement

Please call Member Service at 1-800-228-2144 or (TDHI) 1-800-685-9355, 7:00 a.m. to 9:00 p.m., Monday through Friday, for more information.

Organization (QIO) to review whether your discharge is medically appropriate.

What is the “Quality Improvement Organization”?

The QIO is a group of doctors and other health care experts paid by the federal government to check on and help improve the care given to Medicare patients. They are not part of PacifiCare or your Hospital. There is one QIO in each state. QIOs have different names, depending on which state they are in. The phone number and address of the QIO for your area is:

CMRI
CitiCorp Center
One Sansome Street, Suite 600
San Francisco, CA 94104-4405
1-415-677-2000

The doctors and other health experts in the QIO review certain types of complaints made by Medicare patients. These include complaints about quality of care and complaints from Medicare patients who think the coverage for their Hospital stay is ending too soon.

Getting a QIO review of your Hospital discharge

If you want to have your discharge reviewed, you must act quickly to contact the QIO. The Notice of Discharge & Medicare Appeal Rights gives the name and telephone number of your QIO and tells you what you must do.

- You must ask the QIO for an expedited seventy-two (72) hour review of whether you are ready to leave the Hospital.
- You must be sure that you have made your request to the QIO **no later than noon** on the first working day after you are given written notice that you are being discharged from the Hospital. This deadline is very important. If you meet this deadline, you are allowed to stay in the Hospital past your discharge date without paying for it yourself, while you wait to get the decision from the QIO (see below).

If the QIO reviews your discharge, it will first look at your medical information. Then it will give an opinion about whether it is medically appropriate for you to be discharged on the date that has been set for you. The QIO will make this decision within one full working day after it has received your request and all of the medical information it needs to make a decision.

- If the QIO decides that your discharge date was medically appropriate, you will not be responsible for paying the Hospital charges until noon of the calendar day after the QIO gives you its decision.
- If the QIO agrees with you, then we will continue to cover your Hospital stay for as long as Medically Necessary.

What if you do not ask the QIO for a review by the deadline?

You may have to pay if you stay past your discharge date.

If you do not ask the QIO by noon of the next working day after you are given written notice that you are being discharged from the Hospital, and if you stay in the Hospital after this date, you run the risk of having to pay for the Hospital care you receive on and after this date. However, you can Appeal any bills for Hospital care you receive as described above.

You still have another option: asking for an expedited/72-hour review of your discharge

If you do not ask the QIO to do an expedited seventy-two (72) hour review of your discharge, you can ask us for an expedited seventy-two (72) hour review of your discharge. This is described above. If you ask us for an expedited seventy-two (72) hour review of your discharge and you stay in the Hospital past your discharge date, you run the risk of having to pay for the Hospital care you receive past your discharge date. Whether you have to pay or not depends on the decision we make.

- If we decide, based on the expedited seventy-two (72) hour review, that you need to stay in

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the Hospital, we will continue to cover your Hospital care for as long as Medically Necessary.

- If we decide that you should not have stayed in the Hospital beyond your discharge date, then we will **not** cover any Hospital care you received if you stayed in the Hospital after the discharge date.

Quality Improvement Organization Quality of Care Complaint Process

If you are concerned about the quality of care you have received, you may file a complaint with the QIO in your local area. (The name, address and telephone number of your local QIO are referenced above.)

Informal Complaints

PacifiCare will attempt to resolve any complaint you might have. PacifiCare encourages the informal resolution of complaints (i.e., over the telephone), especially if such complaints result from misinformation, misunderstanding or lack of information. If you have a complaint, please call Member Service. A more formal Member Grievance procedure is available, if your complaint cannot be resolved in this manner.

Formal Complaints

As a Secure Horizons Medicare+Choice Plan Member, you have the right to file a complaint, also called a Grievance, about problems you observe or experience, including:

- Complaints about the quality of services that you receive or delays in providing care
- Complaints regarding such issues as office waiting times, physician behavior, adequacy of facilities, or other similar Member concerns
- General complaints about increases in member liability or benefit design and the Covered Medications List.
- Involuntary Disenrollment situations (see Section 8)

- If you disagree with PacifiCare's decision to process your Referral request under the standard fourteen (14) day timeframe rather than expedited seventy-two (72) hour timeframe
- If you disagree with PacifiCare's decision to process your Appeal request under the standard thirty (30) day timeframe rather than the expedited seventy-two (72) hour timeframe

To use the formal Grievance procedure, submit your Grievance in writing to PacifiCare Appeals and Grievances Unit. PacifiCare will acknowledge the Grievance within five (5) business days of receipt and you will be advised as to whom you may contact at PacifiCare regarding the Grievance. PacifiCare will write you to let you know how PacifiCare has addressed your concern within thirty (30) days of receiving your written Grievance. In some instances, PacifiCare will need additional time to address your concern. If additional time is needed, PacifiCare will keep you informed regarding the status of your Grievance.

PacifiCare is required to track all Appeals and Grievances in order to report cumulative data to CMS and to Secure Horizons Medicare+Choice Plan Members, upon request.

However, complaints about a decision regarding payment or provision of Covered Services that you believe are covered by Medicare and should be arranged or paid for by PacifiCare must be appealed through the Secure Horizons Medicare+Choice Plan Medicare Appeals Procedure.

Grievances are reviewed by PacifiCare in consultation with appropriate departments. PacifiCare will investigate your complaint and send you a written response regarding the disposition of the complaint within thirty (30) calendar days of receiving the complaint. If PacifiCare is unable to complete its review within thirty (30) calendar days, you will be so notified within the thirty (30) day period.

Please call Member Service at 1-800-228-2144 or (TDHI) 1-800-685-9355, 7:00 a.m. to 9:00 p.m., Monday through Friday, for more information.

Binding Arbitration

Any and all disputes of any kind whatsoever, including claims relating to the delivery of services under the plan and claims of medical malpractice (that is as to whether any medical services rendered under the health plan were unnecessary or unauthorized or were improperly, negligent, or incompetently rendered), except for claims subject to ERISA, between Member (including any heirs or assigns) and PacifiCare of California, or any of its parents, subsidiaries or affiliates (collectively, "PacifiCare"), shall be submitted to binding arbitration. Any such dispute will not be resolved by a lawsuit or resort to court process, except as the Federal Arbitration Act provides for judicial review of arbitration proceedings. 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 thirty (30) days following the date demand for arbitration is made, the arbitrator appointment procedures in the Comprehensive Rules will be utilized.

Arbitration hearings shall be held in the county in which the Member lives or at such other location as the parties may agree in writing. Civil discovery may be taken in such arbitration. The arbitrator selected shall have the power to control the timing, scope and manner of the taking of discovery and shall further have the same powers to enforce the parties' respective duties concerning discovery as would a Superior Court of California including, but not limited to, the imposition of sanctions. The arbitrator shall have the power to grant all remedies provided by federal and State 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 requirement of binding arbitration shall not preclude a party from seeking a temporary restraining order or preliminary injunction or other provisional remedies from a court with jurisdiction; however, any and all other claims or causes of action including, but not limited to, those seeking damages, shall be subject to binding arbitration as provided herein. The Federal Arbitration Act, 9 U.S.C. §§ 1-16, shall also apply to the arbitration.

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

Arbitration does not apply to claims and service disputes that are subject to the Medicare reconsideration and Appeals process.

Section 10

Advance Directives: Making Your Health Care Wishes Known

PacifiCare is required by law to inform you of your right to make health care decisions and to execute an Advance Directive. An Advance Directive is a formal document, written by you in advance of an incapacitating illness or injury. As long as you can speak for yourself, Contracting Medical Providers will honor your wishes. If you become so sick you cannot speak for yourself,

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this directive will guide your health care Providers in treating you and will save your family, friends and physicians from having to guess what you would have wanted.

There may be several types of Advance Directives you can choose from, depending on state law.

Most states recognize:

1. DPAHC (Durable Power of Attorney for Health Care)/Medical Durable Power of Attorney
2. Health Care Directive
3. Living Wills
4. Natural Death Act Declarations
5. Cardiopulmonary Resuscitation (CPR) Directive
6. Do Not Resuscitate (DNR) Orders

You are not required to initiate an Advance Directive, and you will not be denied care if you do not have an Advance Directive.

It is necessary for you to provide copies of your completed directive to:

1. your Primary Care Physician,
2. your agent or representative (if you have one), and
3. your family.

If you decide that you want to have an Advance Directive, there are several ways to get this type of legal form. You can get a form from your lawyer, from a social worker, and from some office supply stores

Be sure to keep a copy with you and take a copy to the Hospital when you are hospitalized for medical care. If you have questions regarding your health care choices, please call California Health Insurance Counseling and Advocacy Program at 1-800-434-0222.

Section 11

Coordinating Other Benefits You May Have

Who Pays First?

As a Member, you are always entitled to receive Covered Services through the Secure Horizons Medicare+Choice Plan. However, Medicare law gives PacifiCare or its designee the right to recover payments from certain “third party” insurance companies or from you if you were paid by a “third party.” Because of this, PacifiCare may ask you for information about other insurance you may have. If you have other insurance, you can help PacifiCare obtain payment from the other insurer by promptly providing the requested information.

If any no-fault or any liability insurance is available to you, benefits under that plan must be applied to the costs of health care covered by that plan. Where PacifiCare has provided benefits and a judgment or settlement is made with a no fault or liability insurer, you must reimburse PacifiCare or its designee to the extent of your medical expenses. However, PacifiCare’s reimbursement may be reduced by a share of procurement costs (e.g., attorney fees and costs). Workers’ compensation from treatment of a work-related illness or injury should also be applied to covered health care costs.

If you do not have end-stage renal disease (ESRD), and have coverage under an employer group plan of an employer of twenty (20) or more employees, either through your own current employment or the employment of a spouse, you must use the benefits under that plan prior to using your Secure Horizons Medicare+Choice Plan benefits. Similarly, if you do not have end-stage renal disease (ESRD), but have Medicare based on disability and are covered under an employer group plan of an employer of one hundred (100) or more employees (or a multiple employer plan that

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includes an employer of one hundred (100) or more employees) through a spouse's employer group coverage, you must use the benefits under that plan prior to using your Secure Horizons Medicare+Choice Plan benefits. In such cases you will only receive benefits not covered by your employer group plan through PacifiCare's contract with Medicare (and PacifiCare will only be paid an amount by Medicare to cover such "wrap around" benefits). A special rule applies if you have or develop ESRD.

If you have (or develop) ESRD and are covered under an employer group plan, you must use the benefits of that plan for the first thirty (30) months after becoming eligible for Medicare based on ESRD. Medicare is the primary payer after this coordination period. However, if your employer group plan coverage was secondary to Medicare when you developed ESRD because it was not based on current employment as described above, Medicare continues to be primary payer.

Section 12

Optional Supplemental Benefits

Adding Optional Supplemental Benefits Available With 2003 Secure Horizons Medicare+Choice

Based on where you live, Secure Horizons Medicare+Choice Plans may offer an Optional Supplemental Benefit Plan (the Optional Plus Plan, High Option Dental Plan and/or Optional Dental Plan) which provides supplemental benefits for an additional monthly plan premium. For more information regarding Optional Supplemental Benefit Plans and their availability in your Service Area, please refer to your Member materials or contact Member Service.

Electing an Optional Supplemental Benefit Plan

You may enroll in an Optional Supplemental Benefit Plan by completing an Optional Plan

Transfer Form available through Member Service. If you are an existing Member, you may enroll in an Optional Supplemental Benefit Plan **only once** during the Open Enrollment Period, November 15, 2002 through June 30, 2003. If you are a new Member, you may enroll in an Optional Supplemental Benefit Plan at the time of enrollment, within the thirty (30) days of your Effective Date or until June 30, 2003.

In general, completed Optional Plan Transfer Forms received by the last day of the month will be effective the first day of the following month. For example, if PacifiCare receives your completed Optional Plan Transfer Form on December 31, your Optional Supplemental Benefit Plan benefits would begin on January 1.

If you elect the Optional Plus Plan, you may transfer to the Standard Plan without additional Optional Plus Plan benefits **only once** during the Calendar Year. If you choose the High Option Dental Plan, you may transfer to the Optional Dental Plan **only once** during the Open Enrollment Period. If you have elected the Optional Dental Plan or the High Option Dental Plan, you may transfer to the Standard Plan without optional dental benefits **only once** during the Calendar Year.

Disenrolling From an Optional Supplemental Benefit Plan

If you wish to Disenroll from the Optional Plus Plan, Optional Dental Plan and/or High Option Dental Plan, you must notify PacifiCare in writing. You may either send PacifiCare an Optional Plan Transfer Form or a letter. To obtain an Optional Plan Transfer Form, please call Member Service. Please mail your request to P.O. Box 489, Cypress, CA 90630.

Optional Supplemental Benefit Plan(s) Disenrollment requests received by the last day of the month will be effective the first day of the following month. Members will be responsible for their Optional Supplemental Benefit Plan premium payment if the Disenrollment request is

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received after the last day of the month. Disenrollment from Optional Supplemental Benefit Plans will not result in Disenrollment from Secure Medicare+Choice Plans.

Non-payment of plan premiums for Optional Supplemental Benefits Plan(s) will not result in Disenrollment from the Secure Horizons Medicare+Choice Plan.

Refund of Premium

Members enrolled in an Optional Supplemental Benefit Plan(s) have a monthly plan premium and are entitled to a refund for any overpayments of plan premiums made during the course of the year or at the time of Disenrollment. Overpayments of Optional Supplemental Benefit Plan premiums will be refunded upon request or Disenrollment. PacifiCare will refund any overpayments within thirty (30) days of notification. PacifiCare may apply your overpayment of Optional Supplemental Benefit Plan premiums to your Health Plan Premiums for the standard plan.

(Please note: This section is not applicable to Group Retiree Members. Employer groups and trust administrators may offer Group Retiree Members additional supplemental or buy-up benefits. For information regarding Group Retiree supplemental benefits, if applicable, please refer to the Retiree Benefits Summary document.)

Section 13

General Provisions

Governing Law

This Evidence of Coverage and Disclosure Information is subject to the laws of the State of California and the United States of America, including: the Health Maintenance Organization Act of 1973, and regulations promulgated thereunder by the Department of Health and Human Services of the United States, and Title XVIII of the Social Security Act and regulations promulgated thereunder by CMS. Any provisions required to be

in this Evidence of Coverage and Disclosure Information by any of the above acts and regulations shall bind PacifiCare and you whether or not expressly provided in this document.

Your Financial Liability as a Secure Horizons Medicare+Choice Plan Member

As a Member of Secure Horizons Medicare+Choice Plan, you have the following financial obligations:

- **All Copayments and Coinsurance** specified in the Schedule of Benefits must be paid to the Contracting Medical Provider at the time of service.
- **Plan Premiums for Optional Supplemental Benefits** the Optional Plus Plan, Optional Dental Plan and/or High Option Dental Plan. Non-payment of the Optional Plus Plan, Optional Dental Plan and/or High Option Dental Plan premiums will result in the loss of Optional Supplemental Benefits, but not Disenrollment from Secure Horizons Medicare+Choice Plan.
- **Health Plan Premium** (if applicable) Increases in Health Plan Premiums and/or decreases in the level of coverage are only permitted at the beginning of each contract year (which is usually the Calendar Year) and must be approved by CMS. You will receive written notice in the Fall of the year before changes to your Health Plan Premium become effective.

(Please note: Rate changes for Group Retiree Members enrolled through an employer group or trust administrator are subject to contractual arrangements between PacifiCare and your former employer or trust administrator. Your former employer or trust administrator is responsible for notifying you of any Secure Horizons Medicare+Choice Plan premium changes, contribution changes or employer sponsored benefit changes thirty (30) days before they become effective.)

Please call Member Service at 1-800-228-2144 or (TDHI) 1-800-685-9355, 7:00 a.m. to 9:00 p.m., Monday through Friday, for more information.

PacifiCare may Disenroll you for failure to pay Health Plan Premiums. However, prior to such action, PacifiCare will:

- (a) contact you within twenty (20) days after the due date of the delinquent charges
- (b) provide an explanation of the Disenrollment procedures and any Lock-In requirements
- (c) advise you that failure to pay the Health Plan Premiums within a ninety (90) day grace period may result in your Disenrollment
- (d) give you a written notice of Disenrollment, including an explanation of your right to a hearing under the Grievance procedures

■ Medicare Part A Premium

For Members with Secure Horizons Medicare+Choice Plan Part A equivalent, failing to pay the Part A Premium payments within a ninety (90) day grace period will result in your Disenrollment. Should you decide later to re-enroll in Secure Horizons Medicare+Choice Plan, you must pay any premiums due from your previous enrollment in the plan.

If you are not entitled to Medicare Part A, you may not enroll in any other Medicare+Choice Plan. If you wish to enroll with another Medicare+Choice Organization, you must purchase Medicare Part A. (You were able to remain enrolled with Secure Horizons Medicare+Choice Plan because individuals with Part B only who were enrolled in an HMO before January 1, 1999 are “grandfathered”, and may remain enrolled with the same organization. For instructions on how to purchase Medicare Part A, please see Section 7).

■ Medicare Part B Premium

As a Secure Horizons Medicare+Choice Plan Member, you must continue to pay your Medicare Part B Premium. If you receive a Social Security Administration or Railroad Retirement Board annuity check, this premium is automatically deducted from your check. Otherwise, your premium is paid directly to Medicare by you or someone on your behalf as Medicaid or Medi-Cal.

If you are Disenrolled for non-payment of Health Plan Premiums and you later decide to re-enroll in Secure Horizons Medicare+Choice Plan, you must pay any Health Plan Premiums due from your previous enrollment in Secure Horizons Medicare+Choice Plan.

Until you are notified of your Disenrollment, you are still a Member of Secure Horizons Medicare+Choice Plan and must continue to use Contracting Medical Providers except for Emergency Services or Urgently Needed Services. If you receive services from Non-Contracting Medical Providers without Prior Authorization from PacifiCare, neither PacifiCare nor Medicare will pay for those services.

Member Non-Liability

In the event PacifiCare fails to reimburse a Contracting Medical Provider’s charges for Covered Services or in the event that PacifiCare fails to pay a Non-Contracting Medical Provider for Prior Authorized services occurring when you were actively enrolled in Secure Horizons Medicare+Choice Plan, you will not be liable for any sums owed by PacifiCare.

However, you will be liable if you receive services from Non-Contracting Medical Providers without Prior Authorization. Neither PacifiCare nor Medicare will pay for those services except for:

- Emergency Services
- Urgently Needed Services
- Out-of-area and routine travel renal dialysis (in the United States at a Medicare certified facility) or
- Covered Services for which Secure Horizons Medicare+Choice Plan allows you to self-refer to Contracting Providers

In addition, if you enter into a private contract with a Non-Contracting Medical Provider, neither PacifiCare nor Medicare will pay for those services.

Please call Member Service at 1-800-228-2144 or (TDHI) 1-800-685-9355, 7:00 a.m. to 9:00 p.m., Monday through Friday, for more information.

In the event a Contracting Medical Provider's contract with PacifiCare is terminated while you are under Contracting Medical Provider's care, PacifiCare will pay for the continuation of related Covered Services as long as you retain eligibility, until the Covered Services are completed, unless PacifiCare makes a reasonable and medically appropriate arrangement for those services to be provided by another Contracting Medical Provider. A PacifiCare Medical Director or designee shall determine when the Contracting Medical Provider's services are completed and what is a reasonable and medically appropriate arrangement for the provision of the services by another Contracting Medical Provider.

Third Party Liability

In the case of injuries caused by any act or omission of a third party, and any complications incident thereto, PacifiCare shall furnish all Covered Services. However, you agree to fully reimburse PacifiCare or its designee for the cost of all such services and benefits provided, immediately upon obtaining a monetary recovery, whether due to settlement or judgment, as a result of such injuries.

You agree to cooperate in protecting the interests of PacifiCare or its designee under this provision. You shall not settle any claim, or release any person from liability, without the written consent of PacifiCare, wherein such release or settlement will extinguish or act as a bar to PacifiCare's right of reimbursement.

Reimbursement of Third Party Medical Expenses

If you receive medical services under your Secure Horizons Medicare+Choice Plan coverage after being injured through the actions of another person (a third party) for which you receive a monetary recovery, you will be required to reimburse PacifiCare, or its designee, to the extent permitted under State and federal law, for the cost of such medical services and benefits provided and the reasonable costs actually paid to perfect any lien.

You must obtain the written consent of PacifiCare or its nominee prior to settling any claim, or releasing any third party from liability, if such settlement or release would limit the reimbursement rights of PacifiCare or its nominee.

You are required to cooperate in protecting the interests of PacifiCare or its nominee by providing all liens, assignments or other documents necessary to secure reimbursement to PacifiCare or its nominee. Failure to cooperate with PacifiCare or its nominee in this regard could result in termination of your Secure Horizons Medicare+Choice Plan membership.

Should you settle your claim against a third party and compromise the reimbursement rights of PacifiCare or its nominee without PacifiCare's written consent, or otherwise fail to cooperate in protecting the reimbursement rights of PacifiCare or its nominee, PacifiCare may initiate legal action against you. Attorney fees will be awarded to the prevailing party.

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

If you are receiving benefits as a result of other 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.

If PacifiCare happens to duplicate benefits to which you are entitled under other automobile, accident or liability coverage, PacifiCare may seek reimbursement of the reasonable value of those benefits from you, your insurance carrier, or your health care provider to the extent permitted under State and/or federal law.

Secure Horizons Medicare+Choice Plan will provide benefits over and above your other automobile, accident or liability coverage, if the cost of your health care services exceeds such coverage.

Please call Member Service at 1-800-228-2144 or (TDHI) 1-800-685-9355, 7:00 a.m. to 9:00 p.m., Monday through Friday, for more information.

You are required to cooperate with PacifiCare in obtaining payment from your automobile, accident or liability coverage carrier, and your failure to do so may result in termination of your Secure Horizons Medicare+Choice Plan membership.

Acts Beyond the Control of PacifiCare

If, due to a natural disaster, war, riot, civil insurrection, complete or partial destruction of a facility, ordinance, law or decree of any government or quasi-governmental agency, labor dispute (when said dispute is not within PacifiCare's control), or any other emergency or similar event not within the control of PacifiCare, Contracting Medical Providers may become unavailable to arrange or provide health services pursuant to this Evidence of Coverage and Disclosure Information. PacifiCare shall attempt to arrange for Covered Services insofar as practical and according to PacifiCare's best judgment. Neither PacifiCare nor any Contracting Medical Provider shall have any liability or obligation for delay or failure to provide or arrange for Covered Services if such delay is the result of any of the circumstances described above.

Contracting Medical Providers Are Independent Contractors

The relationships between PacifiCare and its Contracting Medical Groups/IPAs, and Contracting Hospitals are independent contractor relationships. None of the Medical Groups/IPAs, or Contracting Hospitals or their physicians or employees are employees or agents of PacifiCare. An agent would be anyone authorized to act on PacifiCare's behalf. Neither PacifiCare nor any employee of PacifiCare is an employee or agent of the Medical Groups/IPAs, Contracting Medical Providers or Contracting Hospital.

PacifiCare Contracting Arrangements

In order to obtain quality service in an efficient manner, PacifiCare pays its Providers using various payment methods, including capitation, per diem,

incentive and discounted fee-for-service arrangements. Capitation means paying a fixed dollar amount per month for each Member assigned to the Provider. Per diem means paying a fixed dollar amount per day for all services rendered. Incentive means a payment that is based on appropriate medical management by the Provider. Discounted fee-for-service means paying the Provider's usual, customary and regular fee discounted by an agreed-to percentage.

You are entitled to ask if PacifiCare has special financial arrangements with the Contracting Medical Providers that can affect the use of Referrals and other services that you might need. To obtain this information, call Member Service and request information about the Contracting Medical Provider's payment arrangements.

How PacifiCare Contracting Providers Are Compensated

The following is a brief description of how PacifiCare pays its Contracting Medical Providers:

PacifiCare typically contracts with medical groups/IPAs to provide medical services and with Hospitals to provide Hospital services to Members. The Contracting Medical Groups/IPAs in turn, employ or contract with individual physicians. Most of the Contracting Medical Groups/IPAs, receive an agreed upon monthly payment from PacifiCare to provide services to Members. The monthly payment may be either a fixed dollar amount for each Member or a percentage of the monthly plan premium received by PacifiCare. The monthly payment typically covers professional services directly provided by the Contracting Medical Group/IPA, and may also cover certain Referral services. Some of PacifiCare's Contracting Hospitals receive similar monthly payments in return for arranging Hospital services for Members. Other Hospitals are paid on a discounted fee-for-service or fixed charge per day of hospitalization.

Please call Member Service at 1-800-228-2144 or (TDHI) 1-800-685-9355, 7:00 a.m. to 9:00 p.m., Monday through Friday, for more information.

Each year, PacifiCare and the Contracting Medical Group/IPA agree on a budget for the cost of services covered under the program for all Secure Horizons Medicare+Choice Plan Members treated by the Contracting Medical Group/IPA. 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 Contracting Medical Group/IPA shares in the savings. The Contracting Hospital and the Contracting Medical Group/IPA typically participate in programs for hospital services similar to that described above.

Stop-loss insurance protects the Contracting Medical Groups/IPAs and Contracting Hospitals from large financial losses and helps the Providers with resources to cover necessary treatment. PacifiCare provides stop-loss protection to the Contracting Medical Groups/IPAs and Contracting Hospitals that receive capitation payments. If any capitated providers do not obtain stop-loss protection from PacifiCare, they must obtain stop-loss insurance from an insurance carrier acceptable to PacifiCare. You may obtain additional information on compensation arrangements by contacting Member Service or your Contracting Medical Group/IPA.

Physician-Patient Relationship

You are responsible for selecting a Contracting Medical Group/IPA. The physician-patient relationship between you and your Contracting Medical Group/IPA shall be maintained by the Contracting Medical Group/IPA. Secure Horizons Medicare+Choice Plan is not a health care Provider.

PacifiCare does not prohibit or otherwise restrict a Provider, acting within the lawful scope of practice, from advising, or advocating on your behalf about the following:

1. Your health status, medical care or treatment options
2. The risk, benefits, and consequences of treatment or non-treatment

3. The opportunity for you to refuse treatment and to express preferences about future treatment decisions

Facility Locations

Medical services are provided to Secure Horizons Medicare+Choice Plan Members through Contracting Medical Providers, Contracting Physicians, Contracting Hospitals, Contracting Facilities and Contracting Pharmacies. For a complete list of Providers, please refer to the Secure Horizons Medicare+Choice Plan Provider Directory. If you have any questions regarding the Contracting Providers listed in the directory, please contact Member Service or visit the web site at www.securehorizons.com.

For twenty-four (24) hour Emergency and/or Urgent Care telephone numbers, refer to either the Secure Horizons Medicare+Choice Plan Provider Directory or your Secure Horizons Medicare+Choice Plan membership card.

Practitioners and Utilization Review

Utilization Review decision making is based only on appropriateness of care and service. PacifiCare does not compensate practitioners or other individuals conducting utilization review for denials of coverage or service. Financial incentives for Utilization Review decision-makers do not encourage denials of coverage or service.

Notices

Any notice required to be given under this Evidence of Coverage and Disclosure Information shall be in writing and either delivered personally or by United States mail at the addresses set forth below or at such other address as the parties may designate:

If to PacifiCare:

PacifiCare
Attn: Member Service
P.O. Box 489
Cypress, CA 90630

If to you, to your last address known to PacifiCare.

Please call Member Service at 1-800-228-2144 or (TDHI) 1-800-685-9355, 7:00 a.m. to 9:00 p.m., Monday through Friday, for more information.

Technology Assessment

PacifiCare regularly reviews new procedures, devices and drugs, including those related to behavioral health care, to determine whether or not they are safe and effective for Members. The Technology Assessment and Guideline Committee, consisting of staff experts, Primary Care Physicians, pharmacists and Specialists, including behavioral health Specialists, conducts careful reviews of case studies, clinical literature, opinions of review organizations such as ECRI Health Technology Assessment Information Service, HAYES New Technology Summaries or AHCPR (Agency for Health Care Policy and Research), Medicare, and Federal Drug Administration decisions

Public Policy Participation

PacifiCare/Secure Horizons Medicare+Choice Plan affords its Members the opportunity to participate in establishing the public policy of PacifiCare. One-third of PacifiCare of California's Board of Directors is comprised of PacifiCare/Secure Horizons Medicare+Choice Plan Members. If you are interested in participating in the establishment of the PacifiCare/Secure Horizons Medicare+Choice Plan public policy, please call or write PacifiCare Attn: Member Service, P.O. Box 489, Cypress, CA 90630.

Important Information About Organ and Tissue Donations

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

Almost everyone 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 member. There are many resources that can provide the information you need to make a responsible decision.

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 may help to 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 to Learn More

- To obtain your donor card and information on organ and tissue donation, call 1-800-355-SHARE or 1-800-633-6562.
- Request Donor Information from your local Department of Motor Vehicles (DMV)
- On the Internet, contact:
All About Transplantation and Donation at www.transweb.org
Department of Health and Human Services at <http://www.organdonor.gov>
- Sign the donor card in your family's presence.
- Have your family sign as witnesses and pledge to carry out your wishes.
- 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 inform your family so they can act on your wishes.

Please call Member Service at 1-800-228-2144 or (TDHI) 1-800-685-9355, 7:00 a.m. to 9:00 p.m., Monday through Friday, for more information.

As a Secure Horizons Medicare+Choice Plan Member, you have the right to request information on the following:

- General coverage and comparative plan information
- Utilization control procedures
- Quality Control Programs
- Statistical data on Grievances and Appeals
- The financial condition of PacifiCare
- Summary of Provider compensation arrangements

You may write to PacifiCare's Corporate Offices at:

PacifiCare, 5701 Katella Avenue, Cypress, CA 90630

Section 14

Secure Horizons Medicare+Choice Plan Service Area

You are eligible for enrollment and continued coverage as long as you reside in the area listed below:

Fresno, Kern*, Los Angeles,** Orange, Sacramento, Santa Clara, Santa Cruz, and Stanislaus

* Excluding 93527, Inyokern, 93528 and 93558, Johannesburg, 93554, Randsburg, and 93555 and 93556, Ridgecrest

** Excluding 90704, Avalon, Catalina Island

You are also eligible for enrollment and continued coverage as long as you reside in one of the following zip codes in the counties listed below:

County: Alameda

Zip Codes: 94501, 94502, 94516, 94540, 94541, 94542, 94543, 94544, 94545, 94546, 94552, 94557, 94577, 94578, 94579, 94580, 94601, 94602, 94603, 93604, 94605, 94606, 94607, 94608, 94609, 94610, 94611, 94612, 94613, 94614, 94615, 94617, 94618, 94619, 94620, 94621, 94622, 94623, 94624, 92625, 92626, 94627, 94643, 94649, 94659, 94660, 94661, 94662, 94666, 94701, 94702, 94703, 94704, 94705, 94706, 94707, 94708, 94709, 94710, 94712, 94720

County: Contra Costa

Zip Codes: 94409, 94530, 94547, 94564, 94707, 94708, 94801, 94802, 94803, 94804, 94805, 94806, 94807, 94808, 94820, 94850

County: Madera

Zip Codes: 93601, 93604, 93614, 93643, 93644, 93645, 93669

County: Placer

Zip Codes: 95602, 95603, 95604, 95626, 95631, 95648, 95650, 95658, 95661, 95663, 95677, 95678, 95681, 95703, 95713, 95717, 95722, 95736, 95746, 95747, 95765

County: Riverside

Zip Codes: 91752, 92201, 92202, 92203, 92210, 92211, 92220, 92223, 92230, 92234, 92235, 92236, 92239, 92240, 92241, 92253, 92254, 92255, 92258, 92260, 92261, 92262, 92263, 92264, 92270, 92276, 92282, 92292, 92320, 92501, 92502, 92503, 92504, 92505, 92506, 92507, 92508, 92509, 92513, 92514, 92515, 92516, 92517, 92518, 92519, 92521, 92522, 92530, 92531, 92532, 92536, 92539, 92543, 92544, 92545, 92546, 92548, 92549, 92551, 92552, 92553, 92554, 92555, 92556, 92557, 92561, 92562, 92563, 92564, 92567, 92570, 92571, 92572, 92581, 92582, 92583, 92584, 92585, 92586, 92587, 92589, 92590, 92591, 92592, 92593, 92595, 92596, 92599, 92860, 92877, 92878, 92879, 92880, 92881, 92882, 92883

County: San Bernardino

Zip Codes: 91701, 91708, 91709, 91710, 91729, 91730, 91737, 91739, 91743, 91758, 91761, 91762, 91763, 91764, 91766, 91784, 91785, 91786, 91798, 92252, 92256, 92284, 92285, 92286, 92301, 92305, 92307, 92308, 92309, 92310, 92311, 92312, 92313, 92316, 92318, 92323, 92324, 92327, 92329, 92334, 92335, 92336, 92337, 92338, 92339, 92340, 92342, 92345, 92346, 92347, 92350, 92354, 92356, 92357, 92358, 92359, 92364, 92365, 92366, 92368, 92369, 92371, 92372, 92373, 92374, 92375, 92376, 92377, 92382, 92392, 92393, 92394, 92397, 92398, 92399, 92401, 92402, 92403, 92404, 92405, 92406, 92407, 92408, 92410, 92411, 92412, 92413, 92415, 92418, 92420, 92423, 92424, 92427, 93252

Please call Member Service at 1-800-228-2144 or (TDHI) 1-800-685-9355, 7:00 a.m. to 9:00 p.m., Monday through Friday, for more information.

County: San Diego

Zip Codes: 91901, 91902, 91903, 91905, 91906, 91908, 91909, 91910, 91911, 91912, 91913, 91914, 91915, 91916, 91917, 91921, 91931, 91932, 91933, 91934, 91935, 91941, 91942, 91943, 91944, 91945, 91946, 91947, 91948, 91950, 91951, 91962, 91963, 91976, 91977, 91978, 91979, 91980, 91987, 91990, 92003, 92007, 92008, 92009, 92013, 92014, 92018, 92019, 92020, 92021, 92022, 92023, 92024, 92025, 92026, 92027, 92028, 92029, 92030, 92033, 92037, 92038, 92039, 92040, 92046, 92049, 92051, 92052, 92054, 92055, 92056, 92057, 92058, 92059, 92060, 92061, 92064, 92065, 92066, 92067, 92068, 92069, 92070, 92071, 92072, 92074, 92075, 92078, 92079, 92082, 92083, 92084, 92085, 92086, 92088, 92090, 92091, 92092, 92093, 92096, 92101, 92102, 92103, 92104, 92105, 92106, 92107, 92108, 92109, 92110, 92111, 92112, 92113, 92114, 92115, 92116, 92117, 92118, 92119, 92120, 92121, 92122, 92123, 92124, 92126, 92127, 92128, 92129, 92130, 92131, 92132, 92133, 92134, 92135, 92136, 92137, 92138, 92139, 92140, 92142, 92143, 92145, 92147, 92149, 92150, 92152, 92153, 92154, 92155, 92159, 92160, 92161, 92162, 92163, 92164, 92165, 92166, 92167, 92168, 92169, 92170, 92171, 92172, 92173, 92174, 92175, 92176, 92177, 92178, 92179, 92182, 92184, 92186, 92187, 92190, 92191, 92192, 92193, 92194, 92195, 92196, 92197, 92198, 92199

County: San Luis Obispo

Zip Codes: 93401, 93402, 93403, 93405, 93406, 93407, 93408, 93409, 93410, 93412, 93420, 93421, 93424, 93428, 93430, 93433, 93435, 93442, 93443, 93444, 93445, 93448, 93449, 93452, 93453, 93454, 93483

County: San Mateo

Zip Codes: 94002, 94003, 94010, 94011, 94012, 94030, 94031, 94062, 94065, 94066, 94067, 94070, 94071, 94080, 94083, 94096, 94098, 94099, 94128, 94401, 94402, 94403, 94404, 94405, 94406, 94407, 94408, 94409, 94497

County: Santa Barbara

Zip Codes: 93013, 93014, 93067, 93101, 93102, 93103, 93105, 93106, 93107, 93108, 93109, 93110, 93111, 93116, 93117, 93118, 93120, 93121, 93130, 93140, 94150, 93160, 93190, 93199, 93254, 93427, 93434, 93440, 93441, 93454, 93455, 93456, 93457, 93458, 93460, 93463, 93464

County: Ventura

Zip Codes: 90265, 91302, 91307, 91361, 93001, 93002, 93003, 93004, 93005, 93006, 93007, 93009, 93010, 93011, 93012, 93013, 93015, 93016, 93022, 93023, 93024, 93030, 93031, 93032, 93033, 93034, 93035, 93040, 93041, 93042, 93043, 93044, 93060, 93061, 93064, 93066, 93099

Please call Member Service at 1-800-228-2144 or (TDHI) 1-800-685-9355, 7:00 a.m. to 9:00 p.m., Monday through Friday, for more information.

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. NO ACTION IS REQUIRED ON YOUR PART.

At PacifiCare the protection of our members' privacy and the confidentiality of medical information has always been a top priority. We recognize that you depend upon us to safeguard your personal information and uphold your privacy rights. This document, which is based on state and federal law, as well as our own company code of ethics, offers a declaration of our commitment to preserving member confidentiality and privacy.

Our Privacy Practices

This notice describes PacifiCare's privacy practices for both current and former members. It explains how we use health information about you and when we may share that health information with others. It also informs you about your rights with respect to your health information and how you may exercise these rights. We are required by law to maintain the privacy of your health information and to send you a copy of this notice so that you are aware of how we maintain the privacy of your health information.

PacifiCare employees are required to comply with our policies and procedures to protect the confidentiality of health information. Any employee who violates our privacy policy is subject to a disciplinary process. Employee access to health information is limited on a business "need-to-know" basis, such as: to make benefit determinations, pay claims, manage care, underwrite coverage, perform quality assessment measurements, administer a plan or provide customer service.

PacifiCare maintains physical, electronic and process safeguards that restrict unauthorized access to your health information. Such safeguards include secured office facilities, locked file cabinets, and controlled computer network systems and password accounts.

This notice applies to all applicable companies within the PacifiCare family of companies, which includes businesses owned or controlled by PacifiCare Health Systems, Inc. (PacifiCare).

Please share this notice with everyone covered by your policy or contract. You have a right to receive a copy of this notice upon request at any time. If you would like additional copies of the notice, or have questions related to the information contained within the notice, please call Member/ Customer Services at the toll-free number on your health plan

identification card. You may also view a copy of this notice on our Web sites at www.pacificare.com and www.securehorizons.com.

Should any of our privacy practices change, we reserve the right to change the terms of this notice and to make the new notice effective for all health information that we maintain. We will provide you a copy of the revised notice and post the revised notice on our Web sites.

Health Care Information Maintained at PacifiCare

When we refer to "information" or "health information" in this notice, we mean information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health and related health care services. Health information may be transmitted or shared in any form or medium (oral, written, or electronic).

The health information we receive may vary by product; therefore, the examples that follow may not apply to all members, but are designed to represent the general categories of information that may be received and maintained by PacifiCare:

- Information provided by you on applications, forms, surveys and our Web sites, such as your name, address and date of birth
- Information from physicians, hospitals or other health care providers, clinics, medical groups or health care service plans
- Information provided by your employer, benefits plan sponsor or association, regarding any group product that you may have
- Information about your transactions and experiences with our affiliates, others, and us, such as products or services purchased, account balances, payment history, claims history, policy coverage and premiums
- Information from consumer or medical reporting agencies or other third parties, including medical and demographic information

How We May Use or Share Your Information

The following categories describe how we may use and share your health information. For each

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category we provide examples that help illustrate each type of use or disclosure. Not every use or disclosure in a category will be listed. However, the ways in which we are permitted to use and share health information will fall into one of these categories.

For Treatment

We may share health information with your doctors or hospitals to help them provide medical care for you. For example, if you are hospitalized, we may allow the hospital staff access to any medical records sent to us by your doctor. We may also use or share your health information with others to help coordinate and manage your health care. For example, we may talk to your doctor to suggest a disease management or wellness program that can help improve your health.

For Payment

We may use your health information when paying your medical bills submitted to us by you or your health care providers, such as doctors and hospitals. Examples of payment activities include billing, claims management and other related administrative functions.

For Health Care Operations

We may use or share certain health information for necessary health care operations. Examples of health care operations include the following:

- Performing quality assessment and improvement activities
- Evaluating provider and health plan performance
- Providing underwriting coverage
- Conducting or arranging medical reviews to determine medical necessity, level of care or justification of services
- Performing auditing functions
- Resolving internal grievances, such as addressing problems or complaints about your access to care or satisfaction with services
- Making benefit determinations, administering a benefit plan and providing customer service
- Other uses specifically authorized by law

We may also share your health information with other individuals or entities, also known as business associates, that perform payment or health care

operations on behalf of PacifiCare. However, we will not share your health information with these business associates unless they agree in writing to protect the privacy of that information.

To Make Certain Communications to You

We may use or share your health information with a third party acting on behalf of PacifiCare in order to inform you about alternative medical treatments and programs or about health-related products and services that may be of value to you. We may also inform you about enhancements, replacements or substitutions to your health plan coverage.

For members that reside in Oregon and Nevada, if you do not want PacifiCare to share health information as described above, you may “opt-out” by calling the Member/Customer Service toll-free number on your health plan identification card during normal business hours.

For members that reside in Texas, except for communications about treatment or health care operations, PacifiCare may not use or share your health information for marketing purposes unless you provide written permission for us to do so.

Information Not Personally Identifiable

We may use or share your health information when it has been “de-identified.” Health information is considered to be de-identified when it does not personally identify you.

We may also use a “limited data set” that does not contain any information that can directly identify you. This limited data set may only be used for the purposes of research, public health matters or health care operations. For example, a limited data set may include your city, county and zip code, but not your name or street address.

To the Employee Benefit Plan

Under certain circumstances, we may share limited health information about you with the employee benefit plan through which you receive health benefits. For example, we may share summary health information with the employee benefit plan so that they may obtain bids from other health plans, or modify, amend, or terminate coverage with PacifiCare. We may also share health information related to your enrollment, disenrollment and/or participation in a PacifiCare health plan. We will not share individually

identifiable health information with your benefit plan unless they agree to maintain the privacy of your information.

For members that reside in California and Oklahoma, PacifiCare may not share your health information with your employer or benefit plan unless you provide written permission for us to do so.

Special Circumstances and State and Federal Laws

Special situations and certain state and federal laws may require us to use or release your health information. For example, we may be obligated to release your health information for the following reasons:

- To comply with state and federal laws that require us to release your health information to others
- To report information to state and federal agencies that regulate our business, such as the U.S. Department of Health and Human Services and your state's regulatory agencies
- To assist with public health activities; for example, we may report health information to the Food and Drug Administration for the purpose of investigating or tracking a prescription drug and medical device malfunctions
- To report information to public health agencies if we believe there is a serious threat to your health and safety or that of the public or another person; this includes disaster relief efforts
- To report certain activities to health oversight agencies; for example, we may report activities involving audits, inspections, licensure and peer review activities
- To assist court or administrative agencies; for example, we may provide information pursuant to a court order, search warrant or subpoena
- To support law enforcement activities; for example, we may provide health information to law enforcement agents for the purpose of identifying or locating a fugitive, material witness or missing person
- To correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official
- To report information to a government authority regarding child abuse, neglect or domestic violence

- To share information with a coroner or medical examiner as authorized by law (we may also share information with funeral directors, as necessary to carry out their duties)
- To use or share information for procurement, banking or transplantation of organs, eyes or tissues
- To report information regarding job-related injuries as required by your state worker compensation laws
- To share information related to specialized government functions, such as military and veteran activities, national security and intelligence activities and protective services for the President and others
- To researchers when their research has been approved by an institutional review board that has approved the research proposal and established protocols to ensure the privacy of your health information
- To a family member or friend under any of the following circumstances: (1) if you provide a verbal agreement to allow such a disclosure; (2) if you are given an opportunity to object to such a disclosure and you do not raise an objection; or (3) if it can be inferred from the circumstances, based on PacifiCare's professional judgment, that you would not object

Written Permission to Use or Share Your Information

For any other activity or purpose not listed above or as otherwise permitted by law we must obtain your written permission, known as an authorization, prior to using or sharing your health information. If you provide a written authorization and you change your mind, you may revoke your authorization in writing at any time.

Once an authorization has been revoked, we will no longer use or share the health information as outlined in the authorization form; however, you should be aware that we may not be able to retract a use or disclosure that was previously made based on a valid authorization.

Other Restrictions Regarding Use and Disclosure of Your Information

Depending on the state in which you reside, there may be additional laws related to the use and disclosure of health information related to HIV status, communicable diseases, reproductive health, genetic test results, substance abuse, mental health and mental retardation.

Your Rights Regarding Your Health Information

The following are your rights with respect to your health information. If you would like to exercise the following rights, please call Member/Customer Services at the toll-free number on your health plan identification card.

You have the right to ask us to restrict how we use or share your health information for treatment, payment or health care operations. You also have the right to ask us to restrict health information that we have been asked to give to family members or to others who are involved in your health care or payment for your health care.

Please note that while we will try to honor your requests, we are not required by law to agree to the type of restrictions described above.

You have the right to request confidential communications of health information. For example, if you believe that sending your information to your current mailing address would put your safety at risk (e.g., in situations involving domestic disputes or violence), you may ask us to send the information by alternative means (such as by fax) or to an alternate address. We will accommodate reasonable requests for confidential communication of your information.

You have the right to inspect and obtain a copy of the health information we maintain about you in a designated record set. A designated record set refers to a group of records that includes enrollment, payment, claims adjudication, and case or medical management record systems maintained by or for PacifiCare. The types of health information included in a designated record set may vary depending on the state in which you reside.

This right does not obligate us to grant you access to certain types of health information. Please note that under most circumstances we will not provide you with copies of the following information:

- Psychotherapy notes
- Information compiled in reasonable anticipation of, or for use in, a civil or criminal administrative action or proceeding
- Information subject to certain federal laws governing biological products and clinical laboratories
- Medical information compiled and used for quality assurance or peer review purposes

If you request a copy of your designated record set, a fee for the costs of copying, mailing or other associated supplies may be charged.

Additionally, under certain circumstances we may deny your request to inspect or obtain a copy of your health information. If we deny your request, we will notify you in writing and may provide you the option to have the denial reviewed.

If you would like to request access to review or copy your patient medical records, please directly contact your Primary Care Physician or the health care provider who created the records. Patient medical records include records in any form or medium maintained by, or in the custody or control of, a health care provider relating to health history, diagnosis, or condition of a patient, or relating to treatment provided or proposed to be provided to the patient.

You have the right to ask us to make changes to the health information that we maintain about you in your designated record set. These changes are referred to as amendments. We may require that your request be in writing and that you provide a reason for your request.

If we make the amendment, we will notify you that it was made. If we deny your request to amend, we will notify you in writing of the reason for denial. This written notification will explain your right to file a written statement of disagreement. In return, we have a right to rebut your statement. Furthermore, you have the right to request that your initial written request, our written denial and your statement of disagreement be included with your health information for any future disclosures.

You have the right to receive an accounting of certain disclosures of your health information made by us during the six years prior to your request. We may require that your request for an accounting be in writing. Your first accounting is free. Subsequently, you are allowed one free accounting upon request every 12 months. If you request an additional accounting within 12 months of receiving your free accounting, we may charge you a fee. We will inform you in advance of the fee and provide you with an opportunity to withdraw or modify your request.

Please note that, under most circumstances, we are not required to provide you with an accounting of disclosures of the following information:

- Any information collected prior to April 14, 2003
- Information shared for treatment, payment or health care operations
- Information already disclosed to you
- Information shared as part of an authorization request

- Information that is incidental to a use or disclosure that is otherwise permitted
- Information provided for use in a facility directory
- Information that was provided to persons involved in your care or for other notification purposes
- Information shared for national security or intelligence purposes
- Information that was shared or used as part of a limited data set for research, public health or health care operation purposes
- Information disclosed to correctional institutions, law enforcement officials or health oversight agencies

Questions Regarding Use and Disclosure and Your Privacy Rights

How to File a Privacy Complaint

If you believe that your privacy rights have been violated, you may file a complaint with us by calling PacifiCare's Privacy Line at 1-800-481-6982. You may also direct your complaints to the Secretary of the U.S. Department of Health and Human Services.

PacifiCare will not penalize you or take any action against you for filing a complaint.

How to Obtain More Information Regarding Your Rights as Well as the Use and Disclosure of Your Health Information.

If you have any questions about how we use or share your health information or your rights regarding your health information, you may call Member/Customer Services at the toll-free number on your health plan identification card during normal business hours.

PacifiCare Family of Companies includes:

Antero Health Plans, Inc.
 PacifiCare of Arizona, Inc.
 PacifiCare of California
 PacifiCare Behavioral Health of California, Inc.
 PacifiCare of Colorado, Inc.
 PacifiCare Behavioral Health, Inc.
 PacifiCare of Nevada, Inc.
 PacifiCare of Oklahoma, Inc.

PacifiCare Dental
 PacifiCare of Oregon, Inc.
 PacifiCare Dental of Colorado, Inc.
 PacifiCare of Texas, Inc.
 PacifiCare of Washington, Inc.
 Rx Solutions, Inc.
 PacifiCare Life and Health Insurance Company
 PacifiCare Life Assurance Company

Secure Horizons
P.O. Box 489
Cypress, CA 90630

Member Service

1-800-228-2144
TDHI 1-800-685-9355
7:00 a.m. to 9:00 p.m.
Monday through Friday

Sales Information

1-800-610-2660
TDHI 1-800-387-1074
6:00 a.m. to 6:00 p.m. PST
Monday through Friday

Visit our Web site at
www.securehorizons.com

Secure Horizons Medicare+Choice Group Retiree Plans are offered by PacifiCare®, that contracts with the federal government. Anyone with Medicare Parts A and B may apply. Members must continue to pay Medicare premiums and use contracting providers for routine care. Limitations, copayments and coinsurance will apply. All members must meet the eligibility requirements to enroll for group coverage. Health plan premiums vary by employer group.