PacifiCare®
of California

Amendment to Combined Evidence of Coverage and Disclosure Form

Please read the following amendment to the PacifiCare of California Combined Evidence of Coverage and Disclosure Form ("your EOC") carefully. It contains changes to your health coverage that take effect January 1, 2002. This document is part of your EOC and should be kept with your EOC booklet.

YOUR PACIFICARE OF CALIFORNIA COMBINED EVIDENCE OF COVERAGE AND DISCLOSURE FORM IS AMENDED AS FOLLOWS:

A. The following provision ("Cancer Clinical Trials") is added under the section of your EOC captioned "Benefits While Hospitalized as an Inpatient":[1,2]

Cancer Clinical Trials – All Routine Patient Care Costs related to an approved therapeutic clinical trial for cancer (Phases I, II, III and IV) are covered for a Member who is diagnosed with cancer and whose Participating Treating Physician recommends that the clinical trial has a meaningful potential to benefit the Member.

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

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

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

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[1] Members must pay all applicable copayments at the time each service is rendered. Please consult your *Schedule of Benefits* for copayment information, or call Customer Service for more information.

[2] For Point of Service (POS) Members, this benefit is only covered under option one and is excluded from coverage under Options Two and Three.

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

- Drugs or devices that have not been approved by the federal Food and Drug Administration and that are associated with the clinical trial.
- Services other than health care services, such as travel, transportation, housing, companion expenses, and other non-clinical expenses that you may require as a result of the treatment being provided for purposes of the clinical trial.
- Any item or service that is provided solely to satisfy data collection and analysis needs and that is not used in the clinical management of your care.
- Health care services that, except for the fact that they are being provided in a clinical trial, are otherwise specifically excluded from coverage under PacifiCare.
- Health care services customarily provided by the research sponsor free of charge.

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

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

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

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

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

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

B. The following provision ("Cancer Clinical Trials") is added under the section of your EOC captioned *"Benefits Available on an Outpatient Basis"*:[1,2]

Cancer Clinical Trials – Please refer to the benefit described above under Inpatient Cancer Clinical Trials. Outpatient services copayments, coinsurance or deductibles apply.

C. The provision "Hospice Care" under the section of your EOC captioned "*Benefits While Hospitalized as an Inpatient*" is deleted in its entirety and replaced with the following:[1,3]

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

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

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

D. The provision "Hospice Care" under the section of your EOC captioned "*Benefits Available on an Outpatient Basis*" is deleted in its entirety and replaced with the following:[1,3]

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

Hospice Services include skilled nursing services, certified home health aid services and homemaker services under the supervision of a qualified registered nurse; bereavement services; social services/counseling services; medical direction; volunteer services; pharmaceuticals, medical

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[1] Members must pay all applicable copayments at the time each service is rendered. Please consult your *Schedule of Benefits* for copayment information, or call Customer Service for more information.

[2] For Point of Service (POS) Members, this benefit is only covered under option one and is excluded from coverage under Options Two and Three.

[3] For Point of Service (POS) Members, this benefit is also covered as an Out-of-Network service.

equipment and supplies that are reasonable and necessary for the palliation and management of the terminal illness and related conditions; physical and occupational therapy and speech-language pathology services for purposes of symptom control, or to enable the Member to maintain activities of daily living and basic functional skills.

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

E. In the provision "Experimental or Investigational Treatment" under the section of your EOC captioned "*Exclusions and Limitations of Benefits*," the first paragraph is deleted in its entirety and replaced with the following:

Experimental or Investigational Treatment – Experimental or Investigational treatments are not covered unless required by an external, independent review panel pursuant to California Health and Safety Code Section 1370.4 or as described in the Medical Benefits description of "Cancer Clinical Trials" in this *Combined Evidence of Coverage and Disclosure Form*. Unless otherwise dictated by Federal or state law, decisions as to whether a particular treatment is Experimental or Investigational, and therefore not a covered benefit, are determined by PacifiCare's Medical Director or his or her designee based upon criteria established by PacifiCare's Technology Assessment Committee pursuant to the following guidelines.

F. The provision "Custodial Care" under the section of your EOC captioned "*Exclusions and Limitations of Benefits*" is deleted in its entirety and replaced with the following:

Custodial Care – Custodial Care is not covered except for those services provided by an appropriately licensed Hospice Agency or appropriately licensed hospice facility incident to a Member's terminal illness as described in the Medical Benefits description of Hospice Services in this *Combined Evidence of Coverage and Disclosure Form*. Custodial Care includes all homemaker services, respite care, convalescent care or extended care not requiring skilled nursing.

G. The following Definition ("Participating Provider") is added under the section of your EOC captioned "*Definitions*":

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

H. The following provision ("Uniformed Services Employment and Reemployment Rights Act") is added under the section of your EOC captioned "Continuation of Coverage":[4]

Uniformed Services Employment And Reemployment Rights Act – Continuation of Benefits Under USERRA. Continuation coverage under this Health Plan may be available to you through your employer under the Uniform Services Employment and Reemployment Rights Act of 1994,

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[4] Continuation coverage under USERRA only applies if you are enrolled in a group health plan product. This section does not apply to Individual Plans or Conversion policies.

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

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

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

I. The provision "Appeals Process" under the section of your EOC captioned "Responding to Your Concerns" has been deleted in its entirety and replaced with the following:

Appeals Process — PacifiCare's Health Services Department will conduct a review, and an initial determination, including an explanation of the reasons for the determination, will be sent to the Member within thirty (30) days of PacifiCare's receipt of the Member's appeal. For appeals involving the delay, denial or modification of health care services, PacifiCare's written response will describe the criteria or guidelines used and the clinical reasons for its decision, including all criteria and clinical reasons related to Medical Necessity. For determinations delaying, denying, or modifying health care services based on a finding that the services are not Covered Services, the response will specify the provisions in the plan contract that exclude that coverage. If the complaint is related to quality of care, the complaint will be reviewed through the procedure described in the section of this *Combined Evidence of Coverage and Disclosure Form* captioned "Quality Management Review."

If the Member is dissatisfied with the determination, the Member may, within sixty (60) days, submit or request that PacifiCare submit the appeal to voluntary mediation or binding arbitration before JAMS.

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

(ii) Binding Arbitration. With the exception of claims brought pursuant to the Plan's Quality Review Process, any claim, controversy dispute or disagreement between PacifiCare and Member which arises out of or is related to this Agreement that is not resolved by the above appeals and dispute resolution processes shall be resolved by binding arbitration by a single arbitrator. If the amount of the claim is less than $200,000, then the arbitrator shall have no jurisdiction to award more than $200,000. JAMS or such other neutral administrator as PacifiCare shall designate shall administer the arbitration. The JAMS Comprehensive Arbitration Rules and Procedures ("Rules") in effect at the time demand for arbitration is made will be applied to the arbitration. 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 Rules will be utilized. Arbitration hearings shall be held at the neutral administrator's offices in Los Angeles, California or at such other location as the parties may agree in writing. Civil discovery may be taken in such arbitration as provided by California law and civil procedure. The arbitrator(s) 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(s) shall have the power to grant all remedies provided by California law. The arbitrator(s) shall prepare in writing an award that includes the legal and factual reasons for the decision. The parties shall divide equally the fees and expenses of the arbitrator(s) and the neutral administrator except that in cases of extreme hardship, PacifiCare may assume all or part of a Member's share of the fees and expenses of the arbitrator(s) provided the Member has submitted a hardship application with JAMS or such other neutral administrator designated by PacifiCare. The approval or denial of a hardship application shall be determined by such administrator. The arbitrator(s) shall not have the power to commit errors of law or legal reasoning, and the award may be vacated or corrected pursuant to California law. The Federal Arbitration Act, 9 U.S.C. §§ 1-4, shall also apply to the arbitration.

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

Keep this amendment with your PacifiCare EOC/Member Handbook for further reference. If you have any questions or need further information, call PacifiCare Customer Service at 1-800-624-8822 (for HMO Members) or 1-800-913-9133 (for POS Members) [1-800-442-8833 Telecommunications Device for the Hearing Impaired (TDHI)]. Representatives are available to help you Monday through Friday, from 8:00 a.m. to 8:00 p.m.

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Customer Service:
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CM-102-31313.100
PC9540

PacifiCare®
of California

Combined Evidence of Coverage & Disclosure Form

HMO

INSIDE FRONT COVER

Welcome to PacifiCare's® HMO Plan

Congratulations! By becoming a Member of PacifiCare, you've taken advantage of an exciting choice in health care coverage.

PacifiCare coverage is a health care choice that provides you with affordable, quality care. You pay no deductibles and pay only minimal charges (called Copayments) for doctor visits. There are no dollar limits for physician care or hospitalization. And there are no bothersome claim forms. Your care will be managed by a Primary Care Physician selected from PacifiCare's list of participating doctors and medical groups.

Your Combined Evidence of Coverage and Disclosure

This *Combined Evidence of Coverage and Disclosure* is designed to help you better understand the services available to you through PacifiCare, and to assist you in using those services.

Please refer to your *Schedule of Benefits* for a summary listing of benefits, Copayments, exclusions and limitations. Please read the following information so you will know from whom or what group of providers health care coverage may be obtained.

If there is anything you don't understand, please contact our Customer Service department at 1-800-624-8822 or 1-800-442-8833 Telecommunications Device for the Hearing Impaired (TDHI), Monday through Friday 8:00 a.m. to 8:00 p.m.

Note: This *Combined Evidence of Coverage and Disclosure Form* discloses the terms and conditions of coverage with PacifiCare and all applicants have a right to view this document prior to enrollment. This Form should be read completely and carefully. Individuals with special health needs should carefully read those sections that apply to them. You may receive additional information about the benefits of the PacifiCare health plan by calling 1-800-624-8822 or 1-800-442-8833 (TDHI).

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Getting Started

Joining

To join you will need to enroll during the period designated by your employer. At that time, you may choose PacifiCare as your health care plan. An enrollment form has been enclosed for your convenience. In addition, an enrollment form may be obtained from your employee benefits office.

When Does Coverage Begin?

Your PacifiCare coverage begins on the effective date established by your employer.

Eligibility

You are eligible to enroll in PacifiCare if you:

- meet the eligibility requirements defined by your employer;
- reside within PacifiCare's Service Area in California; and
- select a Participating Medical Group located within a 30-mile radius of your Primary Residence or Primary Workplace.

Your Spouse and unmarried children receive the same coverage provided they meet the requirements above. Your employer will determine the age limit for coverage of unmarried children. Coverage can be extended beyond this age limit if the unmarried child is:

- a full-time student at a certified educational institution; or
- physically or mentally handicapped and incapable of self-support.

Please refer to the sections titled Your Family's Eligibility and Total Disability.

Adding Family Members

Family members are also invited to join PacifiCare, as long as they meet your employer's eligibility requirements. If you:

- get married;
- have a baby;
- have an adoptive placement by a recognized county or private agency, or adopt a child as documented by a health facility minor release form, a medical authorization form, or a relinquishment form, granting you or your spouse the right to control the health care;
- obtain child guardianship as documented by a court.

Be sure to submit legal documentation with an enrollment application or Change Request Form to your employer for your new family Member within thirty-one (31) days.

Coverage for newborn children begins at birth, on the date of placement or physical custody for adopted children and on the court order effective date for guardianship. In order for coverage to continue beyond thirty-one (31) days after the birth or adoption, you must submit a Change Request Form prior to the expiration of the thirty-one (31) day period.

Coverage for a new spouse begins on the first day of the month following the submittal of the Change Request Form to your employer group. An application to enroll a Spouse or children who become dependents as a result of marriage must be made within thirty-one (31) days of the marriage.

If you do not enroll your new family Member within the thirty-one (31) day period, you may add them during the next Open Enrollment Period. Your child's enrollment and eligibility can not be denied because your child:

- was born to a single person or unmarried couple.
- is not claimed as a dependent on your Federal Income Tax return.
- does not reside with you or within the PacifiCare Service Area.

Qualified Medical Child Support Orders

A person having legal custody of a child or a custodial parent who is not a PacifiCare Member may ask about obtaining dependent coverage as required by a court or administrative order, including a Qualified Medical Child Support Order, by calling PacifiCare's Customer Service department at 1-800-624-8822 or 1-800-442-8833 (TDHI). A copy of the court or administrative order must be included with the enrollment application. Information including, but not limited to, the identification card, *Combined Evidence Of Coverage and Disclosure Form* or other available information including notice of termination will be provided to the custodial parent, caretaker and/or District Attorney. Coverage will begin on the first of the month following receipt by PacifiCare of an enrollment form with the court or administrative order attached.

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

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

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

Facilities – Provider Locations

In your *Provider Directory* you will find a listing of PacifiCare's Participating Medical Groups and hospitals including their addresses and telephone numbers. This information may also be obtained by calling PacifiCare's Customer Service department.

Geographic Area ("Service Area")

PacifiCare is licensed to serve many locations throughout the state of California. To be eligible for PacifiCare coverage, your residence must be within a PacifiCare licensed zip code. Please refer to your *Provider Directory* or contact PacifiCare's Customer Service department for exact locations of where PacifiCare is licensed to serve you.

Choosing a Physician

As a Member of PacifiCare, you and each family Member need to select a Primary Care Physician. The physician you select will provide or coordinate the provision of your medical and hospital services. The Primary Care Physicians you and your employed dependents choose must be located within a 30-mile radius of either your Primary Residence or Workplace. All other dependents must select a physician within a 30-mile radius of their Primary Residence. Each family Member may choose a different Primary Care Physician.

If you do not select a Primary Care Physician at enrollment, and list him or her on your enrollment application, PacifiCare will assign a Primary Care Physician for you and each of your dependents.

Reproductive Health Disclosure

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

Changing Participating Medical Groups or Primary Care Physicians

You may change your Participating Medical Group or Primary Care Physician by calling PacifiCare's Customer Service department at 1-800-624-8822 or 1-800-442-8833 (TDHI). If your change request is received on or before the 15th of the month, PacifiCare will change your Participating Medical Group or Primary Care Physician effective the first day of the following month. If PacifiCare receives your change request after the 15th of the month, the change will be effective the first day of the second month following the request.

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

Requests for a change of Participating Medical Group or Primary Care Physician may be denied if (a) PacifiCare determines the transfer would have an adverse effect on the quality of care given to you, or (b) the requested Participating Medical Group or Primary Care Physician is not located within a thirty (30)-mile radius of your Primary Residence or Primary Workplace.

PacifiCare may require that a Member select a new Participating Medical Group or Primary Care Physician if there is a breakdown in the Member's relationship with his or her Participating Medical Group or Primary Care Physician. In such an event, the Member shall be required to select a new Participating Medical Group or Primary Care Physician within 31 days of receiving notice from PacifiCare.

Scheduling Appointments

After you have selected a Primary Care Physician, you may simply call your chosen provider to make an appointment.

Referrals To Specialists

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

- If your Primary Care Physician determines you need to see a specialist, he or she will make an appropriate specialist referral.
- Your Primary Care Physician will determine the number of specialist's visits that you require and will provide you with any other special instructions.

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

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

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 Participating Medical Group'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 participating specialist as indicated in the treatment plan, if any. The standing referral will be made according to a treatment plan approved by your Participating Medical Group or PacifiCare, in consultation with your Primary Care Physician, the specialist, and you, if a treatment plan is considered necessary. The treatment plan may limit the number of visits to the specialist, may limit the period of time the visits are authorized, or may require the specialist to provide your Primary Care Physician with regular reports on the health care provided to you. You may request a standing referral by asking your Primary Care Physician or specialist.

Extended Referral for Coordination of Care By 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 participating 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. To receive an "extended specialty referral" your Primary Care Physician must determine, in consultation with the specialist or specialty care center and your Participating Medical Group'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 Participating Medical Group's Medical Director or a PacifiCare Medical Director, in consultation with your Primary Care Physician, the specialist, and you, if a treatment plan is considered necessary. 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.

Direct Access To OB/GYN Physician Services

You may obtain obstetrical and gynecological (OB/GYN) physician services directly from a Participating OB/GYN or Participating Family Practice Physician (designated by your Participating Medical Group/IPA as providing OB/GYN physician services) affiliated with your Participating Medical Group. This means that no prior authorization or referral from your Primary Care Physician is required to obtain OB/GYN physician services from a Participating OB/GYN or Family Practice Physician affiliated with your Participating Medical Group. However, if you directly access an OB/GYN or Family Practice Physician not affiliated with your Participating Medical Group, you will be financially responsible for these services. Any OB/GYN inpatient or Hospital Services, except Emergency or Urgently Needed Services, must be authorized in advance by your Participating Medical Group or PacifiCare.

If you would like to obtain OB/GYN physician services directly from an OB/GYN or Family Practice Physician affiliated with your Participating Medical Group:

- Telephone your Participating Medical Group (the telephone number is listed on your ID Card) and request the names and telephone numbers of the OB/GYNs affiliated with your Primary Medical Group.
- Telephone and schedule an appointment with your selected Participating OB/GYN or Family Practice Physician.

Your selected OB/GYN will communicate with your Primary Care Physician regarding your condition, treatment and any need for follow-up care.

PacifiCare also covers important Wellness Services for our Members. Please refer to the Well-Woman Care section of this brochure for a description of the preventive OB/GYN services available to PacifiCare members.

Continuity of Care for Terminating Physicians

In the event your contracting physician is terminated by PacifiCare or your Participating Medical Group 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 provider 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 post-partum for pregnancy related conditions or until your care can safely be transferred to another provider. This does not apply to physicians who have voluntarily terminated their participation with PacifiCare or a Participating Medical Group.

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); or
- pregnancy in the second or third trimester

and your physician is terminated, you may request permission to continue receiving treatment from the terminated physician beyond the termination date by calling PacifiCare. Your Participating Medical Group's Medical Director in consultation with your terminated physician will determine the best way to manage your ongoing care. PacifiCare must preauthorize 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, you may call PacifiCare Customer Service department.

Authorization, Modification and Denial of Health Care Services

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

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

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

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

- Decisions to approve, modify, or deny requests for authorization of health care services, based on Medical Necessity, will be made in a timely fashion appropriate for the nature of the Member's condition, not to exceed five (5) business days from PacifiCare's or the Participating Medical Group's receipt of the information reasonably necessary to make the decision.
- If the Member's condition poses an imminent and serious threat to their health, including but not limited to potential loss of life, limb, or other major bodily function, or lack of timeliness would be detrimental in regaining maximum function, the decision will be rendered in a timely fashion appropriate for the nature of the Member's condition, not to exceed seventy-two (72) hours after PacifiCare's receipt of the information reasonably necessary and requested by PacifiCare to make the determination.
- If the decision cannot be made within these timeframes because (i) PacifiCare or the Participating Medical Group is not in receipt of all of the information reasonably necessary and requested, or (ii) PacifiCare or the Participating Medical Group requires consultation by an expert reviewer, or (iii) PacifiCare or the Participating Medical Group has asked that an additional examination or test be performed upon the Member, provided the examination or test is reasonable and consistent with good medical practice, PacifiCare or the Participating Medical Group will notify the provider and the Member, in writing, that a decision cannot be made within the required timeframe. The notification will specify the information requested but not received or the additional examinations or tests required, and the anticipated date on which a decision may be rendered. Upon receipt of all information reasonably necessary and requested by PacifiCare or the Participating Medical Group, PacifiCare or the Participating Medical Group shall approve, modify, or deny the request for authorization within the timeframes specified above as applicable.

PacifiCare and Participating Medical Groups notify requesting providers of decisions to approve, modify, or deny requests for authorization of health care services for Members within 24 hours of the decision. Members are notified of decisions to deny, delay or modify requested health care services, in writing, within two business days of the decision, including a description of the reasons for the decision, the criteria or guidelines used, the clinical reasons for decisions regarding Medical Necessity, and information about how to file an appeal of the decision with PacifiCare. PacifiCare's Appeals Process is outlined in the General Information section of this *Combined Evidence of Coverage and Disclosure Form*.

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

Second Medical Opinions

A Member, or his or her treating participating health professional, may submit a request for a second medical opinion to the Participating Medical Group (or in some cases PacifiCare, therefore Member should consult his or her Primary Care Physician). Second medical opinions will be provided or authorized when medically appropriate, including, but not limited to, the following: (i) the Member questions the reasonableness or necessity of recommended surgical procedures; (ii) the Member questions a diagnosis or plan for care for a condition, that threatens loss of life, loss of limb, loss of bodily functions, or substantial impairment, including but not limited to a chronic condition; (iii) the clinical indications are not clear or are complex and confusing, a diagnosis is in doubt due to conflicting test results, or the treating provider is unable to diagnose the condition and the Member requests an additional diagnosis; (iv) the treatment plan in progress is not improving the medical condition of the Member within an appropriate period of time given the diagnosis and plan of care, and the Member requests a second opinion regarding the diagnosis or continuance of the treatment; or (v) the Member has attempted to follow the plan of care or consulted with the initial provider concerning serious concerns about the diagnosis or plan of care.

The request for a second medical opinion will be approved or denied by the Participating Medical Group (or a PacifiCare Medical Director as applicable) in a timely fashion appropriate for the nature of the Member's condition. When the Member's condition is such that the Member faces an imminent and serious threat to his or her health, including, but not limited to, the potential loss of life, limb, or other major bodily function, or lack of timeliness that would be detrimental to the Member's ability to regain maximum function, the second opinion shall be authorized or denied in a timely fashion appropriate for the nature of the Member's condition, not to exceed 72 hours after the Participating Medical Group's (or PacifiCare's as applicable) receipt of the request, whenever possible. When the Member's condition does not create an imminent and serious

threat to his or her health, the second opinion shall be rendered in a timely fashion appropriate for the nature of the Member's condition, not to exceed five (5) business days after receipt of the request by the Participating Medical Group or PacifiCare, as applicable. Second medical opinions will be rendered by an appropriately qualified health care professional. An appropriately qualified health care professional is a Primary Care Physician or a specialist who is acting within his or her scope of practice and who possesses the clinical background related to the illness or condition associated with the request for a second medical opinion.

If the Member is requesting a second medical opinion about care received from his or her Primary Care Physician, the second medical opinion will be provided by an appropriately qualified health care professional of the Member's choice within the same Participating Medical Group/IPA. If the Member is requesting a second medical opinion about care received from a specialist, the second medical opinion will be provided by any provider of the Member's choice from any independent practice association or medical group within the PacifiCare participating provider network of the same or equivalent specialty.

A second medical opinion is an examination by an appropriately qualified health professional documented by a consultation report. The consultation report will be made available to the Member and his or her initial health professional and shall include any recommended procedures or tests that the second opinion health professional believes are appropriate. If the Provider giving the second medical opinion recommends a particular treatment, diagnostic test or service covered by PacifiCare, and is determined to be Medically Necessary by the Member's Participating Medical Group or PacifiCare, the treatment, diagnostic test or service will be provided or arranged by the Member's Participating Medical Group. However, the fact that an appropriately qualified health care professional, furnishing a second medical opinion, recommends a particular treatment, diagnostic test or service does not necessarily mean that the treatment, diagnostic test or service is Medically Necessary or a Covered Service under the Member's PacifiCare Health Plan. The Member shall be responsible for paying an outpatient physician office Copayment, as set forth in the Member's PacifiCare Health Plan, to the PacifiCare participating provider who renders the second medical opinion to the Member.

If a Member's request for a second medical opinion is denied, PacifiCare will notify the Member in writing of the reasons for the denial. The Member may appeal the denial by following the procedures outlined in the Appeals Process section of this *Combined Evidence of Coverage and Disclosure Form*. If the Member obtains a second medical opinion without prior authorization from his or her Participating Medical Group or PacifiCare, the Member will be financially responsible for the costs of such services.

To obtain a copy of the Second Medical Opinion Timeline, Members may call or write PacifiCare Customer Service at:

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

Arranging Hospitalization

Your Primary Care Physician will arrange for Medically Necessary hospital or facility care, including transitional inpatient care or care provided in a subacute or Skilled Nursing Facility. If you have been referred to a specialist and the specialist determines you need hospitalization, your Primary Care Physician and specialist will work together to coordinate your hospital stay.

Your hospital costs, including semiprivate room, tests and doctor visits, will all be covered, minus any required Copayment(s).

Under normal circumstances, your Primary Care Physician will coordinate your admission to a local PacifiCare participating hospital or facility. If your situation warrants, however, you could be transported to a regional medical center.

If medically appropriate, your Primary Care Physician may discharge you from the hospital to a subacute or Skilled Nursing Facility or arrange for you to be cared for in the comfort of your home.

PacifiCare's Case Management Program

PacifiCare's Case Management Program is a program in which PacifiCare of California has licensed registered nurses who, in collaboration with the Member, Member's family and the Member's Participating Medical Group help arrange care for PacifiCare Members experiencing a major illness or recurring hospitalizations. Case Management is a collaborative process, which assesses, plans, implements, coordinates, monitors and evaluates options to meet an individual's health care needs based on the health care benefits and available resources. For further assistance please contact PacifiCare's Customer Service department.

Using Emergency or Urgently Needed Services

Worldwide, wherever you are, PacifiCare provides coverage for emergency medical services.

Emergency Services

Emergency Services are Medically Necessary ambulance and ambulance transport services provided through the 911 emergency response system and medical screening, examination and evaluation by a physician, or other personnel, to the extent provided by law, to determine if an Emergency Medical Condition or psychiatric emergency medical condition exists, and if it does, the care, treatment, and/or surgery by a physician necessary to relieve or eliminate the Emergency Medical Condition or psychiatric emergency medical condition within the capabilities of the facility

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

- Placing the Member's health in serious jeopardy;
- Serious impairment to your bodily functions;
- Serious dysfunction of any bodily organ or part;or
- Active labor, meaning labor at a time that either of the following would occur:

  (1) there is inadequate time to effect safe transfer to another hospital prior to delivery; or

  (2) a transfer poses a threat to the health and safety of the Member or unborn child.

What To Do When You Require Emergency Services

If you believe that you need Emergency Services you should:

- **Call 911 or go directly to the nearest medical facility for treatment.**

It is appropriate for you to use the 911 emergency response system, or alternative emergency system in your area, for assistance in an emergency situation as described above when ambulance transport services are required and you reasonably believe that your condition is immediate and serious and requires emergency ambulance transport services to transport you to an appropriate facility.

You must notify PacifiCare or your Participating Medical Group within 24 hours or as soon as reasonably possible after the initial receipt of Emergency Services to inform them of the location, duration and nature of the services provided.

Urgently Needed Services

An Urgently Needed Service is a Medically Necessary service required outside your Service Area to prevent serious deterioration of your health resulting from unforeseen illness or injury manifesting itself by acute symptoms of sufficient severity, which may include severe pain, such that treatment cannot be delayed until you return to your Service Area.

Urgent situations refer to less serious medical conditions than emergency situations. Examples include:

- broken bones (i.e. arm, leg),
- non-life-threatening cuts which nevertheless require immediate suturing to ensure proper healing,
- acute illnesses when you are outside the PacifiCare Service Area and the delay necessary to return to the Service Area or to contact your Participating Medical Group would result in a serious deterioration in your health.

What To Do When You Require Urgently Needed Services

If you are temporarily outside the Service Area and you believe that you require Urgently Needed Services, you should:

- If possible, call, or have someone on your behalf call, your Primary Care Physician or Participating Medical Group. The telephone numbers for your Primary Care Physician and Participating Medical Group are on the front of your PacifiCare ID card. Assistance is available 24 hours a day, seven days a week.
- Identify yourself as a PacifiCare Member and ask to speak to a physician. If you are calling during non-business hours and a physician is not immediately available, ask to have the physician-on-call paged. A physician should call you back shortly.
- Explain your situation and follow the instructions provided.

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

You must notify PacifiCare or your Participating Medical Group within 24 hours or as soon as reasonably possible after the initial receipt of Urgently Needed Services to inform them of the location, duration and nature of the services provided.

It is very important that you follow the steps outlined under What to Do When You Require Emergency Services and What to Do When You Require Urgently Needed Services. If you do not, you may be financially responsible for services received.

Post-Stabilization and Follow-Up Care

If you require additional services following stabilization of an emergency or urgently needed condition, you should obtain these services from or with the authorization of your Primary Care Physician in your Participating Medical Group or the PacifiCare Out-of-Area Unit. The PacifiCare Out-of-Area Unit can be reached at 1-800-762-8456. Follow-up care provided in an emergency room is not a covered benefit unless you obtain prior authorization from your Primary Care Physician or PacifiCare.

Out-of-Area follow-up care includes, but is not limited to: Routine follow-up care to Emergency or Urgently Needed Services, such as treatments, procedures, X-rays, lab work and doctor's visits, as well as Rehabilitation Services, Skilled Nursing Care or home health care. Prior authorization must be obtained from your Participating Medical Group or PacifiCare for follow-up care to be covered.

Receiving Medical Care "After Hours"

You may need to talk to or see your contracting Primary Care Physician after his or her office has closed for the day. Just call the 24-hour number located on the front of your PacifiCare ID card. The medical professional on-call will advise you how to proceed.

Non-Qualifying Services

Medical or Hospital Services which do not qualify as Emergency or Urgently Needed Services received without prior authorization from your Primary Care Physician in your Participating Medical Group are not covered. Thus, for example, medical care provided outside the Service Area will not be covered if the need for care is for a known or chronic condition that is not showing acute symptoms as described in Emergency Services or Urgently Needed Services.

Payment Responsibility

Premiums (Prepayment Fees)

Your employer is responsible for submitting all of the premiums for you to PacifiCare. However, your employer may require that you pay a portion of the premiums. Please contact your Health Benefits Officer at work for information on the method, amount and frequency of your contribution, if any.

Copayments

When you receive medical care, you may be responsible for paying a charge called a Copayment. Your required Copayment amounts are outlined in the *Schedule of Benefits* included with this brochure. Your Copayment amounts will vary depending upon where you choose to receive your care.

Annual Copayment Maximum

To protect you from large expenses, a limit – called your Annual Copayment Maximum – is placed on the dollar amount of certain Copayments you might have to pay during a calendar year for medical benefits. When the Copayments you make during any calendar year exceed the Annual Copayment Maximum, then no further Copayments will be required for services received during the remainder of the calendar year.

It is important to retain receipts of all Copayments made, in order to submit proof of reaching the Annual Copayment Maximum.

Please refer to your *Schedule of Benefits* for the amount of your Annual Copayment Maximum.

The Annual Copayment Maximum includes Emergency and Urgently Needed Services, and coverage for Severe Mental Illnesses (SMI) of adults and children and for children with Serious Emotional Disturbances of Children (SED), but it does not apply to any PacifiCare of California supplemental benefits offered by your employer.

The family Annual Copayment Maximum is computed at three times the individual maximum unless otherwise specified on your *Schedule of Benefits*.

If you believe you have surpassed your Annual Copayment Maximum, please submit all receipts and a letter of explanation to:

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

Any payments you have made beyond your individual or family Annual Copayment Maximum will be reimbursed by PacifiCare.

Lifetime Benefit Maximum

Your health care coverage may be subject to a Lifetime Benefit Maximum for the duration of your coverage under the PacifiCare Health Plan. Please refer to your *Schedule of Benefits* for the amount of your Lifetime Benefit Maximum, if any. If your *Schedule of Benefits* indicates that your PacifiCare Health Plan has a Lifetime Benefit Maximum, the Lifetime Benefit Maximum will be calculated for you and any Dependents on an individual basis. The Lifetime Benefit Maximum will be reached when total covered charges for Covered Services received by you or any of your Dependents reaches the amount set forth in your *Schedule of Benefits*. Covered charges mean the rates for services negotiated by the Plan or its contracting providers for Covered Services, less the amount of the Member's copayment. Once you reached the Lifetime Benefit Maximum amount no further coverage for the services described in your *Combined Evidence of Coverage and Disclosure Form* will be available under this PacifiCare Health Plan. This Lifetime Benefit Maximum does not apply to any PacifiCare of California supplemental benefits offered by your employer. Some supplemental benefits may be subject to a separate maximum benefit. Please refer to the *Supplement to the Combined Evidence of Coverage and Disclosure Form* for more information. If you or one of your enrolled family members is experiencing a major illness or recurring hospitalizations, PacifiCare's Case Management Program can assist in coordinating resources. Please refer to PacifiCare's Case Management Program in the Accessing Care section of this brochure for further information about this program.

The Lifetime Benefit Maximum is individually cumulative for you and any of your Dependents if you are enrolled in a PacifiCare Health Plan with a Lifetime Benefit Maximum. If you or any of your Dependents end your coverage under a PacifiCare Health Plan with a Lifetime Benefit Maximum, then re-enroll later in another PacifiCare Health Plan with a Lifetime Benefit Maximum, any covered charges calculated under your previous PacifiCare Health Plan will carry over to your new PacifiCare Health Plan.

What If I Get a Bill? (Reimbursement)

If for some reason you are billed for Covered Services, please call our Customer Service department at 1-800-624-8822, Monday through Friday 8:00 a.m. to 8:00 p.m.

If the bill is for Covered Services which have been authorized by your Primary Care Physician in your Participating Medical Group, and you have not exceeded the benefit limits, the bill will be paid on your behalf.

However, if the bill is for non-covered services, or has not been authorized by your Primary Care Physician in your Participating Medical Group, or you have exceeded the benefit limits, the bill will not be paid by PacifiCare and will remain your responsibility.

Bills From Participating Providers

If for some reason you are billed for Covered Services provided or authorized by your Primary Care Physician or Participating Medical Group, please follow these steps:

1. Call the sender and let them know you have received a bill in error and you will be forwarding the bill to PacifiCare.
2. Provide the sender with your PacifiCare health plan information, including your name and PacifiCare Member number.
3. Forward the bill to:

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

Include your name, your PacifiCare Member number and a brief note indicating: "This bill was received for covered services I should not be billed for." No claim forms are required.

Bills From Non-Participating Providers

If you receive a bill for Covered Services from a non-participating provider, forward the bill to PacifiCare's Claims Department at the address listed above along with your name and Member number. No claims forms are required.

You must file claims with PacifiCare within 90 days of the date you receive the services or supplies. If you cannot file the claim within 90 days you must file the claim as soon as reasonably possible. PacifiCare will not pay any claim that is filed more than one year from the date the services or supplies were provided.

If you have any questions regarding what to do if you receive a bill please call PacifiCare's Customer Service department and a Customer Service Associate will assist you with the steps listed above.

If the bill is for covered services which have been authorized by your Primary Care Physician in your Participating Medical Group and you have not exceeded the benefit limits, the bill will be paid on your behalf. However, if the bill is for non-covered services, or has not been authorized by your Primary Care Physician in your Participating Medical Group, or you have exceeded the benefit limits, the bill will not be paid by PacifiCare and will remain your responsibility.

You should know that by law you have certain rights and responsibilities with regard to bills. If you receive properly authorized covered services from a PacifiCare Participating Provider you are not responsible for paying those bills even in the unlikely event that PacifiCare would be unable to pay them on your behalf, for instance, in the case of PacifiCare's insolvency or natural disaster. However, if you receive properly authorized covered services from a non-participating provider, or Emergency or Urgently Needed Services from a non-participating provider, you may be responsible for the amount of those bills in the unlikely event that PacifiCare is financially unable to pay them on your behalf. In the event you receive a bill because a non-participating provider refused to accept payment from PacifiCare, you may submit a claim for reimbursement as described above.

Member Liability (Choice of Physician and Providers)

When covered services are received under the direction of your Participating Medical Group or Physician, you are only responsible for any applicable Copayments.

If you choose to receive services not covered, or services not under the direction of your Participating Medical Group or Physician, you may be responsible for payment of these services. (This does not apply if services were received on an emergency or urgently needed basis.)

Non-covered services are listed in the Exclusions and Limitations of Benefits section of this brochure.

Coordinating Benefits

If you or a family Member are covered by PacifiCare and another health plan, PacifiCare will coordinate its benefits with those of the other plan, provided that you have obtained authorization from your Primary Care Physician. The goal of this kind of coordination is to maximize coverage for allowable expenses, minimize out-of-pocket costs and to prevent any payment duplication.

PacifiCare coordinates benefits in accordance with the National Association of Insurance Commissioners' guidelines and California law.

In order to ensure proper coordination, you must inform PacifiCare of any other health coverage for which you or your dependents may be eligible.

If PacifiCare pays more benefits than appropriate, PacifiCare may recover excess benefit payments from you, the plan with primary responsibility, or any other person or entity that benefited from the overpayment.

It also should be noted that failure to cooperate with PacifiCare in its efforts to coordinate benefits could result in termination of your membership.

Duplication of Benefits with Medicare

You also need to let PacifiCare know if you're eligible for Medicare benefits. PacifiCare may reduce its coverage to avoid duplication of benefits available from Medicare.

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

If you have questions regarding coordination with Medicare benefits, contact your employer or the PacifiCare Customer Service department. For answers to questions regarding Medicare eligibility, contact your local Social Security office.

Non-Duplication of Benefits with Workers' Compensation

If you are receiving benefits as a result of workers' compensation, PacifiCare will not duplicate those benefits.

It is your responsibility to take whatever action is necessary to receive payment under workers' compensation laws, when such payments can reasonably be expected.

If PacifiCare happens, for whatever reason, to duplicate benefits to which you are entitled under workers' compensation law, you are required to reimburse PacifiCare, at prevailing rates, immediately after receiving a monetary award, whether by settlement or judgment.

In the event of a dispute arising between you and your workers' compensation coverage regarding your ability to collect under workers' compensation laws, PacifiCare will provide the benefits described in this agreement, until the dispute is resolved.

If you receive a settlement of workers' compensation which includes payment of future medical costs, you may be liable to reimburse PacifiCare for those costs.

Reimbursement of Third-Party Medical Expenses

If you receive medical services under your PacifiCare 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 nominee, to the extent permitted under California Civil Code Section 3040 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 PacifiCare 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.

PacifiCare will provide benefits over and above your other automobile, accident or liability coverage, if the cost of your health care services exceeds such coverage.

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 PacifiCare membership.

Extraordinary Circumstances

In the unfortunate event of a major disaster, epidemic, war, riot, civil insurrection or complete or partial destruction of facilities, our Participating Medical Groups and hospitals will do their best to provide the services you need.

Under these extreme conditions, go to the nearest doctor or hospital for Emergency Services. PacifiCare will reimburse you later.

Changes in Coverage

Ending Coverage (Termination of Benefits)

Generally, your PacifiCare membership ends when your employer's Group Agreement ends. Please note that your employer group, and not PacifiCare, is responsible for providing you with the termination notice in the event your employer's Group Agreement terminates, for any reason, including non-payment of Health Plan Premiums by your employer. Your membership may also be terminated by PacifiCare for any one of the following reasons:

1. Failure to pay required Copayments, premiums or fees for non-covered services.
2. Fraud or deception in your enrollment application, or in your use of facilities or services.
3. Allowing unauthorized use of your PacifiCare identification card.
4. Your behavior is threatening, violent or abusive such that it seriously threatens or jeopardizes the safety of the employees of PacifiCare or its Participating Medical Groups.
5. Relocation outside PacifiCare's approved Service Area.
6. Loss of your eligibility except as outlined in Your Family's Eligibility, Continuing Coverage and COBRA sections.
7. Failure to cooperate with PacifiCare's coordination of benefits and third-party liability rights.
8. Voluntary termination in a manner determined by your employer.

General Information

When Your Termination of Benefits Is Effective

If your membership is terminated by PacifiCare, you will be provided with a termination notice in writing, which will include the time when the termination is effective. Generally, if you are terminated due to failure by you or your employer group to pay PacifiCare any required Health Plan Premiums, your coverage will terminate effective the last day for which payment was received, provided that you or your employer group have been duly notified. If you are terminated due to fraud or deception in your enrollment application, or in your use of facilities or services, your termination will be effective immediately upon mailing of the termination notice. Finally, if you are terminated for any of the other reasons set forth above, the termination will be effective 15 days after the termination notice is mailed to you by PacifiCare. Under no circumstances will your membership be terminated due to your health status or need for health care services.

If you feel your membership has been unfairly revoked, you may request a review before the California Department of Managed Health Care. For more information contact our Customer Service department.

If you or your eligible dependents are "Totally Disabled" at the time your employer group's coverage ends, please refer to the section of this brochure titled Total Disability for more information.

Your Family's Eligibility

Usually, your family's PacifiCare membership ends when your membership ceases. If there is a divorce, your Spouse loses membership eligibility at the end of the month in which your divorce is final. Dependent children relinquish their membership eligibility if they marry, or reach an age specified by your employer and are not registered on a full-time basis at a certified educational institution.

Unmarried dependent children who are physically or mentally handicapped or have a chronic debilitating condition and reside within the Service Area with either the Subscriber or the Subscriber's separated or divorced Spouse may remain covered or may enroll beyond the limiting age. (Proof of such incapacity must be provided to PacifiCare within 31 days of the dependent reaching the age specified by your employer or within 31 days of the onset of the disability or during an Open Enrollment Period.)

Notifying You of Changes In Your Plan

In most instances, your employer will notify you of any changes in your plan. PacifiCare will give your employer at least 30 days notice before it modifies or cancels your group health plan or any benefits. The plan also may be canceled by your employer upon written notice prior to contract expiration. Amendments, modifications or terminations by either your employer or PacifiCare do not require the consent of the plan's Members. However, it is your employer's responsibility to promptly notify all Members of any modification to the plan.

REPORTING CHANGES IN YOUR STATUS

Please notify your employer of changes in status of the information you provided on your enrollment application within 31 days of the change. For reporting changes in marital and/or dependent status, please see the information in Adding Family Members in the Getting Started section of this *Evidence of Coverage*. If you want to change your Primary Care Physician or Participating Medical Group, you may contact PacifiCare's Customer Service department at 1-800-624-8822 or 1-800-442-8833 (TDHI). The PacifiCare Customer Service department is available to help you with your concerns and provide answers to your questions. You may also write to us at:

PacifiCare of California
P.O. Box 6006
Mail Stop CY24-515
Cypress, CA 90630

Renewal or Reinstatement

Your contract with PacifiCare renews automatically, on a yearly basis, subject to all terms and conditions of the Group Agreement between PacifiCare and your employer. If either your contract or your employer's Group Agreement is terminated by PacifiCare, reinstatement with PacifiCare is subject to all terms and conditions of the Group Agreement between PacifiCare and your employer.

If you have questions about your employer's conditions for renewal or reinstatement, please contact your Health Benefits Officer at your place of work.

Continuation of Coverage

If you stop working full-time or lose your job for any reason, contact your employer to determine if any arrangements can be made for continuing your coverage under your employer's group health plan.

Creditable Coverage

Creditable Coverage is health care coverage as defined in the federal Health Insurance Portability and Accountability Act (HIPAA) which includes group coverage (including FEHBP and Peace Corps), individual coverage (including student health plans), Medicaid, Medicare, CHAMPUS, Indian Health Service or tribal organization coverage, state high-risk pool coverage, and public health plans. Creditable coverage is used to determine (a) the reductions that may apply to an enrollee's pre-existing conditions provisions, and (b) eligibility under HIPAA for individual coverage in any applicable State portability program. Individuals may receive credit for coverage under most medical plans. Employer health plans (for two or more employees) must recognize this credit for previous coverage when applying a pre-existing condition exclusions period.

Once an individual has accumulated twelve (12) months of creditable coverage, an employer health plan may no longer apply a pre-existing condition exclusion. Employer health plans must also recognize and apply credit to any pre-existing condition exclusion period for coverage totaling less than twelve (12) months. This way, no individual may be subject to more than twelve (12) total months under a pre-existing condition exclusion period, except for the following reasons:

1. The individual is a Late Enrollee. Late Enrollees may be subject to eighteen (18) months under a pre-existing condition exclusion.
2. The individual experiences a lapse in coverage of sixty-three (63) days or longer after the most recent period of coverage and before the enrollment date in an employer health plan.

Employer group waiting periods and HMO affiliation periods will not count toward the sixty-three (63)-day break in coverage or the twelve/eighteen (12/18) months of creditable coverage.

This is meant as a brief overview only; for more information on recent health care reform legislation and your rights under the law, please contact your employer.

Certification of Creditable Coverage

To document credit for previous health care coverage, health plans are required to forward Certificates of Creditable Coverage to all Employer Health Plan Subscribers upon cessation of coverage. The Certificate must include the time period you were on the plan and any employer imposed waiting period before coverage became effective (usually the date of hire).

If additional information is needed to properly track your coverage history, including employer imposed waiting periods or HMO affiliation periods, you may need to contact your employer to obtain this information. This Certificate may help you reduce or eliminate the waiting period for pre-existing conditions under another health plan. This Certificate can also be used to obtain individual coverage if you have eighteen (18) months of prior coverage (without a 63-day break in coverage) and you have no other coverage available to you.

Creditable Coverage information for eligible Dependents will be included on the Subscriber's Certificate, unless the Dependent's address of record or coverage information is substantially different from that of the Subscriber's.

Please call Customer Service to obtain additional Certificates of Creditable Coverage. Your first Certificate will be issued free of charge; follow-up requests for the same Certificate may involve a fee.

COBRA

If your employer is subject to the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985, as amended, you and your covered dependents may be entitled to continuation of coverage under your employer's group health care plan. Members may qualify for continuation of coverage if they lose coverage for one of the following reasons:

1. Termination or separation from employment for reasons other than gross misconduct.
2. Reduction of work hours.
3. Subscriber's death.
4. Your Spouse ceases to be eligible due to divorce or legal separation.
5. A dependent child ceases to be an eligible dependent.

Your employer is responsible for providing you notice of your right to receive continuing coverage under COBRA.

Extended COBRA Coverage

You and your Spouse (or former Spouse) may be eligible for an extension of your COBRA continuation coverage if you have worked for your employer for at least five years prior to the date of termination of employment and you are 60 years of age or older on the date employment ends. Such extended coverage will be provided in accordance with Section 1373.621 of the California Health and Safety Code, as amended, and except as otherwise specified in this section, extended coverage shall be under the same terms and conditions as if the coverage under COBRA had remained in force. To extend your COBRA continuation coverage, you or your Spouse must notify PacifiCare in writing within 30 calendar days prior to the date continuation coverage under COBRA is scheduled to end. Continuation coverage following the end of COBRA is subject to the payment of premiums to PacifiCare in accordance with Section 1373.621 of the California Health and Safety Code.

Individual Conversion

Also, you and your dependents may be able to convert to a PacifiCare Individual Conversion Plan once your employer group benefits and continued benefits under COBRA (if applicable) end. There are some enrollment guidelines for this coverage. Please consult the Group Agreement between PacifiCare and your employer for more details concerning individual conversion.

Please Note: If the agreement between your employer and PacifiCare terminates, neither Continuation of Benefits nor Individual Conversion provisions apply. Our Customer Service department and your employer can provide you with more information.

Total Disability

If you or your enrolled dependent(s) are Totally Disabled at the time your employer's Group Agreement is terminated with PacifiCare and continue to be Totally Disabled, PacifiCare will continue to provide coverage to the Totally Disabled Member for the condition causing the total disability for up to 12 months or until the Member is covered under another group health plan which does not have an enforceable pre-existing condition clause.

To qualify for these benefits you must provide written proof of the disability acceptable to PacifiCare from a participating Primary Care Physician within 90 days of the date on which coverage for your entire employer group was terminated. Please refer to the definition of "Totally Disabled or Total Disability" in the Definitions section of this brochure. PacifiCare may require you to periodically submit additional medical information to verify your Total Disability.

How PacifiCare Participating Providers Are Compensated

PacifiCare typically contracts with Participating Medical Groups to provide medical services to Members and with hospitals to provide hospital services. The Participating Medical Groups, in turn, employ or contract with individual physicians.

Most of our Participating Medical Groups receive an agreed-upon monthly payment from PacifiCare to provide services to Members. This monthly payment may be either a fixed dollar amount for each Member or a percentage of the monthly premium received by PacifiCare.

The monthly payment typically covers professional services directly provided by the Participating Medical Group, 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. Most acute care, subacute care, transitional care and skilled nursing facilities are paid on a fixed charge per day per inpatient care.

At the beginning of each year, PacifiCare and each Participating Medical Group agree on a budget for the cost of services under the program for all PacifiCare Members treated by the Participating Medical Group. At the end of the year, the actual cost of services for the year is compared to the agreed-upon budget.

If the actual cost of services is less than the agreed-upon budget, the Participating Medical Group shares in the savings. The hospital and Participating Medical Group typically participate in programs for hospital services similar to that described above.

Stop-loss insurance protects Participating Medical Groups and hospitals from large financial expenses. PacifiCare provides stop-loss protection to our Participating Medical Groups and hospitals that receive the monthly payments described above. If any 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 PacifiCare's compensation arrangements by contacting PacifiCare or your Participating Medical Group.

Public Policy Participation

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

Assessment of New Technology

PacifiCare has a Technology Assessment Committee to evaluate new medical technologies such as new procedures, devices and drugs. This committee is made up of PacifiCare medical directors and practicing doctors from various Participating Medical Groups. In addition, non-contracting specialists, such as cardiologists and urologists, review the committee's assessment of the new technologies.

Responding To Your Concerns

PacifiCare's top priority is meeting its customers' needs, and that means providing responsive service. If you ever have a question or problem, your first step is to call our Customer Service department at 1-800-624-8822 or 1-800-442-8833 (TDHI). A Customer Service Associate will make every effort to assist you.

If you feel the situation has not been addressed to your satisfaction, you may submit a formal appeal through our Member Appeals department. The address is:

PacifiCare of California
Appeals Department
5701 Katella/P.O. Box 6006
Cypress, CA 90630

This written request will initiate the Appeals Process described below. Each level of review will be conducted independently and at no time will a person who has been involved as a decision-maker in a determination made at one level of review be involved in a review of that determination. At the conclusion of each level of review, the reviewers shall file a report in the appeals file indicating the information which has been reviewed and the findings and conclusions of the reviewers.

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

Appeals Process

1. PacifiCare's Health Services department will conduct a review, and an initial determination, including an explanation of the reasons for the determination, will be sent to the Member within thirty (30) days of PacifiCare's receipt of the Member's appeal. For appeals involving the delay, denial or modification of health care services, PacifiCare's written response will describe the criteria or guidelines used and the clinical reasons for its decision, including all criteria and clinical reasons related to Medical Necessity. For determinations delaying, denying, or modifying health care services based on a finding that the services are not Covered Services, the response will specify the provisions in the plan contract that exclude that coverage. If the complaint is related to quality of care, the complaint will be reviewed through the procedure described in the section of this *Combined Evidence of Coverage and Disclosure Form* captioned Quality Management Review.
2. If the Member is dissatisfied after the determination by the Health Services department, the Member may request a review by the Appeals and Grievance Committee by submitting a request within thirty (30) days of the receipt of the Health Services Department's determination. A hearing before the Appeals and Grievance Committee will be scheduled within thirty (30) days of the Member's request for a hearing. The Member's participation at the Appeals and Grievance Committee hearing is encouraged.

3. If the Member is dissatisfied with the redetermination, the Member may, within sixty (60) days, submit or request that PacifiCare submit the appeal to voluntary mediation or binding arbitration before Judicial Arbitration and Mediation Services, Inc.(JAMS).

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

   (ii) Binding Arbitration — With the exception of claims brought pursuant to the Plan's Quality Review Process, any claim, controversy dispute or disagreement between PacifiCare and Member which arises out of or is related to this Agreement that is not resolved by the above appeals and dispute resolution processes shall be resolved by binding arbitration by a single arbitrator. If the amount of the claim is less than $200,000, then the arbitrator shall have no jurisdiction to award more than $200,000. JAMS or such other neutral administrator as PacifiCare shall designate shall administer the arbitration. The JAMS Comprehensive Arbitration Rules and Procedures ("Rules") in effect at the time demand for arbitration is made will be applied to the arbitration. 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 Rules will be utilized. Arbitration hearings shall be held at the neutral administrator's offices in Los Angeles, California or at such other location as the parties may agree in writing. Civil discovery may be taken in such arbitration as provided by California law and civil procedure. The arbitrator(s) 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(s) shall have the power to grant all remedies provided by California law. The arbitrator(s) shall prepare in writing an award that includes the legal and factual reasons for the decision. The parties shall divide equally the fees and expenses of the arbitrator(s) and the neutral administrator except that in cases of extreme hardship, PacifiCare may assume all or part of a Member's share of the fees and expenses of the arbitrator(s) provided the Member has submitted a hardship application with JAMS or such other neutral administrator designated by PacifiCare. The approval or denial of a hardship application shall be determined by such administrator. The arbitrator(s) shall not have the power to commit errors of law or legal reasoning, and the award may be vacated or corrected pursuant to California law. The Federal Arbitration Act, 9 U.S.C. §§ 1-4, shall also apply to the arbitration.

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

Quality Management Review

All complaints that involve quality of care issues are referred to PacifiCare's Health Services department for review. Complaints that affect a Member's immediate condition will receive immediate review. PacifiCare will investigate the complaint, consulting with Member's Participating Medical Group and other PacifiCare departments and reviewing medical records as necessary. You may need to sign an authorization to release your medical records.

Upon completion of the review, the Member will be notified. The results of the Quality Management review are confidential.

If a Member has asserted a claim for benefits or reimbursement as part of a quality of care complaint and if the claim is not resolved by the Quality Management review, the Member may obtain further review of his or her claim through the Appeals Process described previously.

Expedited Review

Complaints involving an imminent and serious threat to the health of the Member, including but not limited to potential loss of life, limb, or major bodily function, will be immediately referred to the PacifiCare Medical Director for expedited review, regardless of whether

such complaints are received orally or in writing.

If a complaint has been sent to the PacifiCare Medical Director for immediate expedited review, PacifiCare will immediately inform the Member in writing of his or her right to notify the Department of Managed Health Care of the grievance. PacifiCare will provide the Member and the Department of Managed Health Care with a written statement of the disposition or pending status of the expedited review no later than three days from receipt of the complaint.

Experimental or Investigational Treatment

If a PacifiCare Medical Director denies a treatment as Experimental or Investigational to a Member who has a terminal illness, PacifiCare, at Member's request, will hold a conference within thirty (30) days of the receipt of request to review the denial and the basis for determining that the proposed treatment or services are Experimental or Investigational. The conference will be held within five (5) days if the treating physician determines, in consultation with the PacifiCare Medical Director, based on professionally recognized standards of practice, that the effectiveness of either the proposed treatment or services would be materially reduced if not provided at the earliest possible date.

Independent Review of Denied Experimental or Investigational Treatment Eligibility Criteria

PacifiCare provides the opportunity to seek an independent review under California's Independent Medical Review System pursuant to Health & Safety Code Section 1370.4 of its coverage decisions regarding Experimental or Investigational therapies for PacifiCare Members who meet all of the following criteria:

1. The Member has a Life-Threatening or Seriously Debilitating condition, defined as:
   - "Life-Threatening" means either or both of the following: (i) diseases or conditions where the likelihood of death is high unless the course of the disease is interrupted; (ii) diseases or conditions with potentially fatal outcomes, where the end point of clinical intervention is survival
   - "Seriously Debilitating" means diseases or conditions that cause major irreversible morbidity;

   and
2. The Member's physician certifies that the Member has a Life-threatening or Seriously Debilitating condition, as defined above, for which standard therapies have not been effective in improving the Member's condition, or for which standard therapies would not be medically appropriate for the Member, or for which there is no more beneficial standard therapy covered by PacifiCare than the therapy proposed pursuant to paragraph (3); and
3. Either (a) the Member's PacifiCare contracted physician has recommended a treatment, drug, device, procedure or other therapy that he or she certifies in writing is likely to be more beneficial to the Member than any available standard therapies, and he or she included a statement of the evidence relied upon by the physician in certifying his or her recommendation; or (b) the Member, or the Member's non-contracting physician who is a licensed, board-certified or board-eligible physician qualified to practice in the area of practice appropriate to treat the Member's condition, has requested a therapy that, based on two documents from the medical and scientific evidence, as defined in California Health and Safety Code Section 1370.4(d), is likely to be more beneficial for you than any available standard therapy. The physician certification must include a statement of the evidence relied upon by the physician in certifying his or her recommendation. Please note that PacifiCare is not responsible for the payment of services rendered by non-contracting providers that are not otherwise covered under the Member's PacifiCare benefits; and
4. A PacifiCare Medical Director has denied the Member's request for a treatment or therapy recommended or requested pursuant to paragraph (3); and
5. The treatment or therapy recommended pursuant to paragraph (3) would be a covered service, except for PacifiCare's determination that the treatment, drug, device, procedure or other therapy is experimental or investigational.

How To Request an Independent Review

Within five (5) business days of a decision to deny coverage for an Experimental or Investigational therapy for a Member who has a Life-Threatening or Seriously Debilitating condition, PacifiCare will send the Member written notice of the denial and of the right to request an independent review if the physician certification and evidence requirements listed in Items 2 & 3 above are met. The denial notice from PacifiCare will include an application form, along with a preaddressed envelope, to be used to request an independent review from the Department of Managed Health Care (DMHC). PacifiCare also will include a physician certification form that must be completed by the Member's physician for the Member to be eligible for an independent review.

A Member who has a Life-Threatening or Seriously Debilitating condition and receives written notice from PacifiCare of its denial of coverage for a requested Experimental or Investigational therapy may request an independent review by completing the application form provided to the Member by PacifiCare and mailing the form to the DMHC in the preaddressed envelope provided by PacifiCare. The Member's physician must provide the physician certification and evidence listed in Items 2 & 3 above. The Member may include the completed physician certification with the Member's application mailed to the DMHC or the Member's physician may mail or fax the physician certification and evidence directly to the DMHC. The DMHC fax number is **1-916-229-0465**. The DMHC may also be reached by calling **1-888-HMO-2219**.

Upon receiving the Member's application for an independent review, the DMHC will review the Member's request and notify the Member in writing as to whether the request has been approved. The DMHC also will notify PacifiCare and the physician providing the certification that the Member's application has been approved.

Independent Review Procedures

If the Member requests an independent review, the review will be performed by an independent medical review organization (IRO) that has a contract with the DMHC. The IRO will select an independent panel which may include up to three (3) physicians or other medical professionals who are experts in the treatment of the Member's medical condition and knowledgeable about the recommended treatment. Neither PacifiCare nor the Member will choose or control the choice of physicians or other medical professional experts. The costs of the independent review will be borne by PacifiCare. The Member pays no application or processing fees of any kind for an independent review.

If the Member requests an independent review, PacifiCare will provide the following documents to the IRO designated by the DMHC within three (3) business days of PacifiCare's receipt of notification from the DMHC that a Member has applied for an independent review of PacifiCare's denial of Experimental or Investigational therapy: (a) the relevant medical records within PacifiCare's possession; (b) any other relevant documents or information used by PacifiCare in determining whether the proposed therapy should be covered and any statement by PacifiCare explaining the reasons for its decision to deny coverage for the proposed therapy; and (c) all information provided to the Member by PacifiCare and any of its contracting providers concerning PacifiCare and provider decisions regarding the Member's condition and care (including a copy of PacifiCare's denial notice to the Member), and any materials that the Member or the Member's physician submitted to PacifiCare in support of the request for coverage of the Experimental or Investigational therapy. If there is any information or evidence the Member or the Member's physician wish to submit to the DMHC in support of the independent review that has not previously been provided to PacifiCare, the Member may include this information with the Member's application to the DMHC for the independent review. Also, the Member's physician must provide to the DMHC or the IRO, as required, copies of any relevant medical records and any newly developed or discovered relevant medical records and respond to any requests for additional medical records or other relevant information from the experts on the panel performing the independent review.

If there is an imminent and serious threat to the health of the Member, PacifiCare will deliver all necessary information and documents listed above to the IRO within twenty-four (24) hours of approval of the request for an independent review. After submitting all of the required material to the IRO, PacifiCare will promptly issue a notification to the Member that includes an annotated list of the documents submitted and offer the Member the opportunity to request copies of those documents from PacifiCare.

The independent review panel will render its analysis and recommendations in writing, in layperson's terms to the maximum extent practicable, within thirty (30) days of receipt of the Member's request for independent review and supporting information, or within less time as follows:

If the Member's physician determines that the proposed course of treatment or therapy would be significantly less effective if not promptly initiated, the analysis and recommendations will be rendered within seven (7) days of the request for expedited review.

If the proposed therapy has not been provided and the Member's provider or the DMHC certifies in writing that an imminent and serious threat to the health of the Member may exist, including but not limited to serious pain, the potential loss of life, limb or major bodily function, or the immediate and serious deterioration of the health of the Member, the analyses and recommendations of the experts must be expedited and rendered within three (3) days of the receipt of the Member's application and supporting information.

If approved by the DMHC, the deadlines for the analyses and recommendations involving both regular and expedited reviews may be extended by the DMHC for up to three (3) days in extraordinary circumstances or for good cause.

Each expert's analysis and recommendation will be written and state the reasons the requested Experimental or Investigational therapy is or is not likely to be more beneficial for the Member than any available standard therapy, and the reasons that the expert recommends that the therapy should or should not be provided by PacifiCare, citing the Member's specific medical condition, the relevant documents provided to the IRO, and the relevant medical and scientific evidence, including but not limited to, the Medical and Scientific Evidence defined in Health & Safety Code Section 1370.4(d), to support the expert's recommendation. The recommendation of the majority of the experts on the panel will prevail. If the experts on the panel are evenly divided as to whether the treatment should be provided, the panel's decision will be deemed to be in favor of coverage.

The IRO will provide the DMHC, PacifiCare, the Member and the Member's physician with each of the experts' analyses and recommendations, and a description of the qualifications of each expert. The IRO will keep the names of the expert reviewers confidential, except in cases where the reviewer is called to testify and in response to court orders.

Upon receipt of the decision from the IRO, the DMHC will immediately issue an adoption letter/determination adopting the decision of the IRO, and will promptly issue a written decision to the parties that will be binding on PacifiCare.

Upon receipt of the written decision adopted by the DMHC that proposed Experimental or Investigational therapy should be provided to the Member, PacifiCare will promptly implement the decision.

In the case of services not yet rendered to the Member, PacifiCare will authorize the services within five working days of receipt of the written decision from the DMHC, or sooner if appropriate for the nature of the Member's medical condition, and will inform the Member and provider of the authorization in accordance with the requirements of California Health & Safety Code Section 1367.01(h)(3).

In the case of reimbursement for services already rendered, PacifiCare will reimburse the provider or Member, whichever applies, within five (5) working days.

In any case where a Member secured urgent care or emergency services outside of PacifiCare's contracted provider network, which services are later found by the IRO to have been medically necessary, the DMHC will require PacifiCare to promptly reimburse the Member for any reasonable costs associated with those services when the DMHC finds that the Member's decision to secure the services outside of PacifiCare's contracted provider network prior to completing the PacifiCare grievance process or seeking an independent medical review was reasonable under the circumstances and the disputed health care services were a covered benefit under the terms and conditions of the PacifiCare subscriber contract.

Coverage for the proposed therapy or treatment will be provided subject to the terms and conditions generally applicable to all other benefits under the Member's PacifiCare Health Plan.

Members or Physicians who want additional information about California's independent review process for denied Experimental or Investigational therapy for Members with Life-Threatening or Seriously Debilitating conditions may request a copy of PacifiCare's information packet by calling PacifiCare's Customer Service department.

Independent Medical Review of Grievances Involving a Disputed Health Care Service

You may request an independent medical review (IMR) of disputed health care services from the Department of Managed Health Care (DMHC) if you believe that health care services have been improperly denied, modified, or delayed by PacifiCare or one of its contracting providers. A "disputed health care service" is any health care service eligible for coverage and payment under your *Subscriber Agreement* that has been denied, modified, or delayed by PacifiCare or one of its contracting providers, in whole or in part due to a finding that the service is not medically necessary. Disputed health care services do not encompass coverage decisions. A "coverage decision" means the approval or denial of health care services by PacifiCare or one of its contracting providers, substantially based on a finding that the provision of a particular service is included or excluded as a covered benefit under the terms and conditions of the health care service plan contract.

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

Eligibility. You are eligible to submit an application for IMR to the DMHC if you meet all of the following criteria:

1. Your provider has recommended a health care service as medically necessary, or (B) You have received urgently needed services or emergency services that a provider determined were medically necessary, or (C) You have been seen by an contracting provider for the diagnosis or treatment of the medical condition for which you seek independent review; and
2. The disputed health care service has been denied, modified, or delayed by PacifiCare or one of its contracting providers, based in whole or in part on a decision that the health care service is not medically necessary; and
3. You have filed a grievance with PacifiCare regarding the decision to deny, delay or modify health care services and the disputed decision is upheld or the grievance remains unresolved after thirty (30) days or three (3) days in the case of an urgent grievance requiring expedited review. If your grievance requires expedited review you may bring it immediately to the Department's attention. The DMHC may waive the requirement that you follow PacifiCare's grievance process in extraordinary and compelling cases.

If your case is eligible for IMR, the dispute will be submitted to one or more medical specialists, independent of the Plan, who will make an independent determination of whether or not the care is medically necessary. You will receive a copy of the assessment made in your case. If the IMR determines the service is medically necessary, PacifiCare will authorize the health care service to be provided within five (5) business days.

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

For more information regarding the IMR process, or to request an application, please call PacifiCare's Customer Service department at 1-800-624-8822.

Review by Director of the Department of Managed Health Care

The California Department of Managed Health Care is responsible for regulating health care service plans. The Department has a toll-free telephone number **(1-888-HMO-2219)** to receive complaints regarding health plans. The hearing and speech impaired may call the Department's direct toll-free telephone number at **1-877-688-9891 TDD** or the California Relay Service's toll-free numbers **1-800-735-2929** or **1-888-877-5378 (TTY)**. The Department's facsimile number is 1-916-229-4328. The Department's Internet Web site **(http://www.hmohelp.ca.gov)** has complaint forms and instructions online. If you have a grievance against PacifiCare, you should first telephone PacifiCare's Customer Service department at **1-800-624-8822** or **1-800-442-8833 (TDHI)** and use the plan's grievance process before contacting the Department. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by PacifiCare, or a grievance that has remained unresolved for more than thirty (30) days, you may call the Department for assistance. PacifiCare's grievance process and the Department's complaint review process are in addition to any other dispute resolution procedures that may be available to you, and your failure to use these processes does not preclude your use of any other remedy provided by law.

Complaints Against Participating Medical Groups, Providers, Physicians and Hospitals

Member's claims against a Participating Medical Group, its Member physicians, or Providers, Physicians or Hospitals, other than claims for benefits under this Agreement, are not governed by this Group Agreement. Member may seek any appropriate legal action against such persons and entities deemed necessary.

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

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 will prevent confusion or uncertainty about your wishes.

It is also helpful to document your decision by completing a donor card in the presence of your family and having them sign as witnesses. The donor card serves as a reminder to your family and medical staff of your personal decision to be a donor. Carry it in your wallet or purse at all times.

How To Learn More

- To get 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 (www.transweb.org)
  - Dept. of Health and Human Services (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 tell your family so they can act on your wishes.

Medical Benefits

When we say our benefits are comprehensive, we mean it. This section includes details of your coverage, grouped together and listed alphabetically as:

- benefits you receive while hospitalized as an inpatient, and
- benefits available on an outpatient basis.

Please take a few moments now to review this important information about your benefits. Refer to your *Schedule of Benefits* for your Copayment responsibilities and further applicable plan information.

Benefits While Hospitalized As an Inpatient

When admitted or authorized by your Primary Care Physician in your Participating Medical Group, the following benefits are provided.

Alcohol, Drug or Other Substance Abuse or Addiction

Detoxification is covered when authorized by Member's Primary Care Physician in Member's Participating Medical Group. Medical problems associated with acute alcohol, drug or other substance abuse are covered by PacifiCare. Rehabilitation for alcohol, drug or other substance abuse or addiction is not covered. (Coverage for the rehabilitation of alcohol, drug or other substance abuse or addiction may be available as a supplemental benefit. If your health plan includes a Behavioral Health supplemental benefit, a brochure describing it will be enclosed with these materials.)

Bone Marrow Transplants

Bone marrow transplants for the treatment of aplastic anemia, leukemia, Wiskott-Aldrich syndrome or severe combined immunodeficiency disease are covered when determined by Member's Participating Medical Group to be Medically Necessary.

Computerized national and international searches for bone marrow donors conducted through a registry are covered up to a maximum of $10,000 or 50 potential donors (per lifetime), whichever occurs first. Member must be the recipient. Search must be provided by a PacifiCare Center of Excellence. These limitations apply to searches only. There is no dollar limitation for transplant services once a donor is identified.

Experimental or Investigational bone marrow transplants are not covered unless required by an external, independent review panel pursuant to California Health and Safety Code 1370.4.

Hospice Care

Hospice Services authorized by Member's Primary Care Physician in Member's Participating Medical Group are covered in a facility or on an outpatient basis when Member (1) has been judged to have six months of life expectancy or less, and (2) has determined to no longer pursue aggressive medical treatment and when the goal of treatment is to provide supportive nursing care and counseling to the Member during the terminal phase of an illness. Covered up to a maximum of one hundred eighty (180) days in a facility or on an outpatient basis per lifetime.

Inpatient Hospital Benefits (Acute Care)

Medically Necessary inpatient Hospital Services authorized by Member's Primary Care Physician in Member's Participating Medical Group are covered, including but not limited to: semi-private room, intensive care, operating room, recovery room, laboratory, surgically implanted devices and professional charges by the hospital pathologist or radiologist and other miscellaneous hospital charges for Medically Necessary care and treatment.

Autologous (self-donated) blood processing costs are limited to blood collected for a scheduled surgery and not to exceed $120.00 per unit which is the average cost for blood processing from other donor sources. Members will be financially responsible for processing costs that exceed the $120.00 per blood unit.

Inpatient Physician Care

The services of physicians while Member is hospitalized as an inpatient are covered, including the services of Member's Participating Medical Group physicians, and other specialty physicians when referred by or with the approval of Member's Participating Medical Group.

Inpatient Rehabilitation Care (Subacute Care)

Medically Necessary services, as determined by Member's Participating Medical Group or PacifiCare's Medical Director, which are provided in an Inpatient Rehabilitation Facility to train or retrain a Member disabled by disease or injury to Member's highest level of functional ability are covered.

Coverage for subacute care includes Medically Necessary inpatient services authorized by the Member's Participating Medical Group provided in an acute care hospital, a comprehensive free-standing rehabilitation facility or a specially designed unit within a Skilled Nursing Facility.

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

Members may call the PacifiCare Customer Service department to obtain a list of contracting subacute or transitional inpatient care facilities.

Members may also call the Customer Service department to request a copy of PacifiCare's utilization review and prior authorization processes that apply to care provided in subacute care, transitional inpatient care and Skilled Nursing Facilities.

Mastectomy/Breast Reconstruction After Mastectomy and Complications from Mastectomy

Surgery to perform a Medically Necessary mastectomy and lymph node dissection is covered, including prosthetic devices or reconstructive surgery to restore and achieve symmetry for the Member incident to the mastectomy. The length of a hospital stay is determined by the attending physician and surgeon in consultation with the Member, consistent with sound clinical principles and processes. Coverage includes any initial and subsequent reconstructive surgeries or prosthetic devices for the diseased breast on which the mastectomy was performed and for a healthy breast if, in the opinion of the attending physician and surgeon, this surgery is necessary to achieve normal symmetrical appearance. Medical treatment for any complications from a mastectomy, including lymphedema, is covered.

Maternity Care

Complete inpatient hospital benefits as previously described, including labor and delivery room, recovery room, delivery by cesarean section, miscarriage, and any complications of pregnancy or childbirth are covered.

(This plan provides a minimum 48-hour inpatient stay for normal vaginal delivery and a minimum 96-hour inpatient stay following delivery by cesarean section. Coverage for inpatient hospital care may be for a time period less than 48 or 96 hours if the decision to discharge the mother and newborn before the 48- or 96-hour time period is made by the treating physician in consultation with the mother. In addition, if the mother and newborn are discharged prior to the 48- or 96-hour time, a post-discharge follow-up visit for the mother and newborn must be provided within 48 hours of discharge, when prescribed by the treating physician.)

Educational courses on lactation, child care and/or child bearing (Lamaze) are not covered.

Newborn Care

Complete prenatal and postnatal Hospital Services including circumcision (if desired) and special care nursery are covered. Coverage for newborn children of the Subscriber begins at birth. In order for coverage to continue beyond thirty-one (31) calendar days after the date of birth, a Change Request Form for the Dependent must be submitted to PacifiCare within thirty-one (31) calendar days from the date of birth.

Reconstructive Surgery

Inpatient Reconstructive Surgery is covered when performed to:

- Correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors or disease; or
- Improve function; or
- Create a normal appearance, to the extent possible.

Examples include repair of congenital defects, such as port wine stain, or developmental abnormalities which are disfiguring, and for which surgical repair leads to improvement of the defect and/or appearance of the enrollee, such as cleft lip or cleft palate.

Reconstructive procedures require utilization review in accordance with standards of care as practiced by physicians specializing in reconstructive surgery and prior authorization by a PacifiCare Medical Director or designee.

Skilled Nursing Care/Transitional Care and Subacute Care

Medically Necessary Skilled Nursing Care is covered in a Skilled Nursing Facility (Medicare-certified) regardless of length of stay. Room and board in the Skilled Nursing Facility are covered only during the first one hundred (100) consecutive days following a "qualifying condition." A qualifying condition is a medical condition which requires skilled nursing services, which as a practical matter – in the determination of PacifiCare and the Member's Participating Medical Group – cannot be

delivered in a setting other than a Hospital or a Skilled Nursing Facility, except that a medical condition will not be considered a qualifying condition if during the sixty (60) days preceding the medical condition the Member has received Skilled Nursing Care.

Members may call the PacifiCare Customer Service department to obtain a list of contracting subacute or transitional inpatient care facilities.

Voluntary Interruption of Pregnancy

Refer to your *Schedule of Benefits* for coverage, if any.

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

Benefits Available On an Outpatient Basis

Unless otherwise noted, the following benefits are available on an outpatient basis when authorized through your Primary Care Physician in your Participating Medical Group.

Alcohol, Drug or Other Substance Abuse or Addiction

Medical evaluation, detoxification and treatment for withdrawal are covered for substance abuse when authorized by Member's Primary Care Physician in Member's Participating Medical Group. Medical problems associated with acute alcohol, drug or other substance abuse are covered by PacifiCare. Rehabilitation for substance abuse or addiction is not covered. (Coverage for the rehabilitation of alcohol, drug or other substance abuse or addiction may be available as a supplemental benefit. If your health plan includes a Behavioral Health supplemental benefit, a brochure describing it will be enclosed with these materials.)

Allergy Testing

Service and supplies for the determination of proper allergy treatment are covered.

Allergy Treatment

Services necessary for the treatment of allergies pursuant to an established treatment plan are covered. Serum is not covered. (Coverage for serum may be available as a supplemental benefit. If your health plan includes an Allergy serum supplemental benefit, a brochure describing it will be enclosed with these materials.)

Ambulance

Use of an ambulance or ambulance transport services (land or air), including but not limited to, those provided through the 911 emergency response system, is covered without prior authorization, when the Member reasonably believes that the medical condition requires Emergency Services requiring ambulance transport services. Use of an ambulance for a non-emergency is covered when specifically authorized by Member's Primary Care Physician in Member's Participating Medical Group.

Ambulance transportation is limited to the nearest available facility having the expertise to treat the Member's Emergency Condition.

Attention Deficit Disorder

The medical management of Attention Deficit Disorder (ADD) is covered as prescribed by the Primary Care Physician, including laboratory monitoring of prescribed drugs.

Breast Cancer Screening, Diagnosis and Treatment

Services necessary for screening, diagnosis of a treatment for breast cancer are covered. Screening and diagnosis will be covered consistent with generally accepted medical practice and scientific evidence, upon referral by the Member's participating physician. Mammography for screening or diagnostic purposes are covered as authorized by your participating nurse practitioner, participating certified nurse midwife or participating physician, providing care to the Member and operating within the scope of practice provided under California law. Treatment for breast cancer is covered as authorized by the Member's Primary Care Physician, Participating Medical Group or PacifiCare, as applicable.

Cochlear Implant Device

Implantable cochlear devices are covered for bilateral, profoundly hearing-impaired individuals who cannot benefit from conventional amplification (hearing aids). Coverage is for members at least 18 months of age who have either profound bilateral sensory hearing loss or for prelingual Members with minimal speech perception under the best hearing-aided condition.

Cochlear Implant Medical and Surgical Services

Medical and surgical services to implant cochlear devices are covered for bilateral, profoundly hearing-impaired individuals who cannot benefit from conventional amplification (hearing aids). Benefit includes short-term hearing rehabilitation services needed to support the mapping and functional assessment of the cochlear device at the authorized participating provider. (For an explanation of speech therapy benefits, please refer to Outpatient Rehabilitation.)

Corrective Appliances and Prosthetics

Prosthetics (except for bionic or myoelectric as explained below) are covered when Medically Necessary as determined by Member's Participating Medical Group or PacifiCare. Prosthetics are durable, custom made devices designed to replace all or part of a permanently inoperative or malfunctioning body part or organ. Examples of covered prosthetics include: initial post cataract extraction contact lens in a surgically affected eye; and removable, non-dental prosthetic devices such as a false eye or limb which do not require surgical connection to nerves, muscles or other tissue. Custom made or custom fitted Corrective Appliances are covered when Medically Necessary as determined by the Member's Participating Medical Group. Corrective Appliances are devices that are designed to support a weakened body part. These appliances are manufactured or custom fitted to an individual Member.

Bionic and Myoelectric prosthetics are not covered. Bionic prosthetics are prosthetics that require surgical connection to nerves, muscles or other tissues. Myoelectric prosthetics are prosthetics, which have electric motors to enhance motion.

Refer to specialized footwear and foot orthotics in exclusion and limitation section of this document

Initial placement of corrective appliances and prosthetics are covered (purchase or rental). Replacements, repairs and adjustments to corrective appliances and prosthetics coverage are limited to normal wear and tear or because of a significant change in the Member's physical condition. All corrective appliances and prosthetics placements, repairs and adjustments must be authorized by the Member's Participating Medical Group or PacifiCare.

Crisis Intervention

Coverage for Crisis Intervention may be available as an additional benefit. Please refer to the *Schedule of Benefits* for coverage, if any.

If your health plan includes an additional Crisis Intervention benefit, outpatient care for Crisis Intervention, up to a maximum of twenty (20) visits each calendar year, is covered when authorized by Member's Primary Care Physician in Member's Participating Medical Group. Crisis Intervention is defined as short-term Medically Necessary treatment required when Member suffers a sudden mental condition which interferes with Member's daily activities and from which Member is incapable of recovering without assistance. Sessions are covered only until Member is restored to Member's pre-crisis function level. Treatment may be provided by a psychiatrist, psychologist or other duly licensed counselor. Treatment may be limited to group therapy when group therapy is appropriate.

Dental Treatment Anesthesia

General anesthesia and associated facility charges are covered for dental procedures rendered in a hospital or surgery center as authorized and directed by the Member's Participating Medical Group, when the clinical status or underlying medical condition of the Member requires dental procedure(s) that would not ordinarily require general anesthesia to be rendered in a hospital or surgery care center. The dental treatment anesthesia will be rendered in a hospital or surgery center when the below criteria are met:

a. The Member is under seven (7) years of age; or

b. The Member is developmentally disabled, regardless of age; or

c. The Member's health is compromised and for whom general anesthesia is Medically Necessary.

Diabetes Management and Treatment

Diabetes management and treatment are covered as prescribed by your Participating Medical Group. Services include outpatient self-management training, education and medical nutrition therapy services, and additional diabetes outpatient self-management, education and medical nutrition therapy upon the direction or prescription of those services by the Member's participating Physician as Medically Necessary. The diabetes outpatient self-management training, education, and medical nutrition therapy services covered under this benefit shall be provided by appropriately licensed or registered health care professionals as prescribed by a participating health care professional legally authorized to prescribe the service.

Equipment and supplies for the management and treatment of Type 1, Type 2 and gestational diabetes are covered when Medically Necessary based upon the medical needs of the Member including:

- Blood glucose monitors; glucose monitors designed to assist the visually impaired; strips; lancets and lancet puncture devices; pen delivery systems (for the administration of insulin); insulin pumps and all related necessary supplies; ketone urine testing strips; insulin syringes; and podiatry services and devices to prevent or treat diabetes related complications. Equipment and supplies do not count against Member's Durable Medical Equipment limitation if applicable.

Visual aids are covered for Members determined to have a visual impairment that would prohibit proper dosing of insulin.

Visual aids do not include eyeglasses, frames or contact lenses and are excluded unless the Member has the supplemental vision benefit.

Durable Medical Equipment (Purchase or Repair)

Durable Medical Equipment is covered when it is designed and Medically Necessary to assist in the treatment of an injury or illness of the Member and is primarily for use in the home. Durable medical equipment is medical equipment which is able to exist for a reasonable period of time without significant deterioration.

Examples of covered Durable Medical Equipment include wheelchairs, hospital beds and standard oxygen machines. Special optional attachments or modifications to Durable Medical Equipment are not covered.

Special optional attachments or modifications to Durable Medical Equipment are not covered.

Initial placement of durable medical equipment are covered (purchase or rental). Replacements, repairs and adjustments to durable medical equipment coverage are limited to normal wear and tear or because of a significant change in the Member's physical condition. All durable medical equipment placements, repairs and adjustments must be authorized by the Member's Participating Medical Group or PacifiCare.

Eligible Materials and Supplies

The following specific medical supplies are covered when authorized through Member's Primary Care Physician in Member's Participating Medical Group: casts (used in connection with surgical procedures), splints, slings and dressings.

Family Planning

Refer to your *Schedule of Benefits* for coverage, if any.

Health Education Services

Counseling classes and educational material on a variety of health subjects are provided as presented by the Participating Medical Group health education staff or its designee.

Hearing Screening

Routine hearing screenings by a participating health professional to determine the need for hearing correction are covered.

Hemodialysis

Acute and chronic hemodialysis services and supplies are covered. (For chronic hemodialysis, application for Medicare Part A and Part B coverage must be made.)

Home Care

Part-time or intermittent skilled home care for Medically Necessary skilled nursing care and skilled rehabilitation services by a licensed nurse and/or physical therapist are covered when authorized by the Member's Participating Medical Group or PacifiCare. Skilled care needs more extensive than part-time, or intermittent may require placement or transfer of a Member to a Skilled Nursing Facility. PacifiCare in consultation with the Member's Participating Medical Group will determine the appropriate setting for the Member's Skilled Care services.

Covered visits per calendar year are specified in the *Schedule of Benefits*. Visit defined as up to two (2) hours of skilled services by a licensed professional nurse or therapist.

Hospice Care

Hospice Services authorized through Member's Primary Care Physician in Member's Participating Medical Group are covered when Member (1) has been judged to have six months of life expectancy or less, and (2) has determined to no longer pursue aggressive medical treatment and when the goal of treatment is to provide supportive nursing care and counseling to the Member during the terminal phase of an illness. Hospice Care benefits include hospice nursing care, social services evaluation, counseling and home health aide services. Hospice Care can be provided in a facility or on an outpatient basis. Paid in full up to a maximum of one hundred eighty (180) days once per lifetime.

Immunizations

Immunizations for children are covered consistent with the most current version of both of the following: (1) the Recommendations for Preventive Pediatric Health Care, as adopted by the American Academy of Pediatrics, and (2) the most current version of the Recommended Childhood Immunization Schedule/United States, jointly adopted by the American Academy of Pediatrics, the Advisory Committee on Immunization Practices and the American Academy of Family Physicians such as Hepatitis B, and Varicella. For children under 2 years of age, refer to Well-Baby Care. Immunizations for adults are covered consistent with the most current version of the U.S. Preventive Services Task Force.

Infertility Services (Basic)

Coverage for Infertility Services may be available as an additional benefit. Please refer to the *Schedule of Benefits* for coverage, if any.

If your health plan includes an additional Infertility Services benefit, procedures consistent with established medical practices in the treatment of infertility are covered when authorized by Member's Primary Care Physician including diagnosis, diagnostic tests, medication and surgery.

In-Vitro Fertilization (IVF), Gamete Intrafallopian Transfer (GIFT) and Zygote Intrafallopian Transfer (ZIFT), as well as procedures related to IVF, GIFT and ZIFT, are not covered. (Additional coverage for infertility may be available as a supplemental benefit. If your health plan includes an Advanced Reproductive Therapy supplemental benefit, a brochure describing it will be enclosed with these materials.)

Infertility is defined as either (1) the presence of a demonstrated condition recognized by a participating licensed physician or surgeon as a cause of infertility, or (2) the inability to conceive a pregnancy or to carry a pregnancy to a live birth after a year or more of regular sexual relations without contraception.

Infusion Therapy

Services are covered when authorized by the Member's Participating Medical Group. Infusion therapy means therapeutic use of drugs or other substances, prepared or compounded, and administered by a qualified provider and given to a Member through a needle or catheter.

Services must be provided in the Member's residence, home or an institution that is not a hospital or is not primarily engaged in providing skilled nursing or rehabilitation services.

The infusion services must be furnished under a plan of treatment that is established, reviewed at least every 30 days, and ordered and authorized by the Member's Participating Medical Group.

Infusion therapy has a separate copayment in addition to a home health or facility copayment.

Injectable Drugs

Outpatient Injectable Medications and Self-Injectable Medications – What is covered: Outpatient injectable medications administered in the physician's office (except insulin) that are Medically Necessary and are a routine part of the medical office visit. Self-injectable medications (except insulin) that are Medically Necessary and prescribed by a participating physician at the Member's Participating Medical Group are covered.

Outpatient injectable medications, including self-injectables, must be obtained through a PacifiCare participating provider or through the Member's Participating Medical Group and may require prior authorization.

Injectable Drug Copayment is not applicable to Allergy Serum, Birth Control, Infertility, Immunizations and Insulin. For coverage regarding these benefits, if any, please refer to the *Schedule of Benefits* and the *Supplement to the Combined Evidence of Coverage and Disclosure Form*.

Laboratory Services

Diagnostic and therapeutic laboratory services are covered when available through and authorized by the Member's Participating Medical Group or PacifiCare.

Maternity Care, Tests and Procedures

Physician visits, laboratory, including the expanded California Department of Health Services Alpha-Feto Protein (AFP) program, and radiology services for complete prenatal and post-partum outpatient maternity care are covered.

Medical Social Services

Referrals to licensed community agencies or social services are covered.

Mental Health Services

Severe Mental Illness (SMI) and Serious Emotional Disturbances (SED) – Coverage includes treatment for Severe Mental Illnesses (SMI) of adults and children and for children the treatment of Serious Emotional Disturbance of Children (SED) as required by state law. Please refer to your *Supplement to the PacifiCare Combined Evidence of Coverage and Disclosure Form* for a description of this coverage.

Coverage for Mental Health Services beyond Severe Mental Illness (SMI) and Serious Emotional Disturbances of Children (SED) may be available as an additional benefit. Please refer to the *Schedule of Benefits* for coverage, if any.

Oral Surgery Services

Dental Services are not covered except as expressly provided below.

Oral surgical procedures are covered when approved by Member's Participating Medical Group in connection with the following: stabilization and emergency treatment within forty-eight (48) hours of an acute accidental injury to sound natural teeth, jaw bone or surrounding tissues; correction of pathological conditions of a non-Dental origin, such as cleft lip and cleft palate, which have resulted in severe functional impairment. (Severe functional impairment is the inability to maintain nutritional status due to pain with limitation of the jaw system.)

Anesthesia and outpatient facility charges for Dental procedures (as defined in the Exclusions and Limitations of Benefits section of this brochure) are covered when necessary to assure proper medical management, control or treatment of a non-Dental Medical Condition. For example: Coverage will be provided for anesthesia incident to a Dental procedure which is required due to the Member's hemophilia, severe cardiac condition or severe respiratory condition.

Medical Services which relate to the mouth, teeth and gums to the extent they are not Dental are covered. Such Medical Services include biopsy and excision of cysts or tumors, treatment of malignant neoplasm disease and treatment of temporomandibular joint syndrome (TMJ) that causes severe functional impairment.

Preventive fluoride treatment is covered when provided prior to an authorized major organ transplant, aggressive chemotherapeutic or radiation therapy protocol. Otherwise fluoride treatment is not covered.

Outpatient Medical Rehabilitation Therapy

Medically Necessary services provided by registered physical, speech or occupational therapists are covered for conditions as determined by Member's Primary Care Physician in Member's Participating Medical Group or PacifiCare's Medical Director.

Outpatient Surgery

Short-stay, day care or other similar outpatient surgery facility are covered when provided as a substitute for inpatient care. Professional services are covered and included as part of inpatient Physician care benefit.

Periodic Health Evaluations

Physician, laboratory, radiology and related services as recommended by the American Academy of Pediatrics (AAP) and U.S. Preventive Services Task Force and authorized through Member's Primary Care Physician in Member's Participating Medical Group are covered to determine Member's health status. Adult male evaluations may include screening and diagnosis of prostate cancer (including but not limited to, prostate-specific antigen testing and digital rectal examinations) when Medically Necessary and consistent with good professional practice. For adult female evaluations, refer to Well-Woman Care. For children under two years of age, refer to Well-Baby Care.

Phenylketonuria (PKU) Testing and Treatment

Testing for Phenylketonuria (PKU) is covered when medically necessary to prevent the development of serious physical or mental disabilities or to promote normal development of function as a consequence of PKU.

Coverage includes FDA-approved special low protein formulas specifically approved for PKU and food products that are specially formulated to have less than one gram of protein per serving.

Food products naturally low in protein are not covered.

Physician Care

Medically Necessary services of the physicians within the Member's Participating Medical Group and other licensed health professionals are covered with the prior authorization and referral of the Member's Participating Medical Group for preventive services, surgical procedures, consultation and treatment.

Physician OB/GYN Care

The Member may obtain obstetrical and gynecological physician services directly from an OB/GYN, Family Practice Physician or surgeon as designated by the Member's Participating Medical Group providing OB/GYN services.

Physician Specialist Care

Care of a Specialist or other designated licensed health care professional with advanced training in an area of medicine is covered upon referral by the Member's Participating Medical Group or PacifiCare.

Radiation Therapy

Radiation Therapy (Standard): Standard photon beam radiation therapy is covered.

Radiation Therapy (Complex): Complex radiation therapy is covered. This therapy requires specialized equipment, as well as specially trained or certified personnel to perform the therapy. Examples include, but are not limited to brachytherapy, radioactive implants, conformal photon beam.

Gamma knife procedures and sterotactic procedures are covered as outpatient surgery. Please refer to your *Schedule of Benefits*.

Radiological Services

Standard X-ray films (with or without oral, rectal, injected or infused contrast medium) for the diagnosis of an illness or injury are covered. Standard X-ray services are X-ray(s) of an extremity, abdomen, head, chest, back, mammograms, nuclear studies, barium studies, and bone density studies. Also see Maternity and Periodic Health Evaluations.

Specialized Scanning and Imaging Procedures: CT, SPECT, PET, MRAs and MRI (with or without contrast media) are covered.

Vision Refractions

Routine testing to determine the need for corrective lenses (refractive error) is covered every twelve (12) months following Member's initial date of eligibility (frames and lenses excluded). Includes prescriptions for lenses. (Coverage for frames and lenses may be available as a supplemental benefit. If your health plan includes a Vision supplemental benefit, a brochure describing it will be enclosed with these materials.)

Vision Screening

Routine eye health assessment and screening by a participating health professional is covered to determine the health of your eyes and the possible need for vision correction.

Well-Baby Care

Preventive health services are covered, including immunizations, provided by the Member's Participating Medical Group or physician up to age two. (An office Copayment applies to infants that are ill at the time of services.)

Well-Woman Care

Includes Pap test by a Participating Medical Group OB/GYN or Family Practice Physician (designated by the Member's Participating Medical Group as providing OB/GYN services) affiliated with your Participating Medical Group, and referral by the Participating Medical Group for screening mammography as recommended by the U.S. Preventive Services Task Force.

Exclusions and Limitations of Benefits

Services and benefits for care and conditions as described below shall be excluded from coverage under this plan unless specifically included as a supplemental benefit.

General Exclusions

The following services are not covered by PacifiCare:

A. (1) All services not specifically included in the *Schedule of Benefits*, this brochure, and the *Supplement to the PacifiCare Medical Combined Evidence of Coverage and Disclosure Form* for Severe Mental Illnesses (SMI) and Serious Emotional Disturbances of Children (SED) coverage. (2) Services rendered without authorization from Member's Primary Care Physician in Member's Participating Medical Group (except for Emergency or Urgently Needed Services, or obstetrical and gynecological physician services obtained directly from an OB/GYN, Family Practice Physician or surgeon (designated by your Participating Medical Group as providing OB/GYN services) affiliated with your Participating Medical Group), and (3) Services prior to Member's start date of coverage or after the time coverage ends.

B. PacifiCare is not responsible for the cost of services rendered by Non-Participating Providers when the Member has refused treatment provided or authorized through Member's Primary Care Physician in Member's Participating Medical Group.

C. PacifiCare is not responsible for the cost of services which, in the judgment of the Health Plan, are not Medically Necessary or not required in accordance with professionally recognized standards of medical practice.

D. PacifiCare is not responsible for the cost of services which are part of a plan of treatment for a non-Covered Service, including services and supplies to treat medical conditions which are the sole, direct and predictable consequences of such non-Covered Services recognized by the organized medical community in the State of California; provided, however, that the Health Plan shall not exclude coverage for Medically Necessary services required to treat medical conditions that may arise but are not predictable in advance, such as unexpected complications of surgery.

Specific Exclusions

Acupuncture, Acupressure, Biofeedback
Acupuncture, acupressure and biofeedback are not covered.

Alcoholism, Drug Addiction or Other Substance Abuse
Rehabilitation for chronic alcoholism, drug addiction or other substance abuse is not covered.

Ambulance Service
Ambulance services are not covered except when received as a Medically Necessary Emergency Service as described in this brochure or when specifically authorized by Member's Primary Care Physician in Member's Participating Medical Group.

Bone Marrow Transplants
Bone marrow transplants are not covered when they are Experimental or Investigational, unless required by an external, independent review panel pursuant to California Health and Safety Code Section 1370.4.

Chiropractic Care
Care and treatment provided by a chiropractor is not covered.

Corrective Appliances and Prosthetics
Replacement of lost corrective appliances or prosthetics is not covered.

Prosthetics that require surgical connection to nerves, muscles or other tissues (bionic) are not covered. Prosthetics that have electric motors to enhance motion (myoelectronic) are not covered.

Cosmetic Surgery or Reconstructive Surgery
Cosmetic surgery is surgery that is performed to alter or reshape normal structures of the body in order to improve appearance. Cosmetic or reconstructive service exclusions determined in accordance with the standard of care as practiced by physicians specializing in reconstructive surgery, include but are not limited to:

(i) A proposed surgery when there is another more appropriate surgical procedure that has been offered to the Member.

(ii) Services that offer only a minimal improvement in the Member's appearance; or

(iii) Services performed without prior authorization by the Participating Medical Group.

When services are determined to be cosmetic, all services to be provided as part of the cosmetic treatment plan are also excluded, including hospital, physician, medical supplies or medications (injectable, intravenous or taken by mouth).

Custodial Care
Custodial Care is not covered. Custodial Care includes all homemaker services, respite care, convalescent care or extended care not requiring skilled nursing.

Dental Care, Dental Appliances
Dental care is not covered. Dental care includes all services required for prevention and treatment of diseases and disorders of the teeth, including but not limited to: oral exams, X-rays, routine fluoride treatment, plaque removal, tooth decay, dental embryonal tissue disorders, periodontal disease, anesthesia, repair and restoration, tooth extraction, replacement of missing teeth, dental implants, dentures and other oral prosthetic devices.

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

Developmental Disorders
Services that are primarily oriented toward treating a social, developmental or learning problem rather than a medical problem are not covered.

Disabilities Connected To Military Services
Treatment for disabilities connected to military service for which a Member is legally entitled to services through a federal governmental agency, and to which Member has reasonable access, are not covered.

Drugs and Prescription Medication
Prescribed and non-prescribed medications are not covered except when provided in an inpatient setting. Notwithstanding the foregoing, injectable drugs are covered (except for insulin and insulin-related drugs, allergy serum and immunizations not covered under the immunization benefit) when they are administered during the course of a physician's office visit or self-administered pursuant to training by an appropriate health care professional.

Durable Medical Equipment, Corrective Appliances and Prosthetics
Replacement of lost Durable Medical Equipment is not covered. Durable Medical Equipment is limited to those items that help the Member in his/her residence. Additional accessories to Durable Medical Equipment for the comfort or convenience of the Member or for ambulation primarily in the community, including home and car remodeling or modifications, are not covered.

Annual benefits limit may apply. Please refer to the *Schedule of Benefits*.

Emergency and Urgently Needed Services
Emergency and Urgently Needed Services are covered in a non-contracting facility only as long as the emergent or urgent condition exists and a transfer would be medically inappropriate. Routine follow-up care including treatments, procedures, X-rays, lab work, physician visits, rehabilitation and Skilled Nursing Care will not be covered without the Participating Medical Group's authorization once it is medically reasonable for the Member to obtain these services from the Participating Medical Group. The fact that the Member is outside the Service Area and that it is inconvenient for the Member to obtain the required services from the Participating Medical Group will not entitle the Member to coverage.

Experimental or Investigational Treatment
Experimental or Investigational treatments are not covered unless required by an external, independent review panel pursuant to California Health and Safety Code Section 1370.4. Unless otherwise dictated by federal or state law, decisions as to whether a particular treatment is Experimental or Investigational, and therefore not a covered benefit, are determined by PacifiCare's Medical Director or his or her designee based upon criteria established by PacifiCare's Technology Assessment Committee pursuant to the following guidelines.

Exclusions and Limitations of Benefits

Any drug, device, treatment or procedure shall be deemed an Experimental or Investigational treatment if, as determined solely by PacifiCare, any one or more of the following criteria are met:

- It cannot be lawfully marketed without the approval of the United States Food and Drug Administration (FDA) and such approval has not been granted at the time of its use or proposed use;
- It is the subject of a current investigational new-drug or new-device application on file with the FDA;
- It is being provided pursuant to a Phase I or Phase II clinical trial or as the experimental or research arm of the Phase III clinical trial, as these Phases are defined in regulations and other official actions and publications issued by the FDA and the Department of Health and Human Services (HHS);
- It is being provided pursuant to a written protocol which describes among its objectives determinations of safety and/or efficacy as compared with the standard means of treatment;
- It is being delivered or should be delivered subject to the approval and supervision of an Institutional Review Board (IRB) as required and defined by federal regulations and other official actions and publications issued by the FDA and the HHS;
- The predominant opinion among experts as expressed in the published authoritative literature is that usage should be substantially confined to research settings;
- The predominant opinion among experts as expressed in the published authoritative literature is that further research is necessary in order to define safety, toxicity, effectiveness or effectiveness compared with conventional alternatives; or
- It is not Investigational or Experimental in itself pursuant to the above, and would not be Medically Necessary, but for the provision of a drug, device, treatment or procedure which is Investigational or Experimental.

The exclusive sources of information to be relied upon by PacifiCare in determining whether a particular treatment is Experimental or Investigational, and therefore not a covered benefit under this Agreement, are limited to the following:

- The Member's medical records;
- The protocol(s) pursuant to which the drug, device, treatment or procedure is to be delivered;
- Any consent document the Member, or his or her representative, has executed or will be asked to execute, in order to receive the drug, device, treatment or procedure;
- The published authoritative medical or scientific literature regarding the drug, device, treatment or procedure at issue as applied to the Medical Condition at issue;
- Opinions of other agency review organizations/review organizations, e.g. ECRI Health Technology Assessment Information Service, HAYES New Technology Summaries or AHCPR (Agency for Health Care Policy and Research);
- Expert medical opinion;
- Regulations and other official actions and publications issued by the FDA and HHS.

A Member with a Life-Threatening or Seriously Debilitating condition may be entitled to an expedited hearing in cases in which a proposed treatment is denied as Experimental or Investigational, as provided in the Subscriber Agreement or pursuant to California Health and Safety Code Section 1370.4.

Foot Care
Routine foot care, including but not limited to removal or reduction of corns and calluses, clipping of toenails, treatment for flat feet, fallen arches and chronic foot strain is not covered, except as PacifiCare determines is Medically Necessary. Also note exclusions for Specialized Footwear.

Hearing Aids and Implantable Hearing Devices
Audiology services (other than screening for acuity) are not covered. Hearing aids and supplies and other implantable hearing devices are not covered except for cochlear devices for bilateral, profoundly hearing-impaired individuals not benefiting from conventional amplification (hearing aids).

Infertility Reversal
Reversal of voluntary sterilization is not covered.

Infertility Services
Infertility services are not covered. Ovum transplants, ovum or ovum bank charges, sperm or sperm bank charges, and the Medical or Hospital Services incurred by surrogate mothers who are not PacifiCare Members are not covered. Infertility services following reversal of elective sterilization, including medications and supplies, are not covered. In-Vitro Fertilization (IVF), Gamete Intrafallopian Transfer (GIFT) and Zygote Intrafallopian Transfer (ZIFT), as well as procedures performed in conjunction with IVF, GIFT and ZIFT, are not covered. (Coverage for Infertility Services may be available as an additional benefit.)

Institution Services and Supplies – Non-Eligible
Any services or supplies furnished by a non-eligible institution, which is defined as an institution other than a legally operated hospital or Medicare-approved Skilled Nursing Facility or which is primarily a place of rest, a place for the aged, a nursing home or any similar institution, regardless of how denominated, are not covered.

Medicare Benefits for Medicare Retirees
The amount payable by Medicare for Medicare-covered services received by Medicare retirees, regardless of whether a Medicare retiree has enrolled in Medicare Part A and Part B, is not covered.

Mental Disorders and Nervous Disorders
Mental Health Services are not covered except for Severe Mental Illnesses (SMI) of adults and children, and for children the treatment of Serious Emotional Disturbances (SED), as required by State law. Please refer to the supplement to the *PacifiCare Medical Combined Evidence of Coverage and Disclosure Form* for a description of this coverage for SMI/SED. (Coverage for Mental Health Services may be available as a supplemental benefit. If your health plan includes this supplemental benefit, a brochure describing these services will be enclosed with these materials.) Coverage for Crisis Intervention may also be available as an additional benefit. Please refer to the *Schedule of Benefits* for coverage, if any.

Academic, educational testing, counseling and remediation are not covered.

Non-Licensed Professionals
Treatment for any illness or injury when not attended by a licensed physician, surgeon or health care professional is not covered.

Nursing – Private Duty
Private duty nursing is not covered, unless determined to be Medically Necessary and ordered by Member's Participating Medical Group and approved by the PacifiCare Medical Director.

Off-Label Drug Use
Off Label Drug Use means that the Provider has prescribed a drug approved by the Food and Drug Administration (FDA) for a use that is different than for which the FDA approved the drug. PacifiCare excludes coverage for Off-Label Drug Use, including off-label self-injectable drugs, except as described in this *Combined Evidence of Coverage and Disclosure Form*. If the self-injectable drug prescribed is for Off-Label Use, the drug and its administration will be covered only when the following criteria are met: (1) The drug is approved by the FDA; (2) The drug is prescribed by a participating licensed health care professional for the treatment of a Life-Threatening condition or for a chronic and Seriously Debilitating condition; (3) The drug is Medically Necessary to treat the condition; (4) The drug has been recognized for treatment of the Life-Threatening or chronic and Seriously Debilitating condition by one of the following: The American Medical Association *Drug Evaluations*, The American Hospital Formulary Service *Drug Information*, *The United States Pharmacopoeia Dispensing Information, Volume I*, or in two articles from major peer-reviewed medical journals that present data supporting the proposed Off-Label Drug Use or uses as generally safe and effective; and (5) The drug is administered as part of a core medical benefit as determined by PacifiCare. Nothing in this section shall prohibit PacifiCare from use of a formulary, copayment, technology assessment panel, or similar mechanism as a means for appropriately controlling the utilization of a drug that is prescribed for a use that is different from the use for which that drug has been approved for marketing by the FDA. Denial of a drug as Investigational or Experimental will allow the Member to use the Independent Medical Review System as outlined in the *Combined Evidence of Coverage and Disclosure Form*.

Organ Donor Services
Medical and Hospital Services and other costs of a donor or prospective donor are not covered when the recipient is not a Member.

Organ Transplants
Organ transplants not Medically Necessary and organ transplants considered Experimental or Investigational as defined herein are not covered unless required by

an external, independent review panel pursuant to California Health and Safety Code Section 1370.4. The following organ transplants are examples of Experimental or Investigational at the time of printing this brochure: pancreas (alone) transplant or pancreas after kidney transplant.

Out-of-Area Services
Medical and Hospital Services, except for Emergency and Urgently Needed Services, are not covered when received outside of the Service Area. Out-of-Area follow-up care and maintenance therapy is not covered unless preapproved by the PacifiCare Out-of-Area Unit or Member's Participating Medical Group. Out-of-Area follow-up care includes, but is not limited to:

- Routine follow-up care to Emergency or Urgently Needed Services, such as treatments, procedures, X-rays, lab work and doctor's visits, as well as Rehabilitation Services, Skilled Nursing Care, Custodial Care or home care.
- Maintenance therapy and Durable Medical Equipment to assist a Member while traveling outside the Service Area, including but not limited to routine dialysis, routine oxygen or a wheelchair, is not covered.

Physical Examinations
Routine physical examinations for insurance, licensing, employment, school, camp, recreational or organizational activities are not covered. Physical examinations for appearances at hearings or court proceedings, examinations precedent to engaging in travel, or other non-preventive purposes or for premarital and pre-adoption purposes are not covered.

Private Rooms and Comfort Items
Personal or comfort items and private rooms during inpatient hospitalization are not covered unless Medically Necessary.

Public Facility Care
Care of conditions for which state or local law requires treatment in a public facility are not covered. However, PacifiCare will reimburse Member for out-of-pocket expenses incurred by the Member for any Covered Services delivered at such public facility. Injuries or illnesses sustained while incarcerated in a state or federal prison are not covered. Emergency and Urgently Needed Services required after participating in a criminal act are covered only until Member is stabilized and placed on a police hold. Notwithstanding the foregoing, in compliance with Health and Safety Code section 1374.12, nothing in this provision shall be deemed to restrict the liability of PacifiCare with respect to Covered Services solely because such services were provided while the Member was in a state hospital.

Recreational, Educational or Hypnotic Therapy
Recreational, educational or hypnotic therapy and any related diagnostic testing is not covered except as provided as part of an otherwise covered inpatient hospitalization.

Sex Transformations
Procedures, services, medications and supplies related to sex transformations are not covered.

Skilled Nursing Facility Care
Skilled Nursing Facility (Medicare-certified) room and board charges incurred beyond one hundred (100) consecutive days per qualifying condition are not covered. A qualifying condition is a medical condition which requires skilled nursing services, which as a practical matter – in the determination of PacifiCare and the Member's Participating Medical Group – cannot be delivered in a setting other than a Hospital or a Skilled Nursing Facility, except that a medical condition will not be considered a qualifying condition if during the sixty (60) days preceding the medical condition the Member has received Skilled Nursing Care.

Specialized Footwear for Foot Disfigurement
Specialized footwear, including foot orthotics, custom-made standard orthopedic shoes, or customized footwear, which is not permanently attached to an orthopedic brace is not covered.

Vision Care
Corrective lenses and frames, contact lenses (except post cataract extraction, keratoconus, aphakic or corneal bandages), contact lens fitting and measurements are not covered.

Weight Alteration Programs (Inpatient or Outpatient)
Weight loss or weight gain programs including, but not limited to, dietary evaluations and counseling, exercise programs, behavioral modification programs, surgery, laboratory tests, food and food supplements, vitamins and other nutritional supplements associated with weight loss or weight gain, are not covered, except for the treatment of anorexia nervosa or bulimia nervosa. Please refer to the supplement to the PacifiCare medical *Combined Evidence of Coverage and Disclosure Form* for a description of this coverage. Surgical treatment for morbid obesity will be covered only when criteria are met as recommended by the National Institute of Health (NIH).

While PacifiCare is dedicated to making its services easily accessible and understandable, the "language" of health care can sometimes be very confusing. To help you understand some of the terms you may encounter, we offer the following definitions:

Appeals and Grievance Committee is a committee composed of Participating Medical Group Physicians which meets monthly, or more frequently if necessary, to review Member Appeals.

Case Management is a multi-disciplinary process that coordinates quality resources and facilitates flexible, individualized treatment goals in conjunction with the Member's Participating Medical Group. It provides cost-effective options for selected individuals with complex needs.

Chronic Condition is a physical or psycho-social state that requires ongoing medical treatment or social services intervention.

Copayments are costs payable by the Member at the time Covered Services are received. Copayments may be a specific dollar amount or a percentage of covered charges. Copayments are in addition to the premium paid by an employer and any payroll contributions required by your employer.

Covered Services are Medically Necessary services or supplies provided under your Group Agreement and *Schedule of Benefits* for emergencies or those services which have been authorized through your Primary Care Physician in your Participating Medical Group.

Custodial Care means personal services required to assist Member in meeting the requirements of daily living. Custodial Care includes, without limitation, assistance in walking, getting in or out of bed, bathing, dressing, feeding, using the lavatory, preparation of special diets or supervision of medication schedules. Custodial Care does not require the continuing attention of trained medical or paramedical personnel.

Dependent is any Member of a Subscriber's family who is enrolled and meets all the eligibility requirements of the Group Agreement and for whom applicable health plan premiums have been received by PacifiCare.

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

- Placing the Member's health in serious jeopardy;
- Serious impairment to bodily functions;
- Serious dysfunction of any bodily organ or part; or
- Active labor, meaning labor at a time that either of the following would occur:

  (1) there is inadequate time to effect safe transfer to another hospital prior to delivery; or

  (2) a transfer poses a threat to the health and safety of the Member or unborn child.

Emergency Services are Medically Necessary ambulance and ambulance transport services provided through the 911 emergency response system and medical screening, examination and evaluation by a physician, or other personnel, to the extent provided by law, to determine if an Emergency Medical Condition or psychiatric emergency medical condition exists, and if it does, the care, treatment, and/or surgery by a physician necessary to relieve or eliminate the Emergency Medical Condition or psychiatric emergency medical condition within the capabilities of the facility.

Enrollment is the execution of a PacifiCare Enrollment Form, or a non-standard Enrollment Form approved by PacifiCare, by the Subscriber on behalf of the Subscriber and his or her Dependents, and acceptance thereof by PacifiCare, conditional upon the execution of this Agreement by Group and PacifiCare and the timely payment of applicable Health Plan Premiums by Group. PacifiCare may, in its discretion and subject to specific protocols, accept a group's enrollment data through an electronic submission.

Experimental or Investigational Treatment is defined in the Exclusions and Limitations of Benefits section of this brochure.

Definitions

Facility is any building, premise or edifice in which health care services or the administration of this Health Plan is carried out.

Group Agreement is the Medical and Hospital Group Subscriber Agreement entered into by PacifiCare and your employer.

Health Plan Premiums are amounts established by PacifiCare to be paid to PacifiCare by Group on behalf of Members in consideration of the benefits provided under this Health Plan.

Hospice Care is services provided when the goal of treatment is to provide supportive care and counseling during the terminal phase of an illness. These services are provided when the individual is judged to have six months of life expectancy or less and no longer elects to pursue aggressive medical treatment for the terminal illness.

Hospital is the general acute care hospital licensed by the State of California, designated by Member's Participating Medical Group and utilized by the Participating Medical Group for the provision of Hospital Services to Member.

Hospital Services are services and supplies performed or supplied by a Hospital on an inpatient or outpatient basis.

Late Enrollee refers to an employee who declined enrollment in the PacifiCare Health Plan when offered and who subsequently requests enrollment outside the designated open enrollment period.

Lifetime Benefit Maximum means the lifetime maximum dollar amount paid for covered charges. Covered charges mean the rates for services negotiated by the Plan or its contracting providers for Covered Services provided to you or a Dependent while enrolled in this PacifiCare Health Plan, less the amount of the Member's copayment. The Lifetime Benefit Maximum is shown on the *Schedule of Benefits* and is calculated for you and each Dependent on an individual basis.

Medically Necessary (or Medical Necessity) refers to Medical or Hospital Services which are determined by a medical director of PacifiCare or the Participating Medical Group to be:

a. Rendered for the treatment or diagnosis of any injury or illness;

b. Appropriate for the symptoms, consistent with diagnosis, and otherwise in accordance with professionally recognized standards, which shall include the consideration of scientific evidence;

c. Not furnished primarily for the convenience of the Member, the attending Physician or other provider of services; and

d. If more than one service, supply or level of care 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.

"Scientific evidence" as referenced in section (b) above, shall include peer-reviewed medical literature, publications, reports, and other authoritative medical sources.

Member is the Subscriber or any Dependent who is enrolled, covered and eligible for PacifiCare.

Open Enrollment Period is a time period determined by PacifiCare and Member's employer during which all eligible group employees and their dependents may enroll.

Outside Providers or Non-Participating Providers are licensed physicians, surgeons, osteopaths, paramedical personnel, hospitals and other licensed health care facilities that provide services to Members enrolled in this Health Plan but do not have written agreements with PacifiCare and are outside the PacifiCare health delivery network.

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

Participating Medical Group is any Individual Practice Association or Medical Group of licensed doctors of medicine or osteopathy which has entered into a written agreement with PacifiCare to provide medical services to Members and their eligible dependents. A Medical Group employs physicians who typically all work at one physical location. An Individual Practice Association, or IPA, contracts with independent contractor physicians who typically work at different office sites.

Physician includes any licensed allopathic or osteopathic physician.

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

Primary Care Physician (PCP) is a PacifiCare contracting physician who is specially trained in internal medicine, general practice, family practice, pediatrics or obstetrics/gynecology, and who is primarily responsible for the coordination of a Member's services.

Primary Residence is the home or address at which the Member actually lives most of the time. A residence will no longer be considered a Primary Residence if: (1) Member moves without intent to return, (2) Member is absent from the residence for 90 consecutive days, or (3) Member is absent from the residence for more than 100 days in any six-month period. Member shall notify PacifiCare of a change in Primary Residence as soon as possible. A change in Primary Residence shall result in disenrollment of the Member if Member's Primary Residence is not within the Service Area.

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

Providers are duly licensed physician groups, physicians, hospitals, Skilled Nursing Facilities, extended care facilities, home health agencies, alcoholism and drug abuse centers, mental health professionals and any other health facilities or providers.

Quality Management Committee is a committee established and maintained by PacifiCare, consisting of at least three (3) Participating Medical Group physicians or Primary Care Physicians, which performs quality assurance reviews.

Rehabilitation Services are the combined and coordinated use of medical, social, educational and vocational measures for training or retraining individuals disabled by disease or injury to seek to obtain their highest level of functional ability. Rehabilitation services may include, but are not limited to, physical, occupational and speech therapy. Rehabilitation services are customarily provided in a rehabilitation facility.

Service Area is the geographic region in the state of California in which PacifiCare is authorized to provide services by the California Department of Managed Health Care.

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

Subscriber is the person who enrolls in PacifiCare and meets all the applicable eligibility requirements of the employer group and PacifiCare, and for whom health plan premiums have been received by PacifiCare.

TMJ (Temporomandibular Joint Syndrome) is a masticatory muscle disorder or intracapsular disorder. Acute masticatory muscular disorder may occur joint abnormalities, as characterized by headaches, joint pain or myofacial pain. Acute intracapsular disorder involves internal derangement – for example, mechanical obstruction involving disc displacement. This may manifest with symptoms including preauricular pain and jaw motion restriction.

Totally Disabled or Total Disability means, for Subscribers, the persistent inability to reliably engage in any substantially gainful activity by reason of any medically determinable physical or mental impairment resulting from an injury or illness. For Dependents, Totally Disabled is the persistent inability to perform activities essential to the daily living of a person of the same age and sex by reason of any medically determinable physical or mental impairment resulting from an injury or illness. Determination of Total Disability shall be made by a Participating Medical Group physician on the basis of a medical examination of the Member and upon concurrence by PacifiCare's Medical Director. The period of disability must be expected to extend for at least six (6) months.

Urgently Needed Services are Medically Necessary services required outside of the Service Area to prevent serious deterioration of a Member's health resulting from unforeseen illness or injury manifesting itself by acute symptoms of sufficient severity, which may include severe pain, such that treatment cannot be delayed until the Member returns to the Service Area.

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

Notes

PacifiCare's Customer Service – We're Here for You

We want you to be happy with PacifiCare, and that means being responsive to any questions you might have. We're ready to serve you and welcome the opportunity.

Count On Us for Efficient Service

Just have your Member number ready when you call – we can access your membership file instantly.

We'll Expedite Your Requests

We're here to assist you when you want to change Primary Care Physicians or Participating Medical Groups.

We're Here To Answer Your Questions

You can feel comfortable asking experienced Customer Service Associates about your benefits – find out how to make the most of your health plan.

Need a Replacement ID Card or Up-to-Date Information?

If you've misplaced your ID card or handbook, just call us for a duplicate copy. We'll also be glad to send you updated literature on PacifiCare's participating physicians and physician network.

Concerns, Comments, Suggestions?

That's what we're here for.

1-800-624-8822 or
1-800-442-8833 TDHI
(Telecommunications Device for the Hearing Impaired)

Monday – Friday
8:00 a.m. – 8:00 p.m.

Answering Questions

If you have any questions about PacifiCare, chances are you'll find the answer by:

1. Reviewing this brochure,
2. Calling PacifiCare's Customer Service department,
3. Asking your employer,
4. Consulting the Group Agreement between PacifiCare and your employer, or
5. Calling your Participating Medical Group's Health Plan Coordinator, if your Primary Care Physician is in a Medical Group.

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

INSIDE BACK COVER

PacifiCare®
of California

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www.pacificare.com

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