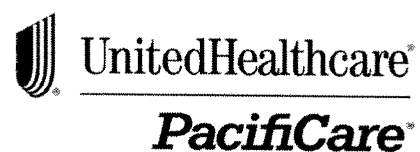
CALIFORNIA



PacifiCare SignatureValue®
Offered by PacifiCare of California

Combined Evidence of Coverage and Disclosure Form (HMO)

Welcome to PacifiCare of California
A UnitedHealthcare Company

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

PacifiCare provides health care coverage to Members who have properly enrolled in our plan and meet our eligibility requirements. To learn more about these requirements, see ***Section 7. Member Eligibility.***

What is this publication?

This publication is called a *Combined Evidence of Coverage and Disclosure Form*. It is a legal document that explains your health care plan and should answer many important questions about your benefits. Many of the words and terms are capitalized because they have special meanings. To better understand these terms, please see ***Section 10. Definitions***.

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

What else should I read to understand my benefits?

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

What if I still need help?

After you become familiar with your benefits, you may still need assistance. Please don't hesitate to call our Customer Service department at 1-800-624-8822 or 1-800-442-8833 (TDHI).

Note: Your *Combined Evidence of Coverage and Disclosure Form* and *Schedule of Benefits* provide the terms and conditions of your coverage with PacifiCare and all applicants have a right to view these documents prior to enrollment. The *Combined Evidence of Coverage and Disclosure Form* should be read completely and carefully. Individuals with special health needs should pay special attention to those sections that apply to them.

You may correspond with PacifiCare at the following address:

PacifiCare of California
P.O. Box 30968
Salt Lake City, UT 84130-0968

1-800-624-8822

PacifiCare's Web site is:

www.pacificare.com

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SECTION 1. GETTING STARTED: YOUR PRIMARY CARE PHYSICIAN

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

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

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

Introduction

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

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

What is a Primary Care Physician?

When you become a Member of PacifiCare, one of the first things you do is choose a doctor to be your Primary Care Physician. This is a doctor who is contracted with PacifiCare and who is primarily responsible for the coordination of your health care services. A Primary Care Physician is trained in internal medicine, general practice, family practice, pediatrics or obstetrics/gynecology. At times, others may participate in the coordination of your health care services, such as a Hospitalist (Please refer to **Section 2. Seeing Your Doctor** for information on Hospitalist programs).

Unless you need Emergency or Urgently Needed care, your Primary Care Physician is your first stop for using these medical benefits. Your Primary Care Physician will also seek authorization for any referrals, as well as initiate any necessary Hospital Services. Either your Primary Care Physician or a Hospitalist may provide the coordination of any necessary Hospital Services.

All Members of PacifiCare are required to have a Primary Care Physician. If you don't select one when you enroll, PacifiCare will choose one for you. Except in an urgent or emergency situation, if you see another health care Provider without the approval of either your Primary Care Physician, Participating Medical Group or PacifiCare, the costs for these services will not be covered.

What is the difference between a Subscriber and an enrolled Family Member?

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

publication. If you're a Subscriber, please pay attention to any instructions given specifically for you. For a more detailed explanation of any terms, see the **Definitions** section of this publication.

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

Choosing a Primary Care Physician

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

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

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

What is a Participating Medical Group?

When you select a Primary Care Physician, you are also selecting a Participating Medical Group. This is the group that's affiliated with both your doctor and PacifiCare. If you need a referral to a specialist or Non-Physician Health Care Practitioner, you will generally be referred to a doctor, Non-Physician Health Care Practitioner or service within this group. Since Participating Medical Groups are independent contractors not employed by PacifiCare, each has its own unique network of affiliated specialists and Providers. Only if a specialist, Non-Physician Health Care Practitioner or service is unavailable will you be referred to a health care Provider outside your medical group.

To learn more about a particular Participating Medical Group, look in your *Provider Directory*, where you will find addresses and phone numbers and other important information about Hospital affiliations or any restrictions limiting the availability of certain Providers.

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

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

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

Choosing a Primary Care Physician for Each Enrolled Family Member

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

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

Continuity of Care for New Members at the Time of Enrollment

Under certain circumstances, as a new Member of PacifiCare, you may be able to continue receiving services from a Non-Participating Provider to allow for the completion of Covered Services provided by a Non-Participating Provider, if you were receiving services from that Provider at the time your coverage became effective, for one of the Continuity of Care Conditions as limited and described in **Section 10. Definitions**.

This Continuity of Care assistance is intended to facilitate the smooth transition in medical care across health care delivery systems for new Members who are undergoing a course of treatment when the Member or the Member's employer changes Health Plans during open enrollment.

For a Member to continue receiving care from a Non-Participating Provider, the following conditions must be met:

1. Continuity of Care services from Non-Participating Provider must be Preauthorized by PacifiCare or the Member assigned Participating Provider;
2. The requested treatment must be a Covered Service under this Plan;
3. The Non-Participating Provider must agree in writing to meet the same contractual terms and conditions that are imposed upon PacifiCare's Participating Providers, including location within PacifiCare's Service Area, payment methodologies and rates of payment.

Covered Services for the Continuity of Care Condition under treatment by the Non-Participating Provider will be considered complete when:

1. The Member's Continuity of Care Condition under treatment is medically stable; and
2. There are no clinical contraindications that would prevent a medically safe transfer to a Participating Provider as determined by a PacifiCare Medical Director in consultation with the Member, the Non-Participating Provider and as applicable, the newly enrolled Member's assigned Participating Provider.

Continuity of Care also applies to those new PacifiCare Members who are receiving Mental Health care services from a Non-Participating Mental Health Provider at the time their coverage becomes effective. Members eligible for continuity of mental health care services may continue to receive mental health services from a Non-Participating Provider for a reasonable period of time to safely transition care to a Mental Health Participating Provider. Please refer to "Inpatient Benefits, Outpatient Benefits" and "Exclusions and Limitations of Benefits" in **Section 5. Your Medical Benefits** of the PacifiCare *Combined Evidence of Coverage and Disclosure Form*, and the *Schedule of Benefits* for supplemental mental health care coverage information, if any. For a description of coverage of mental health care services for the diagnosis and treatment of Severe Mental Illness (SMI) and Serious Emotional Disturbances of a Child (SED), please refer to the behavioral health supplement to this *Combined Evidence of Coverage and Disclosure Form.* A Non-Participating Mental Health Provider means a psychiatrist, licensed psychologist, licensed marriage and family therapist or licensed clinical social worker who has not entered into a written agreement with the network of Providers from whom the Member is entitled to receive Covered Services.

PacifiCare of California
Attention: Continuity of Care Department
Mail Stop: CA124-0181
P.O. Box 6006
Cypress, CA 90630
Fax: 1-888-361-0514

All Continuity of Care requests will be reviewed on a case-by-case basis. Reasonable consideration will be given to the severity of the newly enrolled Member's condition and the potential clinical effect of a change in Provider regarding the Member's treatment and outcome of the condition under treatment.

PacifiCare's Health Services department will complete a clinical review of your Continuity of Care request for the completion of Covered Services with a Non-Participating Provider and the decision will be made and communicated in a timely manner appropriate to the nature of your medical condition. In most instances, decisions for non-urgent requests will be made within five (5) business days of PacifiCare's receipt of the completed form. You will be notified of the decision by telephone and provided with a plan for your continued care. Written notification of the decision and plan of care will be sent to you, by United States mail, within two (2) business days of making the decision. If your request for continued care with a Non-Participating Provider is denied, you may appeal the decision. (To learn more about appealing a denial, please refer to **Section 8. Overseeing Your Health Care**.)

If you have any questions, would like a description of PacifiCare's continuity of care process, or want to appeal a denial, please contact our Customer Service department.

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

If You Are Pregnant

Every Member of PacifiCare needs a Primary Care Physician, including your newborn. Newborns are assigned to the mother's Participating Medical Group from birth until discharge from the Hospital. You may request to reassign your newborn to a different Primary Care Physician or Participating Medical Group following the newborn's discharge by calling PacifiCare's Customer Service department. If a Primary Care Physician isn't chosen for your child, the newborn will remain with the mother's Primary Care Physician or Participating Medical Group. If you call the Customer Service department by the 15th of the current month, your newborn's transfer will be effective on the first day of the following month. If the request for transfer is received after the 15th of the current month, your newborn's transfer will be effective the first day of the second succeeding month. For example, if you call PacifiCare on June 12th to request a new doctor for your newborn, the transfer will be effective on July 1st. If you call PacifiCare on June 16th, the transfer will be effective August 1st. In order for coverage to continue beyond the first 30 days of life, the Subscriber must submit a request to add the baby to his/her employer group/PacifiCare prior to the expiration of the 30-day period to continue coverage beyond the first 30 days of life. If your newborn has not been discharged from the Hospital, is being followed by the Case Management or is receiving acute institutional care at the time of your request, a change in your newborn's Primary Care Physician or Participating Medical Group will not be effective until the first day of the second month following the newborn's discharge from the institution or termination of treatment. When PacifiCare's Case Management is involved, the Case Manager is also consulted about the effective date of your requested Physician change for your newborn.

You can learn more about changing Primary Care Physicians in **Section 4. Changing Your Doctor or Medical Group**. (For more about adding a newborn to your coverage, see **Section 7. Member Eligibility**.)

Does your Group or Hospital restrict any reproductive services?

Some Hospitals and other Providers do not provide one or more of the following services that may be covered under your plan contract 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 the family planning benefits you need, and these benefits have been purchased by your Employer Group, please call our Customer Service department.

SECTION 2. SEEING THE DOCTOR

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

Now that you've chosen a Primary Care Physician, you have a doctor for your routine health care.

*This section will help you begin taking advantage of your health care coverage. It will also answer common questions about seeing a specialist and receiving medical services that are not Emergency Services or Urgently Needed Services. (For information on Emergency Services or Urgently Needed Services, please turn to **Section 3**.)*

Seeing the Doctor – Scheduling Appointments

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

When you see your Primary Care Physician or use one of your health care benefits, you may be required to pay a charge for the visit. This charge is called a Copayment. The amount of a Copayment depends upon the health care service. Your Copayments are outlined in your *Schedule of Benefits*. More detailed information can also be found in **Section 6. Payment Responsibility**.

Referrals to Specialists and Non-Physician Health Care Practitioners

The Primary Care Physician you have selected will coordinate your health care needs. If your Primary Care Physician determines you need to see a specialist or Non-Physician Health Care Practitioner, he or she will make an appropriate referral. (There is an exception for visits to obstetrical and gynecological (OB/GYN) Physicians. This is explained below in "Direct Access to OB/GYN Services.")

Your plan may not cover services provided by all Non-Physician Health Care Practitioners. Please refer to the "Inpatient Benefits, Outpatient Benefits" and "Exclusions and Limitations of Benefits" sections in this *Agreement and Evidence of Coverage and Disclosure Form* for further information regarding Non-Physician Health Care Practitioner services excluded from coverage or limited under this Health Plan.

Your Primary Care Physician will determine the number of specialist or Non-Physician Health Care Practitioner visits that you require and will provide you with any other special instructions. This referral may also be reviewed by, and may be subject to the approval of, the Primary Care Physician's Utilization Review Committee. For more information regarding the role of the Utilization Review Committee, please refer to the definition of "Utilization Review Committee." A Utilization Review Committee meets on a regular basis as determined by membership needs, special requests or issues and the number of authorization or referral requests to be addressed. Decisions may be made outside of a formal committee meeting to assure a timely response to emergency or urgent requests.

PacifiCare Express Referrals®

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

Standing Referrals to Specialists

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

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

Extended Referral for Care by a Specialist

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

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

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

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

OB/GYN: Getting Care Without a Referral

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

Please Remember: if you visit an OB/GYN or family practice Physician not affiliated with your Participating Medical Group without Preauthorization or a referral, you will be financially responsible for these services. All OB/GYN Inpatient or Hospital Services, except Emergency or Urgently Needed Services, need to be authorized in advance by your Participating Medical Group or PacifiCare.

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

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

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

PacifiCare also covers important wellness services for our Members. For more information, see "Health Education Services" in **Section 5. Your Medical Benefits.**

Second Medical Opinions

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

Either you or your treating Participating Provider may submit a request for a second medical opinion. Requests should be submitted to your Participating Medical Group; however, in some cases, the request is submitted to PacifiCare. To find out how you should submit your request, talk to your Primary Care Physician.

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

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

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

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

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

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

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

If your request for a second medical opinion is denied, PacifiCare will notify you in writing and provide the reasons for the denial. You may appeal the denial by following the procedures outlined in **Section 8. Overseeing Your Health Care**. If you obtain a second medical opinion without Preauthorization from your Participating Medical Group or PacifiCare, you will be financially responsible for the cost of the opinion.

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

PacifiCare Customer Service Department
P.O. Box 30968
Salt Lake City, UT 84130-0968

1-800-624-8822

What is PacifiCare's Case Management Program?

PacifiCare has licensed registered nurses who, in collaboration with the Member, Member's designated family and the Member's Participating Medical Group may help arrange care for PacifiCare Members experiencing a major illness or recurring Hospitalizations. Case Management is a collaborative process that assesses, plans, implements, coordinates, monitors and evaluates options to meet an individual's health care needs based on the health care benefits and available resources. Not every Member will be assigned a case manager.

Prearranging Hospital Stays

Your Primary Care Physician or Hospitalist will prearrange any Medically Necessary Hospital or Facility care. Your Primary Care Physician or Hospitalist will prearrange any Medically Necessary Inpatient Transitional Care or care provided in a Subacute/Skilled Nursing Facility. If you've been referred to a specialist and the specialist determines you need Hospitalization, your Primary Care Physician will work with the Specialist to prearrange your Hospital stay.

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

If Medically Necessary, your Primary Care Physician or Hospitalist may discharge you from the Hospital to a Subacute/Skilled Nursing Facility. He or she can also arrange for Home Health Care Visits.

Please note: If a Hospitalist program applies, a Hospitalist may direct your Inpatient Hospital or Facility care In consultation with of your Primary Care Physician.

Hospitalist Program

If you are admitted to a Participating Hospital for a Medically Necessary procedure or treatment, a Hospitalist may coordinate your health care services in consultation with your Primary Care Physician. A Hospitalist is a dedicated Hospital-based Physician who assumes the primary responsibility for managing the process of Inpatient care for Members who are admitted to a Hospital. The Hospitalist will manage your Hospital stay, monitor your progress, coordinates and consult with specialists, and communicate with your, your family and your Primary Care Physician. Hospitalist will work together with your Primary Care Physician during the course of your Hospital stay to ensure coordination and continuity of care and to transition your care upon discharge. Upon discharge from the Hospital, your Primary Care Physician will again take over the primary coordination of your health care services.

SECTION 3. EMERGENCY AND URGENTLY NEEDED SERVICES

- **What is an Emergency Medical Condition?**
- **What to Do When You Require Emergency Services**
- **Post-Stabilization and Follow-up Care**
- **Out-of-Area Services**
- **What to Do When You Require Urgently Needed Services**
- **What to Do if You're Abroad**

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

IMPORTANT!

IF YOU BELIEVE YOU ARE EXPERIENCING AN EMERGENCY MEDICAL CONDITION, CALL 911 OR GO DIRECTLY TO THE NEAREST HOSPITAL EMERGENCY ROOM OR OTHER FACILITY FOR TREATMENT.

What are Emergency Medical Services?

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

What is an Emergency Medical Condition?

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

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

What to Do When You Require Emergency Services

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

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

Post-Stabilization and Follow-up Care

Following the stabilization of an Emergency Medical Condition, the treating health care Provider may believe that you require additional Medically Necessary Hospital (health care) Services prior to your being safely discharged. If the hospital is not part of the contracted network, the medical Facility (Hospital) will contact your Participating Medical Group, or PacifiCare, in order to obtain the timely authorization for these post-stabilization services. If PacifiCare determines that you may be safely transferred, and you refuse to consent to the transfer, the Facility (Hospital) must provide you written notice that you will be financially responsible for 100% of the cost of services provided to you once your emergency condition is stable. Also, if the Facility (Hospital) is unable to determine your name and contact information at PacifiCare in order to request prior authorization for services once you are stable, it may bill you for such services.

IF YOU FEEL THAT YOU WERE IMPROPERLY BILLED FOR SERVICES THAT YOU RECEIVED FROM A NON-CONTRACTING PROVIDER, PLEASE CONTACT PACIFICARE AT 1-800-624-8822.

Following your discharge from the Hospital, any Medically Necessary follow-up medical or Hospital Services must be provided or authorized by your Primary Care Physician in order to be covered by PacifiCare. Regardless of where you are in the world, if you require additional follow-up medical or Hospital Services, please call your Primary Care Physician or PacifiCare's Out-of-Area unit to request authorization. PacifiCare's Out-of-Area unit can be reached during regular business hours (8 a.m. – 5 p.m., PST) at 1-800-542-8789.

Out-of-Area Services

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

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

- Routine follow-up care to Emergency or Urgently Needed Services, such as treatments, procedures, X-rays, lab work and doctor visits, Rehabilitation Services, Skilled Nursing Care or home health care.
- Maintenance therapy and durable medical equipment, including, but not limited to, routine dialysis, routine oxygen, routine laboratory testing or a wheelchair to assist you while traveling outside the geographic area served by your Participating Medical Group.
- Medical care for a known or Chronic Condition without acute symptoms as defined under "Emergency Services" or "Urgently Needed Services."
- Ambulance services are limited to transportation to the nearest Facility with the expertise for treating your condition.

Your Participating Medical Group provides 24-hour access to request authorization for out-of-area care. You can also request authorization by calling the PacifiCare Out-of-Area unit during regular business hours (8 a.m. – 5 p.m., PST) at 1-800-542-8789.

What to Do When You Require Urgently Needed Services

If you need Urgently Needed Services when you are in the geographic area served by your Participating Medical Group, you should contact your Primary Care Physician or Participating Medical Group. The telephone numbers for your Primary Care Physician and/or Participating Medical Group are on the front of your PacifiCare ID card. Assistance is available 24 hours a day, 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 any provided instructions. If your Primary Care Physician or Participating Medical Group is temporarily unavailable or inaccessible, you should seek Urgently Needed Services from a licensed medical professional wherever you are located.

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

Out-of-Area Urgently Needed Services

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

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

When you are temporarily outside the geographic area served by your Participating Medical Group and you believe that you require Urgently Needed Services, you should, if possible, call (or have someone else call on your behalf) your Primary Care Physician or Participating Medical Group as described above in "What to Do When You Require Urgently Needed Services." The telephone numbers for your Primary Care Physician and/or Participating Medical Group are on the front of your PacifiCare ID card. Assistance is available 24 hours a day, 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 any provided instructions.

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

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

International Emergency and Urgently Needed Services

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

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

ALWAYS REMEMBER

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

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

SECTION 4. CHANGING YOUR DOCTOR OR MEDICAL GROUP

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

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

Changing Your Primary Care Physician or Participating Medical Group

Whether you want to change doctors within your Participating Medical Group or transfer out of your Participating Medical Group entirely, you should contact our Customer Service department.

PacifiCare will approve your request to change doctors within your Participating Medical Group if the Primary Care Physician you've selected is accepting new patients and meets the other criteria in **Section 1. Getting Started.**

If you call us by the 15th of the current month, your transfer will be effective on the first day of the following month. If you meet the criteria but your request is received after the 15th of the current month, your transfer will be effective the first day of the second succeeding month. For example, if you meet the above requirements and you call PacifiCare on June 12th to request a new doctor, the transfer will be effective on July 1st. If you meet the above requirements and you call PacifiCare on June 16th, the transfer will be effective August 1st.

If you wish to transfer out of your Participating Medical Group entirely, and you are not an Inpatient in a Hospital, a Skilled Nursing Facility or other medical institution, PacifiCare will approve your request if the Primary Care Physician within the new Participating Medical Group you've selected is accepting new patients and meets the other criteria in **Section 1. Getting Started**. This includes being located within 30 miles of your Primary Residence or Primary Workplace. The effective date of transfer will be the same as referred to above when requesting a transfer within your Participating Medical Group.

Please Note: PacifiCare does not advise that you change your Primary Care Physician if you are an Inpatient in a Hospital, a Skilled Nursing Facility or other medical institution or are undergoing radiation or chemotherapy, as a change may negatively impact your coordination of care.

If you wish to transfer out of your Participating Medical Group and you are an Inpatient in a Hospital, a Skilled Nursing Facility or other medical institution, the change will not be effective until the first day of the second month following your discharge from the institution.

If you are pregnant and wish to transfer out of your Participating Medical Group and your pregnancy has reached the third trimester, to protect your health and the health of your unborn child, PacifiCare does not permit such change until after the pregnancy.

If you change your Participating Medical Group, authorizations issued by your previous Participating Medical Group will not be accepted by your new group. Consequently, you should request a new referral from your new Primary Care Physician within your new Participating Medical Group, which may require further evaluation by your new Participating Medical Group or PacifiCare.

Please note that your new Participating Medical Group or PacifiCare may refer you to a different Provider than the Provider identified on your original authorization from your previous group.

If you are changing Participating Medical Groups, our Customer Service department may be able to help smooth the transition. When PacifiCare's Case Management is involved, the Case Manager is also consulted about the effective date of your Physician change request. At the time of your request, please let us know if you are currently under the care of a specialist, receiving home health services or using durable medical equipment such as a wheelchair, walker, Hospital bed or an oxygen delivery system.

When We Change Your Participating Medical Group

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

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

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

Continuing Care With a Terminated Provider

Under certain circumstances, you may be eligible to continue receiving care from a Terminated Provider to ensure a smooth transition to a new Participating Provider and to complete a course of treatment with the same Terminated Provider or to maintain the same Terminating Provider.

The care must be Medically Necessary, and the cause of Termination by PacifiCare or your Participating Medical Group also has to be for a reason other than a medical disciplinary cause, fraud or any criminal activity.

For a Member to continue receiving care from a Terminated Provider, the following conditions must be met:

1. Continuity of Care services from a Terminated Provider must be Preauthorized by PacifiCare;
2. The requested treatment must be a Covered Service under this Plan;
3. The Terminated Provider must agree in writing to be subject to the same contractual terms and conditions that were imposed upon the Provider prior to Termination, including, but not limited to, credentialing, Hospital privileging, utilization review, peer review and quality assurance requirements, notwithstanding the provisions outlined in the Provider contract related to Continuity of Care;
4. The Terminated Provider must agree in writing to be compensated at rates and methods of payment similar to those used by PacifiCare or Participating Medical Groups/Independent Practice Associations (PMG/IPA) for current Participating Providers providing similar services who are not capitated and who are practicing in the same or a similar geographic area as the Terminated Provider.

Covered Services provided by a Terminated Provider to a Member who at the time of the Participating Provider's contract Termination was receiving services from that Participating Provider for one of the Continuity of Care Conditions will be considered complete when:

i. The Member's Continuity of Care Condition under treatment is medically stable, and
ii. There are no clinical contraindications that would prevent a medically safe transfer to a Participating Provider as determined by a PacifiCare Medical Director in consultation with the Member, the Terminated Participating Provider and, as applicable, the Member's receiving Participating Provider.

Continuity of Care also applies to Members who are receiving Mental Health care services from a Terminated Mental Health Provider, on the effective Termination date. Members eligible for continuity of Mental Health care services may continue to receive Mental Health services from the Terminated Mental Health Provider for a reasonable period of time to safely transition care to a Participating Mental Health Provider. Please refer to "Inpatient Benefits, Outpatient Benefits" and "Exclusions and Limitations of Benefits" in **Section 5. Your Medical Benefits** of the PacifiCare *Combined Evidence of Coverage and Disclosure Form*, and the *Schedule of Benefits* for supplemental Mental Health care coverage information, if any. For a description of coverage of Mental Health care services for the diagnosis and treatment of Severe Mental Illness (SMI) and Serious Emotional Disturbances of a Child (SED), please refer to the behavioral health supplement to this *Combined Evidence of Coverage and Disclosure Form.*

All Continuity of Care requests will be reviewed on a case-by-case basis. Reasonable consideration will be given to the severity of the Member's condition and the potential clinical effect of a change in Provider regarding the Member's treatment and outcome of the condition under treatment.

If you are receiving treatment for any of the specified Continuity of Care Conditions as limited and described in **Section 10. Definitions** and believe you qualify for continued care with the Terminating Provider, please call the Customer Service department and request the form "Request for Continuity of Care Benefits."

Complete and return the form to PacifiCare as soon as possible, but no later than thirty (30) calendar days of the Provider's effective date of Termination. Exceptions to the thirty (30)-calendar-day time frame will be considered for good cause. The address is:

PacifiCare of California
Attention: Continuity of Care Department
Mail Stop: CA124-0181
P.O. Box 6006
Cypress, CA 90630
Fax: 1-888-361-0514

PacifiCare's Health Services department will complete a clinical review of your Continuity of Care request for Completion of Covered Services with the Terminated Provider and the decision will be made and communicated in a timely manner appropriate for the nature of your medical condition. In most instances, decisions for non-urgent requests will be made within five (5) business days of PacifiCare's receipt of the completed form. You will be notified of the decision by telephone, and provided with a plan for your continued care. Written notification of the decision and plan of care will be sent to you, by United States mail, within two (2) business days of making the decision. If your request for continued care with a Terminated Provider is denied, you may appeal the decision. (To learn more about appealing a denial, please refer to **Section 8. Overseeing Your Health Care**.)

If you have any questions, would like a description of PacifiCare's continuity of care process, or want to appeal a denial, please contact our Customer Service department.

Please Note: It's not enough to simply prefer receiving treatment from a Terminated Physician or other terminated Provider. You should not continue care with a terminated Provider without our formal approval. *If you do not receive Preauthorization by PacifiCare or your Participating Medical Group, payment for routine services performed from a Terminated Provider will be your responsibility.*

In the above section "Continuity of Care with a Terminating Provider," **Termination, Terminated** or **Terminating** references any circumstance which Terminates, non-renews or otherwise ends the arrangement by which the Participating Provider routinely renders Covered Services to PacifiCare Members.

SECTION 5. YOUR MEDICAL BENEFITS

- **Inpatient Benefits**
- **Outpatient Benefits**
- **Exclusions and Limitations**

This section explains your medical benefits, including what is and isn't covered by PacifiCare. You can find some helpful definitions in the back of this publication. For any Copayments that may be associated with a benefit, you should refer to your Schedule of Benefits, a copy of which is included with this document. PacifiCare's Commercial HMO Benefit Interpretation Policy Manual and Medical Management Guidelines Manual are available at ***www.pacificare.com****.*

I. Inpatient Benefits

THESE BENEFITS ARE PROVIDED WHEN ADMITTED OR AUTHORIZED BY EITHER THE MEMBER'S PARTICIPATING MEDICAL GROUP OR PACIFICARE. ALL SERVICES MUST BE MEDICALLY NECESSARY AS DEFINED IN THIS *COMBINED EVIDENCE OF COVERAGE AND DISCLOSURE FORM.* The fact that a Physician has ordered a particular service, supply, or treatment will not make it covered under the Health Plan. A service, supply, or treatment must be both Medically Necessary and not excluded from coverage in order to be a Covered Service.

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

1. **Blood and Blood Products** – Blood and blood products are covered. Autologous (self-donated), donor-directed and donor-designated blood processing costs are limited to blood collected for a scheduled procedure.
2. **Bloodless Surgery** – Surgical procedures performed without blood transfusions or blood products, including Rho(D) Immune Globulin for Members who object to such transfusion on religious grounds, are covered only when available within the Member's Participating Medical Group/Hospital.
3. **Bone Marrow and Stem Cell Transplants** – Non-Experimental/Non-Investigational autologous and allogeneic bone marrow and stem cell transplants and transplant services are covered when the recipient is a member and the bone marrow or stem cell services are performed at a Designated Facility. The testing of relatives to determine the compatibility of bone marrow and stem cells is limited to immediate blood relatives who are sisters, brothers, parents and natural children. The testing for compatible unrelated donors, and costs for computerized national and international searches for unrelated allogeneic bone marrow or stem cell donors conducted through a registry, are covered when the Member is the intended recipient. Costs for such searches are covered up to a maximum of $15,000. A Designated Facility center approved by PacifiCare must conduct the computerized searches. There is no dollar limitation for Medically Necessary donor-related clinical transplant services once a donor is identified.
4. **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 Participating Medical Group or PacifiCare.

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

   - Health care services typically provided absent a clinical trial.

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

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

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

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

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

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

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

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

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

5. **Hospice Services** – Hospice services are covered for Members with a Terminal Illness, defined as a medical condition resulting in a prognosis of life expectancy of 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 Aide Services and homemaker services under the supervision of a qualified registered nurse; bereavement services; social services/counseling services; medical direction; volunteer services; pharmaceuticals, medical equipment and supplies that are reasonable and necessary for the palliation and management of the Terminal Illness and related conditions; and physical and occupational therapy and speech-language pathology services for purposes of symptom control or to enable the Member to maintain activities of daily living and basic functional skills.

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

6. **Inpatient Hospital Benefits/Acute Care** – Medically Necessary Inpatient Hospital Services authorized by the Member's Participating Medical Group or PacifiCare are covered, including, but not limited to: semi-private room, nursing and other licensed health professionals, intensive care, operating room, recovery room, laboratory and professional charges by the Hospital pathologist or radiologist and other miscellaneous Hospital charges for Medically Necessary care and treatment.

7. **Inpatient Physician and Specialist Care** – Services from Physicians, including specialists and other licensed health professionals within, or upon referral from, the Member's Participating Medical Group are covered while the Member is Hospitalized as an Inpatient. A specialist is a licensed health care professional with advanced training in an area of medicine or surgery.

8. **Inpatient Rehabilitation Care** – Rehabilitation Services that must be provided in Inpatient rehabilitation Facility are covered. Inpatient rehabilitation consists of the combined and coordinated use of medical, physical, occupational and speech therapy for training or retraining individuals disabled by disease or injury. This benefit does not include Substance Use Disorder rehabilitation.

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

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

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

- Licensed/Certified nurse midwife services are covered only when available within the Member's Participating Medical Group.
- Elective home deliveries are not covered.

A minimum 48-hour Inpatient stay for normal vaginal delivery and a minimum 96-hour Inpatient stay following delivery by Caesarean section are covered. Coverage for Inpatient Hospital care may be for a time period less than the minimum hours if the decision for an earlier discharge of the mother and newborn is made by the treating Physician in consultation with the mother. In addition, if the mother and newborn are discharged prior to the 48-or 96-hour minimum time periods, a post-discharge follow-up visit for the mother and newborn will be provided within 48 hours of discharge, when prescribed by the treating Physician.

11. **Morbid Obesity (Surgical Treatment)** – PacifiCare covers bariatric surgical procedures when Medically Necessary and preauthorized. PacifiCare will use scientifically valid, evidence-based criteria to determine coverage of bariatric surgery, such as the most recent National Institutes of Health (NIH) guidelines, in determining the medical necessity of requests for surgical treatment for morbid obesity. Please refer to your *Schedule of Benefits* for copayment information of this benefit or you may call PacifiCare's Customer Service Department for additional information.
12. **Newborn Care** – Postnatal Hospital Services are covered, including circumcision and special care nursery. A newborn Copayment applies in addition to the Copayment for maternity care, unless the newborn is discharged with the mother within 48 hours of the baby's normal vaginal delivery or within 96 hours of the baby's cesarean delivery. Circumcision is covered for male newborns prior to Hospital discharge. See "Circumcision" under "Outpatient Benefits" for an explanation of coverage after Hospital discharge.
13. **Organ Transplant and Transplant Services** – Non-Experimental and Non-Investigational organ transplants and transplant services are covered when the recipient is a Member and the transplant is performed at a Designated Facility. Listing of the Member at a second Designated Facility is a covered benefit unless the Regional Organ Procurement Agency is the same for both facilities.

    Organ transplant listing is limited to two Designated Facilities. If the Member is listed at two facilities, PacifiCare will only cover costs associated with the transplant surgical procedure (includes donor surgical procedure and services) and post-transplant services at the Facility where the transplant is performed. The Member will be responsible for any duplicated diagnostic costs for a transplant evaluation incurred at the second Facility. Covered Services for living donors are limited to Medically Necessary clinical services once a donor is identified. Transportation and other nonclinical expenses of the living donor are excluded, and are the responsibility of the Member who is the recipient of the transplant. (See the definition for "Designated Facility.")
14. **Reconstructive Surgery** – Reconstructive surgery is covered to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors or disease. The purpose of reconstructive surgery is to correct abnormal structures of the body to improve function or create a normal appearance to the extent possible. Reconstructive procedures require Preauthorization by the Member's Participating Medical Group or PacifiCare in accordance with standards of care as practiced by Physicians specializing in reconstructive surgery.
15. **Skilled Nursing/Subacute and Transitional Care** – Medically Necessary Skilled Nursing Care and Skilled Rehabilitation Care are covered. The Member's Participating Medical Group or PacifiCare will determine where the Skilled Nursing Care and Skilled Rehabilitation Care will be provided. Refer to your *Schedule of Benefits* for the number of days covered under your Health Plan. Subacute and Transitional Care are levels of care provided by a Skilled Nursing Facility to a Member who does not require Hospital acute care, but who requires more intensive licensed Skilled Nursing Facility care than is provided to the majority of the patients in a Skilled Nursing Facility.

Skilled Nursing Facility services will be provided in place of a Hospital stay when Medically Necessary, and when authorized by the Member's Primary Care Physician, or by the Member's Participating Medical Group or by PacifiCare. When the Member is transferred from a Skilled Nursing Facility to an acute Hospital setting, and then back to a Skilled Nursing Facility, the days spent in the acute Hospital are not counted against the calendar day benefit limitation as described in your *Schedule of Benefits.*

Prescription drugs are covered when furnished by the Skilled Nursing Facility and used by the Member during a period of covered Skilled Nursing Facility care. Services or supplies not included in the written treatment plan and Custodial Care are not covered.

Outpatient drugs and prescription medications may be available as a supplemental benefit. Please refer to "Drugs and Prescription Medication" (Outpatient) listed in "Other Exclusions and Limitations."

16. **Substance Use Disorder Detoxification** – Detoxification is the medical treatment of withdrawal related to a Substance Use Disorder. Treatment in an acute care setting is covered for the acute stage of Substance Use Disorder withdrawal when medical complications occur or are highly probable. Medical detoxification is covered when Medically Necessary. Methadone treatment for detoxification is not covered. Rehabilitation for Substance Use Disorder is not covered. (Coverage for rehabilitation of Substance Use Disorder may be available if purchased by the Subscriber's employer as a supplemental benefit. If the Member's Health Plan includes a Behavioral Health supplemental benefit, a brochure describing it will be enclosed with these materials.)
17. **Voluntary Termination of Pregnancy** – Refer to the *Schedule of Benefits* for the terms of any coverage, if any.

II. Outpatient Benefits

The following benefits are available on an Outpatient basis and must be provided by the Member's Primary Care Physician or authorized by the Member's Participating Medical Group or PacifiCare. All services must be Medically Necessary as defined in this *Combined Evidence of Coverage and Disclosure Form.* The fact that a Physician has ordered a particular service, supply, or treatment will not make it covered under the Health Plan. A service, supply, or treatment must be both Medically Necessary and not excluded from coverage in order to be a Covered Service.

1. **Allergy Serum** – Allergy serum, as well as needles, syringes and other supplies for the administration of the serum are covered for the treatment of allergies. Allergy serum, needles and syringes must be obtained through a PacifiCare Participating Physician.
2. **Allergy Testing Treatment** – Services and supplies are covered, including provocative antigen testing, to determine appropriate allergy treatment. Services and supplies for the treatment of allergies, including allergen/antigen immunotherapy and serum are covered according to an established treatment plan.
3. **Ambulance** – The use of an ambulance (land or air) is covered without Preauthorization, when the Member, as a Prudent Layperson, reasonably believes there is an emergency medical or psychiatric condition that requires ambulance transport to access Emergency Services. Such coverage includes, but is not limited to, ambulance or ambulance transport services provided through the 911 emergency response system. Ambulance transportation is limited to the nearest available emergency Facility having the expertise to stabilize the Member's Emergency Medical Condition. Use of an ambulance for a non-Emergency Services is covered only when specifically authorized by the Member's Participating Medical Group or PacifiCare.
4. **Attention Deficit/Hyperactivity Disorder** – The medical management of Attention Deficit/ Hyperactivity Disorder (ADHD) is covered including the diagnostic evaluation and laboratory monitoring of prescribed drugs. Coverage for Outpatient prescribed drugs is only available if the Subscriber's Employer Group has purchased the supplemental Outpatient Prescription Drug Benefit. This benefit does not include non-crisis Mental Health counseling or behavior modification programs. For additional information regarding Covered Mental Health Services please refer to the "Mental Health Services" benefit description in this section.

5. **Blood and Blood Products** – Blood and blood products are covered. Autologous (self-donated), donor-directed and donor-designated blood processing costs are limited to blood collected for a scheduled procedure.
6. **Bloodless Surgery** – Please refer to the benefit described above under "Inpatient Benefits" for "Bloodless Surgery." Outpatient services Copayments and/or deductibles apply for any services received on an Outpatient basis.
7. **Bone-Anchored Hearing Aid** – Bone-anchored hearing aid is covered only when the Member has either of the following:
   a. Craniofacial anomalies in which abnormal or absent ear canals preclude the use of a wearable hearing aid, or
   b. Hearing loss of sufficient severity that it cannot be adequately remedied by a wearable hearing aid.

   Covered Services are available for a bone-anchored hearing aid that is purchased as a result of a written recommendation by a Participating Physician.

   Note: Bone-anchored hearing aid will **not** be subject to the non-implantable hearing aid limit. There will not be a dollar maximum associated with this benefit. Bone-anchored hearing aid will be subject to applicable medical/surgical categories (e.g., inpatient hospital, physician fees) only for Members who meet the medical criteria specified above. Limited to one (1) bone-anchored hearing aid during the entire period of time the Member is enrolled in the Health Plan (per lifetime). Repairs and/or replacement for a bone anchored hearing aid are not covered, except for malfunctions. Deluxe model and upgrades that are not Medically Necessary are not covered.

   Please refer to the "Hearing Aid and Hearing Device" benefit description in this section for non-implantable hearing aid; the Schedule of Benefits for applicable Copayments and to the "Bone-Anchored Hearing Aid" exclusion listed in "Other Exclusions and Limitations."
8. **Cancer Clinical Trials** – Please refer to the benefit described above under Inpatient "Cancer Clinical Trials." Outpatient services Copayments and/or deductibles apply for any Cancer Clinical Trials services received on an Outpatient basis according to the Copayments for that specific Outpatient service. PacifiCare is required to pay for the services covered under this benefit at the rate agreed upon by PacifiCare and a Participating Provider, minus any applicable Copayment, Coinsurance or deductibles. In the event the Member participates in a clinical trial provided by a Non-Participating Provider that does not agree to perform these services at the rate PacifiCare negotiates with Participating Providers, the Member will be responsible for payment of the difference between the Non-Participating Provider's billed charges and the rate negotiated by PacifiCare with Participating Providers, in addition to any applicable Copayment, Coinsurance or deductibles.

   Any additional expenses the Member may have to pay beyond PacifiCare's negotiated rate as a result of using a Non-Participating Provider do not apply to the Member's Annual Copayment Maximum.
9. **Circumcision** – Circumcision is covered for male newborns prior to Hospital discharge. Circumcision is covered after Hospital discharge only when:
   - Circumcision was delayed by the Participating Provider during initial Hospitalization. Unless the delay was for medical reasons, the circumcision is covered after discharge only through the 28-day neonatal period, or
   - Circumcision was determined to be medically inappropriate during initial Hospitalization due to medical reasons (for example, prematurity, congenital deformity, etc.). The circumcision is covered when the Participating Provider determines it is medically safe and the circumcision is performed within 90 days from that determination.

   Circumcision other than noted under the Outpatient Circumcision benefit will be reviewed for Medical Necessity by the Participating Medical Group or PacifiCare Medical Director or designee.

10. **Cochlear Implant Device** – An implantable cochlear device for bilateral, profoundly hearing-impaired individuals or prelingual individuals who are not benefited from conventional amplification (hearing aids) is covered. Please also refer to "Cochlear Implant Medical and Surgical Services."

11. **Cochlear Implant Medical and Surgical Services** – The implantation of a cochlear device for bilateral, profoundly hearing impaired or prelingual individuals who are not benefited from conventional amplification (hearing aids) is covered. This benefit includes services needed to support the mapping and functional assessment of the cochlear device at the authorized Participating Provider. (For an explanation of speech therapy benefits, please refer to "Outpatient Medical Rehabilitation Therapy.")

12. **Dental Treatment Anesthesia** – See "Oral Surgery and Dental Services: Dental Treatment Anesthesia."

13. **Diabetic Management and Treatment** – Coverage includes Outpatient self-management training, education and medical nutrition therapy services. The diabetes Outpatient self-management training, education and medical nutrition therapy services covered under this benefit will be provided by appropriately licensed or registered health care professionals. These services must be provided under the direction of and prescribed by a Participating Provider.

14. **Diabetic Self-Management Items** – Equipment and supplies for the management and treatment of diabetes are covered, based upon the medical needs of the Member, including but not necessarily limited to: blood glucose monitors; blood glucose monitors designed to assist the visually impaired; strips; lancets and lancet puncture devices; pen delivery systems (for the administration of insulin); insulin pumps and all related necessary supplies; ketone urine testing strips; insulin syringes; podiatry services; and devices to prevent or treat diabetes-related complications. Members must have coverage under the Outpatient Prescription Drug Benefit for insulin, glucagon and other diabetic medications to be covered.

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

15. **Dialysis** – Acute and chronic hemodialysis and peritoneal dialysis services and supplies are covered. Chronic dialysis (peritoneal or hemodialysis) must be authorized by the Member's Participating Medical Group or PacifiCare and provided within the Member's Participating Medical Group. The fact that the Member is outside the geographic area served by the Participating Medical Group will not entitle the Member to coverage for maintenance of chronic dialysis to facilitate travel.

16. **Durable Medical Equipment (Rental, Purchase or Repair)** – Durable Medical Equipment is covered when it is designed to assist in the treatment of an injury or illness of the Member, and the equipment is primarily for use in the home. Durable Medical Equipment is medical equipment that can exist for a reasonable period of time without significant deterioration. Examples of covered Durable Medical Equipment include wheelchairs, Hospital beds, standard oxygen-delivery systems and equipment for the treatment of asthma (nebulizers, masks, tubing and peak flow meters, the equipment and supplies must be prescribed by and are limited to the amount requested by the Participating Physician). Outpatient drugs, prescription medications and inhaler spacers for the treatment of asthma are available under the prescription drug benefit if purchased as a supplemental benefit. Please refer to the Pharmacy *Schedule of Benefits*, "Medication Covered by Your Benefit" under "Miscellaneous Prescription Drug Coverage" for coverage.

    Replacements, repairs and adjustments to Durable Medical Equipment are limited to normal wear and tear or because of a significant change in the Member's physical condition. The Member's Participating Medical Group or PacifiCare has the option to repair or replace Durable Medical Equipment items. Replacement of lost or stolen Durable Medical Equipment is not covered. The following equipment and accessories are not covered: Non-Medically Necessary optional attachments and modifications to Durable Medical Equipment for the comfort or convenience of the Member, accessories for portability or travel, a second piece of equipment with or without additional accessories that is for the same or similar

medical purpose as existing equipment and home and/or car modifications to accommodate the Member's condition.

For a detailed listing of covered Durable Medical Equipment, please contact the PacifiCare Customer Service department at 1-800-624-8822.

17. **Family Planning** – Refer to the *Schedule of Benefits* for the specific terms of coverage under your Health Plan.

18. **Footwear** – Specialized footwear, including foot orthotics, custom-made or standard orthopedic shoes are covered for a Member with diabetic foot disease or when an orthopedic shoe is permanently attached to a Medically Necessary orthopedic brace. Replacements, repairs and adjustments to foot orthotics are covered when Medically Necessary and authorized by the Member's Participating Medical Group or PacifiCare.

19. **Health Education Services** – Includes wellness programs such as a stop smoking program available to enrolled Members. PacifiCare also makes health and wellness information available to Members. For more information about the stop smoking program or any other wellness program, call the PacifiCare Customer Service department at 1-800-624-8822, or visit the PacifiCare Web site.

    The Member's Participating Medical Group may offer additional community health programs. These programs are independent of health improvement programs offered by PacifiCare and are not covered. Fees charged will not apply to the Member's Copayment maximum.

20. **Hearing Aid and Hearing Device** – Hearing aid required for the correction of a hearing impairment (a reduction in the ability to perceive sound which may range from slight to complete deafness) is covered. Hearing aid is an electronic amplifying device designated to bring sound more effectively into the ear. A hearing aid consists of a microphone, amplifier and receiver.

    Covered Services are available for a hearing aid that is purchased as a result of a written recommendation by a Participating Physician. Covered Services are provided for the hearing aid and for charges for associated fitting and testing.

    Non-implantable hearing aid benefit will be limited to a single hearing aid (including repairs and replacements) every three (3) years.

    Please refer to the *Schedule of Benefits* for any applicable Copayments, and Deductible Amounts, maximum and benefit limitations in the "Hearing Aid and Hearing Device" listed in "Other Exclusions and Limitations." For implantable hearing aid, refer to "Bone-Anchored Hearing Aid" in this section.

21. **Home Health Care Visits** – A Member is eligible to receive Home Health Care Visits if the Member: (i) is confined to the home (home is wherever the Member makes his or her home but does not include acute care, rehabilitation or Skilled Nursing Facilities); (ii) needs Medically Necessary skilled nursing visits or needs physical, speech or occupational therapy; and (iii) the Home Health Care Visits are provided under a plan of care established and periodically reviewed and ordered by a PacifiCare Participating Provider. "Skilled Nursing Services" means the services provided directly by or under the direct supervision of licensed nursing personnel, including the supportive care of a Home Health Aide. Skilled nursing visits may be provided by a registered nurse or licensed vocational nurse.

    If a Member is eligible for Home Health Care Visits in accordance with the authorized treatment plan, the following Medically Necessary Home Health Care Visits may be included but are not limited to:

    a. Skilled nursing visits;
    b. Home Health Aide Services visits that provide supportive care in the home which are reasonable and necessary to the Member's illness or injury;
    c. Physical, occupational or speech therapy that is provided on a per visit basis;
    d. Medical supplies, durable medical equipment;

e. Infusion therapy medications and supplies and laboratory services as prescribed by a Participating Provider to the extent such services would be covered by PacifiCare had the Member remained in the Hospital, rehabilitation or Skilled Nursing Facility; and

f. Drugs, medications and related pharmaceutical services are covered for those Members enrolled in PacifiCare's Outpatient Prescription Benefit. Outpatient prescription drugs may be available as a supplemental benefit. Please refer to your *Schedule of Benefits*.

If the Member's Participating Medical Group determines that Skilled Nursing Service needs are more extensive than the services described in this benefit, the Member will be transferred to a Skilled Nursing Facility to obtain services. PacifiCare, in consultation with the Member's Participating Medical Group, will determine the appropriate setting for delivery of the Member's Skilled Nursing Services.

Please refer to the *Schedule of Benefits* for any applicable Copayments and benefit limitations.

22. **Hospice Services** – Hospice services are covered for Members with a Terminal Illness, defined as a medical condition resulting in a prognosis of life expectancy of 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 Aide Services and homemaker services under the supervision of a qualified registered nurse; bereavement services; social services/counseling services; medical direction; volunteer services; pharmaceuticals, medical equipment and supplies that are reasonable and necessary for the palliation and management of the Terminal Illness and related conditions; physical and occupational therapy and speech-language pathology services for purposes of symptom control or to enable the Member to maintain activities of daily living and basic functional skills.

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

23. **Immunizations** – Immunizations for children (through age 18 years) are covered only if the immunizations are consistent with the most current version of the Recommended Childhood and Adolescent Immunization Schedule – United States.[1] An exception is made if, within 45 days of the published date of the schedule, the State Department of Health Services determines that the schedule is not consistent with state law. For children under two years of age, refer to "Periodic Health Evaluations, Well-Baby Care."

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

    Travel and/or required work immunizations are not covered, except as otherwise recommended by the national advisory organizations referenced in the footnote below (e.g., Hepatitis B is covered for all adults seeking protection, regardless of risk). Refer to "Immunizations" in "Other Exclusions and Limitations."

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[1] As adopted by the American Academy of Pediatrics, the Advisory Committee on Immunization Practices (ACIP), and the American Academy of Family Physicians.

24. **Infertility Services** – Please refer to the *Schedule of Benefits* for coverage, if any. Coverage for Infertility Services is only available if purchased by the Subscriber's Employer Group as a supplemental benefit. If the Member's Health Plan includes an Infertility Services supplemental benefit, a supplement to the *Combined Evidence of Coverage and Disclosure Form* will be provided to the Member.

25. **Injectable Drugs (Outpatient Injectable Medications and Self-Injectable Medications)** –
    - **Infusion Therapy** – Infusion therapy refers to the therapeutic administration of drugs or other prepared or compounded substances by the Intravenous route (includes chemotherapy). Infusion therapy is covered when furnished as part of a treatment plan authorized by the Member's Primary Care Physician, Participating Medical Group or PacifiCare. The infusions must be administered in the Member's home, Participating Physician's office or in an institution, such as a board and care, Custodial Care, or assisted living Facility that is not a Hospital or institution primarily engaged in providing Skilled Nursing Services or Rehabilitation Services.
    - **Outpatient Injectable Medications** – Outpatient injectable medications (except insulin) include those drugs or preparations which are not usually self-administered and which are given by the Intramuscular or Subcutaneous route. Outpatient injectable medications (except insulin) are covered when administered as a customary component of a Physician's office visit and when not otherwise limited or excluded (e.g., insulin, certain immunizations, infertility drugs, birth control or off-label use of covered injectable medications). Outpatient injectable medications must be obtained through a Participating Provider, the Member's Participating Medical Group or PacifiCare Designated Pharmacy and may require preauthorization by PacifiCare.
    - **Self-Injectable Medications** – Self-injectable medications (except insulin) are defined as those drugs which are either generally self-administered by Intramuscular injection at a frequency of one or more times per week, or which are generally self-administered by the Subcutaneous route. Self-injectable medications (except insulin) are covered when prescribed by a Participating Provider, as authorized by the Member's Participating Medical Group or by PacifiCare. Self-injectable medications must be obtained through a Participating Provider, through the Member's Participating Medical Group or PacifiCare-designated pharmacy/specialty injectable vendor, and may require preauthorization by PacifiCare. A separate Copayment applies to all self-injectable medications for a 30-day supply (or for the prescribed course of treatment if shorter), whether self-administered or injected in the Physician's office, and is applied in addition to any office visit Copayment.

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

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

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

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

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

30. **OB/GYN Physician Care** – See "Physician OB/GYN Care."

31. **Oral Surgery and Dental Services** – Emergency Services for stabilizing an acute injury to sound natural teeth, the jawbone or the surrounding structures and tissues are covered. Coverage is limited to treatment provided within 48 hours of injury or as soon as the Member is medically stable. Other covered oral surgery and dental services include:
    - Oral surgery or dental services, rendered by a Physician or dental professional for treatment of primary medical conditions. Examples include, but are not limited to:
        - Biopsy and excision of cysts or tumors of the jaw, treatment of malignant neoplastic disease(s) and treatment of temporomandibular joint syndrome (TMJ);
        - Biopsy of gums or soft palate;
        - Oral or dental examinations performed on an Inpatient or Outpatient basis as part of a comprehensive workup prior to transplantation surgery;
        - Preventive fluoride treatment prior to an aggressive chemotherapeutic or radiation therapy protocol. Fluoride trays and/or bite guards used to protect the teeth from caries and possible infection during radiation therapy;
        - Reconstruction of a ridge that is performed as a result of and at the same time as the surgical removal of a tumor (for other than dental purposes);
        - Reconstruction of the jaw when Medically Necessary (e.g., radical neck or removal of mandibular bone for cancer or tumor);
        - Ridge augmentation or alveoplasty are covered when determined to be Medically Necessary based on state cosmetic reconstructive surgery law and jawbone surgery law;
        - Setting of the jaw or facial bones;
        - Tooth extraction prior to a major organ transplant or radiation therapy of neoplastic disease to the head or neck;
        - Treatment of maxillofacial cysts, including extraction and biopsy.

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

32. **Oral Surgery and Dental Services: Dental Treatment Anesthesia** – Anesthesia and associated Facility charges for dental procedures provided in a Hospital or Outpatient surgery center are covered when: (a) the Member's clinical status or underlying medical condition requires use of an Outpatient surgery center or Inpatient setting for the provision of the anesthesia for a dental procedure(s) that ordinarily would not require anesthesia in a Hospital or Outpatient surgery center setting; and (b) one of the following criteria is met:
    - The Member is under seven years of age;
    - The Member is developmentally disabled, regardless of age; or
    - The Member's health is compromised and general anesthesia is Medically Necessary, regardless of age.

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

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

33. **Outpatient Medical Rehabilitation Therapy** – Services provided by a registered physical, speech or occupational therapist for the treatment of an illness, disease or injury are covered.

34. **Outpatient Services** – Medically Necessary services, treatments or procedures performed in a hospital outpatient services department setting or a free-standing facility that is not a certified ambulatory surgical center or outpatient surgery department of an acute hospital are covered. Examples include, but are not limited to: endoscopies, hyperbaric oxygen and wound care.

35. **Outpatient Surgery** – Short-stay, same-day or other similar Outpatient surgery facilities and professional services are covered when provided as a substitute for Inpatient care.

36. **Periodic Health Evaluation** – Periodic health evaluations are covered as recommended by PacifiCare and the Member's Primary Care Physician. This may include, but is not limited to, the following screenings:

    - **Breast Cancer Screening and Diagnosis** – Services are covered for the screening and diagnosis of breast cancer. Screening and diagnosis will be covered consistent with generally accepted medical practice and scientific evidence, upon referral by the Member's Primary Care Physician. Mammography for screening or diagnostic purposes is covered as authorized by the Member's participating nurse practitioner, participating nurse midwife or Participating Provider.

    - **Colorectal Screening** – Routine screening beginning at age 50 for men and women at average risk with interval determined by method. Potential screening options include: home Fecal Occult Blood Test (FOBT), flexible sigmoidoscopy, the combination of home FOBT and flexible sigmoidoscopy, colonoscopy, or double-contrast barium enema.

    - **Hearing Screening** – Routine hearing screening by a participating health professional is covered to determine the need for hearing correction.

    - **Human Immunodeficiency Virus (HIV)** - Services for human immunodeficiency virus (HIV) testing, regardless whether the testing is related to a primary diagnosis.

    - **Prostate Screening** – Evaluations for the screening and diagnosis of prostate cancer is covered (including, but not limited to, prostate-specific antigen testing and digital rectal examination). These evaluations are provided when consistent with good professional practice.

    - **Vision Screening** – Annual routine eye health assessment and screening by a Participating Provider are covered to determine the health of the Member's eyes and the possible need for vision correction. An annual retinal examination is covered for Members with diabetes.

    - **Well-Baby Care** – Up to the age of two, preventive health services are covered (including immunizations) when provided by the child's Participating Medical Group.

- **Well-Woman Care** – Medically Necessary services, including annual cervical cancer screening tests. Annual cervical cancer screening tests include a Pap smear (cytology), a human papillomavirus (HPV) screening test that is approved by the U.S. Food and Drug Administration, and the option of any cervical cancer screening test approved by the U.S. Food and Drug Administration, are covered. The Member may receive obstetrical and gynecological Physician services directly from an OB/GYN or Family Practice Physician or surgeon (designated by the Member's Participating Medical Group as providing OB/GYN services) affiliated with Member's Participating Medical Group.

Please refer to your *Schedule of Benefits* for applicable Copayments.

37. **Phenylketonuria (PKU) Testing and Treatment** – Testing for Phenylketonuria (PKU) is covered to prevent the development of serious physical or mental disabilities or to promote normal development or function as a consequence of PKU enzyme deficiency. PKU includes those formulas and special food products that are part of a diet prescribed by a Participating Physician and managed by a health care professional in consultation with a Physician who specializes in the treatment of metabolic disease and who participates in or is authorized by PacifiCare, provided that the diet is deemed Medically Necessary to avert the development of serious physical or mental disabilities or to promote normal development or function as a consequence of PKU. Special food products do not include food that is naturally low in protein, but may include a special low-protein formula specifically approved for PKU and special food products that are specially formulated to have less than one gram of protein per serving.
38. **Physician Care (Primary Care Physician and Specialist)** – Diagnostic, consultation and treatment services provided by the Member's Primary Care Physician are covered. Services of a specialist are covered upon referral by Member's Participating Medical Group or PacifiCare. A specialist is a licensed health care professional with advanced training in an area of medicine or surgery.
39. **Physician OB/GYN Care** – The Member may obtain obstetrical and gynecological Physician services directly from an OB/GYN, Family Practice Physician or surgeon (designated by the Member's Participating Medical Group as providing OB/GYN services) affiliated with the Member's Participating Medical Group.
40. **Prosthetics and Corrective Appliances/Orthotics (Non-Foot Orthotics)** – Prosthetics (except for bionic or myoelectric as explained below) are covered when Medically Necessary as determined by the Member's Participating Medical Group or PacifiCare. Prosthetics are durable, custom-made devices designed to replace all or part of a permanently inoperative or malfunctioning body part or organ. Examples of covered prosthetics include initial contact lens in an eye following a surgical cataract extraction and removable, nondental prosthetic devices such as a limb that does not require surgical connection to nerves, muscles or other tissue.

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

    - Bionic, myoelectric, microprocessor-controlled and computerized prosthetics are not covered.
    - Deluxe upgrades that are not Medically Necessary are not covered.
    - Replacements, repairs and adjustments to both corrective appliances/non-foot orthotics and prosthetics are covered when Medically Necessary. Repair or replacement must be authorized by the Member's Participating Medical Group or PacifiCare.
    - An artificial larynx or electronic speech aid is covered post laryngectomy or for a Member with permanently inoperative larynx condition

    Refer to "Footwear" in "Outpatient Benefits" and "Foot Orthotics/Footwear" in "Other Exclusions and Limitations."

For a detailed listing of covered durable medical equipment, and prosthetic and corrective appliances, please contact the PacifiCare Customer Service department at 1-800-624-8822.

41. **Radiation Therapy (Standard and Complex) –**
    - Standard photon beam radiation therapy is covered.
    - Complex radiation therapy is covered. This therapy requires specialized equipment, as well as specially trained or certified personnel to perform the therapy. Examples include, but are not limited to: brachytherapy (radioactive implants) and conformal photon beam radiation and IMRT. (Gamma knife procedures and stereotactic radiosurgery procedures are covered as Outpatient surgeries for the purpose of determining Copayments. (Please refer to your *Schedule of Benefits* for applicable Copayment, if any.)
42. **Reconstructive Surgery** – Reconstructive surgery is covered to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors or disease. The purpose of reconstructive surgery is to improve function or create a normal appearance to the extent possible. Reconstructive procedures require Preauthorization by the Member's Participating Medical Group or PacifiCare in accordance with standards of care as practiced by Physicians specializing in reconstructive surgery.
43. **Refractions** – Routine testing every 12 months is covered to determine the need for corrective lenses (refractive error), including a written prescription for eyeglass lenses. (Coverage for frames and lenses may be available if the Member's health plan includes a supplemental vision benefit.) Coverage under this benefit also includes one (1) initial pair of eyeglasses when prescribed following cataract surgery with an intraocular lens implant. Eyeglasses must be obtained through Participating Medical Group.
44. **Standard X-rays** –Standard X-rays are covered for the diagnosis of an illness or injury, or to screen for certain defined diseases. Standard X-rays are defined to include conventional plain film X-rays, oral and rectal contrast gastrointestinal studies (such as upper GIs, barium enemas and oral cholecystograms), mammograms, obstetrical ultrasounds and bone mineral density studies (including ultrasound and DEXA scans). See "Specialized Scanning and Imaging Procedures" in "Outpatient Benefits" for coverage and examples of specialized scanning and imaging procedures.
45. **Specialized Scanning and Imaging Procedures** – Specialized Scanning and Imaging Procedures are covered for the diagnosis and ongoing medical management of an illness or injury. Specialized procedures are defined to include those which, unless specifically classified as standard X-rays (see "Standard X-rays," item # 44, in "Outpatient Benefits"), are digitally processed or computer-generated or which require contrast administered by injection or infusion. Examples of Specialized Scanning and Imaging Procedures include, but are not limited to, the following scanning and imaging procedures: CT, PET. SPECT, MRI, MRA, EEG, EMG, and nuclear scans, angiograms (includes heart catheterization), arthrograms, myelograms, and non-obstetrical ultrasounds.
46. **Substance Use Disorder Detoxification** – Detoxification is the medical treatment of withdrawal related to a Substance Use Disorder. Medically Necessary detoxification is covered. Methadone treatment for detoxification is not covered. Outpatient treatment for a Substance Use Disorder is appropriate unless another medical condition requires close Inpatient monitoring. Rehabilitation for Substance Use Disorder is not covered.

III. Exclusions and Limitations of Benefits

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

General Exclusions

1. Services that are rendered without authorization from the Member's Participating Medical Group or PacifiCare (except for Emergency Services or Urgently Needed Services described in this *Combined Evidence of Coverage and Disclosure Form*, and for obstetrical and gynecological Physician services obtained directly from an OB/GYN, Family Practice Physician or surgeon designated by the Member's Participating Medical Group as providing OB/GYN services), are not covered except for Emergency Services and out-of-area Urgently Needed Services.
2. Services obtained from Non-Participating Providers or Participating Providers who are not affiliated with the Member's Participating Medical Group, without authorization from PacifiCare or the Participating Medical Group, are not covered except for Emergency Services and out-of-area Urgently Needed Services.
3. Services rendered prior to the Member's effective date of enrollment or after the effective date of disenrollment are not covered.
4. PacifiCare does not cover the cost of services provided in preparation for a non-Covered Service where such services would not otherwise be Medically Necessary. Additionally, PacifiCare does not cover the cost of routine follow-up care for non-Covered Services (as recognized by the organized medical community in the State of California). PacifiCare will cover Medically Necessary services directly related to non-Covered Services when complications exceed routine follow-up care such as life-threatening complications of cosmetic surgery.
5. Services performed by immediate relatives or members of your household are not covered.
6. Services obtained outside the Service Area are not covered except for Emergency Services or Urgently Needed Services.

Other Exclusions and Limitations

1. **Acupuncture and Acupressure** – Acupuncture and acupressure are not covered. (Coverage for acupuncture and acupressure may be available if purchased by the Subscriber's employer as a supplemental benefit. If the Member's Health Plan includes an acupuncture and acupressure supplemental benefit, a brochure describing it will be enclosed with these materials.)
2. **Air Conditioners, Air Purifiers and Other Environmental Equipment** – Air conditioners, air purifiers and other environmental equipment are not covered.
3. **Ambulance** – Ambulance service is not covered when used only for the Member's convenience or when another available form of transportation would be more appropriate. Wheelchair transportation services (e.g., a private vehicle or taxi faire are also not covered.

   Please refer to "Ambulance" in the "Outpatient Benefits" section and "Organ Transplants" in the "Other Exclusions and Limitations" section.
4. **Artificial Hearts** – Artificial hearts are considered experimental and are, therefore, not covered. A Member may be entitled to an expedited external, independent review of PacifiCare's coverage determination regarding Experimental or Investigational therapies as described in **Section 8**.

5. **Bariatric Surgery** – Bariatric surgery will only be covered when Medically Necessary for the treatment of Morbid Obesity. PacifiCare will use scientifically valid, evidence-based criteria to determine coverage of bariatric surgery, such as the most recent National Institutes of Health (NIH) guidelines, in determining the medical necessity of requests for surgical treatment for morbid obesity. PacifiCare evaluation encourages a multidisciplinary team approach that includes medical, surgical, psychological, and nutritional expertise for those who are seeking surgical weight-loss. After surgery the Member participates in a multi-disciplinary program of diet, exercise, and behavior modification.

   Surgical treatments for morbid obesity and services related to this surgery are subject to prior approval by PacifiCare's Medical Director or designee, and are limited to one (1) procedure per Member's lifetime except as approved by PacifiCare's Medical Director or designee when due to medical or surgical complications, it is Medically Necessary and not as a result of non-compliance. Please also see "Weight Alteration Program (Inpatient or Outpatient)".

6. **Behavior Modification and Non-Crisis Mental Health Counseling and Treatment** – Behavior modification and non-crisis Mental Health counseling and treatment are not covered. Examples include, but are not limited to, art therapy, music therapy and play therapy.

7. **Biofeedback** – Biofeedback services are not covered except for urinary incontinence, fecal incontinence or constipation for Member with organic neuromuscular impairment when part of an authorized treatment plan.

8. **Bloodless Surgery Services** – Bloodless surgery services are only covered to the extent available within the Member's Participating Medical Group.

9. **Bone-Anchored Hearing Aid** – Bone-anchored hearing aid is not covered except when either of the following applies:

   a. For Members with craniofacial anomalies in which abnormal or absent ear canals preclude the use of a wearable hearing aid, or

   b. For Members with hearing loss of sufficient severity that it cannot be adequately remedied by a wearable hearing aid.

   Limited to one bone-anchored hearing aid per Member who meets the above coverage criteria during the entire period of time the Member is enrolled in the Health Plan (per lifetime). Repairs and/or replacement for bone-anchored hearing aid for a Member who meets the above coverage criteria are not covered, other than for malfunctions. Deluxe model and upgrades that are not Medically Necessary are not covered.

10. **Bone Marrow and Stem Cell Transplants** – Autologous or allogeneic bone marrow or stem cell transplants are not covered when they are Experimental or Investigational unless required by an external, independent review panel as described in **Section 8** of this *Combined Evidence of Coverage and Disclosure Form*, under the caption "Independent Medical Review Procedures." The testing for compatible unrelated donors, and costs for computerized national and international searches for unrelated allogeneic bone marrow or stem cell donors conducted through a registry, are covered when the Member is the intended recipient. Costs for such searches are covered up to a maximum of $15,000 per procedure. Unrelated donor searches must be performed at a PacifiCare-approved transplant center. (See "Designated Facility" in **Definitions**.)

11. **Chiropractic Care** – Care and treatment provided by a chiropractor are not covered. (Coverage for chiropractic care may be available if purchased by the Subscriber's employer as a supplemental benefit. If your Health Plan includes a chiropractic care supplemental benefit, a brochure describing it will be enclosed with these materials.)

12. **Communication Devices** – Computers, personal digital assistants and any speech-generating devices (except artificial larynxes) are not covered. For a detailed listing of covered durable medical equipment, and prosthetic and corrective appliances, please contact the PacifiCare Customer Service department at 1-800-624-8822.
13. **Complementary and Alternative Medicine** – Complementary and Alternative Medicine is not covered unless purchased by the Subscriber's Employer Group as a supplemental benefit. Religious non-medical health care is not covered. (See the definition for "Complementary and Alternative Medicine.")
14. **Cosmetic Services and Surgery** – Cosmetic surgery and cosmetic services are not covered. Cosmetic surgery and cosmetic services are defined as surgery and services performed to alter or reshape normal structures of the body in order to improve appearance. Drugs, devices and procedures related to cosmetic surgery or cosmetic services are not covered. Surgeries or services that would ordinarily be classified as cosmetic will not be reclassified as reconstructive, based on a Member's dissatisfaction with his or her appearance, as influenced by that Member's underlying psychological makeup or psychiatric condition.
15. **Custodial Care** – Custodial Care is not covered except for those services provided by an appropriately licensed Hospice agency or appropriately licensed hospice Facility incident to a Member's terminal illness as described in the explanation of Hospice Services in the "Your Medical Benefits" section of this *Combined Evidence of Coverage and Disclosure Form.* Custodial Care does not require the continuing attention of trained medical or paramedical personnel.
16. **Dental Care, Dental Appliances and Orthodontics** – Except as otherwise provided under the Outpatient benefit captioned, "Oral Surgery and Dental Services," dental care, dental appliances and orthodontics are not covered. Dental care means all services required for prevention and treatment of diseases and disorders of the teeth, including, but not limited to: oral exams, X-rays, routine fluoride treatment, plaque removal, tooth decay, routine tooth extraction, dental embryonal tissue disorders, periodontal disease, crowns, fillings, dental implants, caps, dentures, braces and orthodontic procedures. (Coverage for dental care may be available if purchased by the Subscriber's employer as a separate benefit. If your Health Plan includes a dental care separate benefit, a brochure describing it will be enclosed with these materials.)
17. **Dental Treatment Anesthesia** – Dental treatment anesthesia provided or administered in a dentist's office is not covered. Charges for the dental procedure(s) itself, including, but not limited to, professional fees of the dentist or oral surgeon, X-ray and laboratory fees or related dental supplies provided in connection with the care, treatment, filling, removal or replacement of teeth or structures directly supporting the teeth are not covered except for services covered by PacifiCare under the Outpatient benefit, "Oral Surgery and Dental Services."
18. **Dialysis** – Chronic dialysis (peritoneal or hemodialysis) is not covered outside of the Member's Participating Medical Group. The fact that the Member is outside the geographic area served by the Participating Medical Group will not entitle the Member to coverage for maintenance of chronic dialysis to facilitate travel.
19. **Disabilities Connected to Military Services** – Treatment in a government Facility for a disability connected to military service that the Member is legally entitled to receive through a federal governmental agency, and to which Member has reasonable access, is not covered.
20. **Drugs and Prescription Medication (Outpatient)** – Outpatient drugs and prescription medications are not covered; however, coverage for prescription medications may be available as a supplemental benefit. If your Health Plan includes a supplemental benefit, a brochure will be enclosed with these materials. Infusion drugs and infusion therapy are not considered Outpatient drugs for the purposes of this exclusion. Refer to "Outpatient Benefits, Injectable Drugs" and "Infusion Therapy" for benefit coverage. Pen devices for the delivery of medication, other than insulin or as required by law, are not covered.

21. **Durable Medical Equipment** – Replacements, repairs and adjustments to durable medical equipment are limited to normal wear and tear or because of a significant change in the Member's physical condition. Replacement of lost or stolen durable medical equipment is not covered. The following equipment and accessories are not covered: Non-Medically Necessary optional attachments and modifications to durable medical equipment for the comfort or convenience of the Member, accessories for portability or travel, a second piece of equipment with or without additional accessories that is for the same or similar medical purpose as existing equipment and home and/or car modifications to accommodate the Member's physical condition. For a detailed listing of covered durable medical equipment please contact the PacifiCare Customer Service department at 1-800-624-8822.

22. **Educational Services for Developmental Delays and Learning Disabilities** – Educational services to treat developmental delays or learning disabilities are not covered. A Learning Disability is a condition where there is a meaningful difference between a child's current academic level of function and the level that would be expected for a child of that age. Educational services include, but are not limited to, language and speech training, reading and psychological and visual integration training as defined by the American Academy of Pediatrics, *Policy Statement – Learning Disabilities, Dyslexia and Vision: A Subject Review.*

23. **Elective Enhancements** – Procedures, technologies, services, drugs, devices, items and supplies for elective, non-Medically Necessary improvements, alterations, enhancements or augmentation of appearance, skills, performance capability, physical or mental attributes, or competencies are not covered. This exclusion includes, but is not limited to, elective improvements, alterations, enhancements, augmentation, or genetic manipulation related to hair growth, aging, athletic performance, intelligence, height, weight or cosmetic appearance. Please refer to "Reconstructive Surgery" for a description of Reconstructive Surgery services covered by your Health Plan.

24. **Enteral Feeding** – Enteral Feedings (food and formula) and the accessories and supplies are not covered. Formulas and special food products for phenylketonuria (PKU) are covered as described under the outpatient benefit captioned "Phenylketonuria (PKU) Testing and Treatment." Pumps and tubing are covered under the "Durable Medical Equipment" outpatient benefit.

25. **Exercise Equipment and Services** – Exercise equipment or any charges for activities, instructions or facilities normally intended or used for developing or maintaining physical fitness are not covered. This includes, but is not limited to, charges for physical fitness instructors, health clubs or gyms or home exercise equipment or swimming pools, even if ordered by a health care professional.

26. **Experimental and/or Investigational Procedures, Items and Treatments** – Experimental and/or investigational procedures, items and treatments are not covered unless required by an external, independent review panel as described in **Section 8** of this *Combined Evidence of Coverage and Disclosure Form*. Unless otherwise required by federal or state law, decisions as to whether a particular treatment is Experimental or Investigational and therefore not a covered benefit are determined by a PacifiCare Medical Director, or his or her designee. For the purposes of this *Combined Evidence of Coverage and Disclosure Form*, procedures, studies, tests, drugs or equipment will be considered Experimental and/or Investigational if any of the following criteria/guidelines is met:

    - It cannot lawfully be marketed without the approval of the U.S. Food and Drug Administration (FDA) and such approval has not been granted at the time of its use or proposed use.
    - It is a subject of a current investigation of new drug or new device (IND) application on file with the FDA.
    - It is the subject of an ongoing clinical trial (Phase I, II or the research arm of Phase III) as defined in regulations and other official publications issued by the FDA and Department of Health and Human Services (DHHS).

- It is being provided pursuant to a written protocol that describes among its objectives the determination of safety, efficacy, toxicity, maximum-tolerated dose or effectiveness in comparison to conventional treatments.
- Other facilities studying substantially the same drug, device, medical treatment or procedures refer to it as experimental or as a research project, a study, an invention, a test, a trial or other words of similar effect.
- The predominant opinion among experts as expressed in published, authoritative medical literature is that usage should be confined to research settings.
- It is not Experimental or Investigational itself pursuant to the above criteria, but would not be Medically Necessary except for its use in conjunction with a drug, device or treatment that is Experimental or Investigational (e.g., lab tests or imaging ordered to evaluate the effectiveness of an Experimental therapy).

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

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

A Member with a life-threatening or seriously debilitating condition may be entitled to an expedited external, independent review of PacifiCare's coverage determination regarding Experimental or Investigational therapies as described in **Section 8. Overseeing Your Health Care**, "Experimental or Investigational Treatment Decisions."

27. **Eyewear and Corrective Refractive Procedures** – Corrective lenses and frames, contact lenses and contact lens fitting and measurements are not covered (except for the treatment of keratoconus, aphakia, as a corneal bandage, and one pair after each cataract extraction). Surgical and laser procedures to correct or improve refractive error are not covered. (Coverage for frames and lenses may be available if the Subscriber's employer purchased a vision supplemental benefit. If your Health Plan includes a vision supplemental benefit, a brochure describing it will be enclosed with these materials.) Routine screenings for glaucoma are limited to Members who meet the medical criteria.
28. **Family Planning** – Family planning benefits, other than those specifically listed in the *Schedule of Benefits* that accompanies this document, are not covered.
29. **Follow-up Care: Emergency Services or Urgently Needed Services** – Services following discharge after receipt of Emergency Services or Urgently Needed Services, including, but not limited to, treatments, procedures, X-rays, lab work, Physician visits, rehabilitation and Skilled Nursing Care are not covered without the Participating Medical Group's or PacifiCare's authorization. The fact that the Member is outside the Service Area and that it is inconvenient for the Member to obtain the required services from the Participating Medical Group will not entitle the Member to coverage.

30. **Foot Care** – Except as Medically Necessary, routine foot care, including, but not limited to, removal or reduction of corns and calluses and clipping of toenails, is not covered.

31. **Foot Orthotics/Footwear** – Specialized footwear, including foot orthotics and custom-made or standard orthopedic shoes is not covered, except for Members with diabetic foot disease or when an orthopedic shoe is permanently attached to a Medically Necessary orthopedic brace. (Coverage for specialized footwear for foot disfigurement may be available if the Subscriber's employer purchased a footwear supplemental benefit. If your Health Plan includes a footwear supplemental benefit, a brochure describing it will be enclosed with theses materials.) Replacements, repairs and adjustments to foot orthotics are covered when Medically Necessary and authorized by the Member's Participating Medical Group or PacifiCare.

32. **Genetic Testing, Treatment or Counseling** – Genetic testing treatment of counseling are excluded for all of the following:
    - Non-PacifiCare Members
    - Solely to determine the gender of a fetus
    - Non-medical reasons (e.g., court-ordered tests, work-related tests, paternity tests)
    - Non-Medically Necessary screening of newborns, children or adolescents to determine carrier status for inheritable disorders when there would not be an immediate medical benefit or when results would not be used to initiate medical interventions/treatment while a newborn, a child or adolescence. Members who have no clinical evidence or family history of a genetic abnormality
    - Members who do not meet PacifiCare's Medical Necessity criteria for genetic testing and counseling

    Refer to "Maternity Care, Tests, Procedures, and Genetic Testing" in the "Outpatient Benefits" section for coverage of amniocentesis and chorionic villus sampling.

33. **Government Services and Treatment** – Any services that the Member receives from a local, state or federal governmental agency are not covered, except when coverage under this Health Plan is expressly required by federal or state law or as noted below:
    - **Services While Confined or Incarcerated** – Services required for injuries or illnesses experienced while under arrest, detained, imprisoned, incarcerated or confined pursuant to federal, state or local law are not covered. However, PacifiCare will reimburse Members their out-of-pocket expenses for services received while confined/incarcerated, or, if a juvenile, while detained in any Facility, if the services were provided or authorized by your Primary Care Physician or Participating Medical Group in accordance with the terms of this Health Plan or were Emergency Services or Urgently Needed Services. This exclusion does not restrict PacifiCare's liability with respect to expenses for Covered Services solely because the expenses were incurred in a state or county hospital; however, PacifiCare's liability with respect to expenses for Covered Services provided in a state hospital is limited to the rate PacifiCare would pay for those Covered Services if provided by a Participating Hospital.

34. **Hearing Aids and Hearing Devices** – Hearing aid is covered up to the limits described in the *Schedule of Benefits*. Hearing aid or hearing device is limited to a single hearing aid (including repair or replacement) every three years.

35. **Hospice Services** – Hospice services are not covered for:

    a. Members who do not meet the definition of terminally ill. Terminal illness is defined as a medical condition resulting in a prognosis of life expectancy of one year if the disease follows its natural course.

    b. Hospice services that are not reasonable and necessary for the management of a terminal illness (e.g., care provided in a non-certified Hospice program).

Note: Hospice services provided by a Non-Participating Hospice agency are not covered except in certain circumstances in counties in California in which there are no Participating Hospice agencies and only when prior authorized and arranged by PacifiCare or the Member's Participating Medical Group.

36. **Human Growth Hormone** – Human growth hormone injections for the treatment of idiopathic short stature are covered only when determined Medically Necessary by a PacifiCare Medical Director or designee.

37. **Immunizations** – Immunizations and vaccines solely for international travel and/or required for work, insurance, school, marriage, adoption, immigration, camp, volunteer work, licensure, certification or registration, sports or recreational activities are not covered, except as otherwise recommended by the national advisory organizations referenced in the section, "Outpatient Benefits", "Immunizations", (e.g., Hepatitis B is covered for all adults seeking protection, regardless of risk).

38. **Implants** – The following implants and services are not covered:
    - Surgical implantation or removal of breast implants for nonmedical reasons.
    - Replacement of breast implants when the initial surgery was done for non-medical reasons, such as for cosmetic breast augmentation mammoplasty or after cosmetic breast reduction mammoplasty.

    PacifiCare will cover Medically Necessary services directly related to non-Covered Services when complications exceed routine follow-up care.

39. **Infertility Reversal** – Reversals of sterilization procedures are not covered.

40. **Infertility Services** – Infertility services are not covered unless purchased by the Subscriber's Employer Group. Please refer to your *Schedule of Benefits*. The following services are excluded under the PacifiCare Health Plan: ovum transplants, ovum or ovum bank charges, sperm or sperm bank charges and the Medical or Hospital Services incurred by surrogate mothers who are not PacifiCare Members are not covered. Medical and Hospital Infertility Services for a Member whose fertility is impaired due to an elective sterilization, including surgery, medications and supplies, are not covered.

41. **Institutional Services and Supplies** – Except for skilled nursing services provided in a Skilled Nursing Facility, any services or supplies furnished by a Facility that is primarily a place of rest, a place for the aged, a nursing home or any similar institution, regardless of affiliation or denomination, are not covered. (Skilled nursing services are covered as described in this *Combined Evidence of Coverage and Disclosure Form* in the sections entitled "Inpatient Benefits" and "Outpatient Benefits.") Members residing in these Facilities are eligible for Covered Services that are determined to be Medically Necessary by Member's Participating Medical Group or PacifiCare and are provided by Member's Primary Care Physician or authorized by Member's Participating Medical Group or PacifiCare.

42. **Maternity Care, Tests and Procedures** – Elective home deliveries are not covered. Educational courses on lactation, childcare and/or prepared childbirth classes are not covered.

43. **Medicare Benefits for Medicare Eligible Members** – The amount payable by Medicare for Medicare-Covered Services is not covered by PacifiCare for Medicare-Eligible Members, whether or not a Medicare-Eligible Member has enrolled in Medicare Part A and Medicare Part B.

44. **Mental Health and Nervous Disorders** – Mental Health Services are not covered except for diagnosis and treatment of Severe Mental Illness for adults and children, and for diagnosis and treatment of Serious Emotional Disturbances of Children. Please refer to the behavioral health supplement to this *Combined Evidence of Coverage and Disclosure Form* for a description of this coverage. Academic or educational testing, as well as educational counseling or remediation are not covered.

45. **Non-Physician Health Care Practitioners** – This Plan may not cover services of all Non-Physician Health Care Practitioners. Treatment by Non-Physician Health Care Practitioners, such as acupuncturists, psychologists, chiropractors, licensed clinical social workers, and marriage and family therapists, may be available if purchased as a supplemental benefit. (For coverage of Severe Mental Illnesses (SMI) of adults and children, and for children, the treatment of Serious Emotional Disturbances (SED), refer to "Outpatient Benefits, Mental Health Services.")

46. **Nurse Midwife Services** – Licensed/Certified nurse midwife services are covered only when available within the Member's Participating Medical Group. Elective home deliveries are not covered.

47. **Nursing Services, Private Duty** – Private-Duty Nursing Services are not covered. Private-Duty Nursing Services encompass nursing services for recipients who require more individual and continuous care than is available from a visiting nurse or routinely provided by the nursing staff of the Hospital or Skilled Nursing Facility.

48. **Nutritional Supplements or Formulas** – Formulas, food, vitamins, herbs and dietary supplements are not covered, except as described under the Outpatient description of "Phenylketonuria (PKU) Testing and Treatment."

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

    - The drug is approved by the FDA;
    - The drug is prescribed by a Participating Provider for the treatment of a life-threatening condition or for a chronic and seriously debilitating condition;
    - The drug is Medically Necessary to treat the condition;
    - The drug has been recognized for treatment of the life-threatening or chronic and seriously debilitating condition by one of the following: *The American Hospital Formulary Service Drug Information, DRUGDEX System by Micromedex, The United States Pharmacopoeia Dispensing Information,* 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 unless there is clear and convincing contradictory evidence presented in a major peer-reviewed medical journal.

    Nothing in this section shall prohibit PacifiCare from use of a Formulary or Copayment.

50. **Oral Surgery and Dental Services** – Dental services, including, but not limited to, crowns, fillings, dental implants, caps, dentures, braces and orthodontic procedures, are not covered.

51. **Oral Surgery and Dental Services: Dental Treatment Anesthesia** – Dental anesthesia in a dental office or dental clinic is not covered. Professional fees of the dentist are not covered. (Please see "Dental Care, Dental Appliances and Orthodontics" and "Dental Treatment Anesthesia.")

52. **Organ Donor Services** – Medical and Hospital Services, as well as other costs of a donor or prospective donor, are only covered when the recipient is a Member. The testing of blood relatives to determine compatibility for donating organs is limited to sisters, brothers, parents and natural children. The testing for compatible unrelated donors, and costs for computerized national and international searches for unrelated allogeneic bone marrow or stem cell donors conducted through a registry, are covered when the Member is the intended recipient. Costs for such searches are covered up to a maximum of $15,000 per procedure. Donor searches are only covered when performed by a Provider included in the "Designated Facility."

53. **Organ Transplants** – All organ transplants must be Preauthorized by PacifiCare and performed in a Designated Facility.

- Transportation is limited to the transportation of the Member and one escort to a Designated Facility greater than 60 miles from the Member's Primary Residence as Preauthorized by PacifiCare. Transportation and other nonclinical expenses of the living donor are excluded, and are the responsibility of the Member, who is the recipient of the transplant. (See the definition for "Designated Facility.")
- Food and housing is not covered unless the Designated Facility is located more than 60 miles from the Member's Primary Residence, in which case food and housing is limited to $125 a day to cover both the Member and escort, if any (excludes alcohol and tobacco) as Preauthorized by PacifiCare. Food and housing expenses are not covered for any day a Member is not receiving Medically Necessary transplant services.
- Listing of the Member at a second Designated Facility is a covered benefit unless the Regional Organ Procurement Agency (the agency that obtains the organ) is the same for both facilities. Organ transplant listing is limited to two Designated Facilities. If the Member is listed at two facilities, PacifiCare will only cover the costs associated with the transplant surgical procedure (includes donor surgical procedure and services) and post-transplant services at the Facility where the transplant is performed. The Member is responsible for any duplicated diagnostic costs for a transplant evaluation incurred at the second Facility. (See the definition for "Regional Organ Procurement Agency" under "Designated Facility").
- Artificial heart implantation and non-human organ transplantation are considered Experimental and are therefore excluded. Please refer to the exclusion entitled "Experimental and/or Investigational Procedures, Items and Treatment" and to the "Independent Medical Review" process outlined in **Section 8**.

54. **Pain Management** – Pain management services are covered for the treatment of chronic and acute pain only when they are received from a Participating Provider and authorized by PacifiCare or its designee.
55. **Phenylketonuria (PKU) Testing and Treatment** – Food products naturally low in protein are not covered.
56. **Physical or Psychological Examinations** – Physical or psychological examinations for court hearings, travel, premarital, pre-adoption, employment or other nonpreventive health reasons are not covered. Court-ordered or other statutorily allowed psychological evaluation, testing, and treatment are not covered unless Medically Necessary and preauthorized by PacifiCare.
57. **Private Rooms and Comfort Items** – Personal or comfort items, and non-Medically Necessary private rooms during Inpatient Hospitalization are not covered.
58. **Prosthetics and Corrective Appliances/Non-Foot Orthotics** – Replacement of prosthetics or corrective appliances/non-foot orthotics are covered when determined Medically Necessary by the Member's Participating Medical Group or PacifiCare. Bionic, myoelectric, microprocessor-controlled and computerized prosthetics are not covered. Deluxe upgrades that are not Medically Necessary are not covered. For a detailed listing of covered durable medical equipment and prosthetics and corrective appliances, please contact the PacifiCare Customer Service department at 1-800-624-8822.
59. **Pulmonary Rehabilitation Programs** – Pulmonary rehabilitation programs are covered only when determined to be Medically Necessary by a PacifiCare Medical Director or designee.

60. **Reconstructive Surgery** – Reconstructive surgeries are not covered under the following circumstances:
    - When there is another more appropriate surgical procedure that has been offered to the Member; or
    - When only a minimal improvement in the Member's appearance is expected to be achieved.

    Preauthorizations for proposed reconstructive surgeries will be reviewed by Physicians specializing in such reconstructive surgery who are competent to evaluate the specific clinical issues involved in the care requested.
61. **Recreational, Lifestyle, Educational or Hypnotic Therapy** – Recreational, lifestyle, educational or hypnotic therapy, and any related diagnostic testing is not covered.
62. **Rehabilitation Services and Therapy** – Rehabilitation services and therapy will be provided only as Medically Necessary and are either limited or not covered, as follows:
    - Speech, occupational or physical therapy is not covered when medical documentation does not support the Medical Necessity because of the Member's inability to progress toward the treatment plan goals or when a Member has already met the treatment goals.
    - Speech therapy is limited to Medically Necessary therapy to treat speech disorders caused by a defined illness, disease or surgery (for example, cleft palate repair.
    - Cognitive Rehabilitation Therapy is limited to an initial neuropsychological testing by an authorized Physician or licensed Provider and the Medically Necessary treatment of functional deficits as a result of traumatic brain injury or cerebral vascular insult. This benefit is limited to Outpatient rehabilitation limitation, if any.
    - Exercise programs are only covered when they require the direct supervision of a licensed physical therapist and are part of an authorized treatment plan.
    - Activities that are motivational in nature or that are primarily recreational, social or for general fitness, are not covered.
    - Aquatic/pool therapy is not covered unless conducted by a licensed physical therapist and part of an authorized treatment plan.
    - Massage therapy is not covered.

    The following Rehabilitation Services, special evaluations and therapies are not covered:
    - Biofeedback (except for urinary incontinence, fecal incontinence or constipation for Members with organic neuromuscular impairment when part of an authorized treatment plan.)
    - Cognitive Behavioral Therapy.
    - Developmental Testing beyond initial diagnosis other than for pervasive developmental disorder.
    - Hypnotherapy
    - Psychological Testing
    - Vocational Rehabilitation

    (Please refer to **Section 10** for definitions of capitalized terms.)
63. **Respite Care** – Respite care is not covered, unless part of an authorized Hospice plan and is necessary to relieve the primary caregiver in a Member's residence. Respite care is covered only on an occasional basis, not to exceed five consecutive days at a time.
64. **Routine Laboratory Testing Out-of-Area** – Routine laboratory tests are not a covered benefit while the Member is outside of the geographic area served by the Member's Participating Medical Group. Although it may be Medically Necessary, out-of-area routine laboratory testing is not considered an Urgently Needed Service because it is not unforeseen and is not considered an Emergency Service.

65. **Third-Party Liability** – Expenses incurred due to liable third parties are not covered, as described in the section "PacifiCare's Right to the Repayment of a Debt as a Charge Against Recoveries From Third Parties Liable for a Member's Health Care Expenses."

66. **Services Provided at No Charge to Member** – Services and supplies that are provided free of charge if the Member did not have coverage under this Health Plan or for which the Member will not be held financially responsible, unless PacifiCare has agreed to payment arrangements prior to the provision of the services or supplies to the Member.

67. **Sexual Dysfunction or Inadequacy Medications** – Sexual dysfunction or inadequacy medications/drugs, procedures, services, and supplies, including penile implants/prosthesis except testosterone injections for documented low testosterone levels, are not covered.

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

69. **Substance Use Disorder Rehabilitation** – Inpatient, Outpatient and day treatment rehabilitation for chronic Substance Use Disorder is not covered. Methadone treatment for detoxification is not covered. (Coverage for rehabilitation of Substance Use Disorder may be available if purchased by the Subscriber's employer as a supplemental benefit. If the Member's health plan includes a Behavioral health supplemental benefit, a brochure describing it will be enclosed with these materials.)

    Not Covered:

    - Rapid anesthesia opioid detoxification;
    - Substance Use Disorder rehabilitation services beyond detoxification are not covered;except if the Subscriber's Employer Group has purchased the supplemental Behavioral Health Benefit;

    Services that are required by a court order as a part of parole or probation, or instead of incarceration.

70. **Surrogacy** – Infertility and maternity services for non-Members are not covered.

71. **Telehealth and Telemedicine** – Telehealth and Telemedicine services are not covered except as provided by California law unless determined to be Medically Necessary by a PacifiCare Medical Director.

72. **Transportation** – Transportation is not a covered benefit except for ambulance transportation as defined in this *Combined Evidence of Coverage and Disclosure Form.* Also see "Organ Transplants" listed in "Other Exclusions and Limitations."

73. **Vision Care** – See "Eyewear and Corrective Refractive Procedures" listed in "Other Exclusions and Limitations."

74. **Vision Training** – Vision therapy rehabilitation and ocular training programs (orthoptics) are not covered.

75. **Visual Aids** – Visual aids are not covered, except as specified under the outpatient benefit for "Diabetic Self-Management Items." Electronic and non-electronic magnification devices are not covered. (Coverage for frames and lenses may be available if the Subscriber's employer purchased a vision supplemental benefit.)

76. **Weight Alteration Programs (Inpatient or Outpatient)** – Weight loss or weight gain programs are not covered. These programs include, but are not limited to, dietary evaluations, counseling, exercise, behavioral modification, food and food supplements, vitamins and other nutritional supplements. Also excluded are non-authorized weight loss program laboratory tests associated with monitoring weight loss or weight gain, except as described under Inpatient benefits "Morbid Obesity (Surgical Treatment)." For the treatment of anorexia nervosa and bulimia nervosa, please refer to the behavioral health supplement of your *Combined Evidence of Coverage and Disclosure Form.*

SECTION 6. PAYMENT RESPONSIBILITY

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

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

What are Premiums (Prepayment Fees)?

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

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

What are Copayments (Other Charges)?

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

Annual Copayment Maximum

For certain Covered Services, a limit is placed on the total amount you pay for Copayments during a calendar year. This limit is called your Annual Copayment Maximum and when you reach it, for the remainder of the calendar year, you will not pay any additional Copayments for these Covered Services.

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

PacifiCare of California
Customer Service Department
P.O. Box 30968
Salt Lake City, UT 84130-0968

Remember, it's important to send us **all** Copayment receipts along with your letter. They confirm that you've reached your Annual Copayment Maximum. You will be reimbursed by PacifiCare for Copayments you make beyond your individual or family Annual Copayment Maximum. Copayments paid for certain Covered Services are not applicable to a Member's Annual Copayment Maximum; these services are specified in the *Schedule of Benefits*.

Note: The calculation of your Annual Copayment Maximum will not include supplemental benefits that may be offered by your Employer Group (e.g., coverage for Outpatient prescription drugs). However, The Annual Copayment Maximum includes coverage for Severe Mental Illnesses (SMI) of adults and children and Serious Emotional Disturbances of a Child (SED).

If You Get a Bill (Reimbursement Provisions)

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

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

    PacifiCare of California
    Claims Department
    P.O. Box 30968
    Salt Lake City, UT 84130-0968

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

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

What is a *Schedule of Benefits*?

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

Bills From Non-Participating Providers

If you receive a bill for a Covered Service from a Physician who is not one of our Participating Providers, and the service was Preauthorized and you haven't exceeded any applicable benefit limits, PacifiCare will pay for the service, less the applicable Copayment. (Preauthorization isn't required for Emergency Services and Urgently Needed Services. See **Section 3. Emergency and Urgently Needed Services.**) You may also submit a bill to us if a Non-Participating Provider has refused payment directly from PacifiCare.

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

PacifiCare of California
Claims Department
P.O. Box 30968
Salt Lake City, UT 84130-0968

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

PacifiCare will make a determination within 30 working days from the date PacifiCare receives a claim containing all information reasonably necessary to decide the claim. PacifiCare will not pay any claim that is filed more than 180 calendar days from the date the services or supplies were provided. PacifiCare also will not pay for excluded services or supplies unless authorized by your Primary Care Physician, your Participating Medical Group or directly by PacifiCare.

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

How to Avoid Unnecessary Bills

Always obtain your care under the direction of PacifiCare, your Participating Medical Group, or your Primary Care Physician. By doing this, you only will be responsible for paying any related Copayments and for charges in excess of your benefit limitations. Except for Emergency or Urgently Needed Services, if you receive services not authorized by PacifiCare or your Participating Medical Group, you may be responsible for payment. This is also true if you receive any services not covered by your plan. (Services not covered by your plan are included in **Section 5. Your Medical Benefits.**)

Your Billing Protection

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

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

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

Coordination of Benefits

Coordination of Benefits (COB) is a process, regulated by law, which determines the financial responsibility for payment when a person has group health care coverage under more than one plan. "Plan" is defined below. COB is designed to provide maximum coverage for medical and Hospital Services at the lowest cost by avoiding excessive or duplicate payments.

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

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

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

Definitions

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

A. A **Plan** is any of the following that provides benefits or services for medical or dental care or treatment.

1. **Plan** includes: group insurance, closed panel (HMO, POS, PPO or EPO) coverage or other forms of group or group-type coverage (whether insured or uninsured); Hospital indemnity benefits in excess of $200 per day; medical care components of group long-term care contracts, such as Skilled Nursing Care; or other governmental benefits, as permitted by law (Medicare is not included as a "Plan" as defined here;

however, PacifiCare does coordinate benefits with Medicare. Please refer to **Section 6,** "Important Rules for Medicare and Medicare Eligible Members."

2. **Plan** does not include: non-group coverage of any type, including, but not limited to, individual or family insurance; amounts of Hospital indemnity insurance of $200 or less per day; school accident-type coverage; benefits for non-medical components of group long-term care policies; Medicare supplement policies, a state plan under Medicaid; and coverage under other governmental plans, unless permitted by law.

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

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

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

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

1. If a covered person is confined in a private Hospital room, the difference between the cost of a semi-private room in the Hospital and the private room; (unless the patient's stay in a private Hospital room is Medically Necessary) is not an Allowable Expense.
2. If a person is covered by two or more Plans that compute their benefit payments on the basis of usual and customary fees, any amount in excess of the highest of the usual and customary fees for a specific benefit is not an Allowable Expense.
3. If a person is covered by two or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable Expense.
4. If a person is covered by one Plan that calculates its benefits or services on the basis of usual and customary fees and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary Plan's payment arrangements shall be the allowable expense for all plans.
5. The amount a benefit is reduced by the Primary Plan because a covered person does not comply with the Plan provisions. Examples of these provisions are precertification of admissions and preferred Provider arrangements.

D. **Claim Determination Period** means a calendar year or that part of the calendar year during which a person is covered by this Plan.

E. **Closed Panel Plan** is a plan that provides health benefits to covered persons primarily in the form of services through a panel of Providers that have contracted with, or are employed by, the Plan, and that limits or excludes benefits for services provided by other Providers, except in cases of emergency or referral by a panel Member.

F. **Custodial Parent** means a parent awarded custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than one half of the calendar year without regard to any temporary visitation.

Order of Benefit Determination Rules

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

A. The Primary Plan pays or provides its benefits as if the Secondary Plan or Plans did not exist.

B. A Plan that does not contain a coordination of benefits provision is always primary. There is one exception: Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits may provide that the supplementary coverage shall be excess to any other parts of the plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan Hospital and surgical benefits, and insurance type coverages that are written in connection with a closed panel plan to provide out-of-network benefits.

C. A Plan may consider the benefits paid or provided by another Plan in determining its benefits only when it is secondary to that other Plan.

D. The first of the following rules that describes which Plan pays its benefits before another Plan is the rule that will apply.

   1. **Subscriber (Non-Dependent) or Dependent.** The Plan that covers the person other than as a Dependent; for example as an employee, Member, Subscriber or retiree, is primary, and the plan that covers the person as a Dependent is secondary.

   2. **Child Covered Under More Than One Plan.** The order of benefits when a child is covered by more than one plan is:

      a. **Birthday Rule.** The Primary Plan is the Plan of the parent whose birthday is earlier in the year if:

         - The parents are married;
         - The parents are not separated (whether or not they ever have been married); or
         - A court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage.

         If both parents have the same birthday, the plan that covered either of the parents longer is primary.

      b. If the specific terms of a court decree state that one of the parents is responsible for the child's health care expenses or health care coverage, that Plan is primary if the parent has enrolled the child in the Plan and provided the Plan with a copy of the court order as required in the Eligibility section of this *Combined Evidence of Coverage and Disclosure Form*. This rule applies to Claim Determination Periods or plan years, commencing after the Plan is given notice of the court decree.

      c. If the parents are not married and/or are separated (whether or not they ever have been married) or are divorced, the order of benefits is:

         - The Plan of the Custodial Parent;
         - The Plan of the Spouse or Domestic Partner of the Custodial Parent;
         - The Plan of the non-Custodial Parent; and then
         - The Plan of the Spouse of the non-Custodial Parent.

3. **Active or Inactive Employee.** The Plan that covers a person as an employee who is neither laid off nor retired (or his or her Dependent) is primary in relation to a Plan that covers the person as a laid off or retired employee (or his or her Dependent). If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule is ignored. Coverage provided an individual by one Plan as a retired worker and by another Plan as a Dependent of an actively working Spouse or Domestic Partner will be determined under the rule labeled D(1).
4. **COBRA Continuation Coverage.** If a person whose coverage is provided under a right of continuation provided by federal (COBRA) or state law (similar to COBRA) also is covered under another Plan, the Plan covering the person as an employee, Member, Subscriber or retiree (or as that person's Dependent) is primary, and the continuation coverage is secondary. If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule is ignored.
5. **Longer or Shorter Length of Coverage.** If the preceding rules do not determine the order or payment, the Plan that covered the person as an employee, Member, Subscriber or retiree for the longer period is primary.

Effect on the Benefits of This Plan

A. When this Plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Plans during a Claim Determination Period are not more than 100 percent of total Allowable Expenses.

B. If a covered person is enrolled in two or more Closed Panel Plans and if, for any reason, including the person's having received services from a non-panel Provider, benefits are not payable by one Closed Panel Plan, COB shall not apply between that Plan and other Closed Panel Plans.

Right to Receive and Release Needed Information

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

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

PacifiCare's Right to Pay Others

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

Right of Recovery

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

Important Rules for Medicare and Medicare-Eligible Members

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

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

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

Workers' Compensation

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

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

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

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

Payment Responsibility When an Injury or Sickness Is Caused by a Third Party's Act or Omission

Applicability

This provision applies when a Member suffers an injury or sickness through an act or omission of another person(s) (the "third party").

Third-Party Liability – Expenses Incurred Due to Liable Third Parties Are Not Covered

Health care expenses incurred by a Member for which a third party or parties or a third party's (parties') insurance company (collectively, "liable third party") is liable or legally responsible by reason of negligence, a wrongful intentional act or the breach of any legal obligation on the part of such third party are expressly excluded from coverage under this Health Plan. However, in all cases, PacifiCare will pay for the arrangement or provision of health care services for a Member that would have been Covered Services except that they were required due to a liable third party, in exchange for the agreement as expressly set forth in the section of the *Combined Evidence of Coverage and Disclosure Form* captioned "PacifiCare's Right to the Repayment of a Debt as a Charge Against Recoveries From Third Parties Liable for a Member's Health Care Expenses."

PacifiCare's Right to the Repayment of a Debt as a Charge Against Recoveries From Third Parties Liable for a Member's Health Care Expenses

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

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

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

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

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

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

SECTION 7. MEMBER ELIGIBILITY

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

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

Who is a PacifiCare Member?

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

The following Family Members are eligible to enroll in PacifiCare:

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

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

- Was born to a single person or unmarried couple;
- Is not claimed as a Dependent on a federal income tax return;
- Does not reside with the Subscriber or within the PacifiCare Service Area.

Eligibility

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

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

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

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

Effective Date of Coverage for New Subscribers and Family Members to Be Added Outside Open Enrollment

Coverage for a newly enrolled Subscriber and his or her eligible Family Members begins on the date agreed to by the Employer Group or under the terms of the signed Group Agreement provided we receive the completed enrollment form and any required Health Plan Premium within 30 days of the date the Subscriber becomes eligible to enroll in the Health Plan.

The effective date of enrollment when adding Family Members outside of the initial or Open Enrollment Period is explained below. (**Please Note:** PacifiCare enrolls applicants in the order that they become eligible and up to our capacity for accepting new Members.)

What is a Service Area?

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

Open Enrollment

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

Adding Family Members to Your Coverage

The Subscriber's Spouse or Domestic Partner and eligible children may apply for coverage with PacifiCare during the employer's Open Enrollment Period. If you are declining enrollment for yourself or your Dependents (including your Spouse or Domestic Partner) because of other health plan insurance or group health plan coverage, you may be able to enroll yourself and your Dependents in PacifiCare if you and your Dependents lose eligibility for that other coverage (or if the Employer Group stops contributing toward your or your Dependents' other coverage). However, you must request enrollment within 30 days after your or your Dependents' other coverage ends (or after the Employer Group stops contributing toward your or your Dependents' other coverage). In addition, if you have a new Dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your Dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption or placement for adoption. (Guardianship is not a qualifying event for other Family Members to enroll). Under the following circumstances, new Family Members may be added outside the Open Enrollment Period. To obtain more information, contact our Customer Service department.

1. **Getting Married.** When a new Spouse or child becomes an eligible Family Member as a result of marriage, coverage begins on the date of the marriage if we receive a completed application to enroll a Spouse or child eligible as a result of marriage within 30 days of the marriage.

2. **Domestic Partnership.** When a new Domestic partner or Domestic Partner's child becomes an eligible Family Member as a result of a domestic partnership, coverage begins on the date of the domestic partnership. An application to enroll a Domestic Partner or child eligible as a result of a domestic partnership must be made within 30 days of the domestic partnership.
3. **Having a Baby**. Newborns are covered for the first 30 days of life. In order for coverage to continue beyond the first 30 days of life, a Change Request Form must be submitted to PacifiCare prior to the expiration of the 30-day period.
4. **Adoption or Placement for Adoption.** Subscriber may enroll an adopted child if Subscriber obtains an adoptive placement from a recognized county or private agency, or if the child was adopted as documented by a health Facility minor release form, a medical authorization form or a relinquishment form, granting Subscriber, Subscriber's Spouse or Domestic Partner the right to control the health care for the adoptive child. or absent such a document, on the date there exists evidence of the Subscriber's Spouse's or Domestic Partner's right to control the health care of the child placed for adoption. For adopted children, coverage is effective on the date of adoption or placement for adoption. An application must be received within 30 days of the adoption placement.
5. **Guardianship.** To enroll a Dependent child for whom the Subscriber, Subscriber's Spouse or Domestic Partner has assumed legal guardianship, the Subscriber must submit a Change Request Form to PacifiCare along with a certified copy of a court order granting guardianship within 30 days of when the Subscriber, Subscriber's Spouse or Domestic Partner assumed legal guardianship. Coverage will be retroactively effective to the date the Subscriber assumed legal guardianship.

Qualified Medical Child Support Order

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

A person having legal custody of a child or a custodial parent who is not a PacifiCare Member may ask about obtaining Dependent coverage as required by a court or administrative order, including a Qualified Medical Child Support Order, by calling PacifiCare's Customer Service department. A copy of the court or administrative order must be included with the enrollment application. Information including, but not limited to, the ID card, *Combined Evidence of Coverage and Disclosure Form* or other available information, including notice of termination, will be provided to the custodial parent, caretaker and/or District Attorney. Coverage will begin on the date of the court or administrative order provided we receive the completed enrollment form with the court or administrative order attached and any required Health Plan Premium.

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

Continuing Coverage for Student and Disabled Dependents

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

Continuing Coverage for Student Dependents

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

Continuing Coverage for a Full-Time Student Dependent Child on Medical Leave of Absence from School

Coverage for an Enrolled Dependent child who is over the dependent age limit and enrolled as a Full-Time Student at a secondary or post-secondary school will not end for any of the following reasons:

A. Any break in the school calendar will not disqualify the Dependent child from coverage.

B. If the Dependent child takes a medical leave of absence, and the nature of the Dependent child's injury, illness, or condition would render the Dependent child incapable of self-sustaining employment and the Dependent child is chiefly dependent on the Subscriber for support and maintenance, and meets the same proof of incapacity and dependency as required under the provisions described in **Section 7. Member Eligibility** under the heading "Continuing Coverage for Certain Disabled Dependents", the Dependent may continue coverage under the plan contract.

C. If the Dependent child takes a medical leave of absence from school, but the nature of the Dependent child's injury, illness, or condition does not meet the requirements of paragraph B above, the Dependent child's coverage will not terminate for a period not to exceed 12 months or until the date on which the coverage is scheduled to terminate pursuant to the terms and conditions of the Group Agreement, whichever comes first. The period of coverage under this paragraph will begin on the first day of the medical leave of absence from school or on the date the Physician determines the injury, illness, or condition prevented the Dependent child from attending school, whichever comes first.

A written certification by the treating Physician is required. The certification must state that the Enrolled Dependent child is suffering from a serious Sickness or Injury and that the leave of absence is Medically Necessary.

For purposes of this extended coverage provision, the term "leave of absence" includes any change in enrollment at the secondary or post-secondary school that causes the loss of Full-time Student status.

Continuing Coverage for Certain Disabled Dependents

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

1. The unmarried Dependent is incapable of self-sustaining employment by reason of a physically or mentally disabling injury, illness or condition; and
2. The unmarried Dependent is chiefly Dependent upon the Subscriber for support and maintenance.

At least 90 days prior to a disabled Dependent reaching the Limiting Age, PacifiCare will send notice to you, the Subscriber, that coverage for the disabled Dependent will terminate at the end of the Limiting Age unless proof of such incapacity and dependency is provided to PacifiCare by the Member within 60 days of receipt of notice.

PacifiCare shall determine if the disabled Dependent meets the conditions above prior to the disabled Dependent reaching the Limiting Age. Otherwise, coverage will continue until PacifiCare makes a determination.

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

If you are enrolling a disabled child for new coverage, PacifiCare may request initial proof of incapacity and dependency of the child, and then yearly, to ensure that the child continues to meet the conditions above. You, as the Subscriber, must provide PacifiCare with the requested information within 60 days of receipt of the request. The child must have been covered as a dependent of the Subscriber or Spouse under a previous health plan at the time the child reached the age limit.

Late Enrollment

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

1. The eligible employee (on his or her own behalf, or on behalf of any eligible Family Members) declined in writing to enroll in PacifiCare when they were first eligible because they had other health care coverage; and
2. PacifiCare cannot produce a written statement from the Employer Group or eligible employee stating that prior to declining coverage, the eligible employee (on his or her own behalf, or on behalf of any eligible Family Members) was provided with, and signed, acknowledgment of, an explicit written notice in boldface type specifying that failure to elect coverage with PacifiCare during the initial enrollment period permits the Company to impose, beginning on the date the eligible employee (on his or her behalf, or on behalf of any eligible Dependents) elects coverage under the Health Plan, an exclusion of coverage under the Health Plan for a period of 12 months unless the eligible employee or Family Member can demonstrate that he or she meets the requirements for late enrollment.
3. The other health care coverage is no longer available due to:
   a. The employee or eligible Family Member has exhausted COBRA continuation coverage under another group Health Plan; or
   b. The termination of employment or reduction in work hours of a person through whom the employee or eligible Family Member was covered; or
   c. The termination of the other Health Plan coverage; or
   d. The cessation of an employer's contribution toward the employee or eligible Family Member coverage; or
   e. The death, divorce or legal separation of a person through whom the employee or eligible Family Member was covered; or
   f. The loss of coverage under the Healthy Families Program as a result of exceeding the program's income or age limits, or loss of no share-of-cost Medi-Cal coverage; or
   g. The employee or eligible Family Member incurs a claim that would exceed a lifetime limit on all benefits; or
   h. The employee or eligible Family Member previously declined coverage under the Health Plan, but the employee or eligible Family Member becomes eligible for a premium assistance subsidy under Medicaid or Children's Health Insurance Program (CHIP). Coverage will begin only if we receive the completed enrollment application and any required Health Plan Premiums within 60 days of the date of the determination of subsidy eligibility; or

i. The employee or eligible Family Member loses eligibility under Medicare or Children's Health Insurance Program (CHIP). Coverage will begin only if we receive the completed enrollment application and any required Health Plan Premiums within 60 days of the date coverage ended.

4. The Court has ordered health care coverage be provided for your Spouse or minor child.

If the employee or an eligible Family Member meets these conditions, the employee must request enrollment with PacifiCare no later than 30 days following the termination of the other Health Plan coverage. PacifiCare may require proof of loss of the other coverage unless otherwise noted above. Enrollment will be effective on the date agreed to by the Employer Group under the terms of the signed Group Agreement or the first day of the month following receipt by PacifiCare of a completed request for enrollment.

Notifying You of Changes in Your Plan

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

Updating Your Enrollment Information

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

Renewal and Reinstatement (Renewal Provisions)

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

About Your PacifiCare Identification (ID) Card

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

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

Ending Coverage (Termination of Benefits)

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

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

When the Group Agreement between the Employer Group and PacifiCare is terminated, all Members covered under the Group Agreement become ineligible for coverage on the date of termination. If the Group Agreement is terminated by PacifiCare for nonpayment of Premiums, coverage for all Members covered under the Group Agreement will be terminated effective the last day for which Premiums were received. According to the terms of the Group Agreement, the Employer Group is responsible for notifying you if and when the Group Agreement is terminated, except in the event the Group Agreement is terminated for the nonpayment of Health Plan Premiums. In that circumstance, PacifiCare will notify you directly of such termination.

Cancellation of the Group Contract for Nonpayment of Premiums

If the Group Contract is cancelled because the Group failed to pay the required Premiums when due, then coverage for you and all your Dependents will end retroactively back to the last day of the month for which Premiums were paid; however, this retroactive period will not exceed the 60 days before the date the Plan mails you the Notice Confirming Termination of Coverage.

PacifiCare will mail your Employer a notice at least 15 days before any cancellation of coverage. This Prospective Notice of Cancellation will provide information to your employer regarding the consequences of your employer's failure to pay the Premiums due within 15 days of the date the notice was mailed.

If payment is not received from your employer within 15 days of the date the Prospective Notice of Cancellation is mailed, PacifiCare will cancel the Group Contract and mail you a Notice Confirming Termination of Coverage, which will provide you with the following information:

- That the Group Contract has been cancelled for nonpayment of Premiums.
- The specific date and time when your Group coverage ended.
- The Plan telephone number you can call to obtain additional information, including whether your Employer obtained reinstatement of the Group Contract. This confirmation of reinstatement will be available on request 16 days after the date the Notice Confirming Termination of Coverage is mailed.
- An explanation of your options to purchase continuation coverage, including coverage effective as of the retroactive termination date so you can avoid a break in coverage, and the deadline by which you must elect to purchase such continuation coverage, which will be 63 days after the date the Plan mails you the Notice Confirming Termination of Coverage.

Reinstatement of the Contract after Cancellation

If the Group Contract is cancelled for the group's nonpayment of Premiums, the Plan will permit reinstatement of the Group Contract once during any 12-month period if the group pays the amounts owed within 15 days of the date of the Notice Confirming Termination.

Other Reasons for Termination of Coverage

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

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

Termination for Good Cause

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

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

If coverage is terminated for any of the above reasons, you forfeit all rights to enroll in the PacifiCare conversion plan (discussed below) or COBRA Plan and lose the right to re-enroll in PacifiCare in the future.

Under no circumstances will a Member be terminated due to health status or the need for health care services. If a Member is Totally Disabled when the group's coverage ends, coverage for the Totally Disabling condition may be extended (please refer below to "Total Disability"). Any Member who believes his or her enrollment has been terminated due to the Member's health status or requirements for health care services may request a review of the termination by the California Department of Managed Health Care. For more information, contact our Customer Service department.

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

Ending Coverage – Special Circumstances for Enrolled Family Members

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

Total Disability

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

Coverage Options Following Termination (Individual Continuation of Benefits)

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

Federal COBRA Continuation Coverage

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

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of group health plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your Spouse and your Dependent children could become qualified beneficiaries if coverage under the group health plan is lost because of the qualifying event. Qualified beneficiaries who elect COBRA continuation coverage may be required to pay for COBRA continuation coverage. Please consult with your Employer Group regarding any applicable Premiums.

If you are a Subscriber covered by this Health Plan, you have a right to choose COBRA continuation coverage if you lose your group health coverage because either of the following qualifying events happens:

- Your hours of employment are reduced to less than the number of hours required for eligibility, or
- Your employment ends for any reason other than gross misconduct on your part.

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

1. Your Spouse dies;
2. Your Spouse's hours of employment are reduced to less than the number of hours required for eligibility;
3. Your Spouse's employment ends (for reasons other than his or her gross misconduct);
4. Your Spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
5. You become divorced or legally separated from your Spouse.

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

1. The Subscriber dies;
2. The Subscriber's hours of employment are reduced to less than the number of hours required for eligibility;
3. Subscriber's employment ends (for reasons other than his or her gross misconduct);
4. The Subscriber becomes entitled to Medicare benefits (Part A, Part B, or both);
5. The Subscriber becomes divorced or legally separated; or
6. The Dependent child ceases to be a Dependent eligible for coverage under this Health Plan.

When is COBRA coverage available?

Your Employer Group (or, if applicable, its COBRA administrator) will offer COBRA continuation coverage to qualified beneficiaries only after they have been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the Subscriber, or the Subscriber becoming entitled to Medicare benefits (under Part A, Part B, or both), your Employer Group must notify its COBRA administrator of the qualifying event. (Similar rights may apply to certain retirees, Spouses and Dependent children if your Employer Group commences a bankruptcy proceeding and these individuals lose coverage.)

You Must Give Notice of Some Qualifying Events

For the other qualifying events (divorce or legal separation of the Subscriber or a Dependent child losing eligibility for coverage as a Dependent child under the Health Plan), the Subscriber or enrolled Family Member has the responsibility to inform the Employer Group (or, if applicable, its COBRA administrator) within 60 days after the qualifying event occurs. Please consult your Employer Group regarding its plan procedures for providing notice of qualifying events.

How is COBRA coverage provided?

Once your Employer Group (or, if applicable, its COBRA administrator) receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered by the Employer Group (or its COBRA administrator) to each of the qualified beneficiaries. Under federal law, you must be given at least 60 days to elect COBRA continuation coverage. The 60-day election period is measured from the later of:

1. the date coverage ends due to a qualifying event; or
2. the date you receive the election notice provided by your Employer Group (or its COBRA administrator).

Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Subscribers covered by this Health Plan may elect COBRA continuation coverage on behalf of their Spouses and parents or legal guardians may elect COBRA continuation coverage on behalf of Dependent children. **If you do not choose COBRA continuation coverage on a timely basis, your group health insurance coverage under this Health Plan will end.**

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the Subscriber, the Subscriber becoming entitled to Medicare benefits (under Part A, Part B, or both), the Subscriber's divorce or legal separation, or a Dependent child losing eligibility as a Dependent child under this Health Plan, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the Subscriber's hours of employment, and the Subscriber became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the Subscriber lasts until 36 months after the date of Medicare entitlement. For example, if a Subscriber becomes entitled to Medicare eight months before the date on which his employment terminates, COBRA continuation coverage for his Spouse and Dependent children can last up to 36 months after the date of

Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus eight months). Otherwise, when the qualifying event is the end of employment or reduction of the Subscriber's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability Extension of 18-Month Period of Continuation Coverage

If you or any of your Family Members covered under this Health Plan is determined by the Social Security Administration to be disabled and you notify your Employer Group (or, if applicable, its COBRA administrator) in a timely fashion, you and your entire Family Members may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. Please consult your Employer Group regarding their plan procedures for providing notice of disability.

Second Qualifying Event Extension of 18-Month Period of Continuation Coverage

If a Family Member experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the Spouse and Dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to your Employer Group (or, if applicable, COBRA administrator). This extension may be available to the Spouse and any Dependent children receiving continuation coverage if the Subscriber dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the Dependent child stops being eligible under this Health Plan as a Dependent child, but only if the event would have caused the Spouse or Dependent child to lose coverage under this Health Plan had the first qualifying event not occurred.

Please contact your Employer Group (or, if applicable, its COBRA administrator) for more information regarding the applicable length of COBRA continuation coverage available.

COBRA May Terminate Before Maximum Coverage Period Ends

Under COBRA, the continuation coverage may terminate before the maximum coverage period if any of the following events occur:

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

COBRA Premium

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

If You Have Questions About COBRA

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

1401 Extended Continuation Coverage After COBRA

In the event your COBRA coverage began on or after January 1, 2003, and you have used all of your COBRA benefits as described above, you may be eligible to continue benefits under California Continuation Coverage at 110 percent of the Premium charged for similarly situated eligible employees currently working at your former employment. A notice will be provided to you by PacifiCare at the time your COBRA benefits will run out, allowing up to 18 more months under California Continuation COBRA. However, your California Continuation COBRA benefits will not exceed a combined total of 36 months from the date COBRA coverage began.

Example: As a result of termination from your former employer (for reasons other than gross misconduct), you applied for and received 18 continuous months of group Health Plan benefits under your federal COBRA benefits. California Continuation COBRA may extend your benefits another 18 consecutive months. Your combined total of benefits between COBRA and California Continuation COBRA is 36 months.

1401 Extended Continuation Coverage Enrollment and Premium Information After COBRA

You must notify PacifiCare within 60 days from the date your COBRA coverage terminated or will terminate because of your qualifying event if you wish to elect this continuation coverage, or within 60 days from the date you received notice from PacifiCare. If you fail to notify PacifiCare within 60 days of the date of your qualifying event, you will lose your rights to elect and enroll on California Continuation Coverage after COBRA. The 60-day period will be counted from the event which occurred last. Your request must be in writing and delivered to PacifiCare by first-class mail, or other reliable means of delivery, including personal delivery, express mail or private courier company. Upon receipt of your written request, an enrollment package to elect coverage will be mailed to you by PacifiCare. You must pay your initial Premiums to PacifiCare within 45 days from the date PacifiCare mails your enrollment package after you notified PacifiCare of your intent to enroll. Your first Premium must equal the full amount billed by PacifiCare. Your failure to submit the correct Premium amount billed to you within the 45-day period, which includes checks returned to PacifiCare by your financial institution for non-sufficient funds (NSF), will disqualify you from this available coverage and you will not be allowed to enroll.

Note: In the event you had a prior qualifying event and you became entitled to enroll on COBRA coverage prior to January 1, 2003, you are not eligible for an extension of these benefits under California Continuation COBRA, even if you enroll in PacifiCare on or after January 1, 2003. Your qualifying event is the first day in which you were initially no longer eligible for your group Health Plan coverage from your former employer, regardless of who your prior insurance carrier may have been at that time.

Termination of 1401 Extended Continuation Coverage After COBRA

Your coverage under California Continuation Coverage will terminate when:

1. You have received 36 months of continuation coverage after your qualifying event date; or
2. If you cease or fail to make timely Premiums; or
3. Your former employer or any successor employer ceases to provide any group benefit plan to his or her employees; or
4. You no longer meet eligibility for PacifiCare coverage, such as moving outside the PacifiCare Service Area; or
5. The contract for health care services between your employer and PacifiCare is terminated; or

6. You become entitled for Medicare. **Note:** If you were eligible for the 29-month extension as a result of disability and you are later determined by the Social Security Administration to no longer be disabled, your benefits will terminate the later of 36 months after your qualifying event or the first of the month following 31 days from date of the final Social Security Administration determination, but only if you send the Social Security Administration notice to PacifiCare within 30 days of the determination.
7. If you were covered under a prior carrier and your former employer replaces your prior coverage with PacifiCare coverage, you may continue the remaining balance of your unused coverage with PacifiCare, but only if you enroll with and pay Premiums to PacifiCare within 30 days of receiving notice of your termination from the prior group Health Plan.

If the contract between your former employer and PacifiCare terminates prior to the date your continuation coverage would terminate under California Continuation COBRA, you may elect continuation coverage under your former employer's new benefit plan for the remainder of the time period you would have been covered under the prior group benefit plan.

Extending Your Coverage: Converting to an Individual Conversion Plan

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

An application for the conversion plan must be received by PacifiCare within 63 days of the date of termination of your group coverage. However, if the Employer Group terminates its Group Agreement with PacifiCare or replaces the PacifiCare group coverage with another carrier within 15 days of the date of termination of the Group coverage or the Subscriber's participation, transfer to the Individual Conversion Health Plan is not permitted. You also will not be permitted to transfer to the Individual Conversion Health Plan under any of the following circumstances:

1. You failed to pay any amounts due to the Health Plan;
2. You were terminated by the Health Plan for good cause or for fraud or misrepresentation as described in the section "Termination for Good Cause;"
3. You knowingly furnished incorrect information or otherwise improperly obtained benefits of the Health Plan;
4. You are covered or are eligible for Medicare;
5. You are covered or are eligible for Hospital, medical or surgical benefits under state or federal law or under any arrangement of coverage for individuals in a group, whether insured or self-insured*;
6. The Employer Group's Hospital, medical or surgical expense benefit program is self-insured; or
7. You are covered for similar benefits under an Individual policy or contract.

Please Note: If you were not previously eligible under the PacifiCare group Health Plan benefit as described above you may not enroll on PacifiCare's Individual Conversion Plan. This includes any future Dependents not currently enrolled as a Member of your PacifiCare group Health Plan under your former employer.

***Note also:** If you elect COBRA or California Continuation COBRA coverage, you are eligible for guaranteed issuance of a HIPAA individual contract at the time your COBRA or California Continuation COBRA coverage ends. However, if you select Individual Conversion coverage instead, you will not be eligible for a HIPAA-guaranteed product.

Benefits or rates of an Individual Conversion plan Health Plan are different from those in your group plan. An Individual Conversion Health Plan is also available to:

1. Currently enrolled Dependents, if the Subscriber dies;

2. Dependents who are currently enrolled and are no longer eligible for group Health Plan coverage due either to marriage or exceeding the maximum age for Dependent coverage under the group plan, as determined by the employer;
3. Dependents who are currently enrolled and lose coverage as a result of the Subscriber entering military service;
4. Spouse of the Subscriber who is currently an enrolled Dependent under PacifiCare, if your marriage has terminated due to divorce or legal separation.

Written applications and the first Premium payment for all conversions must be received by PacifiCare within 63 days of the loss of group coverage. This is an additional option to PacifiCare Members. This means you do not need to enroll and use any benefits you may have access to through COBRA or California Continuation COBRA to be eligible. For more details, please contact our Customer Service department.

Individual Conversion Plan Premiums are due on the first day of the coverage month (i.e., January 1st for January coverage). If you fail to pay your Individual Conversion Plan Premium when the Premium payment is due, PacifiCare will send you a 15-day cancellation notice reminding you that your Premium is overdue. If Premium is received within 15 days of PacifiCare's cancellation notification you will experience no break in coverage and no change in benefits. However, if you do not pay your Premium, enrollment will be cancelled effective 15 days after PacifiCare mailed the cancellation notice. A termination notice will be sent to you at that time and any Premium payments for coverage after the effective date of cancellation received after the 15-day notice period has expired will be refunded to you within 20 business days. However, you remain financially responsible for unpaid Premium for coverage prior to the effective date of cancellation.

Certificate of Creditable Coverage

According to the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), a Certificate of Creditable Coverage will be provided to the Subscriber by either PacifiCare or the Employer Group when the Subscriber or a Dependent ceases to be eligible for benefits under the employer's health benefit plan. Certificates of Creditable Coverage will also be provided upon request while the Subscriber or Dependent is covered under the Health Plan and up to 24 months after coverage under the Health Plan ceases. A Certificate of Creditable Coverage may be used to reduce or eliminate a pre-existing condition exclusion period imposed by a subsequent Health Plan. Creditable coverage information for Dependents will be included on the Subscriber's Certificate, unless the Dependent's address of record or coverage information is substantially different from the Subscriber's. Please contact the PacifiCare Customer Service department if you need a duplicate Certificate of Creditable Coverage. If you meet HIPAA eligibility requirements, you may be able to obtain individual coverage using your Certificate of Creditable Coverage.

Your Rights Under HIPAA Upon Termination of This Group Contract

HIPAA is the acronym for the federal law known as the Health Insurance Portability and Accountability Act of 1996. HIPAA protects health insurance coverage for workers and their families when they change or lose their jobs. California state law provides similar and additional protections.

If you lose your group health insurance coverage and meet certain important criteria, you are entitled to purchase coverage under an individual contract from any Health Plan that sells health insurance coverage to individuals. Significant protections come with the HIPAA individual contract: no pre-existing condition exclusions, guaranteed renewal at the option of the enrollee so long as the Plan offers coverage in the individual market and the enrollee pays the Premiums, and limitations on the amount of the Premium charged by the Health Plan.

Every Health Plan that sells health care coverage contracts to individuals must fairly and affirmatively offer, market, and sell HIPAA individual contracts to all Federally Eligible Defined Individuals. The plan may not reject an application from a Federally Eligible Defined Individual for a HIPAA individual contract if:

1. The Federally Eligible Defined Individual agrees to make the required Premium payments;

2. The Federally Eligible Defined Individual, and his or her Dependents to be covered by the plan contract, work or reside in the service area in which the plan operates. You are a Federally Eligible Defined Individual if, as of the date you apply for coverage:
   - You have 18 or more months of creditable coverage without a break of 63 days or more between any of the periods of creditable coverage or since the most recent coverage has been terminated;
   - Your most recent prior creditable coverage was under a group, government or church plan. (COBRA and California Continuation COBRA are considered Employer Group coverage);
   - You were not terminated from your most recent creditable coverage due to nonpayment of Premiums or fraud;
   - You are not eligible for coverage under a group Health Plan, Medicare, or Medi-Cal (Medicaid);
   - You have no other health insurance coverage; and
   - You have elected and exhausted fully any continuation coverage you were offered under COBRA or California Continuation COBRA.

There are important terms you need to understand, important factors you need to consider, and important choices you need to make in a very short time frame regarding the options available to you following termination of your group health care coverage. For example, if you are offered, but do not elect and exhaust COBRA or California Continuation COBRA coverage, you are not eligible for guaranteed issuance of a HIPAA individual contract. You should read carefully all of the information set forth in this section. If you have questions or need further information please contact PacifiCare Customer Service department.

If you believe your HIPAA rights have been violated, you should contact the Department of Managed Health Care at 1-888-HMO-2219 or visit the Department's Web site at **www.dmhc.ca.gov**.

Health Insurance Portability and Accountability Act of 1996 (HIPAA)

You may be eligible for the PacifiCare HIPAA Guaranteed Issue product, regardless of health status, if you:

1. Have had at least 18 months of prior creditable coverage, with the most recent prior creditable coverage under a group Health Plan, governmental plan or church plan, and with no break in creditable coverage greater than 63 days;
2. Are not currently entitled to coverage under a group Health Plan, Medicare or Medicaid*;
3. Do not currently have other health insurance coverage;
4. Your most recent creditable coverage was not terminated because of nonpayment of Premiums or fraud; and
5. If you were eligible, you elected and have used all federal COBRA continuation coverage available to you.

***Please note:** If you elect COBRA or California Continuation COBRA coverage, you are eligible for guaranteed issuance of a HIPAA individual contract at the time your COBRA or California Continuation COBRA ends. However, if you select Individual Conversion coverage instead, you will not be eligible for a HIPAA-guaranteed product.

HIPAA-eligible individuals need not be under age sixty-five (65) or meet medically underwritten requirements, but must qualify under the criteria for guaranteed issuance under HIPAA. Please contact PacifiCare's Customer Service for more information.

Uniformed Services Employment and Reemployment Rights Act (USERRA)

Continuation coverage under this Health Plan may be available to you through your employer under the Uniform Services Employment and Reemployment Rights Act of 1994, as amended (USERRA). The continuation coverage is equal to, and subject to the same limitations as, the benefits provided to other Members regularly enrolled in this Health Plan. These benefits may be available to you if you are absent from employment by reason of service in the United States uniformed services, up to the maximum 24-month period if you meet the USERRA requirements. USERRA benefits run concurrently with any benefits that may be available through COBRA. Your employer will provide written notice to you for USERRA continuation coverage.

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

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 two percent additional surcharge or administrative fee, not to exceed 102 percent 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 for maintaining 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.

California Military Families Financial Relief Act

Members of the United Sates Military Reserve and National Guard who terminate coverage as a result of being ordered to active duty on or after January 1, 2007, may have their coverage reinstated without waiting periods or exclusion of coverage for preexisting conditions. Please contact Member Service for information on how to apply for reinstatement of coverage following active duty as a reservist.

SECTION 8. OVERSEEING YOUR HEALTH CARE DECISIONS

- **How PacifiCare Makes Important Decisions**
- **What to Do if You Have a Problem**
- **Quality of Care Review**
- **Appeals and Grievances**
- **Independent Medical Reviews**

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

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

How PacifiCare Makes Important Health Care Decisions

Authorization, Modification and Denial of Health Care Services

Medical Necessity reviews may be conducted by PacifiCare, or in many situations, by a Participating Medical Group. Processes are used to review, approve, modify or deny, based on Medical Necessity, requests by Providers for authorization of the provision of health care services to Members.

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

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

The reviewer makes these decisions within at least the following time frame 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 business days from PacifiCare's, or in many situations, the Participating Medical Group's receipt of the information reasonably necessary and requested to make the decision.
- If the Member's condition poses an imminent and serious threat to their health, including, but not limited to, potential loss of life, limb or other major bodily function, or if lack of timeliness would be detrimental in regaining maximum function or to the Member's life or health, the decision will be rendered in a timely fashion appropriate for the nature of the Member's condition, not to exceed 72 hours after PacifiCare's or in many situations, the Participating Medical Group's receipt of the information reasonably necessary and requested by the reviewer to make the determination (an Urgent Request).

If the decision cannot be made within these time frames because (i) PacifiCare, or in many situations the Participating Medical Group is not in receipt of all of the information reasonably necessary and requested or (ii consultation by an expert reviewer is required, or (iii) the reviewer 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, the reviewer will notify the Provider and the Member, in writing, upon the earlier of the expiration of the required time frame above or as soon as PacifiCare or the Participating Medical Group becomes aware that they will not be able to meet the required time frame.

The notification will specify the information requested but not received or the additional examinations or tests required, and the anticipated date on which a decision may be rendered following receipt of all reasonably necessary requested information. Upon receipt of all information reasonably necessary and requested by

PacifiCare, or in many situations the Participating Medical Group, the reviewer shall approve, modify or deny the request for authorization within the time frame specified above as applicable.

The reviewer will 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. The written decision will include the specific reason(s) for the decision, the clinical reason(s) for modifications or denials based on a lack of Medical Necessity, or reference to the benefit provision on which the denial decision was based, and information about how to file an appeal of the decision with PacifiCare. In addition, the internal criteria or benefit interpretation policy, if any, relied upon in making this decision will be made available upon request by the Member.

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

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

PacifiCare's Utilization Management Policy

PacifiCare distributes its policy on financial incentives to all its Participating Providers, Members and employees. PacifiCare also requires that Participating Providers and staff who make utilization decisions, and those who supervise them, sign a document acknowledging receipt of this policy. The policy affirms that a utilization management decision is based solely on the appropriateness of a given treatment and service, as well as the existence of coverage. PacifiCare does not specifically reward Participating Providers or other individuals conducting utilization review for issuing denials of coverage. Financial incentives for Utilization Management decision-makers do not encourage decisions that result in either the denial or modification of Medically Necessary Covered Services.

Medical Management Guidelines

The Medical Management Guidelines Committee (MMGC), consisting of PacifiCare Medical Directors, provides a forum for the development, review and adoption of medical management guidelines to support consistent, appropriate medical care determinations. The MMGC develops guidelines using evidence-based medical literature and publications related to medical treatment or service. The Medical Management Guidelines contain practice and utilization criteria for use when making coverage and medical care decisions prior to, subsequent to or concurrent with the provisions of health care services.

Technology Assessment

PacifiCare regularly reviews new procedures, devices, and drugs to determine whether or not they are safe and efficacious for our Members. New procedures and technology that are safe and efficacious are eligible to become Covered Services. If the technology becomes a Covered Service it will be subject to all other terms and conditions of the plan, including Medical Necessity and any applicable Member Copayments, or other payment contributions.

In determining whether to cover a service, PacifiCare uses proprietary technology guidelines to review new devices, procedures and drugs, including those related to behavioral health. When clinical necessity requires a rapid determination of the safety and efficacy of a new technology or new application of an existing technology for an individual Member, a PacifiCare Medical Director makes a Medical Necessity determination based on individual Member medical documentation, review of published scientific evidence and when appropriate seeks relevant specialty or professional opinion from an individual who has expertise in the technology.

Utilization Criteria

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

- Nationally published guidelines for utilization management (Specific guideline information available upon request.
- HCIA-Sachs Length of Stay© Guidelines (average length of Hospital stays by medical or surgical diagnoses)
- PacifiCare Medical Management Guidelines (MMG) and Benefit Interpretation Policies (BIP). (*PacifiCare's Medical Management Guideline Manual* and *Commercial HMO Benefit Interpretation Policy Manual* are available at **www.pacificare.com**.)

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

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

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

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

What to Do if You Have a Problem

Sometimes you may have an unexpected problem. When this happens, your first step should be to call our Customer Service department. We'll assist you and attempt to find a solution to your situation.

If you have a concern about your treatment or a decision regarding your medical care, you may be able to request a second medical opinion. You can read more about requesting, as well as the requirements for obtaining a second opinion, in **Section 2. Seeing the Doctor**.

If you feel that your problem is not resolved or that your situation requires additional action, you may also submit a Grievance requesting an Appeal or Quality Review. To learn more about this, read the following section: "Appealing a Health Care Decision or Requesting a Quality of Care Review."

Appealing a Health Care Decision or Requesting a Quality of Care Review

Submitting a Grievance

PacifiCare's Grievance system provides Members with a method for addressing Member dissatisfaction regarding coverage decisions, care or services. Our appeals and quality of care review procedures are designed to resolve your Grievance. This is done through a process that includes a thorough and appropriate investigation. To initiate an appeal or request a quality of care review, call our Customer Service department at 1-800-624-8822, where a Customer Service representative will document your oral appeal. You may also file an appeal using the Online Grievance form at **www.pacificare.com** or write to the Appeals Department at:

Appeals & Grievances
PacifiCare, A UnitedHealthcare Company
P.O. Box 6107
Mail Stop CA124-0160
Cypress, CA 90630-9972

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

PacifiCare will review your complaint and if it 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, a health care professional who has the education, training and relevant expertise in the field of medicine necessary to evaluate the specific clinical issues that serve as the basis of your appeal.

Quality of Clinical Care and Quality of Service Review

All quality of clinical care and quality of service complaints are investigated by PacifiCare's Health Services Department. PacifiCare conducts this quality review by investigating the complaint and consulting with your Participating Medical Group, treating Providers and other PacifiCare internal departments. Medical records are requested and reviewed as necessary, and as such, you may need to sign an authorization to release your medical records. We will respond to your complaint in a manner, appropriate to the clinical urgency of your situation. You will also receive written notification regarding the disposition of your quality of clinical care and/or quality of service review complaint within 30 calendar days of PacifiCare's receipt of your complaint. Please be aware that the results of the quality of clinical care review are confidential and protected from legal discovery in accordance with state law.

The Appeals Process

You may submit an appeal for a denial of a service or denied claims within 180 calendar days of your receipt of an initial determination through our Appeals Department. PacifiCare's Health Services department will review your appeal within a reasonable period of time appropriate to the medical circumstances and make a determination within 30 calendar days of PacifiCare's receipt of the appeal. For appeals involving the delay, denial or modification of health care services related to Medical Necessity, PacifiCare's written response will include the specific reason for the decision, describe the criteria or guidelines or benefit provision on which the denial decision was based, and notification that upon request the Member may obtain a copy of the actual benefit provision, guideline protocol or other similar criterion on which the denial is based. For determinations delaying, denying or modifying health care services based on a finding that the services are not Covered Services, the response will specify the provisions in the *Combined Evidence of Coverage and Disclosure Form* that exclude that coverage.

Expedited Review Appeals Process

Appeals involving an imminent and serious threat to your health including, but not limited to, severe pain or the potential loss of life, limb or major bodily function will be immediately referred to PacifiCare's clinical review personnel. If your case does not meet the criteria for an expedited review, it will be reviewed under the standard appeal process. If your appeal requires expedited review, PacifiCare will immediately inform you of your review status and your right to notify the Department of Managed Health Care (DMHC) of the Grievance.

You and the DMHC will be provided a written statement of the disposition or pending status of the expedited review no later than three calendar days from receipt of the Grievance. You are not required to participate in the PacifiCare appeals process prior to contracting the DMHC regarding your expedited appeal.

Voluntary Mediation and Binding Arbitration

If you are dissatisfied with PacifiCare's Appeal Process determination, you can request that PacifiCare submit the appeal to voluntary mediation or binding arbitration before JAMS.

Voluntary Mediation

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

Binding Arbitration

All disputes of any kind, including, but not limited to, claims relating to the delivery of services under the plan and claims for medical malpractice between the Member (including any heirs, successors or assigns of Member) and PacifiCare, except for claims subject to ERISA, will be submitted to Binding Arbitration. Medical malpractice includes any issues or allegations that medical services rendered under the health plan were unnecessary or unauthorized or were improperly, negligently or incompetently rendered. This means that disputes between the Member and PacifiCare will not be resolved by a lawsuit or by pursuing other court processes and remedies, except to the extent the Federal Arbitration Act provides for judicial review of arbitration proceedings. Under this provision, neither the Court nor any arbitrator may delay arbitration of disputes or refuse to order disputes to arbitration. The intent of this arbitration provision, and the parties, is to put litigation on hold so that issues can be resolved through the binding arbitration process. Any disputes about the scope of arbitration, about the arbitration itself or about whether an issue falls under this arbitration provision will be resolved by the arbitrator to avoid ambiguities and litigation costs.

The Member and PacifiCare understand and agree that they are giving up their constitutional rights to have disputes decided in a court of law before a jury and are instead accepting the use of Binding Arbitration by a single arbitrator. The arbitration will be performed by JAMS or another arbitration service as the parties may agree in writing. The arbitration will be conducted under the JAMS Comprehensive Arbitration Rules and Procedures. The parties will attempt in good faith to agree to the appointment of an arbitrator, but if agreement cannot be reached within 30 days following the date demand for arbitration is made, the arbitrator will be chosen using the appointment procedures set out in the JAMS Comprehensive Arbitration Rules and Procedures. These rules may be viewed by the Member at the JAMS Web site, **www.jamsadr.com**. If the Member does not have access to the internet, the Member may request a copy of the rules from PacifiCare, and arrangements will be made for the Member to obtain a hard copy of the rules and procedures.

Arbitration hearings will be held in Orange County, California or at a location agreed to in writing by the Member and PacifiCare. The expenses of JAMS and the arbitrator will be paid in equal shares by the Member and PacifiCare. Each party will be responsible for any expenses related to discovery conducted by them and their own attorney fees. In cases of extreme hardship, PacifiCare may assume all or part of the Member's share of the fees and expenses of JAMS and the arbitrator, provided the Member submits a hardship application to JAMS

and JAMS approves the application. The approval or denial of the hardship application will be determined solely by JAMS. The Member will remain responsible for their own attorney fees, unless an award of attorney fees is allowable under the law and the arbitrator makes an award of attorney fees to the Member. Following the arbitration, the arbitrator will prepare a written award that includes the legal and factual reasons for the decision.

Nothing in this Binding Arbitration provision is intended to prevent the Member or PacifiCare from seeking a temporary restraining order or preliminary injunction or other provisional remedies from a court. However, any and all other claims or causes of action, including, but not limited to those seeking damages, restitution, or other monetary relief, will be subject to this Binding Arbitration provision. Any claim for permanent injunctive relief will be stayed pending completion of the arbitration. The Federal Arbitration Act, 9 U.S.C. Sections 1-16, will apply to the arbitration.

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

Experimental or Investigational Treatment

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

Independent Medical Review

If you believe that a health care service included in your coverage has been improperly denied, modified or delayed by PacifiCare or one of its Participating Providers, you may request an independent medical review (IMR) of the decision. IMR is available for denials, delays or modifications of health care services requested by you or your Provider based on a finding that the requested service is Experimental or Investigational or is not Medically Necessary. Your case also must meet the statutory eligibility criteria and procedural requirements discussed below. If your Complaint or appeal pertains to a Disputed Health Care Service subject to Independent Medical Review (as discussed below), you must file your Complaint or appeal within 180 calendar days of receiving a denial notice.

Eligibility for Independent Medical Review

Experimental or Investigational Treatment Decisions

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

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

1. Your Physician certifies that you have a Life-Threatening or Seriously Debilitating condition for which:
   - Standard therapies have not been effective in improving your condition; or
   - Standard therapies would not be medically appropriate for you; or

- There is no more beneficial standard therapy covered by PacifiCare than the proposed Experimental or Investigational therapy proposed by your Physician under the following paragraph.

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

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

Disputed Health Care Services

You may also request IMR of a Disputed Health Care Service. A Disputed Health Care Service is any health care service eligible for coverage and payment under your Health Plan that has been denied, modified or delayed by PacifiCare or one of its Participating Providers, in whole or in part, due to a finding that the service is not Medically Necessary. (**Note:** Disputed Health Care Services do not encompass coverage decisions. Coverage decisions are decisions that approve or deny health care services substantially based on whether or not a particular service is included or excluded as a covered benefit under the terms and conditions of your health care coverage.)

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

1. (a) Your Provider has recommended a health care service as Medically Necessary; or (b) you have received Urgently Needed Services or Emergency Services that a Provider determined were Medically Necessary; or (c) you have been seen by a Participating Provider for the diagnosis or treatment of the medical condition for which you seek IMR;
2. The health care service has been denied, modified or delayed by PacifiCare or one of its Participating Providers; and
3. You have filed an appeal with PacifiCare regarding the decision to deny, delay or modify health care services and the disputed decision is upheld or the appeal remains unresolved after 30 days (or three days in the case of an urgent appeal requiring expedited review). (**Note:** If there is an imminent and serious threat to your health, the DMHC may waive the requirement that you complete the appeals process or participate in the appeals process for at least 30 calendar days if the DMHC determines that an earlier review is necessary in extraordinary and compelling cases if the DMHC finds that you have acted reasonably.)

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

Independent Medical Review Procedures

Applying for Independent Medical Review Procedures

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

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

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

Accepted Applications for Independent Medical Review

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

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

1. The relevant medical records in the possession of PacifiCare or its Participating Providers;
2. All information provided to you by PacifiCare and any of its Participating Providers concerning PacifiCare and Provider decisions regarding your condition and care (including a copy of PacifiCare's denial notice sent to you);
3. Any materials that you or your Provider submitted to PacifiCare and its Participating Providers in support of the request for the health care services;

4. Any other relevant documents or information used by PacifiCare or its Participating Providers in determining whether the health care service should have been provided and any statement by PacifiCare or its Participating Providers explaining the reasons for the decision. The Plan shall provide copies of these documents to you and your Provider unless any information in them is found by the DMHC to be privileged.

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

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

If there is any information or evidence you or your Provider wish to submit to the DMHC in support of IMR that was not previously provided to PacifiCare, you may include this information with your application to the DMHC. Also as required, you or your Provider must provide to the DMHC or the IRO copies of any relevant medical records, and any newly developed or discovered relevant medical records after the initial documents are provided, and respond to any requests for additional medical records or other relevant information from the expert reviewers.

The Independent Medical Review Decision

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

- In the case of a review of an Experimental or Investigational determination, if your Physician determines that the proposed treatment or therapy would be significantly less effective if not promptly initiated. In this instance, the analysis and recommendations will be rendered within seven calendar days of the request for expedited review. The review period can be extended up to three calendar days for a delay in providing required documents at the request of the expert. The organization shall complete its review and make its determination in writing, and in layperson's terms to the maximum extent practicable, within 30 days of the receipt of the application for review and supporting documentation, or within less time as prescribed by the director.
- If the disputed health care service has not been provided and the enrollee's Provider or the Department certifies in writing that an imminent and serious threat to the health of the enrollee 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 enrollee, the analyses and determinations of the reviewers shall be expedited and rendered within three days of the receipt of the information.
- Subject to the approval of the DMHC, the deadlines for analyses and determinations involving both regular and expedited reviews may be extended by the director for up to three days in extraordinary circumstances or for good cause.

The IRO will provide the DMHC, PacifiCare, you and your Physician with each of the experts' analyses and recommendations, and a description of the qualifications of each expert. The IRO will keep the names of the expert reviewers confidential, except in cases where the reviewer is called to testify and in response to court orders. In the case of an Experimental or Investigational determination, the experts' analyses will state the reasons the requested Experimental or Investigational therapy is or is not likely to be more beneficial for you than any available standard therapy and the reasons for recommending why the therapy should or should not be provided by PacifiCare, citing your specific medical condition, the relevant documents provided and the relevant medical and scientific evidence supporting the experts' recommendation. In the case of a review of a Disputed Health Care Service denied as not Medically Necessary, the experts' analyses will state whether the Disputed Health Care Service is Medically Necessary and cite your medical condition, the relevant documents in the record and the reviewers' relevant findings.

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

When a Decision is Made

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

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

- The services are found by the IRO to have been Medically Necessary;
- The DMHC finds your decision to secure services outside of PacifiCare's Participating Provider network prior to completing the PacifiCare Grievance process or seeking IMR was reasonable under the circumstances; and
- The DMHC finds that the Disputed Health Care Services were a covered benefit under the PacifiCare Subscriber contract.

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

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

Review by the Department of Managed Health Care

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a Grievance against your Health Plan, you should first telephone your Health Plan at **1-800-624-8822** or **1-800-442-8833 (TDHI)** and use your Health Plan's Grievance process before contacting the department. Utilizing this Grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a Grievance involving an emergency, a Grievance that has not been satisfactorily resolved by your Health Plan, or a Grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a Health Plan related to the Medical Necessity of a proposed service or treatment, coverage decisions for treatments that are Experimental or Investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number **(1-888-HMO-2219)** and a TDHI line **(1-877-688-9891)** for the hearing- and speech-impaired. The department's Internet Web site **http://www.hmohelp.ca.gov** has Complaint forms, IMR application forms and instructions online.

Complaints Against Participating Medical Groups, Providers, Physicians and Hospitals

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

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

ERISA Rights

The following is a general description of the claims procedures applicable to Employers subject to the Employee Retirement Income Security Act of 1974, as amended (ERISA). Members should contact their Employer's benefit administrator to determine whether the Employer is subject to ERISA.

1. A description of PacifiCare's claims procedures, including the process for obtaining Preauthorization of a Covered Service, is set forth in this *Combined Evidence of Coverage and Disclosure Form.*
2. PacifiCare or its Participating Medical Group processes initial requests from Members (or their authorized representatives) for Covered Services pursuant to the following time frames:

   a. **Non-Urgent Pre-Service Requests**. Members will be notified of decisions to authorize or deny requests for Covered Services within a reasonable period of time appropriate to the medical condition of the Member but not later than 15 days from the receipt of the request. PacifiCare or its Participating Medical Group may extend the initial time frame for up to 15 days due to circumstances beyond its control. However, if the extension is necessary due to the Member's failure to submit the information necessary for PacifiCare or its Participating Medical Group to make a decision regarding the request, the Member will be notified of the extension, informed of the specific information necessary to make a decision, and provided at least 45 days to provide the specified information. In addition, the time period for making the determination is suspended from the date on which extension notification is received by the Member until the date on which (i) the Member responds with the specified information or (ii) the end of the period of time provided to submit the specified information, whichever is earlier.

   b, **Urgent Requests**. A request for Covered Services will be treated as an "urgent request" if making a determination pursuant to the time frames in Section (a) above (i) could seriously jeopardize the life or health of the Member, or (ii) if in the opinion of a Physician with knowledge of the Member's medical condition, would subject the Member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the request. In the event of an urgent request, PacifiCare or its Participating Medical Group will notify the Member of its determination to authorize or deny as soon as possible, taking into account the Member's medical condition, but not later than 72 hours after receipt of the urgent request. In the event PacifiCare or its Participating Medical Group does not have the information necessary to make a decision regarding the request, PacifiCare or its Participating Medical Group will notify the Member as soon as reasonably possible, but not later than 24 hours after receipt of the request and will inform the Member of the specific information necessary for PacifiCare or its Participating Medical Group to make a determination regarding the request, and the reasonable time frame (no less than 48 hours) for the Member to provide the specified information. PacifiCare or its Participating Medical Group will make a determination as soon as possible but no later than 48 hours after the earlier of (i) the receipt of the requested information, or (ii) the end of the period of time provided to submit the specified information.

c. **Concurrent Care Requests**. If the Member requests an extension of a previously authorized and currently ongoing course of treatment, and the request is an "urgent request" as defined in Section (b) above, PacifiCare or its Participating Medical Group will approve or deny the request as soon as possible, taking into account the Member's medical condition, and will notify the Member of the decision within 24 hours of the request, provided the Member made the request to PacifiCare or its Participating Medical Group at least 24 hours prior to the expiration of the previously authorized course of treatment. If the concurrent care request is not an "urgent request" as defined in Section (b) above, PacifiCare or its Participating Medical Group will treat the request as a new request for a Covered Service under the Health Plan and will follow the time frame for non-urgent requests as discussed in Section (a) above.

d. **Post-Service Claim.** Members will be notified of denials (in whole or in part) of an initial post-service claim within a reasonable period of time, but not later than 30 days after receipt of the claim. PacifiCare or its Participating Medical Group may extend the initial time frame for up to 15 days due to circumstances beyond its control. However, if the extension is necessary due to the Member's failure to submit the information necessary for PacifiCare or its Participating Medical Group to make a decision regarding the request, the Member will be notified of the extension, informed of the specific information necessary to make a decision, and provided at least 45 days to provide the specified information. In addition, the time period for making the determination is suspended from the date on which extension notification is received by the Member until the date on which (i) the Member responds with the specified information or (ii) the end of the period of time provided to submit the specified information, whichever is earlier.

3. **Appeal.** Members have up to 180 days following receipt of an adverse determination within which to appeal the determination. Members are entitled to a full and fair appeals process. Members may submit written comments, documents, records and information in support of their appeal. PacifiCare will notify the Member of its decision regarding the appeal no later than:
   - 72 hours for an urgent request
   - 30 days for a non-urgent pre-service request (the denial of an initial request for a service not yet provided)
   - 60 days for a post-service claim (the denial of a claim for services already provided but not yet paid for)
4. The Member agrees that their Provider will be their "authorized representative (pursuant to ERISA) regarding the receipt of approvals of requests for Covered Services for purposes of medical management.
5. ERISA provides for a maximum of two (2) mandatory appeal levels. Members enrolled in employee welfare benefit plans subject to ERISA may have the right to bring civil action under Section 502(a) of ERISA if all required reviews of their claim have been completed and the claim has not been approved.
6. A Member's participation in a voluntary appeal level does not affect their legal rights provided under ERISA. Any statute of limitations applicable to pursuing civil action will be tolled during the period of a voluntary level of appeal.
7. Binding Arbitration of claims, as described in this section of this *Combined Evidence of Coverage and Disclosure Form*, will be limited to claims that are not subject to ERISA.

SECTION 9. GENERAL INFORMATION

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

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

What should I do if I lose or misplace my membership card?

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

Does PacifiCare offer a translation service?

PacifiCare uses a telephone translation service for almost 140 languages and dialects. That's in addition to select Customer Service representatives who are fluent in Spanish. Translated Member materials are available upon request. Interpretation services may also be available at the Participating Provider office. Please contact the Participating Provider for specific language interpretation availability.

Does PacifiCare offer hearing- and speech-impaired telephone lines?

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

How is my coverage provided under extraordinary circumstances?

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

Nondiscrimination Notice

PacifiCare does not exclude, deny covered benefits to, or otherwise discriminate against any Member on the ground of race, color, or national origin, or on the basis of disability or age in participation in, or receipt of the Covered Services under, any of its Health Plans, whether carried out by PacifiCare directly or through a Participating Medical Group or any other entity with which PacifiCare arranges to carry out Covered Services under any of its Health Plans.

This statement is in accordance with the provisions of Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, and Regulations of the U.S. Department of Health and Human Services issued pursuant to these statutes at Title 45 Code of Federal Regulations Parts 80, 84, and 91.

How does PacifiCare compensate its Participating Providers?

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

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

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

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

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

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

Stop-loss insurance protects Participating Medical Groups and Participating Hospitals from large financial expenses for health care services. PacifiCare provides stop-loss protection to our Participating Medical Groups and Participating Hospitals that receive the monthly payments described above. If any Participating Hospital or Participating Medical Group does not obtain stop-loss protection from PacifiCare, it must obtain stop-loss insurance acceptable to PacifiCare.

PacifiCare arranges with additional Providers or their representatives for the provision of Covered Services that cannot be performed by your assigned Participating Medical Group or Participating Hospital. Such services include authorized Covered Services that require a specialist not available through your Participating Medical Group or Participating Hospital or Emergency and Urgently Needed Services. PacifiCare or your Participating Medical Group pays these Providers at the lesser of the Provider's reasonable charges or agreed-to rates. Your responsibility for Covered Services received from these Providers is limited to payment of applicable Copayments. (For more about Copayments, see **Section 6. Payment Responsibility**.) You may obtain additional information on PacifiCare's compensation arrangements by contacting PacifiCare or your Participating Medical Group.

How do I become an organ and tissue donor?

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

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

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

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

How can I learn more about being an organ and tissue donor?

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

On the Internet, contact:

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

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

How can I participate in the establishment of PacifiCare's public policy participation?

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

SECTION 10. DEFINITIONS

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

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

Binding Arbitration – The submission of a dispute to one or more impartial persons for a final and binding decision, except for fraud or collusion, on the part of the arbitrator. This means that once the arbitrator has issued a decision, neither party may appeal the decision. Any such dispute will not be resolved by a lawsuit or resort to court process, except as California law provides for judicial review of arbitration proceedings.

Biofeedback – Biofeedback therapy provides visual, auditory or other evidence of the status of certain body functions so that a person can exert voluntary control over the functions, and thereby alleviate an abnormal bodily condition. Biofeedback therapy often uses electrical devices to transform bodily signals indicative of such functions as heart rate, blood pressure, skin temperature, salivation, peripheral vasomotor activity, and gross muscle tone into a tone or light, the loudness or brightness of which shows the extent of activity in the function being measured.

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

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

Claim Determination Period – A calendar year.

Cognitive Behavioral Therapy – Psychotherapy where the emphasis is on the role of thought patterns in moods and behaviors.

Cognitive Rehabilitation Therapy –Cognitive Rehabilitation Therapy is therapy for the treatment of functional deficits as a result of traumatic brain injury and cerebral vascular insult. It is intended to help in achieving the return of higher level cognitive ability. This therapy is direct (one-on-one) patient contact.

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

Completion of Covered Services – Covered Services for the Continuity of Care Condition under treatment by the Terminated Provider or Non-Participating Provider will be considered complete, when (i) the Member's Continuity of Care Condition under treatment is medically/clinically stable, and (ii) there are no clinical contraindications that would prevent a medically/clinically safe transfer to a Participating Provider as determined by a PacifiCare Medical Director in consultation with the Member, the Terminated Provider or Non-Participating Provider, and as applicable, the Member's assigned Participating Provider.

Continuity of Care Condition(s) – The Completion of Covered Services will be provided by: (i) a Terminated Provider to a Member who, at the time of the Participating Provider's contract Termination, was receiving Covered Services from that Participating Provider, or (ii) Non-Participating Provider for a newly enrolled Member who, at the time his or her coverage became effective with PacifiCare, was receiving Covered Services from the Non-Participating Provider, for one of the Continuity of Care Conditions, as limited and described below:

1. **An Acute Condition** – A medical condition, including medical and Mental Health[1], that involves a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention and that has a limited duration. Completion of Covered Services will be provided for the duration of the Acute Condition.
2. **A Serious Chronic Condition** – A medical condition due to disease, illness, or other medical or mental health problem[2] or medical or mental health[2] disorder that is serious in nature, and that persists without full cure or worsens over an extended period of time, or requires ongoing treatment to maintain remission or prevent deterioration. Completion of Covered Services will be provided for the period of time necessary to complete the active course of treatment and to arrange for a clinically safe transfer to a Participating Provider, as determined by a PacifiCare Medical Director in consultation with the Member, and either (i) the Terminated Provider or (ii) the Non-Participating Provider and as applicable, the receiving Participating Provider, consistent with good professional practice. Completion of Covered Services for this condition will not exceed twelve (12) months from the agreement's Termination date or twelve (12) months from the effective date of coverage for a newly enrolled Member.
3. **A Pregnancy** diagnosed and documented by (i) the Terminated Provider prior to Termination of the agreement, or (ii) by the Non-Participating Provider prior to the newly enrolled Member's effective date of coverage with PacifiCare. Completion of Covered Services will be provided for the duration of the pregnancy and the immediate postpartum period.
4. **A Terminal Illness** – An incurable or irreversible condition that has a high probability of causing death within one (1) year or less. Completion of Covered Services will be provided for the duration of the Terminal Illness, not to exceed twelve (12) months, provided that the prognosis of death was made by the:

   (i) Terminated Provider prior to the agreement Termination date or

   (ii) Non-Participating Provider prior to the newly enrolled Member's effective date of coverage with PacifiCare.
5. **The Care of a Newborn** – Services provided to a child between birth and age thirty-six (36) months. Completion of Covered Services will not exceed twelve (12) months from the: (i) Provider agreement Termination date, or (ii) the newly enrolled Member's effective date of coverage with PacifiCare, or (iii) extend beyond the child's third (3rd) birthday.
6. **Surgery or Other Procedure** – Performance of a surgery or Other Procedure that has been authorized by PacifiCare or the Member's assigned Participating Provider as part of a documented course of treatment and has been recommended and documented by the: (i) Terminating Provider to occur within 180 calendar days of the agreement's Termination date, or (ii) Non-Participating Provider to occur within 180 calendar days of the newly enrolled Member's effective date of coverage with PacifiCare.

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[1] Except pursuant to the CA Health and Safety Code 1374.72, Inpatient coverage for Behavioral Health is not a covered benefit under the PacifiCare HMO/POS Commercial core coverage.

[2] PacifiCare Behavioral Health of California, Inc. (PBH)] will coordinate Continuity of Care for Members whose employer has purchased supplemental benefits and for Members requesting continued care with a terminated or Non-Participating Provider for "Serious Mental Illnesses" and "Serious Emotional Disturbances of a Child" as defined in CA Health and Safety Code, Section 1374.72, special diets, and supervision of medication that usually can be self-administered. Custodial Care includes all homemaker services, respite care, convalescent care or extended care not requiring skilled nursing. Custodial Care does not require the continuing attention of trained medical or paramedical personnel.

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

Copayments – The fee that a Member is obligated to pay, if any, at the time he or she receives a Covered Service. Copayments may be a specific dollar amount or a percentage of the cost of the Covered Services. Copayments are fees paid by the Member in addition to the Premium paid by an Employer Group and any payroll contributions required by the Member's Employer Group.

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

Custodial Care – Care and services that assist an individual in the activities of daily living. Examples include: assistance in walking, getting in or out of bed, bathing, dressing, feeding and using the toilet; preparation of special diets; and supervision of medication that usually can be self-administered. Custodial Care includes all homemaker services, respite care, convalescent care or extended care not requiring skilled nursing. Custodial Care does not require the continuing attention of trained medical or paramedical personnel. The mere provision of Custodial Care by a medical professional, such as a Physician, licensed nurse or registered therapist, does not mean the services are not custodial in nature. If the nature of the services can be safely and effectively performed by a trained non-medical person, the services will be considered Custodial Care.

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

Designated Facility – A facility that has entered into an agreement with PacifiCare, or with an organization contracting on PacifiCare's behalf, to render Covered Services for the treatment of specified diseases or conditions. The fact that a hospital is a Participating Hospital does not mean that it is a Designated Facility.

Developmental and Neurodevelopmental Testing – Developmental and Neurodevelopmental Testing is a battery of diagnostic tests for the purpose of determining a child's developmental status and need for early intervention services. This may include, but is not limited to, psychological and behavioral developmental profiles.

Domestic Partner is a person who meets the eligibility requirements, as defined by the Employer Group, and the following:

- Is eighteen (18) years of age or older;
- Is mentally competent to consent to contract;
- Resides with the Subscriber and intends to do so indefinitely;
- Is jointly responsible with the Subscriber for their common welfare and financial obligations;
- Is unmarried or not a member of another domestic partnership; and
- Is not related by blood to the Subscriber to a degree of closeness that would prohibit marriage in the state of residence.

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

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

1. there is inadequate time to effect safe transfer to another Hospital prior to delivery or
2. a transfer poses a threat to the health and safety of the Member or unborn child.

Emergency Services – Medical screening, examination and evaluation by a Physician or other personnel – to the extent provided by law – to determine if an Emergency Medical Condition or psychiatric Emergency Medical Condition exists. If this condition exists, Emergency Services include the care, treatment and/or surgery by a Physician necessary to relieve or eliminate the Emergency Medical Condition or psychiatric Emergency Medical Condition within the capabilities of the Facility. (For a detailed explanation of Emergency Services, see **Section 3. Emergency and Urgently Needed Services**.)

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

Enteral Feeding – Provision of nutritional requirements through a tube into the stomach or bowel. It may be administered by syringe, gravity, or pump.

Experimental or Investigational – Defined in **Section 5** under the "Exclusions and Limitations of Benefits" section of this *Combined Evidence of Coverage and Disclosure Form.*

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

Grievance (Complaint) – A written or oral expression of dissatisfaction regarding the plan and/or Provider, including quality of care concerns, and shall include a Complaint, dispute, request for reconsideration or appeal made by a Member or the Member's representative.

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

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

Health Plan Premiums (or Premiums) – Amounts established by PacifiCare to be paid to PacifiCare by Employer on behalf of Subscriber and his or her Dependents in consideration of the benefits provided under this Health Plan.

Home Health Aide – A person who has completed Home Health Aide training as required by the state in which the individual is working. Home Health Aides must work under a plan of care ordered by a Physician and under the supervision of a licensed nurse or licensed therapist.

Home Health Aide Services – Medically Necessary personal care such as bathing, exercise assistance and light meal preparation, provided by trained individuals and ordered along with skilled nursing and/or therapy visits.

Home Health Care Visit – Defined as up to two (2) hours of skilled services by a registered nurse or licensed vocational nurse or licensed therapist or up to four (4) hours of Home Health Aide Services.

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

Hospitalist – A Physician whose sole practice is the management of acutely and/or chronically ill patients' health services in a Hospital setting.

Hospital Services – Services and supplies performed or supplied by a licensed Hospital on an Inpatient or Outpatient basis.

Hypnotherapy – Medical Hypnotherapy is treatment by hypnotism or inducing sleep.

Infertility – Either: (1) the inability to conceive a pregnancy or to carry a pregnancy to a live birth after a year or more of regular sexual relations without contraception; or (2) the presence of a demonstrated condition recognized by a licensed Physician who is a Participating Provider as a cause of Infertility.

Intramuscular – Injection into the muscle.

Intravenous – Injection into the vein.

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

Learning Disability – A Learning Disability is a condition which manifests as a significant discrepancy between estimated cognitive potential and actual level of educational performance and which is not a result of generalized Mental Retardation, educational or psychosocial deprivation, psychiatric disorder or sensory loss.

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

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

a. A health intervention for the purpose of treating a medical condition;

b. The most appropriate supply or level of service, considering potential benefits and harms to the Member;

c. Known to be effective in improving health outcomes. For existing interventions, effectiveness is determined first by scientific evidence, then by professional standards, then by expert opinion. For new interventions, effectiveness is determined by scientific evidence; and

d. If more than one health intervention meets the requirements of (a) through (c) above, furnished in the most cost-effective manner that may be provided safely and effectively to the Member. "Cost-effective" does not necessarily mean lowest price.

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

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

i. *Treating Physician* means a Physician who has personally evaluated the patient.

ii. A *health intervention* is an item or service delivered or undertaken primarily to treat (that is, prevent, diagnose, detect, treat or palliate) a medical condition or to maintain or restore functional ability. A *medical condition* is a disease, illness, injury, genetic or congenital defect, pregnancy or a biological or psychological condition that lies outside the range of normal, age-appropriate human variation. A health intervention is defined not only by the intervention itself, but also by the medical condition and the patient indications for which it is being applied.

iii. *Effective* means that the intervention can reasonably be expected to produce the intended results and to have expected benefits that outweigh potential harmful effects.

iv. *Health outcomes* are outcomes that affect health status as measured by the length or quality (primarily as perceived by the patient) of a person's life.

v. *Scientific evidence* consists primarily of controlled clinical trials that either directly or indirectly demonstrate the effect of the intervention on health outcomes. If controlled clinical trials are not available, observational studies that suggest a causal relationship between the intervention and health outcomes can be used. Partially controlled observational studies and uncontrolled clinical series may be suggestive but do not by themselves demonstrate a causal relationship unless the magnitude of the effect observed exceeds anything that could be explained either by the natural history of the medical condition or potential Experimental biases. For existing interventions, the scientific evidence should be considered first and, to the greatest extent possible, should be the basis for determinations of medical necessity. If no scientific evidence is available, professional standards of care should be considered. If professional standards of care do not exist, or are outdated or contradictory, decisions about existing interventions should be based on expert opinion. Giving priority to scientific evidence does not mean that coverage of existing interventions should be denied in the absence of conclusive scientific evidence. Existing interventions can meet the definition of medical necessity in the absence of scientific evidence if there is a strong conviction of effectiveness and benefit expressed through up-to-date and consistent professional standards of care or, in the absence of such standards, convincing expert opinion.

vi. A *new intervention* is one that is not yet in widespread use for the medical condition and patient indications being considered. New interventions for which clinical trials have not been conducted because of epidemiological reasons (i.e., rare or new diseases or orphan populations) shall be evaluated on the basis of professional standards of care. If professional standards of care do not exist, or are outdated or contradictory, decisions about such new interventions should be based on convincing expert opinion.

vii. An intervention is considered *cost-effective* if the benefits and harms relative to costs represent an economically efficient use of resources for patients with this condition. In the application of this criterion to an individual case, the characteristics of the individual patient shall be determinative.

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

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

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

Mental Retardation and Related Conditions – An individual is determined to have mental retardation based on the following three criteria: Intellectual functioning level (IQ) is below 70-75; significant limitations exist in two or more adaptive skill areas; and the condition is present from childhood (defined as age 18 or less).

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

Non-Physician Health Care Practitioners – include, but are not limited to: psychologists, acupuncturists, optometrists, podiatrists, chiropractors, licensed clinical social workers, marriage and family therapists and nurse midwives.

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

PacifiCare-Designated Pharmacy – PacifiCare participating pharmacy designated to dispense injectable medications. A PacifiCare-Designated Pharmacy may include Prescription Solutions® Mail Service Pharmacy or alternative specialty injectable vendor as determined by PacifiCare.

Participating Hospital – Any general acute care Hospital licensed by the State of California that has entered into a written agreement with PacifiCare to provide Hospital Services to PacifiCare's Members. Participating Hospitals are independent contractors and are not employees of PacifiCare.

Participating Medical Group – An independent practice association (IPA) or medical group of Physicians that has entered into a written agreement with PacifiCare to provide Physician services to PacifiCare's Members. An IPA contracts with independent contractor Physicians who work at different office sites. A medical group employs Physicians who typically all work at one or several physical locations. Participating Medical Groups are independent contractors and are not employees of PacifiCare.

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

Participating Provider – A Hospital or other health care entity, a Physician or other health care professional, or a health care vendor who has entered into a written Agreement with the network of Providers from whom the Member is entitled to receive Covered Services. Participating Providers are independent contractors and are not employees of PacifiCare.

Physician – Any licensed allopathic or osteopathic Physician.

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

Primary Care Physician – A Participating Provider who is a Physician trained in internal medicine, general practice, family practice, pediatrics or obstetrics/gynecology and who has accepted primary responsibility for coordinating a Member's health care services. Primary Care Physicians are independent contractors and are not employees of PacifiCare.

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

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

Private-Duty Nursing Services – Private-Duty Nursing Services encompass nursing services for recipients who require more individual and continuous care than is available from a visiting nurse or routinely provided by the nursing staff of the Hospital or Skilled Nursing Facility.

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

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

Psychiatric Emergency Medical Condition – Means a mental disorder where there are acute symptoms of sufficient severity to render either an immediate danger to yourself or others, or you are immediately unable to provide for use, food, shelter or clothing due to the mental disorder.

Psychological Testing – Psychological Testing includes the administration, interpretation and scoring of tests such as WAIS-R, Rorschach, MMPI and other medically accepted tests for evaluation of intellectual strengths, psychopathology, psychodynamics, mental health risks, insight, motivation and other factors influencing treatment and prognosis.

Regional Organ Procurement Agency – is an organization designated by the federal government and responsible for procurement of organs for transplantation and the promotion of organ donation.

Rehabilitation Services – The individual or combined and coordinated use of medical, physical, occupational and speech therapy for training or retraining individuals disabled by disease or injury.

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

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

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

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

- Anorexia nervosa;
- Bipolar disorder;
- Bulimia nervosa;
- Major depressive disorder;
- Obsessive-compulsive disorder;
- Panic disorder;
- Pervasive developmental disorder or autism;
- Schizoaffective disorder;
- Schizophrenia.

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

Skilled Nursing Care – The care provided directly by or under the direct supervision of licensed nursing personnel, including the supportive care of a Home Health Aide.

Skilled Nursing Facility – A comprehensive free-standing rehabilitation Facility or a specially designed unit within a Hospital licensed by the State of California to provide Skilled Nursing Care.

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

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

Subacute and Transitional Care – Care provided to a Member as an inpatient of a Skilled Nursing Facility that is more intensive than is provided to the majority of the patients in a Skilled Nursing Facility.

Subcutaneous – Injection under the skin.

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

Substance Use Disorder – Alcoholism and substance use disorder that are listed in the current Diagnostic and Statistical Manual of the American Psychiatric Association, unless those services are specifically excluded or determined not to be Medically Necessary. The fact that a disorder is listed in the Diagnostic and Statistical Manual of the American Psychiatric Association does not mean that treatment of the disorder is a Covered Service.

Telehealth – A health service, other than a Telemedicine, delivered by a licensed or certified health professional acting within the scope of the health professional's license or certification who does not perform a Telemedicine medical service that requires the use of advanced telecommunications technology, other than by telephone or facsimile, including:

1. Compressed digital interactive video, audio or data transmission;
2. Clinical data transmission using computer imaging by way of still-image capture and store and forward; and
3. Other technology that facilitates access to health care services or medical specialty expertise.

Telemedicine – The use of interactive audio, video or other electronic media to deliver health care. This includes the use of electronic media for diagnosis, consultation, treatment, transfer of medical data and medical education. This term does not include services performed using a telephone or facsimile machine.

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

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

Usual and Customary Charges (U&C) means charges for medical services or supplies for which PacifiCare is legally liable and which do not exceed the average charged rate charged for the same or similar services or supplies in the geographic region where the services or supplies are received. Usual and Customary Charges are determined by referencing the 80th percentile of the most current survey published by Medical Data Research (MDR) for such services or supplies. The MDR survey is a product of Ingenix, Inc., formerly known as Medicode.

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

Vocational Rehabilitation – The process of facilitating an individual in the choice of or return to a suitable vocation, when necessary, assisting the patient to obtain training for such a vocation. Vocational Rehabilitation can also mean preparing an individual regardless of age, status (whether U.S. citizen or immigrant), or physical condition to cope emotionally, psychologically, and physically with changing circumstances in life, including remaining at school or returning to school, work or work equivalent (homemaker).

NOTE: THIS *COMBINED EVIDENCE OF COVERAGE AND DISCLOSURE FORM* PROVIDES A DESCRIPTION OF THE BENEFITS AVAILABLE TO YOU UNDER YOUR PACIFICARE HEALTH PLAN. THE AGREEMENT BETWEEN PACIFICARE AND YOUR EMPLOYER CONTAINS ADDITIONAL TERMS SUCH AS PREMIUMS, LENGTH OF CONTRACT, AND GROUP TERMINATION. A COPY OF THE GROUP AGREEMENT WILL BE FURNISHED UPON REQUEST AND IS AVAILABLE AT PACIFICARE AND YOUR EMPLOYER GROUP'S PERSONNEL OFFICE.

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