EL DORADO COUNTY

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Offered by PacifiCare of California

15/100%

HMO Schedule of Benefits

These services are covered as indicated when authorized through your Primary Care Physician in your Participating Medical Group.

General Features

Calendar Year Deductible	0
Maximum Benefits	Unlimited
Annual Copayment Maximum[1] (3 individual maximum per family)	$2,000/individual
Office Visits	$15 Copayment
Hospital Benefits (Autologous (self donated) blood limited up to $120.00 per unit)	Paid in full
Emergency Services (Copayment waived if admitted)	$50 Copayment
Urgently Needed Services (Medically Necessary services required outside geographic area served by your Participating Medical Group. Please consult your brochure for additional details. Copayment waived if admitted)	$50 Copayment
Pre-Existing Conditions	All conditions covered, provided they are covered benefits

Benefits Available While Hospitalized as an Inpatient

Bone Marrow Transplants (Donor searches limited to $15,000 per procedure)	Paid in full
Cancer Clinical Trials[2]	Paid at negotiated rate Balance (if any) is the responsibility of the Member
Hospice Services (Prognosis of life expectancy of one year or less)	Paid in full
Hospital Benefits[3] (Autologous (self donated) blood limited up to $120.00 per unit)	Paid in full
Mastectomy/Breast Reconstruction (After mastectomy and complications from mastectomy)	Paid in full
Maternity Care	Paid in full
Mental Health Services (As required by state law, coverage includes treatment for Severe Mental Illness (SMI) of adults and children and the treatment of Serious Emotional Disturbance of Children (SED). **Please refer to your Supplement to the PacifiCare Combined Evidence of Coverage and Disclosure Form for a description of this coverage.)**	Paid in full
Newborn Care[3]	Paid in full
Physician Care	Paid in full
Reconstructive Surgery	Paid in full
Rehabilitation Care (Including physical, occupational and speech therapy)	Paid in full

Benefits Available While Hospitalized as an Inpatient (Continued)

Skilled Nursing Facility Care (Up to 100 consecutive calendar days from the first treatment per disability)	Paid in full
Substance Use Disorder Detoxification	Paid in full
Voluntary Termination of Pregnancy (Medical/medication and surgical) 1st trimester 2nd trimester (12-20 weeks) – After 20 weeks, not covered unless Medically Necessary, such as the mother's life is in jeopardy or fetus is not viable.	 $125 Copayment $125 Copayment

Benefits Available on an Outpatient Basis

Allergy Testing/Treatment (Serum is covered)	$15 Office Visit Copayment
Ambulance	Paid in full
Cancer Clinical Trials[2]	Paid at negotiated rate Balance (if any) is the responsibility of the Member
Cochlear Implant Devices (Additional Copayment for outpatient surgery or inpatient hospital benefits and outpatient rehabilitation therapy may apply)	Paid in full
Dental Treatment Anesthesia (Additional Copayment for outpatient surgery or inpatient hospital benefits may apply)	$15 Office Visit Copayment
Dialysis (Physician office visit Copayment may apply)	$15 Copayment per treatment
Durable Medical Equipment ($5,000 annual benefit maximum per calendar year)	Paid in full
Durable Medical Equipment for the Treatment of Pediatric Asthma (Includes nebulizers, peak flow meters, face masks and tubing for the Medically Necessary treatment of pediatric asthma of Dependent children under the age of 19. Does not apply to the annual Durable Medical Equipment benefit maximum.)	Paid in full
Family Planning/Voluntary Termination of Pregnancy Vasectomy Tubal Ligation (Additional Copayment for inpatient hospital benefits may apply if performed on an inpatient basis.) Insertion/Removal of Intra-Uterine Device (IUD) Intra-Uterine Device (IUD) Removal of Norplant Depo-Provera Injection Depo-Provera Medication (Limited to one Depo-Provera injection every 90 days) Voluntary Termination of Pregnancy (Medical/medication and surgical) 1st trimester 2nd trimester (12-20 weeks) – After 20 weeks, not covered unless Medically Necessary, such as the mother's life is in jeopardy or fetus is not viable.	 $50 Copayment $100 Copayment $15 Office Visit Copayment $50 Copayment $15 Office Visit Copayment $15 Office Visit Copayment $35 Copayment $125 Copayment $125 Copayment
Health Education Services	Paid in full
Hearing Aid – Standard $5,000 Benefit Maximum every three years. Limited to a single hearing aid (including repair/replacement) every three years.	Paid in full

Benefits Available on an Outpatient Basis (Continued)

Hearing Aid – Bone Anchored[5] Limited to a single hearing aid during the entire period of time the member is enrolled in the Health Plan (per lifetime). Repairs and/or replacements are not covered, except for malfunctions. Deluxe model and upgrades that are not medically necessary are not covered.	Depending upon where the covered health service is provided, benefits for bone anchored hearing aid will be the same as those stated under each covered health service category in this Schedule of Benefits
Hearing Screening	$15 Office Visit Copayment
Home Health Care Visits (Up to 100 visits per calendar year)	Paid in full
Hospice Services (Prognosis of life expectancy of one year or less)	Paid in full
Immunizations (For children under two years of age, refer to Well-Baby Care)	$15 Office Visit Copayment
Infertility Services	Not covered
Infusion Therapy (Infusion Therapy is a separate Copayment in addition to a home health care or an office visit Copayment. Copayment applies per 30 days or treatment plan, whichever is shorter)	Paid in full
Injectable Drugs (Outpatient Injectable Medications and Self-Injectable Medications) (Copayment not applicable to allergy serum, immunizations, birth control, Infertility and insulin. The Self-Injectable medications Copayment applies per 30 days or treatment plan, whichever is shorter. Please see the PacifiCare Combined Evidence of Coverage and Disclosure Form for more information on these benefits, if any. Office visit Copayment may also apply)	$50 Copayment per visit[4]
Laboratory Services (When available through or authorized by your Participating Medical Group)	Paid in full
Maternity Care, Tests and Procedures	Paid in full
Mental Health Services (As required by state law, coverage includes treatment for Severe Mental Illness (SMI) of adults and children and the treatment of Serious Emotional Disturbance of Children (SED). **Please refer to your Supplement to the PacifiCare Combined Evidence of Coverage and Disclosure Form for a description of this coverage.)**	$15 Office Visit Copayment
Oral Surgery Services	Paid in full
Outpatient Medical Rehabilitation Therapy at a Participating Free-Standing or Outpatient Facility (Including physical, occupational and speech therapy)	$15 Office Visit Copayment
Outpatient Surgery at a Participating Free-Standing or Outpatient Surgery Facility	Paid in full
Periodic Health Evaluations (Physician, laboratory, radiology and related services as recommended by the American Academy of Pediatrics (AAP), Advisory Committee on Immunization Practices (ACIP) and U.S. Preventive Services Task Force and authorized through your Primary Care Physician in your Participating Medical Group to determine your health status. For children under two years of age, refer to Well-Baby Care)	$15 Office Visit Copayment
Physician Care (For children under two years of age, refer to Well-Baby Care)	$15 Office Visit Copayment
Prosthetics and Corrective Appliances	Paid in full

Benefits Available on an Outpatient Basis (Continued)

Radiation Therapy Standard: (Photon beam radiation therapy) Complex: (Examples include, but are not limited to, brachytherapy, radioactive implants and conformal photon beam; Copayment applies per 30 days or treatment plan, whichever is shorter; GammaKnife and stereotactic procedures are covered as outpatient surgery. Please refer to outpatient surgery for Copayment amount if any)	 Paid in full Paid in full
Radiology Services Standard: Specialized scanning and imaging procedures: (Examples include but are not limited to, CT, SPECT, PET, MRA and MRI – with or without contrast media)	 Paid in full Paid in full
Substance Use Disorder Detoxification	Paid in full
Vision Screening/Refractions	$15 Office Visit Copayment
Well-Baby Care (Preventive health service, including immunizations as recommended by the American Academy of Pediatrics (AAP), Advisory Committee on Immunization Practices (ACIP) and U.S. Preventive Services Task Force and authorized through your Primary Care Physician in your Participating Medical Group for children under two years of age. The applicable office visit Copayment applies to infants that are ill at time of services)	Paid in full
Well-Woman Care (Includes Pap smear (by your Primary Care Physician or an OB/GYN in your Participating Medical Group) and referral by the Participating Medical Group for screening mammography as recommended by the U.S. Preventive Services Task Force)	$15 Office Visit Copayment

[1] Annual Copayment Maximum does not include Copayments for pharmacy and supplemental benefits, except Behavioral Health Supplemental Benefits.

[2] Cancer Clinical Trial services require preauthorization by PacifiCare. If you participate in a Cancer Clinical Trial provided by a Non-Participating Provider that does not agree to perform these services at the rate PacifiCare negotiates with Participating Providers, you will be responsible for payment of the difference between the Non-Participating Providers billed charges and the rate negotiated by PacifiCare with Participating Providers, in addition to any applicable Copayments, coinsurance or deductibles.

[3] The inpatient hospital benefits Copayment does not apply to newborns when the newborn is discharged with the mother within 48 hours of the normal vaginal delivery or 96 hours of the cesarean delivery. Please see the Combined Evidence of Coverage and Disclosure Form for more details.

[4] In instances where the negotiated rate is less than your Copayment, you will pay only the negotiated rate.

[5] 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 in the Combined Evidence of Coverage and Disclosure Form. Limited to one (1) bone anchored hearing aid during the 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.

Except in the case of a Medically Necessary Emergency or an Urgently Needed Service (outside geographic area served by your Participating Medical Group), each of the above-noted benefits is covered when authorized by your Participating Medical Group or PacifiCare. A Utilization Review Committee may review the request for services.

Note: This is not a contract. This is a Schedule of Benefits and its enclosures constitute only a summary of the Health Plan.

The Medical and Hospital Group Subscriber Agreement and the PacifiCare of California Combined Evidence of Coverage and Disclosure Form and additional benefit materials must be consulted to determine the exact terms and conditions of coverage. A specimen copy of the contract will be furnished upon request and is available at the PacifiCare office and your employer's personnel office. PacifiCare's most recent audited financial information is also available upon request.

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

Customer Service:
800-624-8822
800-442-8833 (TDHI)
www.pacificare.com

PCA484517-000
ETA/EUA/EVA
Effective 7/01/10

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HMO Pharmacy Schedule of Benefits

Summary of Benefits	Generic Formulary	Brand-name Formulary	Non-Formulary
Retail Pharmacy Copayment (per Prescription Unit or up to 30 days)	**$10**	**$20**	**$25**
Mail Service Pharmacy Copayment (three Prescription Units or up to a 90-day supply)	**$20**	**$40**	**$50**

This *Schedule of Benefits* provides specific details about your prescription drug benefit, as well as the exclusions and limitations. Together, this document and the *Supplement to the Combined Evidence of Coverage and Disclosure Form* as well as the medical *Combined Evidence of Coverage and Disclosure Form* determine the exact terms and conditions of your prescription drug coverage.

What do I pay when I fill a prescription?

You will pay only a Copayment when filling a prescription at a PacifiCare Participating Pharmacy. You will pay a Copayment every time a prescription is filled. Your Copayments are as shown in the grid above.

There are selected brand-name medications where you will pay a generic Copayment of just $10. A copy of the Selected Brands List is available upon request from PacifiCare's Customer Service department and may be found on PacifiCare's Web site at **www.pacificare.com**.

Preauthorization

Selected generic Formulary, brand-name Formulary and non-Formulary medications require a Member to go through a Preauthorization process using criteria based upon Food and Drug Administration (FDA) approved indications or medical findings, and the current availability of the medication. PacifiCare reviews requests for these selected medications to ensure that they are Medically Necessary, being prescribed according to treatment guidelines consistent with standard professional practice and are not otherwise excluded from coverage.

Because PacifiCare offers a comprehensive Formulary, selected non-Formulary medications will not be covered until one or more Formulary alternatives, or non-Formulary preferred drugs have been tried. PacifiCare understands that situations arise when it may be Medically Necessary for you to receive a certain medication without trying an alternative drug first. In these instances, your Participating Physicians will need to provide evidence to PacifiCare in the form of documents, lab results, records or clinical trials that establish the use of the requested medications as Medically Necessary. Participating Physicians may call or fax Preauthorization requests to PacifiCare. Applicable Copayments will be charged for prescriptions that require Preauthorization if approved.

For a list of the selected medications that require PacifiCare's Preauthorization, please contact PacifiCare's Customer Service department.

Medication Covered by Your Benefit

When prescribed by your Participating Physician as Medically Necessary and filled at a Participating Pharmacy, subject to all the other terms and conditions of this outpatient prescription drug benefit, the following medications are covered:

- **Disposable all-in-one prefilled insulin pens**, insulin cartridges and needles for nondisposable pen devices are covered when Medically Necessary, in accordance with PacifiCare's Preauthorization process.
- **Federal Legend Drugs**: Any medicinal substance which bears the legend: "Caution: Federal law prohibits dispensing without a prescription."
- **Generic Drugs:** Comparable generic drugs may be substituted for brand-name drugs unless they are on PacifiCare's Selected Brands List. A copy of the Selected Brands List is available upon request from PacifiCare's Customer Service department or may be found on PacifiCare's Web site at **www.pacificare.com**.
- **Miscellaneous Prescription Drug Coverage**: For the purposes of determining coverage, the following items are considered prescription drug benefits and are covered when Medically Necessary: glucagons, insulin, insulin syringes, blood glucose test strips, lancets, inhaler extender devices, urine test strips and

anaphylaxis prevention kits (including, but not limited to, EpiPen®, Ana-Kits® and Ana-Guard®). See the medical *Combined Evidence of Coverage and Disclosure Form* for coverage of other injectable medications in Section Five under "Your Medical Benefits."

- **Oral Contraceptives:** Federal Legend oral contraceptives, prescription diaphragms and oral medications for emergency contraception.
- **State Restricted Drugs**: Any medicinal substance that may be dispensed by prescription only, according to state law.

Exclusions and Limitations

While the prescription drug benefit covers most medications, there are some that are not covered or limited. These drugs are listed below. Some of the following excluded drugs may be covered under your medical benefit. Please refer to Section Five of your medical *Combined Evidence of Coverage and Disclosure Form* titled "Your Medical Benefits" for more information about medications covered by your medical benefit.

- **Administered Drugs**: Drugs or medicines delivered or administered to the Member by the prescriber or the prescriber's staff are not covered. Injectable drugs are covered under your medical benefit when administered during a Physician's office visit or self-administered pursuant to training by an appropriate health care professional. Refer to Section Five of your medical *Combined Evidence of Coverage and Disclosure Form* titled "Your Medical Benefits" for more information about medications covered under your medical benefit.
- **Compounded Medication**: Any medicinal substance that has at least one ingredient that is Federal Legend or State Restricted in a therapeutic amount. Compounded medications are not covered unless Preauthorized as Medically Necessary by PacifiCare.
- **Diagnostic Drugs**: Drugs used for diagnostic purposes are not covered. Refer to Section Five of your medical *Combined Evidence of Coverage and Disclosure Form* for information about medications covered for diagnostic tests, services and treatment.
- **Dietary or nutritional** products and food supplements, whether prescription or nonprescription, including vitamins (except prenatal), minerals and fluoride supplements, health or beauty aids, herbal supplements and/or alternative medicine, are not covered. Phenylketonura (PKU) testing and treatment is covered under your medical benefit including those formulas and special food products that are a part of a diet prescribed by a Participating Physician provided that the diet is Medically Necessary. For additional information, refer to Section Five of your medical *Combined Evidence of Coverage and Disclosure Form.*
- **Drugs prescribed by a dentist** or drugs when prescribed for dental treatment are not covered.
- **Drugs when prescribed to shorten the duration of a common cold** are not covered.
- **Enhancement medications** when prescribed for the following nonmedical conditions are not covered: weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging for cosmetic purposes, and mental performance. Examples of drugs that are excluded when prescribed for such conditions include, but are not limited to, Penlac®, Retin-A®, Renova®, Vaniqa®, Propecia®, Lustra®, Xenical® or Meridia®. This exclusion does not exclude coverage for drugs when Preauthorized as Medically Necessary to treat morbid obesity or diagnosed medical conditions affecting memory, including, but not limited to, Alzheimer's dementia.
- **Infertility:** All forms of prescription medication when prescribed for the treatment of infertility are not covered. If your Employer has purchased coverage for infertility treatment, prescription medications for the treatment of infertility may be covered under that benefit. Please refer to Section Five of your medical *Combined Evidence of Coverage and Disclosure Form* titled "Your Medical Benefits" for additional information.
- **Injectable Medications**: Except as described under the section "Medications Covered by Your Benefit," injectable medications, including, but not limited to, self-injectables, infusion therapy, allergy serum, immunization agents and blood products, are not covered as an outpatient prescription drug benefit. However, these medications are covered under your medical benefit as described in and according to the terms and conditions of your medical *Combined Evidence of Coverage and Disclosure Form.* Outpatient injectable medications administered in the Physician's office (except insulin) are covered as a medical benefit when part of a medical office visit. Injectable medications may be subject to PacifiCare's Preauthorization requirements. For additional information, refer to Section Five of your medical *Combined Evidence of Coverage and Disclosure Form* under "Your Medical Benefits."
- **Inpatient Medications**: Medications administered to a Member while an inpatient in a Hospital or while receiving Skilled Nursing Care as an inpatient in a Skilled Nursing Facility are not covered under this *Pharmacy Schedule of Benefits.* Please refer to Section Five of your medical *Combined Evidence of Coverage and Disclosure Form* titled "Your Medical Benefits" for information on coverage of prescription medications while hospitalized or in a Skilled Nursing Facility. Outpatient prescription drugs are covered for Members receiving Custodial Care in a rest home, nursing home, sanitarium, or similar facility if they are obtained from a Participating Pharmacy in accordance

with all the terms and conditions of coverage set forth in this *Schedule of Benefits* and in the Pharmacy Supplement to the *Combined Evidence of Coverage and Disclosure Form*. When a Member is receiving Custodial Care in any facility, relatives, friends or caregivers may purchase the medication prescribed by a Participating Physician at a Participating Pharmacy and pay the applicable Copayment on behalf of the Member.

- **Investigational or Experimental Drugs:** Medication prescribed for experimental or investigational therapies are not covered, unless required by an external, independent review panel pursuant to California Health and Safety Code Section 1370.4. Further information about Investigational and Experimental procedures and external review by an independent panel can be found in the medical *Combined Evidence of Coverage and Disclosure Form* in Section Five, "Your Medical Benefits" and Section Eight, "Overseeing Your Health Care" for appeal rights.
- **Medications dispensed by a non-Participating Pharmacy** are not covered except for prescriptions required as a result of an Emergency or Urgently Needed Service.
- Medications prescribed by non-Participating Physicians are not covered except for prescriptions required as a result of an Emergency or Urgently Needed Service.
- **New medications that have not been reviewed for safety, efficacy and cost-effectiveness and approved** by PacifiCare are not covered unless Preauthorized by PacifiCare as Medically Necessary.
- **Non-Covered Medical Condition**: Prescription medications for the treatment of a non-covered medical condition are not covered. This exclusion does not exclude Medically Necessary medications directly related to non-Covered Services when complications exceed follow-up care, such as life-threatening complications of cosmetic surgery.
- **Off-Label Drug Use**. Off-Label Drug Use means that the Provider has prescribed a drug approved by the Food and Drug Administration (FDA) for a use that is different than that for which the FDA approved the drug. PacifiCare excludes coverage for Off-Label Drug Use, including off-label, self-injectable drugs, except as described in the medical *Combined Evidence of Coverage and Disclosure Form* and any applicable Attachments. If a drug is prescribed for Off-Label Drug Use, the drug and its administration will be covered only if it satisfies the following criteria: (1) The drug is approved by the FDA. (2) The drug is prescribed by a participating licensed health care professional. (3) The drug is Medically Necessary to treat the medical condition. (4) The drug has been recognized for treatment of a medical condition by one of the following: *The American Hospital Formulary Service Drug Information, The United States Pharmacopeia 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. Nothing in this section shall prohibit PacifiCare from use of a Formulary, Copayment, technology assessment panel, or similar mechanism as a means for appropriately controlling the utilization of a drug that is prescribed for a use that is different from the use for which that drug has been approved for marketing by the FDA. Denial of a drug as Investigational or Experimental will allow the Member to use the Independent Medical Review System as defined in the medical *Combined Evidence of Coverage and Disclosure Form*.
- **Over-the-Counter Drugs:** Medications (except insulin) available without a prescription (over-the-counter) or for which there is a nonprescription chemical and dosage equivalent available, even if ordered by a Physician, are not covered. All nonprescription (over-the-counter) contraceptive jellies, ointments, foams or devices are not covered.
- **Prior to Effective Date**: Drugs or medicines purchased and received prior to the Member's effective date or subsequent to the Member's termination are not covered.
- **Replacement** of lost, stolen or destroyed medications are not covered.
- **Saline and irrigation solutions** are not covered. Saline and irrigation solutions are covered when Medically Necessary, depending on the purpose for which they are prescribed, as part of the home health or durable medical equipment benefit. Refer to your medical *Combined Evidence of Coverage and Disclosure Form* Section Five for additional information.
- **Sexual Dysfunction Medication:** All forms of medications when prescribed for the treatment of sexual dysfunction, which includes, but is not limited to, erectile dysfunction, impotence, anorgasmy or hyporgasmy, are not covered. An example of such medications includes Viagra.
- **Smoking cessation products,** including, but not limited to, nicotine gum, nicotine patches and nicotine nasal spray, are not covered. However, smoking cessation products are covered when the Member is enrolled in a smoking cessation program approved by PacifiCare. For information on PacifiCare's smoking cessation program, refer to the medical *Combined Evidence of Coverage and Disclosure Form* in Section Five, "Your Medical Benefits, in the section titled "Outpatient Benefits", under "Health Education Services" or contact Customer Service or visit our Web site at **www.pacificare.com**.

- **Therapeutic devices or appliances,** including, but not limited to, support garments and other nonmedical substances, insulin pumps and related supplies (these services are provided as durable medical equipment) and hypodermic needles and syringes not related to diabetic needs or cartridges are not covered. Birth control devices and supplies or preparations that do not require a Participating Physician's prescription by law are also not covered, even if prescribed by a Participating Physician. For further information on certain therapeutic devices and appliances that are covered under your medical benefit, refer to your medical *Combined Evidence of Coverage and Disclosure Form* in Section Five, titled "Your Medical Benefits" under "Outpatient Benefits" located, for example, in subsections titled "Diabetic Self Management", "Durable Medical Equipment," or "Home Health Care and Prosthetics and Corrective Appliances."
- **Workers' Compensation**: Medication for which the cost is recoverable under any workers' compensation or occupational disease law or any state or government agency, or medication furnished by any other drug or medical service for which no charge is made to the patient is not covered. Further information about workers' compensation can be found in the medical *Combined Evidence of Coverage and Disclosure Form* in Section Six under "Payment Responsibility."

PacifiCare reserves the right to expand the Preauthorization requirement for any drug product.

Questions? Call the HMO Customer Service department at 1-800-624-8822 or TDHI 1-800-442-8833.

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

Customer Service:
800-624-8822
800-442-8833 (TDHI)
www.pacificare.com

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Your Outpatient Prescription Drug Benefit
Supplement to the Combined Evidence of Coverage and Disclosure Form

Understanding Your Outpatient Prescription Drug Benefit

This brochure contains important information for our members about the PacifiCare outpatient prescription drug benefit. As part of PacifiCare's commitment to you, we want to provide you with the tools that will help you better understand and utilize your Pharmacy and Prescription Drug Plan. In an effort to eliminate confusion, PacifiCare has provided you with answers for your pharmacy questions such as:

- What is a Formulary?
- What is the difference between a name brand and generic drug?
- Who can write my prescription?
- What happens in emergency situations?
- What is the Mail Service Pharmacy Program?
- What is Preauthorization?

What else should I read to understand my pharmacy benefits?

We want our members to get the most from their prescription drug benefit plan, so please read this Supplement to the Combined Evidence of Coverage and Disclosure Form ("Supplement") carefully. You need to become familiar with the terms used for explaining your coverage, because *understanding these terms is essential to understanding your benefit.* Along with reading this publication, be sure to review your Pharmacy Schedule of Benefits. Your Pharmacy Schedule of Benefits provides the details of your particular pharmacy benefit plan, including the exclusions and limitations, applicable Copayments and PacifiCare's Preauthorization process. Together, these documents explain your outpatient pharmacy coverage. These documents should be read completely and carefully for a comprehensive understanding of your outpatient pharmacy benefits.

Your medical Combined Evidence of Coverage and Disclosure Form Schedule of Benefits together with this Supplement to the Combined Evidence of Coverage and Disclosure Form and the Pharmacy Schedule of Benefits provide the terms and conditions of your benefit coverage. All applicants have a right to view these documents prior to enrollment.

What is covered, what is not?

PacifiCare covers Medically Necessary drugs that are not otherwise excluded from coverage by PacifiCare and Preauthorization may be required. Refer to your Pharmacy Schedule of Benefits for a description of covered medications as well as the limitations and exclusions for certain medications.

Formulary Drugs

What is a Formulary?

A Formulary is a list that contains a broad range of FDA approved generic and some brand name medications that are covered under your prescription drug benefit. Please refer to your Pharmacy Schedule of Benefits to determine how the Formulary applies to your prescription drug benefit.

Why are Formularies necessary?

Medication costs continue to rise. Formularies list those medications that offer value while maintaining quality of care to help reduce health care and premium costs.

Who decides which medications are on the Formulary?

Medications are added or deleted from the Formulary only after careful review by a committee of practicing physicians and pharmacists. This committee, called a Pharmacy and Therapeutics (P&T) Committee, has the responsibility of reviewing new and existing drugs. This committee decides which drugs provide quality treatment at the best value. Updates to the Formulary occur quarterly. You may obtain a copy of the Formulary by contacting Customer Service or from PacifiCare's web site at **www.pacificare.com**.

Please remember that the inclusion of a specific drug on the Formulary does not guarantee that your licensed physician will prescribe that drug for treatment of a particular condition.

What if my outpatient prescription medication is not on the Formulary?

Formularies list alternative medications, which are designed to be safe and effective. These medications generally have the same effect on your body. If your medication is not listed on PacifiCare's Formulary, ask your licensed physician or Participating Pharmacist for

an alternative prescription medication that is on the Formulary and medically appropriate for you. Non-formulary drugs may be generic or brand name drugs. For alternative non-Formulary medications, please review the Preauthorization process in your Pharmacy Schedule of Benefits.

How is a medication added or deleted from the Formulary?

A medication must first demonstrate safety and effectiveness to be added to the Formulary. Only after this is determined is the cost of the medication considered. Some medications have similar safety and effectiveness, but one or two are available at a lower cost. In these cases, the least costly medications are added to the Formulary.

When does the Formulary change? If a change occurs, will I have to pay more to use a drug I had been using?

The National Pharmacy and Therapeutics Committee meets regularly, on a quarterly basis, to review the Formulary and add or remove medications. If you are prescribed a maintenance medication, we will notify you 30 days prior to the change in tiers that will result in a higher copayment. We make available on our web site a listing of the Formulary and the most recent Formulary changes. See the section "Formulary Updates" on the pharmacy page of our web site. Refer to your Pharmacy Schedule of Benefits to find out if your Copayments are dependent on Formulary status.

If you are currently taking a prescription drug which is covered by PacifiCare for a specific medical condition and PacifiCare removes that drug from the Formulary, PacifiCare will continue to cover that drug. It will be covered provided your licensed physician continues to prescribe the drug for your specific medical condition and provided that the drug is appropriately prescribed and continues to be considered safe and effective for treatment of your medical condition. Continued coverage is subject to all terms and conditions of your PacifiCare Health Plan, including the exclusions and limitations of your Pharmacy Schedule of Benefits.

Generic Prescription Drugs

What is the difference between generic and brand name drugs?

When a new drug is put on the market, for many years it is typically available only under a manufacturer's brand name. At first, this new drug is protected by a patent. Only after the patent expires are competing manufacturers allowed to offer the same drug. This type of drug is called a generic drug.

While the name of the drug may not be familiar to you, a generic drug has the same medicinal benefits as its brand name competitor. In fact, a manufacturer must provide proof to the Food and Drug Administration (FDA) that a generic drug has the identical active chemical compound as the brand name product. A generic product must meet rigid FDA standards for strength, quality, purity, and potency.

Only when a generic drug meets these standards is it considered the brand name drug's equivalent. When the FDA approves a new generic drug, PacifiCare may choose to replace the brand name drug on the Formulary with the generic drug.

NOTE: If you have a question about our Formulary or a particular drug, please contact PacifiCare's Customer Service department at 1-800-624-8822 or TDHI 1-800-442-8833 or visit PacifiCare's web site at ***www.pacificare.com.***

Therapeutic substitution of medication

If there is no generic equivalent available for a specific brand name drug, your licensed physician may prescribe a 'therapeutic substitute' instead. Unlike a generic, which has the identical active ingredient as the brand name version, a therapeutic substitute has a chemical composition that is different but acts similarly in clinical and therapeutic ways when compared to competing brand name counterparts. If your licensed physician specifies therapeutic substitution, you will receive the therapeutic substitution medication and pay the applicable Copayment (refer to your Schedule of Benefits for the amount of your Copayment).

Filling Your Prescription

Who can write my prescription?

To be eligible for coverage, your prescription must be written by a licensed physician.

How do I use my prescription drug benefit?

Your outpatient prescription drug benefit helps to cover the cost for some of the outpatient medications prescribed by a licensed physician. Using your benefit is simple.

- Obtain your prescription from your licensed physician.
- Present your prescription for a covered outpatient medication and PacifiCare Member ID card at any PacifiCare Participating Pharmacy. If ordering by phone, be sure to mention that you are a PacifiCare Member. Note that some prescription medications must be Preauthorized by PacifiCare.
- Pay the applicable Copayment (refer to your Schedule of Benefits for the amount of your Copayment) for a Prescription Unit or its retail cost, whichever is less.
- Receive your medication.

How much do I have to pay to get a prescription filled?

Refer to your Pharmacy Schedule of Benefits for specific details and Copayment amounts.

Where do I go to fill a prescription?

PacifiCare has a well-established network of pharmacies including most major pharmacy and supermarket chains as well as many independent pharmacies. A listing of Participating Pharmacies is available in the back of this brochure. Contact our Customer Service department at 1-800-624-8822 or TDHI 1-800-442-8833 to help locate a Participating Pharmacy near you or visit our web site at www.pacificare.com for an up-to-date list.

When do I request a refill?

You may refill a prescription when a minimum of seventy-five (75 percent) of the quantity is consumed based on the days supply.

I take maintenance medication on a continuing basis. How can I have my prescriptions filled when I am on vacation?

The most convenient and affordable way to obtain maintenance medications is to obtain a 90-day supply through our mail service program (for additional details refer to the Mail Service section in this document). It is important to plan ahead, because it takes approximately seven days to receive your 90-day supply from the mail service program. Early refills for vacation are also available from Participating Pharmacies in certain circumstances – talk with your pharmacist about obtaining a vacation override. Our Customer Service Associates can also help you with planning for your medication needs while traveling call 1-800-624-8822 or TDHI 1-800-442-8833.

What if I am sick and need a prescription when I'm away from home?

If you are sick and need an outpatient prescription medication filled when away from home, you may visit one of our Participating Pharmacies within our national pharmacy network and receive the medication for the applicable Copayment. For the nearest network pharmacy, contact Customer Service at 1-800-624-8822 or TDHI 1-800-442-8833 or visit our web site at **www.pacificare.com**.

What happens in an emergency situation?

While in most circumstances you must fill your prescription at a Participating Pharmacy, you may fill your prescription for outpatient medication at a Non-Participating Pharmacy in an Emergency or Urgent situation. In such situations, you must pay the total cost of the prescription at the time you receive the medication and you will be reimbursed by PacifiCare for the cost of the medication, less the applicable Copayment. However, if PacifiCare determines that you obtained the prescription medication from a Non-Participating Pharmacy without an Emergency or Urgent situation, you will be responsible for the total cost of the medication and PacifiCare will not reimburse you.

To obtain reimbursement for Emergency or Urgently Needed prescription medications, you must follow the instructions below under "How do I obtain reimbursement?". You are only eligible for reimbursement for prescriptions related to urgent or emergency situations as defined by PacifiCare (refer to your medical Combined Evidence of Coverage and Disclosure Form) minus the applicable Copayment.

Remember: You should only fill a prescription at a Non-Participating Pharmacy in an Urgent or Emergency situation.

How do I obtain reimbursement?

Call the Customer Service department at 1-800-624-8822 or TDHI 1-800-442-8833 or visit PacifiCare's web site at www.pacificare.com to obtain the Direct Reimbursement Form. Provide the following: Direct Member Reimbursement Form, copies of the prescription receipts showing the prescription number, name of the medication, date filled, pharmacy name, name of the member for whom the prescription was written, proof of payment and a description of why a PacifiCare Participating Pharmacy was not available. Send these documents to: PacifiCare Pharmacy Department, P.O. Box 6037, Cypress, CA 90630.

You should submit the Direct Reimbursement Form within 90 days, or as soon as reasonably possible from the date of service. Payment will be forwarded to you once your request for reimbursement is determined by PacifiCare to be appropriate.

Emergency after hours

PacifiCare will cover an emergency after hours prescription without Preauthorization in the following situations:

- The prescription is for medication in conjunction with a hospital discharge, emergency room, or urgent care facility visit limited to a seven (7) day supply except for antibiotics which may be dispensed in up to a fifteen (15) day supply.
- Medications used for acute treatment and immediate use is required.
- Any time the prescribing physician states that failure to supply the medication will result in a severe medical event or hospital admission.
- Note: After hours Preauthorization will not be approved for any of the following situations:
- Continuation of a restricted medication based solely on a previous authorization or previous use.
- A change to an existing Preauthorization to extend the days' supply.
- A change to an existing Preauthorization to correct erroneous information.
- Early refills of maintenance medications.

- Early refills for signature changes or dosage changes.

When I fill a prescription, how much medication do I receive?

For a single Copayment, Members receive one Prescription Unit which represents a maximum of one month's (30 days supply) fill of outpatient prescription medication that can be obtained at one time. For most oral medications, a Prescription Unit is up to a 30-day supply of medication.

Medications dispensed in quantities other than the 30-day supply maximum are listed below:

- **Medications with quantity limitations:** The Prescription Unit for some medications may be set at a smaller quantity to promote appropriate medication use and patient safety. These quantity limits are based on generally accepted pharmaceutical practices and the manufacturer's labeling. For example, antibiotics typically require less than a 30 day supply; and certain drugs such as controlled substances and migraine medications may be limited due to the expectation of patient need and in accordance with manufacturer's recommended dosages. Drugs with quantity limitations may be dispensed in greater quantities if Medically Necessary and Preauthorized by PacifiCare.
- **Defined or pre-packaged units of medications:** Prescriptions such as inhalers, eye drops, creams, or other types of medications that are normally dispensed in pre-packaged or defined units of 30 day or less will be considered a single Prescription Unit.
- **Medication obtained through PacifiCare's Mail Service Program:** If you use the PacifiCare Mail Service Pharmacy Program, you will receive three Prescription Units or up to a 90-day supply of maintenance medications (except for pre-packaged medications as described above).

PacifiCare's Mail Service Program

What is the Mail Service Pharmacy program?

PacifiCare offers a Mail Service Pharmacy Program through *Prescription Solutions®*. The Mail Service Pharmacy Program provides convenient service and savings on maintenance medications that you may take on a regular basis by allowing you to purchase certain drugs for receipt by mail. You get quality medications mailed directly to your home or address of your choice within the United States, in a discreetly labeled envelope to ensure privacy and safety. Shipping and handling is at no additional charge.

If you use our Mail Service Pharmacy Program, you will generally get your maintenance medication within seven (7) working days after receipt of your order. All orders are shipped in discreetly labeled envelopes for privacy and safety.

Here's how to fill prescriptions through the Mail Service Pharmacy Program.

1. Call your licensed physician to obtain a new prescription for each medication. When you call, ask the physician to write the prescription for a 90-day supply which represents three (3) Prescription Units with up to three (3) additional refills. The doctor will tell you when to pick up the written prescription. (Note: Prescription Solutions® must have a new prescription to process any new mail service request.)
2. After picking up the prescription, complete the Mail Service Form included in your enrollment materials. (To obtain additional forms or for assistance in completing the form, call PacifiCare's Customer Service department at 1-800-624-8822 or TDHI 1-800-442-8833. You can also find the form at the web site address **www.rxsolutions.com**.)
3. Enclose the prescription and appropriate Copayment via check, money order, or credit card. Your Pharmacy Schedule of Benefits will have the applicable Copayment for the Mail Service Pharmacy Program. Make the check or money order payable to ***Prescription Solutions®***. No cash please.

When you receive your prescription, you'll get detailed instructions that tell you how to take the medication, possible side effects and any other important information about the medication. If you have questions, registered pharmacists are available to help you by calling Prescription Solutions® at 1-800-562-6223 or TDHI 1-800-498-5428.

Note: Medications such as Schedule II substances (e.g., Morphine, Ritalin and Dexedrine), antibiotics, drugs used for short-term or acute illnesses, and drugs that require special packaging (including refrigeration), are not available through our Mail Service Pharmacy Program. Prescription medications prescribed for the treatment of sexual dysfunction are not available through the Mail Service Pharmacy Program.

Important Tip: If you are starting a new medication, please request two prescriptions from your licensed physician. Have one filled immediately at a Participating Pharmacy while mailing the second prescription to PacifiCare's Mail Service Pharmacy. Once you receive your medication through the mail service, you should stop filling the prescription at the Participating Pharmacy.

Preauthorization

What is Preauthorization?

PacifiCare covers Medically Necessary prescription medications when prescribed by a licensed physician and Preauthorization may be required. For example, medications when prescribed for cosmetic purposes, such as wrinkle creams, are not generally covered. Medication quantities may also be limited to ensure that they are being used safely and effectively, and copayments, exclusions and limitations vary. Please be sure to read your Pharmacy Schedule of Benefits, which describes the details of your prescription drug coverage, including the types of medications that require Preauthorization, and that are limited or excluded. Prescriptions that require Preauthorization will be charged at the applicable Copayment if approved.

We want to make sure our Members receive optimal care and appropriate medication use is a big part of maintaining your overall health. That is why we have systems in place to make sure your medication is Medically Necessary and prescribed according to treatment guidelines consistent with standard professional practice. We also want to make sure you are not taking more medication than you need or are taking medication for a longer period of time than is necessary, and that you are receiving follow-up care. PacifiCare reserves the right to require Preauthorization and/or limit the quantity of any prescription. The following is a list of factors that PacifiCare takes into consideration when completing a Preauthorization review:

- The prescription is for the treatment of a covered medical condition and the expected beneficial effects of the prescription outweigh the harmful effects.
- There is sufficient evidence to draw conclusions about the effect of the prescription on the medical condition being treated and on your health outcome.
- The prescription represents the most cost-effective method to treat the medical condition.
- The prescription drug is prescribed according to established, documented and approved indications that are supported by the weight of scientific evidence.

What do I do if I need Preauthorization?

We understand that situations may arise in which it may be Medically Necessary to take a medication above the preset limits or for a particular condition/circumstance. In these instances, since your licensed physician understands your medical history and health conditions, he/she can request Preauthorization. We have made the process simple and easy. Your licensed physician can call or fax the Preauthorization request to Prescription Solutions®, which is PacifiCare's pharmacy benefit manager. The Preauthorization staff of qualified pharmacists and technicians is available Monday through Friday from 6:00 a.m. to 6:00 p.m. to assist licensed physicians. Most authorizations are completed within 24 hours. The most common reason for delay in the authorization process is insufficient information. Your licensed physician may need to provide information on diagnosis and medication history and/or evidence in the form of documents, records or lab tests which establish that the use of the requested medication meets plan criteria.

Does this plan limit or exclude certain drugs my health care provider may prescribe or encourage substitutions for some drugs?

Your PacifiCare pharmacy benefit provides you access to a wide range of FDA-approved brand and generic medications. The Formulary is developed with the input from licensed physicians and pharmacists and is based on assessment of the drug's quality, safety, effectiveness and cost. If a medication is not included on the Formulary, it may be because the Plan's Formulary includes other drugs that are frequently prescribed for the same condition as those that are not included on the Formulary. For example, PacifiCare may have an equivalent generic medication on the Formulary for the brand-name medication prescribed by your licensed physician. It is also important to remember there may be other options available for treating a particular medical condition. Non-Formulary medications may require Preauthorization and will be approved when Medically Necessary unless otherwise excluded by PacifiCare as described in the Exclusions and Limitations Section of the Pharmacy Schedule of Benefits. Refer to the Section entitled "What do I do if I need Preauthorization" in this document for additional information.

What should I do if I want to appeal a Preauthorization decision?

As a PacifiCare Member, you have the right to appeal any Preauthorization decision. Contact Customer Service at 1-800-624-8822 or TDHI 1-800-442-8833 for details on the Preauthorization or appeals process. Please refer to your medical Combined Evidence of Coverage and Disclosure Form for more details on the appeals process and the expedited review process.

Helpful tips:

- Take your medications list with you to the doctor's office.
- Ask your doctor if the drug prescribed is on the PacifiCare Formulary.

- Talk with your doctor about Formulary alternative medications to treat your medical condition.
- You and your doctor can access the most current Formulary information on our web site at **www.pacificare.com** including information on Formulary alternatives.

Definitions

Contract Year – The twelve-month period that begins on the first day of the month the Agreement become effective

Calendar Year – The time period beginning on January 1 and ending on December 31.

Formulary – The Formulary is a list that contains a broad range of FDA approved generic and some brand name medications that under State or Federal laws are to be dispensed by a prescription only. The Formulary does not include all prescription medications.

Non-Participating Pharmacy – A pharmacy that has NOT contracted with PacifiCare to provide outpatient prescription drugs to our Members.

Participating Pharmacy – A pharmacy that has contracted with PacifiCare to provide outpatient prescription drugs to our Members.

Preauthorization – PacifiCare's review process that determines whether a prescription drug is Medically Necessary and not otherwise excluded prior to the Member receiving the prescription drug.

Prescription Unit – The maximum amount (quantity) of prescription medication that may be dispensed per single Copayment. For most oral medications, a Prescription Unit represents up to a 30-day supply of medication. The Prescription Unit for some medications may be set at a smaller quantity to promote appropriate medication use and patient safety. Quantity limits are based on generally accepted pharmaceutical practices and the manufacturer's labeling. Prescriptions that are normally dispensed in pre-packaged or commercially available units of 30 days or less will be considered a single Prescription Unit, including but not limited to, one inhaler, one vial of ophthalmic medication, one tube of topical ointment or cream.

Selected Brands List – The brand-name drugs included on the PacifiCare Formulary in place of their generic equivalents. These drugs are available at the generic drug Copayment amount.

Non-Formulary Preferred Drug: Non-Formulary drug that is more cost effective than a similar non-Formulary drug.

Pharmacy Listing

For the most up to date list visit the web site at www.pacificare.com

- Albertson's Food and Drug
- Bel Air Market Pharmacies
- Costco
- CVS
- Gemmel Pharmacy Group
- Horton & Converse Pharmacies
- K Mart Pharmacies
- Long's Drug Stores
- Medicine Shoppe Pharmacies
- Neighborcare Pharmacies
- Raley's Pharmacies
- Ralph's Pharmacies
- Rite Aid Pharmacies
- Safeway Pharmacies
- Save Mart Pharmacies
- Sav-On Pharmacies
- Sharp-Rees-Stealy Pharmacies
- Talbert Health Services
- Target Pharmacies
- United Drugs
- Vons Food and Drug
- Walgreen's
- Wal-Mart

Questions? Call PacifiCare Customer Service at 1-800-624-8822 (HMO) or 1-800-442-8833 (TDHI).

PacifiCare® of California
P.O. Box 30968
Salt Lake City, UT 84130-0968
M-F, 8 a.m. to 8 p.m.
www.pacificare.com

PCA417814-000
Rev 10/08

PacifiCare of California

Changes in Federal Law that Impact Covered Services or Eligibility

There are numerous changes in Federal law, effective in 2009, which may impact the Covered Services or eligibility stated in the *Combined Evidence of Coverage and Disclosure Form* and *Schedule of Benefits*. A summary of those changes and the dates the changes are effective appear below.

Americans with Disabilities Act

Changes in interpretation of the *Americans with Disabilities Act* result in the following additional benefits:

- Covered Services are provided for a single hearing aid (including repair and replacement) every three (3) years required for the correction of a hearing impairment and for charges for associated fitting and testing.

  Covered Services for hearing aid is subject to payment requirements (Copayments, deductible and out-of-pocket maximums) that mirror those applicable to *Durable Medical Equipment (Rental, Purchase or Repair)* as shown in the *Schedule of Benefits*, however Covered Services for hearing aid will never exceed $5,000 every three years and a single hearing aid every three years.

- Bone anchored hearing aid is a Covered Service for which benefits are provided under the applicable medical/surgical benefit categories in the *Combined Evidence of Coverage and Disclosure Form* only for Members who have either of the following:

  - Craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid.
  - Hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid.

  Covered Services for bone anchor hearing aid is limited to one per Member during the entire period of time the Member is enrolled under the Health Plan. Repairs and/or replacements are not covered, except for malfunctions. Deluxe model and upgrades that are not medically necessary are not covered.

Mental Health Parity Act

For Employer Groups with 51 or more employees:

Effective for Health Plans that are new or renewing on or after October 3, 2009, benefits are subject to the *Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008* (the "Mental Health Parity Act"). This means that mental health or substance use disorders that are Covered Services under the Health Plan must be treated in the same manner and provided at the same level as Covered Services for the treatment of other sickness or injury. Covered Services for outpatient mental health services and alcohol, drug or other substance use detoxification office visits described in the *Combined Evidence of Coverage and Disclosure Form* and any applicable mental health or substance use disorder supplemental benefit rider are payable under the same terms as specialist physician office visits. Covered Services for inpatient/intermediate mental health services and alcohol, drug or other substance use detoxification described in the *Combined Evidence of Coverage and Disclosure Form* and any applicable mental health or substance use disorder supplemental benefit rider are payable under the same terms as Inpatient Hospital Benefits. Covered Services for mental health services and alcohol, drug or other substance use detoxification are not subject to any annual maximum benefit limit (including any day, visit or dollar limit). These Covered Services will continue to apply to any overall calendar year maximum or maximum benefits stated in the *Schedule of Benefits* and any applicable mental health or substance use disorder supplemental benefit rider.

Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA)

Effective April 1, 2009, the *Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA)* expands special enrollment rights under the Health Plan.

An eligible employee and/or Dependent may be able to enroll during a special enrollment period. A special enrollment period is not available to an eligible employee and his or her Dependents if coverage under the prior plan was terminated for cause, or because premiums were not paid on a timely basis.

A special enrollment period applies for an eligible employee and/or Dependent who did not enroll during the initial enrollment period or Open Enrollment Period if the following are true:

- The eligible employee and/or Dependent had existing health coverage under Medicaid or Children's Health Insurance (CHIP) at the time they had an opportunity to enroll during the initial enrollment period or Open Enrollment Period; and

  Coverage under the prior plan ended because the eligible employee and/or Dependent loses eligibility under Medicaid or Children's Health Insurance Program (CHIP). Coverage will begin only if we receive the completed enrollment form and any required Health Plan Premiums within 60 days of the date coverage ended.

- The eligible employee previously declined coverage under the Health Plan, but the eligible employee and/or Dependent 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 form and any required Health Plan Premiums within 60 days of the date of determination of subsidy eligibility.

Michelle's Law

Effective for Health Plans that are new or renewing on or after October 9, 2009, coverage for enrolled Dependent children who are required to maintain full-time student status in order to continue eligibility under the Health Plan is subject to a new statute known as "Michelle's Law" (H.R. 2851). This law amends *ERISA*, the *Public Health Service Act*, and *the Internal Revenue Code* and requires group health plans, which provide coverage for dependent children who are post-secondary school students, to continue such coverage if the student loses the required student status because he or she must take a medically necessary leave of absence from studies due to a serious illness or injury.

Women's Health and Cancer Rights Act of 1998

As required by the *Women's Health and Cancer Rights Act of 1998*, Covered Services are provided for mastectomy, including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema).

If you are receiving Covered Services in connection with a mastectomy, benefits are also provided for the following Covered Services, as you determine appropriate with your attending Physician:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and treatment of physical complications of the mastectomy, including lymphedema.

The amount you must pay for such Covered Services (including Copayments and any annual deductible) are the same as are required for any other Covered Service. Limitations on benefits are the same as for any other Covered Service.

Statement of Rights under the Newborns' and Mothers' Health Protection Act

Under Federal law, group health plans ("plans") and health insurance issuers ("issuers") offering group health insurance coverage generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (e.g. your Physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under Federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under Federal law, require that a Physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of- pocket costs, you may be required to obtain Preauthorization. For information on Preauthorization, contact the Customer Service Department.

Notice of Privacy Practices

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

We* are required by law to protect the privacy of your health information. We are also required to send you this notice, which explains how we may use information about you and when we can give out or "disclose" that information to others. You also have rights regarding your health information that are described in this notice.

The terms "information" or "health information" in this notice include any personal information that is created or received by a health care provider or health plan that relates to your physical or mental health or condition, the provision of health care to you, or the payment for such health care.

We have the right to change our privacy practices. If we do, we will provide the revised notice to you within 60 days by direct mail or post it on our website, www.pacificare.com.

**For purposes of this Notice of Privacy Practices, "we" or "us" refers to the following UnitedHealthcare entities:*

ACN Group of California, Inc.; All Savers Insurance Company; American Medical Security Life Insurance Company; AmeriChoice of New Jersey, Inc.; AmeriChoice of New York, Inc.; AmeriChoice of Pennsylvania, Inc.; Arizona Physicians IPA, Inc.; Dental Benefit Providers of California, Inc.; Dental Benefit Providers of Illinois, Inc.; Dental Benefit Providers of Maryland, Inc.; Evercare of Arizona, Inc.; Evercare of Texas, L.L.C.; Fidelity Insurance Company; Golden Rule Insurance Company; Great Lakes Health Plan, Inc.; IBA Health and Life Assurance Company; Investors Guaranty Life Insurance Company; MAMSI Life and Health Insurance Company; MD-Individual Practice Association, Inc.; Midwest Security Life Insurance Company; National Pacific Dental, Inc.; Neighborhood Health Partnership, Inc.; Nevada Pacific Dental, Inc.; Optimum Choice, Inc.; Optimum Choice of the Carolinas, Inc.; Optimum Choice, Inc. of Pennsylvania; Oxford Health Insurance, Inc.; Oxford Health Plans (CT), Inc.; Oxford Health Plans (NJ), Inc.; Oxford Health Plans (NY), Inc.; PacifiCare Behavioral Health, Inc.; PacifiCare Behavioral Health of California, Inc.; PacifiCare Behavioral Health NY IPA, Inc.; PacifiCare Behavioral Health of New Jersey, Inc.; PacifiCare Dental; PacifiCare Dental of Colorado, Inc.; PacifiCare Insurance Company, Inc.; PacifiCare Life and Health Insurance Company; PacifiCare Life Assurance Company; PacifiCare of Arizona, Inc.; PacifiCare of California; PacifiCare of Colorado, Inc.; PacifiCare of Nevada, Inc.; PacifiCare of Oklahoma, Inc.; PacifiCare of Oregon, Inc.; PacifiCare of Texas, Inc.; PacifiCare of Washington, Inc.; Pacific Union Dental, Inc.; Rooney Life Insurance Company; Spectera, Inc.; Spectera Vision, Inc.; Spectera Vision Services of California, Inc.; Unimerica Insurance Company; Unimerica Life Insurance Company of New York; United Behavioral Health; UnitedHealthcare of Alabama, Inc.; UnitedHealthcare of Arizona, Inc.; UnitedHealthcare of Arkansas, Inc.; UnitedHealthcare of Colorado, Inc.; UnitedHealthcare of Florida, Inc.; UnitedHealthcare of Georgia, Inc.; UnitedHealthcare of Illinois, Inc.; UnitedHealthcare of Kentucky, Ltd.; UnitedHealthcare of Louisiana, Inc.; UnitedHealthcare of the Mid-Atlantic, Inc.; UnitedHealthcare of the Midlands, Inc.; UnitedHealthcare of the Midwest, Inc.; UnitedHealthcare of Mississippi, Inc.; UnitedHealthcare of New England, Inc.; UnitedHealthcare of New Jersey, Inc.; UnitedHealthcare of New York, Inc.; UnitedHealthcare of North Carolina, Inc.; UnitedHealthcare of Ohio, Inc.; UnitedHealthcare of Tennessee, Inc.; UnitedHealthcare of Texas, Inc.; UnitedHealthcare of Utah; UnitedHealthcare of Wisconsin, Inc.; UnitedHealthcare Insurance Company; UnitedHealthcare Insurance Company of Illinois; UnitedHealthcare Insurance Company of New York; UnitedHealthcare Insurance Company of Ohio; UnitedHealthcare Insurance Company of the River Valley; UnitedHealthcare Plan of the River Valley, Inc.; and U.S. Behavioral Health Plan, California.

How We Use or Disclose Information

We must use and disclose your health information to provide information:

- To you or someone who has the legal right to act for you (your personal representative);
- To the *Secretary of the Department of Health and Human Services*, if necessary, to make sure your privacy is protected; and
- Where required by law.

We have the right to use and disclose health information to pay for your health care and operate our business. For example, we may use your health information:

- **For Payment** of premiums due us and to process claims for health care services you receive.
- **For Treatment.** We may disclose health information to your physicians or hospitals to help them provide medical care to you.
- **For Health Care Operations.** We may use or disclose health information as necessary to operate and manage our business and to help manage your health care coverage. For example, we might talk to your physician to suggest a disease management or wellness program that could help improve your health.
- **To Provide Information on Health Related Programs or Products** such as alternative medical treatments and programs or about health related products and services.
- **To Plan Sponsors.** If your coverage is through an employer group health plan, we may share summary health information and enrollment and disenrollment information with the plan sponsor. In addition, we may share other health information with the plan sponsor for plan administration if the plan sponsor agrees to special restriction on its use and disclosure of the information.
- **For Appointment Reminders.** We may use health information to contact you for appointment reminders with providers who provide medical care to you.

We may use or disclose your health information for the following purposes under limited circumstances:

- **To Persons Involved With Your Care.** We may use or disclose your health information to a person involved in your care, such as a family member, when you are incapacitated or in an emergency, or when permitted by law.
- **For Public Health Activities** such as reporting disease outbreaks.
- **For Reporting Victims of Abuse, Neglect or Domestic Violence** to government authorities, including a social service or protective service agency.
- **For Health Oversight Activities** such as governmental audits and fraud and abuse investigations.
- **For Judicial or Administrative Proceedings** such as in response to a court order, search warrant or subpoena.
- **For Law Enforcement Purposes** such as providing limited information to locate a missing person.
- **To Avoid a Serious Threat to Health or Safety** by, for example, disclosing information to public health agencies.
- **For Specialized Government Functions** such as military and veteran activities, national security and intelligence activities, and the protective services for the President and others.
- **For Workers Compensation** including disclosures required by state workers compensation laws of job-related injuries.
- **For Research Purposes** such as research related to the prevention of disease or disability, if the research study meets all privacy law requirements.

- **To Provide Information Regarding Decedents.** We may disclose information to a coroner or medical examiner to identify a deceased person, determine a cause of death, or as authorized by law. We may also disclose information to funeral directors as necessary to carry out their duties.
- **For Organ Procurement Purposes.** We may use or disclose information for procurement, banking or transplantation of organs, eyes or tissue.

If none of the above reasons applies, **then we must get your written authorization to use or disclose your health information**. If a use or disclosure of health information is prohibited or materially limited by other applicable law, it is our intent to meet the requirements of the more stringent law. In some states, your authorization may also be required for disclosure of your health information. In many states, your authorization may be required in order for us to disclose your highly confidential health information, as described below. Once you give us authorization to release your health information, we cannot guarantee that the person to whom the information is provided will not disclose the information. You may take back or "revoke" your written authorization, except if we have already acted based on your authorization. To revoke an authorization, contact the phone number listed on your ID card.

Highly Confidential Information

Federal and applicable state laws may require special privacy protections for highly confidential information about you. "Highly confidential information" may include confidential information under Federal law governing alcohol and drug abuse information as well as state laws that often protect the following types of information:

- HIV/AIDS;
- Mental health;
- Genetic tests;
- Alcohol and drug abuse;
- Sexually transmitted diseases and reproductive health information; and
- Child or adult abuse or neglect, including sexual assault.

Attached to this notice is a *Summary of State Laws on Use and Disclosure of Certain Types of Medical Information.*

What Are Your Rights

The following are your rights with respect to your health information.

- **You have the right to ask to restrict** uses or disclosures of your information for treatment, payment, or health care operations. You also have the right to ask to restrict disclosures to family members or to others who are involved in your health care or payment for your health care. We may also have policies on dependent access that may authorize certain restrictions. **Please note that while we will try to honor your request and will permit requests consistent with its policies, we are not required to agree to any restriction.**
- **You have the right to ask to receive confidential communications** of information in a different manner or at a different place (for example, by sending information to a P.O. box instead of your home address).
- **You have the right to see and obtain a copy** of health information that may be used to make decisions about you such as claims and case or medical management records. You also may receive a summary of this health information. You must make a written request to inspect and copy your health information. In certain limited circumstances, we may deny your request to inspect and copy your health information.

- **You have the right to ask to amend** information we maintain about you if you believe the health information about you is wrong or incomplete. If we deny your request, you may have a statement of your disagreement added to your health information.
- **You have the right to receive an accounting** of disclosures of your information made by us during the six years prior to your request. This accounting will not include disclosures of information: (i) made prior to April 14, 2003; (ii) for treatment, payment, and health care operations purposes; (iii) to you or pursuant to your authorization; and (iv) to correctional institutions or law enforcement officials; and (v) other disclosures that federal law does not require us to provide an accounting.
- **You have the right to a paper copy of this notice.** You may ask for a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You may obtain a copy of this notice at our website, **www.pacificare.com**.

Exercising Your Rights

- **Contacting your Health Plan.** If you have any questions about this notice or want to exercise any of your rights, please call the customer service phone number on your ID card.
- **Filing a Complaint.** If you believe your privacy rights have been violated, you may file a complaint with us at the following address:

UnitedHealthcare

Customer Service - Privacy Unit

PO Box 740815

Atlanta, GA 30374-0815

You may also notify the *Secretary of the U.S. Department of Health and Human Services* of your complaint. We will not take any action against you for filing a complaint.

Financial Information Privacy Notice

We (including our affiliates listed at the bottom of this page)* are committed to maintaining the confidentiality of your personal financial information. For the purposes of this notice, "personal financial information" means information, other than health information, about an enrollee or an applicant for health care coverage that identifies the individual, is not generally publicly available and is collected from the individual or is obtained in connection with providing health care coverage to the individual.

We collect personal financial information about you from the following sources:

- Information we receive from you on applications or other forms, such as name, address, age and social security number; and
- Information about your transactions with us, our affiliates or others, such as premium payment history.

We do not disclose personal financial information about our enrollees or former enrollees to any third party, except as required or permitted by law.

We restrict access to personal financial information about you to employees and service providers who are involved in administering your health care coverage and providing services to you. We maintain physical, electronic and procedural safeguards that comply with federal standards to guard your personal financial information.

**For purposes of this Financial Information Privacy Notice, "we" or "us" refers to the entities on the first page of the Notice of Privacy Practices, plus the following UnitedHealthcare affiliates: ACN Group, Inc.; ACN Group IPA of New York, Inc.; Alliance Recovery Services, LLC; AmeriChoice Health Services, Inc.; Behavioral Health Administrators; Continental Plan Services, Inc.; Coordinated Vision Care, Inc.; DBP-KAI, Inc.; Disability Consulting Group, LLC; DCG Resource Options, LLC; Definity Health Corporation; Definity Health of New York, Inc.; Dental Benefit Providers, Inc.; Dental Insurance Company of America; Exante Bank, Inc.; Fidelity Benefit Administrators, Inc.; HealthAllies, Inc.; IBA Self Funded Group, Inc.; Illinois Pacific Dental, Inc.; Lifemark Corporation; MAMSI Insurance Resources, LLC; Managed Physical Network, Inc.; Mid Atlantic Medical Services, LLC; Midwest Security Administrators, Inc.; Midwest Security Care, Inc.; National Benefit Resources, Inc.; NPD Dental Services; NPD Insurance Company, Inc.; OneNet PPO, LLC; Oxford Benefit Management, Inc.; Oxford Health Plans LLC; Pacific Dental Benefits; PacifiCare Behavioral Health NY IPA, Inc.; PacifiCare Health Plan Administrators, Inc.; ProcessWorks, Inc.; Spectera of New York, IPA, Inc.; Uniprise, Inc.; United Behavioral Health of New York, I.P.A., Inc.; UnitedHealth Advisors, LLC; UnitedHealthcare Services, Inc.; UnitedHealthcare Services Company of the River Valley, Inc.; UnitedHealthcare Service LLC; United Medical Resources, Inc.*

Summary of State Laws on Use and Disclosure of Certain Types of Medical Information

This information is intended to provide an overview of state laws that are more stringent than the federal *Health Insurance Portability and Accountability Act (HIPAA) Privacy Rules* with respect to the use or disclosure of protected health information in the categories listed below.

Sexually Transmitted Diseases and Reproductive Health	
Disclosure of sexually transmitted diseases and reproductive health related information may be: (1) limited to specified circumstances; and/or (2) restricted by the patient.	HI, MS, NM, NY, NC, OK, WA, VA
Disclosure of sexually transmitted diseases and reproductive health information must be accompanied by a written statement meeting certain requirements.	NM
There are specific requirements that must be followed when an insurer uses or requests sexually transmitted disease tests or reproductive health information for insurance or underwriting purposes.	MS
Alcohol and Drug Abuse	
Disclosure of alcohol and drug abuse information may be: (1) limited to specified circumstances; (2) restricted by the patient; and/or (3) prohibited under certain circumstances.	GA, HI, KY, MA, NH, OK, VA, WA, WI
A specific written statement must accompany any alcohol and drug abuse information disclosures.	WI
Specific requirements must be followed when an insurer uses or requests drug and alcohol tests or information for insurance or underwriting purposes.	KY, VA
Genetic Information	
An authorization is required for each disclosure of genetic information.	CA, HI, KY, LA, RI, TN
Genetic information may be disclosed only under specific circumstances.	AZ, CO, FL, GA, HI, IL, MD, MA, MO, NV, NH, NJ, NM, NY, OR, TX, VT
Restrictions apply to (1) the use; and/or (2) the retention of genetic information.	CO, GA, IL, NV, NJ, NM, OR, VT, WY
Specific requirements must be followed when an insurer uses or requests a genetic test for insurance or underwriting purposes.	FL, IL, IN, LA, NV, WY

HIV/AIDS	
Disclosure of HIV/AIDS related information may only be: (1) limited to specific circumstances; and/or (2) restricted by the patient.	AZ, AR, CA, CO, CT, DE, DC, FL, GA, HI, IL, IN, IA, KY, ME, MA, MI, NH, NJ, NM, NY, NC, OH, OK, OR, PA, TX, UT, VT, VA, WA, WV, WI
A specific written statement must accompany any HIV/AIDS related information.	AZ, CT, KY, NM, OR, PA, WV
Certain restrictions apply to the retention of HIV/AIDS related information.	MA, NH
Specific requirements must be followed when an insurer uses or requests an HIV/AIDS test for insurance or underwriting purposes.	AR, DE, FL, IA, MA, NH, PA, UT, VA, VT, WA, WV
Improper disclosure may be subject to penalties.	DE
Disclosure to the individual and/or designated physician may be required.	MA, NH
Mental Health	
Disclosure of mental health information may be: (1) limited to specific circumstances; (2) restricted by the patient; and/or (3) prohibited or prevented under certain circumstances.	AL, AZ, CA, CO, CT, DC, FL, GA, HI, ID, IL, IN, IA, KY, ME, MA, MD, MI, MN, NM, NY, OK, PA, TN, TX, VT, VA, WA, WV, WI
A specific written statement must accompany any mental health information disclosures.	WI
Specific requirements must be followed when an insurer uses or requests mental health information for insurance or underwriting purposes.	IA, KY, ME, MA, NM, TN, VA
Child or Adult Abuse	
Abuse related information may only be disclosed under specific circumstances.	AL, LA, NM, TN, UT, VA, WI