PacifiCare®

Combined Evidence of Coverage and Disclosure

University of California

2000

You, your doctor and PacifiCare

I N T R O D U C I N G

PacifiCare's HMO Plan

PacifiCare® offers you and your family an exciting choice in health care coverage. As a Member you'll enjoy a wide range of benefits at an affordable cost. You will receive those benefits without claim forms and without paying costly deductibles. Just pay the Copayment as referenced on your Schedule of Benefits. Then relax. We'll take care of the rest.

- Doctor visits are just one Copayment. Some services may require a higher Copayment as referenced in your Schedule of Benefits.
- No claim forms to worry about.
- Worldwide emergency coverage.
- Additional services to help maintain your good health.

Please refer to the Schedule of Benefits at the end of this brochure for your Copayment responsibilities and further applicable plan information.

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

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

Table of Contents

Table of Contents

Benefit Changes Effective January 1, 2000

Hearing Aids

One standard hearing aid per ear up to a total benefit maximum of $2,000 every 36 months will now be provided.

Behavioral Health

Mental Health Inpatient and Alternative Levels of Care are now paid in full when medically necessary.

Substance Abuse Rehabilitation, Inpatient and Alternative Levels of Care are now paid in full when medically necessary.

Clinically and medically necessary services are expanded to include:

- Short-term outpatient counseling, Acute inpatient care, and Alternatives to inpatient treatment which include the following intermediate levels of care:
  - Partial hospitalization,
  - Residential care,
  - Day treatment, and
  - Structured outpatient services.

Outpatient Prescription Drugs

Retail Copayments: $5 Generic/$10 Brand Name

Mail Service Copayments: $10 Generic/$20 Brand Name

Mandatory Generic Substitution Provision applies. If a generic is available and a brand drug is requested by the member or the physician, the member is required to pay the generic copay plus the difference between the cost of the brand and the generic. If a generic equivalent is not available, the member will pay the brand copay for the drug.

Eligibility – Covering Your Family Members

You are eligible to enroll in PacifiCare if you reside within PacifiCare's Service Area in California, select a Participating Medical Group located within a 30-mile radius of your Primary Residence or Primary Workplace, and meet the eligibility requirements defined by the University of California Group Insurance Regulations. Portions of the regulations are summarized below.

Subscriber

Employee: You are eligible if you are appointed to work at least 50% time for one year or more or are appointed at 100% time for three months or more. A person appointed at least 50% time with the following notation on their appointment form is eligible: ending date is for funding purposes only; intent of employment is indefinite (for more than one year).

To remain eligible, employees must maintain an average regular paid time of at least 20 hours a week and maintain an eligible appointment of at least 50% time.

Annuitant (including Survivor Annuitant): You may continue University medical plan coverage when you retire or start collecting disability or survivor benefits from the University of California retirement plan, or any other defined benefit plan to which the University contributes.

These conditions apply:

1. You were enrolled in a University medical plan immediately before retiring;
2. The effective date of your Annuitant status is within 120 calendar days of the date employment ends (or the date of the Employee/Annuitant's death in the case of a Survivor Annuitant);
3. Your monthly check is large enough to cover your portion of any of the medical plan premium;
4. You elect to continue coverage at the time you retire;
5. You meet the University's service credit requirements for Annuitant medical eligibility; and
6. Your medical coverage is continuous from the date employment ends.

Family Members

Spouse: The Subscriber's legal spouse, except if you are a Survivor Annuitant you may not enroll your new spouse.

Child: Any of your natural or legally adopted children who are unmarried and under age 23.

The following children are also eligible:

(a) Any unmarried stepchildren under age 23, who reside with you, who are dependent upon you or your spouse for at least 50% of their support and are your or your spouse's dependents for income tax purposes.

(b) Any unmarried grandchildren under age 23, who reside with you, who are dependent upon you or your spouse for at least 50% of their support and who are your or your spouse's dependents for income tax purposes.

(c) Any unmarried children under age 18 for whom you are the legal guardian, who reside with you, who are dependent upon you for at least 50% of their support and who are your dependents for income tax purposes.

Your signature on the enrollment form, or if you enroll electronically then your electronic enrollment, attests to the conditions in (a), (b), and (c) above. You will be asked to submit a copy annually of your Federal income tax return (IRS Form 1040 or IRS equivalent showing the covered dependent and your signature) to the University to verify income tax dependency.

Any unmarried child, as defined previously (except for a child for whom you are the legal guardian) who is incapable of self-support due to a physical or mental handicap may continue to be covered past age 23 provided:

- the child is dependent upon you for at least 50% of his or her support;
- is your Dependent for income tax purposes;
- the incapacity began before age 23;
- the child was enrolled in a medical plan before age 23; and
- coverage is continuous.

Application must be made to PacifiCare 31 days prior to the child's 23rd birthday and is subject to approval by the Plan. PacifiCare may periodically request proof of continued disability. Your signature on the enrollment form, or if you enroll electronically then your electronic enrollment, attests to these conditions. You will be asked to submit a copy annually of your Federal income tax return (IRS Form 1040 or IRS equivalent showing the covered Dependent and your signature) to the University to verify income tax dependency.

Incapacitated children approved for continued coverage under a University-sponsored medical plan are eligible for continued coverage under any other University-sponsored medical plan. If enrollment is transferred from one plan to another, a new application for coverage is not required.

If you are a newly hired Employee with an over-age, incapacitated Dependent child, you may continue University medical plan coverage for that child under the same general terms as a current employee. The child must have had continuous group medical coverage since age 23, and you must apply for coverage during your "Period of Initial Eligibility" (PIE).

If the over-age handicapped child is not the Employee's, Annuitant's, or Survivor Annuitant's natural or legally adopted child, the child must reside with the Employee, Annuitant or Survivor Annuitant in order for the coverage to be continued past age 23.

Other Eligible Dependents: You may enroll an adult dependent relative or same-sex domestic partner and their Dependents eligible children as set forth in the University of California Group Insurance Regulations. For information on who qualifies and on the requirements to enroll an adult dependent relative or same-sex domestic partner, contact your local Benefits Office.

Eligible persons may be covered under only one of the following categories: as an Employee, as an Annuitant, as a Survivor Annuitant, or as a Dependent, but not under any combination of these. If both husband and wife are eligible, each may enroll separately or one may cover the other as a Dependent. If they enroll separately, neither may enroll the other as a Dependent. Eligible children may be enrolled under either parent's coverage, but not under both.

The University and/or the Plan reserve the right to periodically request documentation to verify eligibility of dependents. Such documentation could include a marriage certificate, birth certificate(s), adoption records, or other such official documentation.

ENROLLMENT

You may enroll yourself and any eligible Dependents during your Period of Initial Eligibility (PIE). The PIE starts the day you become eligible for benefits or acquire a newly eligible Dependent.

You may enroll any newly eligible Dependent below during his or her PIE. The PIE starts the day your Dependent becomes eligible for benefits.

(a) For a new spouse, eligibility begins on the date of marriage. Survivor Annuitants may not add new spouses to their coverage.

(b) For a newborn child, eligibility begins on the child's date of birth.

(c) For newly adopted children, eligibility begins on the earlier of:

  i) the date the Employee or Employee's spouse has the legal right to control the child's health care, or

  ii) the date the child is placed in the Employee's physical custody.

If not enrolled during the PIE beginning on that date, there is an additional PIE beginning on the date that the adoption becomes final.

If you decline enrollment for yourself or your eligible Dependents because of other medical plan coverage and that coverage ends, you may in the future be able to enroll yourself or your eligible Dependents in a medical plan for which you are eligible provided that you enroll within the PIE. The PIE starts on the day the other coverage is no longer in effect.

If you move or are transferred out of a University HMO plan's service area, or will be away from the plan's service area for more than two months, you will have a PIE to enroll in another University medical plan. The PIE begins with the effective date of the move or the date the Employee leaves the service area.

A PIE ends on the date 31 days after it begins (or on the preceding business day for the local Accounting or Benefits Office if the 31st day is on a weekend or a holiday).

To enroll yourself or an eligible Dependent, submit the appropriate enrollment form to the local Accounting or Benefits Office (or enroll electronically) during the PIE.

You and your eligible Dependents may also enroll during a group open enrollment period established by the University.

If you or your eligible Dependent fails to enroll during a PIE or open enrollment period, you may enroll at any other time upon completion of a 90 consecutive calendar day waiting period. The 90 day waiting period starts on the date the enrollment form is received by the local Accounting or Benefits Office and ends 90 consecutive calendar days later.

An Employee who currently has two or more covered Dependents may add a newly eligible Dependent after the PIE. Retroactive coverage for such enrollment is limited to the later of:

(a) a maximum of 365 days prior to the date your Dependent is enrolled (either by receipt of their enrollment form by the local Accounting or Benefits Office or by electronic enrollment), or

(b) the date the Dependent became eligible.

Medicare Enrollment

Annuitants and their Dependents who become eligible for Medicare hospital insurance (Part A) as primary coverage, must enroll and remain in both the hospital (Part A) and the medical (Part B) portions of Medicare. This includes those who are entitled to Medicare benefits through non-University employment.

You should visit your local Social Security Office three months before your 65th birthday to inquire about how you can enroll in Medicare. If you qualify for disability benefits from Social Security, contact your local Social Security Office for information about when you will be eligible for Medicare enrollment.

To enroll in a University-sponsored Medicare plan, simply complete a Medicare declaration form. This notifies the University that you are covered by Part A and Part B of Medicare.

Medicare declaration forms are available from the University of California's Customer Service Center.

Upon receipt by the University of California of confirmation of Medicare enrollment, the Annuitant/Dependent will be changed from the carrier's non-Medicare plan to the Medicare plan.

Anyone enrolled in a risk (lock-in) plan through a non-University group is not eligible for the Medicare risk plan through PacifiCare.

Annuitants or Dependents who are eligible for, but decline to enroll in, both parts of Medicare, will be assessed a monthly offset to cover the increased costs of remaining in the non-Medicare plan.

Annuitants/Dependents who are not entitled to Social Security and Medicare Part A will not be required to enroll in Part B. A notarized affidavit attesting to their ineligibility for Part A will be required. Forms may be obtained from the University's Customer Service Center.

This requirement does not apply to active employees and their Dependents who are age 65 or older and who currently are eligible for medical coverage through their Employer.

For further information, please contact the University of California's Customer Service Center at 1-800-888-8267.

When Does Coverage Begin?

Coverage for newly eligible Employees and their Dependents is effective on the date of eligibility provided they are enrolled (either by receipt of an enrollment form by the local Accounting or Benefits Office or by electronic enrollment) within the Period of Initial Eligibility (PIE).

Coverage for newly eligible Dependents is effective on the date the Dependent becomes eligible provided they are enrolled (either by receipt of an enrollment form by the local Accounting or Benefits Office or by electronic enrollment) within the PIE. There is one exception to this rule: coverage for a newly eligible adopted child enrolling during the additional PIE is effective on the date the adoption becomes final.

For enrollees who complete a 90 day waiting period, coverage is effective on the 91st consecutive calendar day after the date the enrollment form is received by the local Accounting or Benefits Office.

The effective date of coverage for enrollment during an open enrollment period is the date announced by the University.

In order to change from individual to two-party coverage and from two-party to family coverage, you will need to complete a new enrollment form at the local Accounting or Benefits Office (or enroll electronically) within the PIE following the event, e.g., marriage, birth.

Choosing a Physician

As a Member of PacifiCare, you and each family member need to select a Primary Care Physician. The physician you select will provide or coordinate the provisions of your medical and hospital services.

The Physician you and your employed dependents choose must be located within a 30-mile radius of either your Primary Residence or Workplace. All other dependents must select a physician within a 30-mile radius of your Primary Residence. Each family member may choose a different physician.

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

Note: For the definition of a Participating Medical Group please refer to the Definitions section of this brochure.

SELECTING A PHYSICIAN FOR YOUR NEWBORN

You are encouraged to select your baby's Primary Care Physician during your last few months of pregnancy. For the first thirty-one (31) days of the child's life, he or she must be enrolled in a parent's medical group. The child may transfer anytime after. Please contact the PacifiCare Customer Service Department to help you with your selection.

Scheduling Appointments

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

Facilities – Provider Locations

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

Geographic Area ("Service Area")

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

Referrals to Specialists

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

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

This referral may also be reviewed by the Participating Medical Group'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 urgently needed requests.

Standing Referrals to Specialists

You may receive a standing referral to a specialist if your Primary Care Physician determines, in consultation with the specialist and your Participating Medical Group's Medical Director or a PacifiCare Medical Director, that you need continuing care from a specialist. A "standing referral" means a referral by your Primary Care Physician for more than one visit to a participating specialist as indicated in the treatment plan, if any. The standing referral will be made according to a treatment plan approved by your Participating Medical Group or PacifiCare, in consultation with your Primary Care Physician, the specialist, and you, if a treatment plan is considered necessary. The treatment plan may limit the number of visits to the specialist, may limit the period of time the visits are authorized, or may require the specialist to provide your Primary Care Physician with regular reports on the health care provided to you. You may request a standing referral by asking your Primary Care Physician or specialist.

Extended Referral for Coordination of Care by Specialist

If you have a life-threatening, degenerative, or disabling condition or disease that requires specialized medical care over a prolonged period of time, you may receive a referral to a participating specialist or specialty care center that has expertise in treating the condition or disease for the purpose of having the specialist coordinate your health care. To receive an "extended specialty referral" your Primary Care Physician must determine, in consultation with the specialist or specialty care center and your Participating Medical Group's Medical Director or a PacifiCare Medical Director, that this extended specialized medical care is Medically Necessary. The extended specialty referral will be made according to a treatment plan approved by your Participating Medical Group's Medical Director or a PacifiCare Medical Director, in consultation with your Primary Care Physician, the specialist, and you, if a treatment plan is considered necessary. After the extended specialty referral is made, the specialist will serve as the main coordinator of your care, subject to the approved treatment plan. You may request an extended specialty referral by asking your Primary Care Physician or specialist.

Direct Access to OB/GYN Physician Services

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

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

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

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

Continuity of Care for Terminating Physicians

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

If you are receiving treatment for:

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

and your physician is terminated, you may request permission to continue receiving treatment from the terminated physician beyond the termination date by calling PacifiCare. Your Participating Medical Group's Medical Director in consultation with your terminated physician will determine the best way to manage your ongoing care. PacifiCare must preauthorize services for continued care. If you have any questions, or would like a copy of PacifiCare's Continuity of Care Policy, or would like to appeal a denial of your request for continuation of services from your terminated physician, you may call PacifiCare Customer Service Department.

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

Authorization and Denial of Services

PacifiCare of California contracts with Participating Medical Groups and Primary Care Physicians who are responsible for providing and coordinating health care benefits for its Members. Any Primary Care Physician may initiate a referral to a specialist on behalf of a Member. Generally, the referral is submitted to the Primary Care Physician's Medical Group's Utilization Review Committee. Members are generally notified of authorizations by telephone. Members are notified of denials in writing. The Member is notified of his or her right to appeal the denial in the denial notice. The Appeals Process is outlined in the "General Information" section of this brochure. If you would like a more detailed description of PacifiCare of California's Criteria for Authorizing or Denying Health Care Services, you may contact Customer Service at 1-800-624-8822.

Second Medical Opinions

You, or your treating Primary Care Physician, may request a Second Medical Opinion by submitting a request to the Participating Medical Group (or in some cases PacifiCare, therefore you should consult your Primary Care Physician). The request will be evaluated by the Participating Medical Group (or a PacifiCare Medical Director as applicable) based on the nature of the recommended procedure or disease progression and your signs and symptoms. Decisions regarding Second Medical Opinions will be rendered within the following time limits:

- Emergency Procedures – within 24 hours,
- Urgent Procedures – within 72 hours, and
- Elective Procedures – within 14 calendar days.

Second Medical Opinions can only be rendered by a physician qualified to review and treat the medical condition in question. "Out-of-Network" referrals will be approved only when the services requested are not available within the Participating Medical Group (or PacifiCare of California's participating network of providers as appropriate). If a Second Medical Opinion is denied, you may appeal the denial by following the procedures outlined in the "Appeals Process" section of this brochure. For more information, please contact PacifiCare's Customer Service Department.

Arranging Hospitalization

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

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

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

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

Using Emergency or Urgently Needed Services

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

Emergency Services

An Emergency Service is a Medically Necessary Medical or Hospital Service required as a result of a medical condition manifesting itself by the sudden onset of acute symptoms of sufficient severity, which may include severe pain, such that a layperson, who possesses an average knowledge of health and medicine could reasonably assume that the condition requires immediate medical treatment and could expect the absence of immediate medical attention to result in:

- placing your health in serious jeopardy,
- serious impairment to your bodily functions, or
- serious dysfunction of any bodily part.

Emergency Services including medical transportation will be provided for any medical condition that meets this criteria. Examples of emergencies include heart attacks, strokes, poisonings and sudden inability to breathe.

Urgently Needed Services

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

Urgent situations refer to less serious Medical Conditions than emergency situations. Examples include:

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

What to Do When You Require Emergency or Urgently Needed Services

Wherever you are, if you believe that you require Emergency Services or Urgently Needed Services, you should:

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

If you are unable to contact your Primary Care Physician or Participating Medical Group or if the severity of the injury or illness is such that the time required to make the call would reasonably result in a serious deterioration in your health or place your life or health in serious jeopardy, then you should:

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

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

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

Follow-Up Care

If you require additional services following stabilization of an emergency or urgently needed condition, you should obtain these services from or with the authorization of your Primary Care Physician in your Participating Medical Group. **Follow-up care provided in an emergency room is not a covered benefit.**

Out-of-Area follow-up care includes, but is not limited to: Routine follow-up care to Emergency or Urgently Needed Services, such as treatments, procedures, X-rays, lab work and doctor's visits, as well as Rehabilitation Services, Skilled Nursing Care, Custodial Care or home health care.

Non-Qualifying Services

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

Payment Responsibility

Premiums (Prepayment Fees)

The University of California is responsible for submitting employer premium contributions on your behalf to PacifiCare. Any employee contributions that may be required will be communicated to you in advance, by the University of California.

Copayments

When you receive medical care, you may be responsible for paying a minimal charge called a Copayment. Your required Copayment amounts are outlined in the Schedule of Benefits located at the end of this brochure. Your Copayment amounts will vary depending upon where you receive your care.

Annual Copayment Maximum

To protect you from large expenses, a limit, called your annual copayment maximum, is placed on the dollar amount of certain Copayments you might have to pay during a calendar year. When the Copayments you make during any calendar year reach the annual copayment maximum, no further Copayments will be required for covered services received during the remainder of the calendar year.

- It is important to keep receipts of all Copayments made, including Emergency and Urgently Needed Services, in order to submit proof of reaching the annual copayment maximum.
- Please refer to your Schedule of Benefits for the amount of your annual copayment maximum.
- This maximum does not apply to supplemental benefits such as outpatient prescription drugs.
- The family annual copayment maximum is computed at three times the individual maximum.

If you believe you have surpassed your annual copayment maximum, please submit all receipts and a letter of explanation to:

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

Any payments you have made beyond your individual or family annual copayment maximum will be reimbursed.

What If I Get A Bill? (Reimbursement)

If for some reason you are billed for covered services, submit the bill as soon as reasonably possible to:

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

Or call our Customer Service Department at 1-800-624-8822, Monday through Friday 8:00 a.m. to 8:00 p.m.

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

You should know that by law you have certain rights and responsibilities with regard to bills. If you receive properly authorized covered services from a PacifiCare participating provider you are not responsible for paying those bills even in the unlikely event that PacifiCare would be unable to pay them on your behalf. However, if you receive properly authorized covered services from a non-participating provider, or Emergency or Urgently Needed Services from a non-participating provider, you may be responsible for the amount of those bills in the unlikely event that PacifiCare would be unable to pay them on your behalf.

Member Liability

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

- If you choose to receive services not covered or services not under the direction of your Participating Medical Group or Primary Care Physician, you may be responsible for payment of these services. (This does not apply if services were received on an emergency or urgently needed basis.)
- Non-covered services are listed in the "Exclusions and Limitations of Benefits" sections of this brochure.

Coordinating Benefits

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

- PacifiCare coordinates benefits in accordance with the National Association of Insurance Commissioners' guidelines and California law.
- In order to ensure proper coordination, you must inform PacifiCare of any other health coverage for which you or your dependents may be eligible.
- If PacifiCare pays more benefits than appropriate, PacifiCare may recover excess benefit payments from you, the plan with primary responsibility, or any other person or entity that benefited from the overpayment.
- It also should be noted that failure to cooperate with PacifiCare in its efforts to coordinate benefits could result in termination of your membership.

Duplication of Benefits with Medicare

You also need to let PacifiCare know if you are eligible for Medicare benefits.

- PacifiCare may reduce its coverage to avoid duplication of benefits available from Medicare.
- You should be aware that if you are eligible for Medicare, but fail to enroll in Medicare, your PacifiCare coverage will be reduced by the amount you could have received from Medicare.

Non-Duplication of Benefits with Workers' Compensation

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

- It is your responsibility to take whatever action is necessary to receive payment under workers' compensation laws, when such payments can reasonably be expected.
- If PacifiCare happens, for whatever reason, to duplicate benefits to which you are entitled under workers' compensation law, you are required to reimburse PacifiCare, at prevailing rates, immediately after receiving a monetary award, whether by settlement or judgment.
- In the event of a dispute arising between you and your workers' compensation coverage regarding your ability to collect under workers' compensation laws, PacifiCare will provide the benefits described in this agreement until the dispute is resolved.
- If you receive a settlement of workers' compensation which includes payment of future medical costs, you may be liable to reimburse PacifiCare for those costs.

Reimbursement of Third-Party Medical Expenses

If you are ever injured through the actions of another person (a third party) and receive compensation for your medical care, you will be required to reimburse PacifiCare, or its nominee, for the reasonable value of medical services and benefits provided. The amount of reimbursement shall not exceed the amount of compensation you receive from the third party.

- You must obtain PacifiCare's written consent prior to settling any claim, or releasing any third party from liability, if such a release would limit PacifiCare's right of reimbursement.
- Should you settle your claim against a third party and compromise PacifiCare's reimbursement rights, PacifiCare reserves the right to initiate legal action. Attorney fees will be awarded to the prevailing party.
- You are required to cooperate in protecting the interest of PacifiCare by providing PacifiCare with all liens, assignments or other documents. Failure to cooperate with PacifiCare in this regard could result in membership termination.

Extraordinary Circumstances

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

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

Changes in Coverage

Ending Coverage (Termination of Benefits)

Except as provided in any extension of benefits provision, your coverage will end on the earliest of:

Employee

- The last day of the eligible period for which premiums have been paid by the University.
- The date you cease to be eligible for coverage.
- The date you or the University fail to make contributions.
- The date the plan ends.

Dependents

- The date your coverage ends.
- The date you or the University fails to make contributions for Dependent coverage.
- The date your Dependents cease to be eligible for Dependent coverage.

A Dependent's coverage stops on the last day of the month in which he/she is no longer eligible. For spouses, this means the last day of the month when the divorce, legal separation or annulment is final. You are required to complete a new enrollment form when a Dependent is no longer eligible.

In addition, your PacifiCare coverage may terminate under the following circumstances:

- Failure to pay required copayments, premiums or fees for non-covered services.
- Fraud or deception in your enrollment application or in use of facilities or services.
- Allowing unauthorized use of your PacifiCare identification card.
- Consistently uncooperative, abusive, unruly or disruptive behavior that interferes with the provision of services or administration of the plan. In addition, you may be disenrolled for continued refusal of recommended medical treatment.
- Relocation outside of PacifiCare's approved service area.
- Failure to cooperate with PacifiCare's coordination of benefits and third-party liability rights.

If your membership eligibility is terminated, you will be notified in writing of the effective date of termination. Termination of coverage for an employee shall automatically cancel the enrollment of all covered Dependents. If a Dependent's coverage is terminated only the coverage for that Dependent will be canceled.

Under no circumstances will your membership be terminated due to your health status or need for health care services.

If you feel that your membership has been unfairly revoked, you may request a review before the California Department of Corporations. For more information, please contact our Customer Service Department.

Notifying You of Changes in Your Plan

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

Notifying Us of Any Change in Your Status

Please notify us of any change in status to the information you provided on your enrollment application within 30 days of the change. This information includes your address, marital status and the status of any of your dependents. Simply call Customer Service or write to us at:

PacifiCare of California
5701 Katella Avenue
Mail Stop CY24-515
Cypress, CA 90630

Renewal or Reinstatement

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

If you have questions about the University of California's conditions for renewal or reinstatement, please contact your Benefits Office at your place of work.

Continuing Coverage

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

Optional Continuation of Coverage

Under the Consolidated Omnibus Budget Reconciliation Act of 1995 (COBRA), as amended, enrolled persons who would lose coverage under the PacifiCare medical plan due to certain "Qualifying Events" are entitled to elect, without having to submit evidence of good health, continued coverage at their own expense. Continued coverage shall be the same as for active eligible employees and their eligible dependents under the University group plan. If coverage is modified for active eligible employees and their eligible dependents, it shall also be modified in the same manner for persons with continued coverage (Qualified Beneficiaries) and an appropriate adjustment in premiums may be made.

Right to Continue Benefits – A right under this part is subject to the rest of these provisions:

1. You have the right to continue benefits under the plan for yourself and any enrolled dependents if your coverage would have ended for either of the following Qualifying Events:
   (a) because your employment ended for a reason other than gross misconduct; or
   (b) because your work hours were reduced (including approved leave without pay or layoff).

Each of your eligible dependents has the right to continue benefits under the plan under the following circumstances:

2. In the case of your Eligible Dependent spouse, your spouse may continue coverage for himself or herself and for any enrolled dependent children if your spouse's coverage would have ended because of any of the following Qualifying Events:
   (a) because your employment ended for a reason other than gross misconduct; or
   (b) because your work hours were reduced (including approved leave without pay or layoff); or
   (c) at your death; or
   (d) because you became entitled to Medicare benefits; or
   (e) when your spouse ceased to be an Eligible Dependent as a result of divorce, legal separation, or annulment.

If coverage ends under (e) immediately above, please see "Notice" below.

3. In the case of your Eligible Dependent child, your child may continue coverage for himself or herself if your child's coverage would have ended because of any of the following Qualifying Events:
   (a) because your employment ended for a reason other than gross misconduct; or
   (b) because your work hours were reduced (including approved leave without pay or layoff); or
   (c) at your death; or
   (d) because you became entitled to Medicare benefits; or
   (e) because of your divorce, legal separation, or annulment; or
   (f) when your Eligible Dependent child ceased to be an Eligible Dependent under the rules of the plan.

If coverage of an eligible dependent ends due to an event shown in (e) or (f) immediately above, please see "Notice" below.

For the qualifying event (a) or (b), if you became entitled to Medicare due to age within 18 months before the qualifying event, your eligible dependent spouse or your eligible dependent child may continue COBRA coverage for up to 36 months counted from the date you become entitled to Medicare.

If a second Qualifying Event occurs to a Qualified Beneficiary who already has continuation coverage because your employment has ended or work hours were reduced, that Qualified Beneficiary's coverage may be continued up to a maximum of 36 months from the date of the first Qualifying Event.

Notice – If your coverage for an Eligible Dependent ends due to your divorce, legal separation, or annulment, or if your Eligible Dependent child ceases to be an Eligible Dependent under the rules of the plan, you or your Eligible Dependent must give written notice of the event to the Employer at the local Benefits Office within sixty (60) days of the event or eligibility to elect continuation coverage will be lost.

Continuation – Once aware of a Qualifying Event, the Employer will give a written election notice of the right to continue the coverage to you (or to your Qualified Beneficiary in the event of your death). Such notice will state the amount of the premium required for the continued coverage. If a person wants to continue the coverage, the Election Notice must be completed and returned to the address below, along with the first month's premium within sixty (60) days of the later of: (1) the date of the Qualifying Event; or (2) the date the Qualified Beneficiary received notice informing the person of the right to continue.

PacifiCare of California
5701 Katella Avenue
Cypress, California 90630-5028

Benefits of the continuation plan are identical to this group medical plan and cost is explained below under "Cost of Continuation Coverage."

The continued coverage period runs concurrently with any other University continuation provisions (e.g., during leave without pay) except continuation under the Family and Medical Leave Act (FMLA). Coverage will be continued from the date it would have ended until the first of these events occurred:

- With respect to yourself and any Qualified Beneficiaries, the day 18 months from the earlier of the date: (1) your employment ends for a reason other than gross misconduct, or (2) your work hours are reduced. But, coverage may continue for all Qualified Beneficiaries for up to 11 additional months while the Qualified Beneficiary is determined to be disabled under Title II or XVI of the United States Social Security Act if:
  - the disability was determined to exist at the time, or during the first 60 days of the 18 months of COBRA coverage; and
  - the person gives PacifiCare written notice of the disability within sixty (60) days after the determination of disability is made and within 18 months after the date employment ended or work hours were reduced.

  PacifiCare must be notified if there is a final determination under the United States Social Security Act that the person is no longer disabled. The notice must be provided within thirty (30) days after the final determination. The coverage will end on the first of the month that starts more than thirty (30) days after the determination.
- With respect to Qualified Beneficiaries (other than yourself), the day 36 months from the earliest of the date: (1) of your death; or (2) of your entitlement to Medicare benefits; or (3) of your divorce, annulment, or legal separation from your spouse; or (4) your dependent child ceases to be an Eligible Dependent under the rules of the Plan. The 36 months will be counted from the date of the earliest Qualifying Event.

With respect to any Qualified Beneficiary:

- If the person fails to make any premium payment required for the continued coverage, the end of the period for which the person has made required payments.
- The day the person becomes covered (after the day the person made the election for continuation coverage) under any other group health plan, on an insured or uninsured basis. This item by itself will not prevent coverage from being continued until the end of any period for which pre-existing conditions are excluded or benefits for them are limited under the other health plan.
- The day the person becomes entitled to Medicare benefits.
- The day the Employer no longer provides group health coverage to any of its employees.

California Extension of Continuation of Coverage (CalCOBRA) – Employees entitled to COBRA continuation coverage due to employment termination on or after January 1, 1996 are entitled to extend medical coverage for themselves and their spouses after their initial 18-month COBRA period ends, provided the employee was at least age 60 on the date employment ended, had worked for the University for at least five continuous years immediately prior to termination, and was eligible for and elected COBRA continuation medical plan coverage in connection with the termination of employment. This continuation does not apply to children of a former employee. The continuation will end on the earlier of:

- the date the individual turns 65;
- the date the University no longer maintains the group plan, including any replacement plan;
- the date the individual is covered by a group medical plan not maintained by the University;
- the date the individual becomes entitled to Medicare;

- with respect to the spouse or former spouse only, the date five years from the date COBRA ends for the spouse or former spouse.

If the employee's coverage terminates, the spouse may continue coverage until one of the terminating events applies to the spouse. PacifiCare will notify eligible COBRA Qualified Beneficiaries before the end of the maximum eighteen month COBRA continuation period. If an eligible individual wishes to continue the coverage they must apply, in writing, to the medical carrier no later than 30 days before the end of the COBRA continuation period.

Cost of Continuation of Coverage – The cost of the coverage will include any portion previously paid by the Employer and shall not be more than 102% of the applicable group rate during the period of basic COBRA coverage; or not more than 150% any time during the 11-month disability extension period (i.e. during the 19th through the 29th months); or not more than 213% during the extension period allowed by CalCOBRA.

For information on Open Enrollment actions for which a Qualified Beneficiary may be eligible and/or any applicable plan modifications and premium adjustments, contact University of California Human Resources and Benefits at 1-800-888-8267 extension 70651 during the month of November.

(*Please Note:* When your continuation coverage ends, you may be able to convert your coverage to an Individual Conversion Plan if you wish.)

Creditable Coverage

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

Once an individual has accumulated twelve (12) months of creditable coverage, an Employer health plan may no longer apply a pre-existing condition exclusion.

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

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

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

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

Certification of Creditable Coverage

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

If additional information is needed to properly track your coverage history, including employer imposed waiting periods or HMO affiliation periods, you may need to contact your Employer to obtain this information. This Certificate may help you meet the waiting period for pre-existing conditions under another health plan.

Creditable coverage information for eligible Dependents will be included on the Subscriber's Certificate.

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

Individual Conversion

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

Agreement between PacifiCare and your employer for more details concerning individual conversion.

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

Total Disability

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

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

How PacifiCare Participating Providers are Compensated

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

- Most of our Participating Medical Groups receive an agreed-upon monthly payment from PacifiCare to provide services to Members. This monthly payment may be either a fixed dollar amount for each Member or a percentage of the monthly premium received by PacifiCare.
- The monthly payment typically covers professional services directly provided by the Participating Medical Groups and may also cover certain referral services.
- Some of PacifiCare's participating hospitals receive similar monthly payments in return for arranging hospital services for Members. Other hospitals are paid on a discounted fee-for-service or fixed charge per day of hospitalization. Most acute care, subacute care, transitional care and skilled nursing facilities are paid on a fixed charge per day per inpatient care.

At the beginning of each year, PacifiCare and each Participating Medical Group agree on a budget for the cost of services under the program for all PacifiCare Members treated by the Participating Medical Group.

- At the end of the year, the actual cost of services for the year is compared to the agreed-upon budget.
- If the actual cost of services is less than the agreed-upon budget, the Participating Medical Group shares in the savings. The hospital and Participating Medical Group typically participate in programs for hospital services similar to that described above.
- PacifiCare provides stop-loss protection to our Participating Medical Groups and hospitals that receive the monthly payments described above. If any providers do not obtain stop-loss protection from PacifiCare, they must obtain stop-loss insurance from an insurance carrier acceptable to PacifiCare.

You may obtain additional information on PacifiCare's compensation arrangements by contacting PacifiCare or your Participating Medical Group.

Responding to Your Concerns

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

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

PacifiCare Appeals Dept.
5701 Katella/P.O. Box 6006
Cypress, CA 90630

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

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

Appeals Process

1. PacifiCare's Health Services Department will conduct a review, and an initial determination will be sent to the Member within thirty (30) days. If the complaint is related to quality of care, the complaint will be reviewed through the Quality Management Review procedure described below.
2. If the Member is dissatisfied after the determination by the Health Services Department, the Member may request a review by the Physician Review Committee by submitting a request within thirty (30) days of the receipt of the Health Services Department's determination. A hearing before the Physician Review Committee will be scheduled within thirty (30) days of the Member's request for a hearing. The Member's attendance at the Physician Review Committee hearing is encouraged.
3. If the complaint is not resolved to the Member's satisfaction by PacifiCare's Physician Review Committee, the Member may within thirty (30) days request a redetermination. If the complaint involves an issue which requires medical care decision-making, such as a decision regarding a clinical issue, the necessity for treatment, or the type of treatment or level of care proposed or utilized, the complaint will be reviewed by two PacifiCare Medical Directors. If the complaint involves an issue which does not require medical decision-making, it will be reviewed by a PacifiCare Executive Officer. Within thirty (30) days following the Member's request, a redetermination shall be made and sent to the Member.
4. If the Member is dissatisfied with the redetermination the Member may, within sixty (60) days, submit or request that PacifiCare submit the Appeal to voluntary mediation or binding arbitration before an arbitration association.

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

   (ii) Binding Arbitration - Pursuant to California law any claim of up to $200,000 must be decided by a single neutral arbitrator who shall be chosen by the parties and who shall have no jurisdiction to award more than $200,000. However, PacifiCare and the Member may agree in writing to waive the requirement to use a single arbitrator and instead use a tripartite arbitration panel that includes the two party-appointed arbitrators or a panel of three neutral arbitrators, or another multiple arbitrator system mutually agreeable to the parties.

   The Member shall have three business days to rescind the waiver agreement unless the agreement has also been signed by the Member's attorney, in which case the waiver cannot be rescinded. Member agrees to be bound by the rules of procedure and decision of the arbitration association. The provisions of Code of Civil Procedure Section 1283.05, permitting the taking of depositions and the obtaining of discovery, shall apply to the arbitration.

   In cases of extreme hardship, PacifiCare may assume all or part of a Member's share of the fees and expenses of the neutral arbitrator provided the Member has submitted a hardship application with the arbitration association. The approval or denial of a hardship application shall be determined by the arbitration association.

   If a request for binding arbitration is not submitted within sixty (60) days, the redetermination will be final and binding. However, Members who have legitimate health or other reasons which would prevent them from electing binding arbitration within sixty (60) days will have as long as necessary to accommodate their special needs in order to elect binding arbitration. Further, Members who seek review by the Department of Corporations (see "Review by Commissioner of Corporations" in this brochure) within sixty (60) days of the redetermination will have an additional sixty (60) days from the date of the final resolution of the matter by the Department of Corporations to elect binding arbitration.

Upon submission of a dispute to an arbitration association, Member and PacifiCare agree to be bound by the rules of procedure and decision of the arbitration association. The provisions of California Code of Civil Procedure Section 1283.05, permitting the taking of depositions and the obtaining of discovery, shall be incorporated into and made applicable to this Agreement. The arbitrators shall prepare in writing and provide to the parties an award including factual findings and the legal reasons on which the decision is based. The arbitrators shall not have the power to commit errors of law or legal reasoning, and the award may be vacated or corrected pursuant to California Code of Civil Procedure Sections 1286.2 or 1286.6 for any such error.

PACIFICARE AND MEMBER UNDERSTAND THAT BY ENROLLING IN THE PACIFICARE HEALTH PLAN AND AGREEING TO BE BOUND BY THIS AGREEMENT, THEY ARE EACH VOLUNTARILY GIVING UP THEIR CONSTITUTIONAL RIGHT TO HAVE ALL DISPUTES BETWEEN PACIFICARE AND MEMBER, INCLUDING, BUT NOT LIMITED TO, ALLEGATIONS OF MEMBER AGAINST PACIFICARE OF MEDICAL MALPRACTICE AND OTHER DISPUTES RELATING TO THE DELIVERY OF SERVICES UNDER THE PACIFICARE HEALTH PLAN DECIDED IN A COURT OF LAW BEFORE A JURY, AND INSTEAD ARE ACCEPTING THE USE OF BINDING ARBITRATION.

Quality Management Review

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

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

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

Expedited Review

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

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

Independent Third-Party Review

During the PacifiCare appeals process you will be notified an external independent review is available to any member whose appeal has been denied by PacifiCare on the basis that services were not Medically Necessary. PacifiCare's external independent review process provides for consideration by an independent third party and all information regarding your case is held confidential. The external independent review agency will render a decision within 30 days from the date of receipt of your case. An expedited review can be requested for any case for which the standard 30-day timeframe would pose a serious threat to the Member's health. You will be notified of your right to an external independent review in our response to your internal appeal.

Note: This provision of external independent review is subject to change based on pending legislation, regulatory review, and other developing internal processes. This does not apply to members who meet criteria with a terminal condition for Independent External Review of Experimental or Investigational Therapies as described in this brochure, pursuant to Health and Safety Code 1370.4.

Experimental or Investigational Treatment

If the Participating Medical Group or the PacifiCare Medical Director deny a treatment as Experimental or Investigational to a Member who has a terminal illness, PacifiCare, at Member's request, will hold a conference within thirty (30) days of the receipt of request to review the denial and the basis for determining that the

proposed treatment or services are Experimental or Investigational. The conference will be held within five (5) days if the treating physician determines, in consultation with the PacifiCare Medical Director, based on professionally recognized standards of practice, that the effectiveness of either the proposed treatment or services would be materially reduced if not provided at the earliest possible date.

Denials of Experimental or Investigational Therapies for Terminal Illness

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

(ii) External, Independent Review of Experimental or Investigational Therapies – PacifiCare provides an external, independent review process to review its coverage decisions regarding experimental or investigational therapies for PacifiCare Members who meet all of the following criteria:

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

PacifiCare's external, independent review for experimental and investigational treatment will be provided as follows:

If the Member meets all of the criteria listed above, PacifiCare will notify the Member in writing of the opportunity to request the external, independent review within five (5) business days of its decision to deny coverage. If the Member qualifies, the Member may request the external, independent review by calling PacifiCare's Appeals and Grievance Department at 1-800-624-8822 or by sending a written request to:

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

The review will be performed by an impartial, independent review entity that has been accredited by the State of California. The entity will select an independent panel of at least three physicians or other providers who are experts in the treatment of the Member's medical condition and knowledgeable about the recommended treatment. A panel of two experts may be arranged at PacifiCare's request, if the Member consents in writing.

The independent entity may arrange for a panel of one expert only if the independent entity certifies in writing that there is only one expert qualified and able to review the recommended treatment. Neither PacifiCare nor the Member will choose or control the choice of physicians or other provider experts. The costs of the external, independent review will be borne by PacifiCare.

The external, independent review panel will render its analysis and recommendation within thirty (30) days of PacifiCare's receipt of the Member's request for review. If the Member's physician determines that the proposed course of treatment or therapy would be significantly less effective if not promptly initiated, the analysis and recommendation will be rendered within seven (7) days of the request for expedited review.

If the majority of the experts on the panel recommend providing the proposed treatment or therapy, the recommendation will be binding on PacifiCare. If the experts on the panel are evenly divided as to whether the treatment should be provided, the panel's decision will be deemed to be in the Member's favor. If less than a majority of the experts on the panel recommend providing the treatment or therapy, PacifiCare will not be required to provide the treatment or therapy. Coverage for the proposed therapy or treatment will be provided subject to the terms and conditions generally applicable to all other benefits under the Member's PacifiCare Health Plan.

Review by Commissioner of Corporations

The California Department of Corporations is responsible for regulating health care service plans. The department's Health Plan Division has a toll-free telephone number **(1-800-400-0815)** to receive complaints regarding health plans. The hearing and speech impaired may use the California Relay Service's toll-free telephone numbers **(1-800-735-2929 (TTY)** or **1-888-877-5378 (TTY))** to contact the department. The department's Internet website **(http://www.corp.ca.gov)** has complaint forms and instructions online. If you have a grievance against your health plan, you should first telephone your plan at **1-800-624-8822** or **1-800-442-8833 (TDHI)** and use the plan's grievance process before contacting the Health Plan Division. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your plan, or a grievance that has remained unresolved for more than 60 days, you may call the Health Plan Division for assistance. The plan's grievance process and the Health Plan Division's complaint review process are in addition to any other dispute resolution procedures that may be available to you, and your failure to use these processes does not preclude your use of any other remedy provided by law.

Complaints Against Participating Medical Groups, Providers, Physicians and Hospitals

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

Your Rights Under the Plan

As a participant in a University of California Medical Plan, you are entitled to certain rights and protection. All plan participants shall be entitled to:

- Examine, without charge, or instead of or in addition to, at the Plan Administrator's office, and at other specified locations, all plan documents, including the insurance contract.
- Obtain copies of all Plan documents for a reasonable charge upon written request to the Plan Administrator.
- If there is a difference between the University of California Group Insurance Regulations and the PacifiCare Combined Evidence of Coverage and Disclosure or the PacifiCare contract, the University's Group Insurance Regulations will take precedence.

Important Information about Organ and Tissue Donations

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

Almost Anyone Can be a Donor

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

Be Sure to Share Your Decision

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

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

How to Learn More

- To get your donor card and information on organ and tissue donation call 1-800-355-SHARE or 1-800-633-6562
- Request Donor Information from your local Department of Motor Vehicles (DMV)
- On the Internet, contact:
  - All About Transplantation and Donation (www.transweb.org)
  - Dept. of Health & Human Services at (www.organdonor.gov)
- Sign the donor card in your family's presence
- Have your family sign as witnesses and pledge to carry out your wishes
- Keep the card with you at all times where it can be easily found

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

Plan Administration

By authority of The Regents, University of California Human Resources and Benefits, located in Oakland, California, administers this plan in accordance with applicable plan documents and regulations, custodial agreements, University of California Group Insurance Regulations, group insurance contracts/service agreements, and state and federal laws. No person is authorized to provide benefits information not contained in these source documents, and information not contained in these source documents cannot be relied upon as having been authorized by The Regents. The terms of these documents apply if the information in this booklet is not the same. What is written in this booklet does not constitute a guarantee of plan coverage or benefits – particular rules and eligibility requirements must be met before benefits can be received. Health and welfare benefits are subject to legislative appropriation and are not accrued or vested benefit entitlements.

This section describes how the Plan is administered and what your rights are.

Sponsorship and Administration of the Plan

The University of California is the plan sponsor and administrator for the plan described in this brochure. If you have a question, you may direct it to:

University of California
Human Resources and Benefits
300 Lakeside Drive, 5th Floor
Oakland, CA 94612-3557
1-800-888-8267 x70651

Claims under the plan are processed by PacifiCare at the following address and phone number:

PacifiCare of California
P.O. Box 6006
Cypress, CA 90630-6006
1-800-624-8822

Type of Plan

This Plan is a health and welfare plan that provides group medical care benefits. This Plan is one of the benefits offered by the University of California's employee health and welfare benefits program.

Plan Year

The Plan year is January 1 through December 31.

Continuation of the Plan

The University of California intends to continue the Plan of benefits described in this booklet but reserves the right to terminate or amend it at any time. The plan is not a vested plan. The right to terminate or amend applies to all Employees, Annuitants and plan beneficiaries. The University of California will also determine the terms of the plan, such benefits, premiums and what portion of the premiums the University will pay. The portion of the premium the University pays is subject to state appropriation which may change or be discontinued in the future.

Agent for Serving Legal Process

Legal process may be served on PacifiCare at the address listed previously. Legal process may be served on the University of California at the address also listed previously.

Non-Discrimination Statement

In conformance with applicable law and University policy, the University of California is an affirmative action/equal opportunity employer.

Inquiries regarding the University's affirmative action and equal opportunities policies may be directed to Assistant Vice President – Ellen Switkes – Academic Affairs at (510) 987-9479 (for academic employee-related matters) or to Mattie L. Williams – Business and Finance at (510) 987-0865 (for staff employee-related matters.)

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

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

Please take a few moments now to review this important information about your benefits.

Benefits While Hospitalized as an Inpatient

When admitted or authorized by Member's Primary Care Physician in Member's Participating Medical Group, the following benefits are provided. Please refer to the Schedule of Benefits at the end of this brochure for your Copayment responsibilities and further applicable plan information.

Alcohol, Drug or Other Substance Abuse or Addiction

Detoxification is covered when authorized by Member's Primary Care Physician in Member's Participating Medical Group. Medical problems associated with acute alcohol, drug or other substance abuse are covered by PacifiCare. Rehabilitation for alcohol, drug or other substance abuse or addiction is covered as a supplemental benefit (see "Behavioral Health Benefits" section).

Paid in Full

Bone Marrow Transplants

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

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

Experimental or Investigational bone marrow transplants are not covered.

Paid in Full

Hospice Care

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

Paid in Full

Inpatient Hospital Benefits (Acute Care)

Medically Necessary inpatient Hospital Services authorized by Member's Primary Care Physician in Member's Participating Medical Group are covered, including: semiprivate room, intensive care, definitive observation, isolation charges, operating room, recovery room, labor and delivery room, laboratory, diagnostic and therapeutic radiology, nuclear medicine, pharmacy, inhalation therapy, dialysis, EKG, EEG, EMG, blood and blood plasma, anesthesia supplies, surgically implanted devices and implanted breast prosthesis post-mastectomy, private nursing, and professional charges by the hospital pathologist or radiologist, coordinated discharge planning and other miscellaneous hospital charges for Medically Necessary care and treatment.

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

Paid in Full

Inpatient Physician Care

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

Paid in Full

Inpatient Rehabilitation Care (Subacute Care)

Medically Necessary services, as determined by Member's Participating Medical Group or PacifiCare's Medical Director, which are provided in an Inpatient Rehabilitation Facility to train or retrain a Member disabled by disease or injury to Member's highest level of functional ability are covered. Inpatient rehabilitation services include room and board, physical, speech and occupational therapy, and other customarily provided services in an Inpatient Rehabilitation Facility when Medically Necessary.

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

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

Members may call PacifiCare's Customer Service Department to obtain a list of contracting subacute or transitional inpatient care facilities. Members may also call the Customer Service Department to request a copy of PacifiCare's utilization review and prior authorization processes that apply to care provided in subacute care, transitional inpatient care and skilled nursing care facilities.

Paid in Full

Mastectomy/Breast Reconstruction after Mastectomy and Complications from Mastectomy

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

Maternity Care

Complete inpatient hospital benefits as previously described, including delivery by cesarean section, miscarriage, involuntary termination of pregnancy and any complications of pregnancy or childbirth, are covered. Educational courses on lactation, child care and/or child bearing (Lamaze) are not covered.

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

Paid in Full

Newborn Care

Complete prenatal and post-natal Hospital Services including circumcision (if desired) and special care nursery are covered. Coverage for newborn children of the Subscriber begins at birth. For the first thirty-one (31) days of the child's life, he or she must be enrolled in a parents medical group. The child may transfer anytime after. In order for coverage to continue beyond thirty-one (31) days after the date of birth, a Change Request Form for the Dependent must be submitted to PacifiCare within thirty-one (31) days from the date of birth.

Paid in Full

Reconstructive Surgery

Inpatient Reconstructive Surgery is covered when performed to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease to do either of the following:

- To improve function; or
- To create a normal appearance, to the extent possible.

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

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

Paid in Full

Skilled Nursing Care/Transitional Care

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

Paid in Full

Voluntary Interruption of Pregnancy

Refer to your Schedule of Benefits for coverage.

Benefits Available on an Outpatient Basis

The following benefits are available on an outpatient basis when authorized through Member's Primary Care Physician in Member's Participating Medical Group.

Alcohol, Drug or Other Substance Abuse or Addiction

Medical evaluation, detoxification and treatment for withdrawal are covered for substance abuse when authorized by Member's Primary Care Physician in Member's Participating Medical Group. Medical problems associated with acute alcohol, drug or other substance abuse are covered by PacifiCare. Rehabilitation for substance abuse or addiction is covered as a supplemental benefit (please see "Behavioral Health Benefits" section of this brochure).

$5 Copayment

Allergy Testing

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

$5 Copayment

Allergy Treatment

Services necessary for the treatment of allergies pursuant to an established treatment plan are covered. Serum is covered.

$5 Copayment

Ambulance

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

Paid in Full

Attention Deficit Disorder

The medical management of attention deficit disorder (ADD) is covered as prescribed by the Primary Care Physician, including laboratory monitoring of prescribed drugs.

$5 Copayment

Cochlear Implants

Medical and surgical services to implant cochlear devices are covered for bilateral, profoundly hearing-impaired individuals who cannot benefit from conventional amplification (hearing aids). Benefit includes the cochlear device and short-term hearing rehabilitation.

Paid in Full

Durable Medical Equipment, Corrective Appliances and Prosthetics (Purchase or Repair)

Durable Medical Equipment is covered when it is designed and Medically Necessary to assist an injury or illness of the Member and is appropriate for use in the home. Durable medical equipment is medical equipment which is able to exist for a reasonable period of time without significant deterioration. Examples of covered durable medical equipment include glucose monitoring devices, apnea monitoring devices, transneuromuscular stimulator (TENS) devices, wheelchairs, manually-operated hospital beds and oxygen. Special optional attachments or modifications for the convenience of a Member are not covered (see Exclusions herein).

Corrective Appliances are covered when Medically Necessary as determined by the Member's Participating Medical Group. Corrective Appliances are devices such as crutches, trusses, braces or orthotics which are designed to support a weakened body part.

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

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

Corrective appliances, prosthetics and durable medical equipment purchase or rental is limited to initial placement, repair or adjustment, and replacement due to normal wear or because of a significant change in the Member's physical condition (as determined by the Member's Participating Medical Group or PacifiCare's Medical Director).

Paid in Full

Eligible Materials and Supplies

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

Paid in Full

Family Planning

The following services are covered when authorized by Member's Primary Care Physician in Member's Participating Medical Group: vasectomy, tubal ligation, voluntary interruption of pregnancy through the first twenty weeks (voluntary interruption of pregnancy after the 20th week will be covered only when the mother's life is in jeopardy), insertion of intra-uterine device (IUD), insertion of Norplant and the Norplant device and injection of Depo-Provera. However, neither the IUD nor the Depo-Provera medication is covered. For applicable copayments see the Schedule of Benefits at the end of this brochure.

Health Education Services

Counseling classes and educational material on a variety of health subjects such as prenatal care, family planning and diabetes control are provided as presented by the Participating Medical Group health education staff or their designee.

Paid in Full

Hearing Screening

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

$5 Copayment

Hemodialysis

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

$5 Copayment

Home Care

Part-time or intermittent skilled home care is covered when authorized by Member's Primary Care Physician in Member's Participating Medical Group. If extensive home care is required, Member may be required to transfer to an alternative care setting such as a Skilled Nursing Facility. Temporary private duty Skilled Nursing Care to train family members willing and capable of providing care in the home is covered up to sixty (60) consecutive days. Unsuccessful training of the family member may result in placement in an alternative care setting.

Paid in Full

Hospice Care

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

Paid in Full up to a Maximum of one hundred eighty (180) days once per lifetime.

Immunizations

Immunizations for children are covered consistent with the most current version of both of the following: (1) the Recommendations for Preventive Pediatric Health Care, as adopted by the American Academy of Pediatrics; and (2) the most current version of the Recommended Childhood Immunization Schedule/United States, jointly adopted by the American Academy of Pediatrics, the Advisory Committee on Immunization Practices and the American Academy of Family Physicians. The following immunizations may be covered: DPT, DP, Tetanus Toxoid, Oral Polio, Measles, Mumps, Rubella, Hepatitis B, Haemophilus Influenza Type B and Varicella. For children under 2 years of age, refer to Well-Baby Care. Immunizations for adults are covered consistent with the most current version of the U.S. Preventive Services Task Force.

$5 Copayment

Infertility Services

Procedures consistent with established medical practices in the treatment of infertility are covered, including diagnosis, diagnostic tests, medication and surgery. Infertility is defined as either (1) the presence of a demonstrated condition recognized by a Physician as a cause of infertility, or (2) the inability to conceive a pregnancy or to carry a pregnancy to a live birth after a year or more of regular sexual relations without contraception, or after six previous cycles of intra-uterine insemination (not at health plan expense) without pregnancy. However, In-Vitro Fertilization (IVF), Gamete Intrafallopian Transfer (GIFT) and Zygote Intrafallopian Transfer (ZIFT), as well as procedures related to IVF, GIFT and ZIFT, are not covered.

50% of Cost Copayment

Laboratory and Radiology

Diagnostic and therapeutic laboratory and radiology services are covered.

Paid in Full

Maternity Care, Tests and Procedures

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

Paid in Full

Medical Social Services

Referrals to licensed community agencies or social services are covered.

Paid in Full

Mental Health Services (Crisis Intervention Only)

Please note: Additional benefits are covered through PacifiCare Behavioral Health and are described in the Behavioral Health Benefits section of this book.

Outpatient care for Crisis Intervention, up to a maximum of twenty (20) visits each calendar year, is covered when authorized by Member's Primary Care Physician in Member's Participating Medical Group. Crisis Intervention is defined as short-term Medically Necessary treatment required when Member suffers a sudden mental condition which interferes with Member's daily activities and from which Member is

incapable of recovering without assistance. Sessions are covered only until Member is restored to Member's pre-crisis function level. Treatment may be provided by a psychiatrist, psychologist or other duly licensed counselor. Treatment may be limited to group therapy when group therapy is appropriate.

$20 Copayment per visit

Oral Surgery Services

Dental Services are not covered except as expressly provided below. Oral surgical procedures are covered when approved by Member's Participating Medical Group in connection with the following: stabilization and emergency treatment within forty-eight (48) hours of an acute accidental injury to sound natural teeth, jaw bone or surrounding tissues; correction of pathological conditions of a non-Dental origin, such as cleft lip and cleft palate, which have resulted in severe functional impairment. (Severe functional impairment is the inability to maintain nutritional status due to pain with limitation of the jaw system.)

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

Medical Services which relate to the mouth, teeth and gums to the extent they are not Dental are covered. Such Medical Services include biopsy and excision of cysts or tumors, treatment of malignant neoplasm disease and treatment of temporomandibular joint syndrome (TMJ) that causes severe functional impairment. (TMJ is a masticatory muscle disorder or intracapsular disorder. Acute masticatory muscular disorder may occur with joint abnormalities, as characterized by headaches, joint pain or myofacial pain. Acute intracapsular disorder involves internal derangement – for example, mechanical obstruction involving disc displacement. This may manifest with symptoms including preauricular pain and jaw motion restriction.)

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

Paid in Full

Outpatient Medical Rehabilitation Therapy

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

$5 Copayment

Outpatient Surgery

Short-stay, day care or other similar outpatient surgery facility when provided as a substitute for inpatient care as described under the sections of your EOC captioned "Inpatient Hospital (Acute Care)" and "Reconstructive Surgery". Professional Services included as part of Inpatient Physician Care benefit.

Paid in Full

Periodic Health Evaluations

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

$5 Copayment

Physician Care

Medically Necessary diagnostic and treatment services of Member's Participating Medical Group and other licensed health professionals are covered with the prior authorization and referral of the Member's Primary Care Physician in Member's Participating Medical Group, including preventive services, surgical procedures, consultation and treatment. The Member may obtain obstetrical and gynecological physician services directly from an OB/GYN or Family Practice Physician (designated by the Member's Participating Medical Group as providing OB/GYN services) affiliated with your Participating Medical Group. Such benefits are subject to exclusions, limitations and conditions as stated herein. In addition, self-injectable drugs are covered (except for insulin and insulin-related drugs

and immunizations not covered under the immunization benefit) when they are administered during the course of a physician's office visit or self-administered pursuant to training by an appropriate health care professional. (Coverage for insulin and insulin-related drugs is available as part of the Outpatient Prescription Drug.)

$5 Copayment

Vision Refractions

Routine testing to determine the need for corrective lenses (refractive error) is covered every twelve (12) months following Member's initial date of eligibility (frames and lenses excluded). Includes prescriptions for lenses.

$5 Copayment

Vision Screening

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

$5 Copayment

Well-Baby Care

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

Paid in Full

Well-Woman Care

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

$5 Copayment

EXCLUSIONS AND LIMITATIONS

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

General Exclusions

The following services are not covered by PacifiCare.

A. (1) All services not specifically included in this packet, (2) services rendered without authorization from Member's Primary Care Physician in Member's Participating Medical Group (except for Emergency or Urgently Needed Services, or obstetrical and gynecological physician services obtained directly from an OB/GYN or Family Practice Physician (designated by your Participating Medical Group as providing OB/GYN services) affiliated with your Participating Medical Group), and (3) services prior to Member's start date of coverage or after the time coverage ends.

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

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

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

Specific Exclusions

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

Alcoholism, Drug Addiction or Other Substance Abuse
Rehabilitation for chronic alcoholism, drug addiction or other substance abuse is covered through PacifiCare Behavioral Health and is described in the "Behavioral Health Benefits" section of this brochure.

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

Bone Marrow Transplants
Bone marrow transplants are not covered when they are Experimental or Investigational.

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

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

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

ii. Services that offer only a minimal improvement in the member's appearance; or

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

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

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

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

Developmental Disorders
Services that are primarily oriented toward treating a social, developmental or learning problem rather than a medical problem, including autism, dyslexia and behavioral modification therapy, are not covered.

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

Drugs and Prescription Medication
Prescribed and non-prescribed medications are covered as a supplemental benefit as described in the "Outpatient Prescription Drug Program" section of this brochure, except when provided in an inpatient setting. Injectable drugs are covered (except for insulin and insulin-related drugs and immunizations not covered under the immunization benefit) when they are administered during the course of a physician's office visit or self-administered pursuant to training by an appropriate health care professional.

Durable Medical Equipment, Corrective Appliances and Prosthetics
Replacement of lost durable medical equipment, corrective appliances or prosthetics is not covered. Additional optional accessories to durable medical equipment, corrective appliances or prosthetics which are primarily for the comfort or convenience of the Member, including home and car remodeling or modification, are not covered. Prosthetics that require surgical connection to nerves, muscles or other tissues (bionic) are not covered. Prosthetics that have electric motors to enhance motion (myoelectronic) are not covered.

Eating Disorder Programs (Inpatient or Outpatient)
Eating disorder programs for dietary control, surgery or other treatment of obesity are not covered, including, but not limited to, food and food supplements, laboratory tests and medications in association with weight reduction programs, vitamins, gastric bubble or other similar procedures. Phenylketonuria (PKU) formula is limited to ages thirteen (13) and under.

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

Experimental or Investigational Treatment
Experimental or Investigational treatments are not covered. Unless otherwise dictated by federal or state law, decisions as to whether a particular treatment is Experimental or Investigational, and therefore not a covered benefit, are determined by PacifiCare's Medical Director or his or her designee based upon criteria established by PacifiCare's Technology Assessment Committee pursuant to the following guidelines.

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

- It cannot be lawfully marketed without the approval of the United States Food and Drug Administration (FDA) and such approval has not been granted at the time of its use or proposed use;
- It is the subject of a current investigational new-drug or new-device application on file with the FDA;
- It is being provided pursuant to a Phase I or Phase II clinical trial or as the experimental or research arm of the Phase III clinical trial, as these Phases are defined in regulations and other official actions and publications issued by the FDA and the Department of Health and Human Services (HHS);

- It is being provided pursuant to a written protocol which describes among its objectives determinations of safety and/or efficacy as compared with the standard means of treatment;
- It is being delivered or should be delivered subject to the approval and supervision of an Institutional Review Board (IRB) as required and defined by federal regulations and other official actions and publications issued by the FDA and the HHS;
- The predominant opinion among experts as expressed in the published authoritative literature is that usage should be substantially confined to research settings;
- The predominant opinion among experts as expressed in the published authoritative literature is that further research is necessary in order to define safety, toxicity, effectiveness or effectiveness compared with conventional alternatives; or
- It is not Investigational or Experimental in itself pursuant to the above, and would not be Medically Necessary, but for the provision of a drug, device, treatment or procedure which is Investigational or Experimental.

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

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

A terminally ill Member may be entitled to an expedited hearing in cases in which a proposed treatment is denied as Experimental or Investigational as provided in the Subscriber Agreement.

Family Planning
Intra-uterine devices (IUD) and Depo-Provera medication are not covered.

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

Hearing Aids and Implantable Hearing Devices
Audiology services (other than screening for acuity and cochlear devices for bilateral, profoundly hearing-impaired individuals not benefiting from conventional amplification) are covered as a supplemental benefit as described in the "Hearing Aid Benefits" section of this brochure.

Infertility Reversal
Reversal of voluntary sterilization is not covered.

Infertility Services
Ovum transplants, ovum or ovum bank charges, sperm or sperm bank charges, and the Medical or Hospital Services incurred by surrogate mothers are not covered. Medical or Hospital Services following reversal of elective sterilization, including medications and supplies, are not covered. In-Vitro Fertilization (IVF), Gamete Intrafallopian Transfer (GIFT) and Zygote Intrafallopian Transfer (ZIFT), as well as procedures related to IVF, GIFT and ZIFT, are not covered.

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

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

Mental Disorders
Behavioral Health benefits are covered through PacifiCare Behavioral Health as described in the "Behavioral Health Benefits" section of this brochure.

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

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

Nutritional Supplement Formulas
Phenylketonuria (PKU) formula is limited to ages thirteen (13) and under.

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

Organ Transplants
Organ transplants not Medically Necessary and organ transplants considered Experimental or Investigational as defined herein are not covered. The following organ transplants are examples of Experimental or Investigational at the time of printing this brochure: pancreas (alone) transplant or pancreas after kidney transplant.

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

Maintenance therapy and durable medical equipment to assist a Member while traveling outside the Service Area, including but not limited to routine dialysis, routine oxygen or a wheelchair, is not covered.

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

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

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

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

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

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

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

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

Outpatient Prescription Drug Program

Retail:
$ 5 Generic Formulary
$10 Brand Name Formulary Copayment

PacifiCare covers outpatient prescription drugs contained on the PacifiCare Managed Formulary and Non-Formulary drugs pre-authorized by PacifiCare, when ordered by a PacifiCare Participating Physician and filled at a PacifiCare Participating Pharmacy.

How to Use the Prescription Drug Program

- Present your prescription and PacifiCare ID card at any PacifiCare Participating Pharmacy.
- Pay the applicable Copayment for each one-month supply of prescription drugs you have filled or the retail cost of the prescription, whichever is less.
- Receive your medication(s).

What You Will Pay

You will need to pay the applicable Copayment each time a prescription is filled.

You may purchase up to a one-month supply of prescription drugs included on the PacifiCare Formulary through a PacifiCare Participating Pharmacy for the amount of your Copayment.

The Copayment amount for maintenance medications shall be one Copayment for each one-month supply received through a Participating Pharmacy for up to a two (2) month supply. Members may receive up to a three (3) month supply of maintenance medications through the PacifiCare Mail Service Center for the price of two (2) retail Copayments.

If you or your physician request that a prescription be filled with a brand-name drug that has one or more FDA-approved generic equivalents and is not included on PacifiCare's Selected Brands List, you will be required to pay the generic Copayment plus the difference between the cost of the generic drug and the brand-name drug. Prescriptions that are filled with Medically Necessary brand-name drugs and pre-authorized by PacifiCare will be available at the applicable Copayment amount.

The Copayment for specified smoking cessation products is $20 per 30-day supply.

PacifiCare's Formulary

Your PacifiCare Prescription Drug Benefit uses a managed Formulary. This means that you may only receive the drugs listed on the Formulary except when non-Formulary drugs have been pre-authorized by PacifiCare.

What is a Prescription Drug Formulary?

A formulary is a list of preferred medications used to treat health plan members. Formularies have been used for inpatient treatment in hospitals for many years to help ensure quality and affordability. Lately, more and more health care plans have turned to formularies to help achieve these goals. Health plans usually print and distribute their formularies to their participating health care providers yearly. PacifiCare's Formulary is available for your review at www.pacificare.com or by calling PacifiCare's Customer Service department.

Please note: The presence of a medication on the Formulary does not guarantee that your doctor will prescribe that drug to treat your particular medical condition. If you would like additional information about the Formulary or a particular drug, please contact PacifiCare's Customer Services Department or visit PacifiCare's web site at www.pacificare.com.

How Drugs Get on the Formulary

The PacifiCare Formulary includes over 1,600 drugs, both brand name and generic, and has been developed to include medications that cover the majority of medical conditions. In most cases, when a medication is not included on the Formulary, it is because there is a Formulary alternative which can be prescribed for the same condition. The Formulary alternative may be either a brand name or a generic drug. A panel of pharmacists, medical directors, and physicians known as the Pharmacy and Therapeutics Committee developed the PacifiCare Formulary. Formulary deletions occur twice a year. However, drugs may be added more frequently.

The Committee's criteria for including a drug on the PacifiCare Formulary is based on the following attributes of the drug:

- FDA Approved.
- Safety.
- Quality.
- Efficacy (the medication's ability to produce a desired effect).
- Cost.

Only after a medication is deemed to be safe and effective is the cost of the medication considered. For example, if two medications have similar safety and effectiveness factors, but one drug is significantly less expensive than the other, the lower cost medication would be selected for inclusion on the Formulary.

Generic vs. Brand Name Drugs

The PacifiCare Formulary is made up of two types of medications: generic and brand-name drugs. When a pharmaceutical company applies for a patent for a new drug, a generic equivalent cannot be introduced for 17 years from the time the application is filed. But once that term is up, any manufacturer may produce and market the drug under its generic name. Since generics don't have to recoup the research and marketing costs that come with the introduction of a brand-name medication, costs are usually significantly lower. In fact, the average generic drug costs 40% to 70% less than its equivalent brand-name counterpart.

Under the PacifiCare pharmacy plan, a comparable generic product will often be substituted for the brand-name drug, if one is available. This is because:

- Generic drugs have the same active ingredients as the brand-name drug. Only the inactive ingredients, such as the fillers, can differ from the brand-name version. This explains why the generic may be a different color or shape than the brand name.
- Generic drugs must meet FDA standards for identity, strength, quality, purity and potency.
- 70% to 80% of all generic drugs are made by the same pharmaceutical company that manufactured the original brand-name products.
- Generic drugs provide greater value for lower cost.

What Is Covered

When Medically Necessary, the prescription drug benefit will be provided for the following medications contained on the PacifiCare managed Formulary and non-Formulary drugs pre-authorized by PacifiCare, when ordered by a PacifiCare Participating Physician and filled at a PacifiCare Participating Pharmacy.

- Federal Legend Drugs: Any medicinal substance which bears the legend: "Caution: Federal law prohibits dispensing without a prescription."
- State Restricted Drugs: Any medicinal substance which may be dispensed by prescription only according to State law.
- Compounded Medication: Any medicinal substance which has at least one ingredient that is Federal Legend or State Restricted in a therapeutic amount.
- Insulin, insulin syringes, blood glucose test strips, lancets, inhaler extender devices, and anaphylaxis prevention kits.
- Federal Legend oral contraceptives, prescription diaphragms.
- Generic Drugs: For brand-name drugs that have FDA-approved generic equivalents, prescriptions will be filled with a generic drug unless a brand-name drug is Medically Necessary or is on PacifiCare's Selected Brands List. A copy of the Selected Brands List is available to Member upon request from PacifiCare's Customer Service Department. However, the Member or physician may request that a prescription be filled with a brand-name drug that has one or more FDA-approved generic equivalents and is not included on PacifiCare's Selected Brands List by the Member paying the generic Copayment **plus** the difference between the cost of the generic drug and the brand-name drug. Prescriptions that are filled with Medically Necessary brand-name drugs and pre-authorized by PacifiCare will be available to Member at the applicable Copayment amount.
- Specified smoking cessation products when a Member meets nicotine dependency criteria and is enrolled and continues to participate in PacifiCare's StopSmoking Program℠.
- Drugs to treat sexual dysfunction are covered with a limitation. For oral medications, up to 8 pills may be covered per month. Contact the plan for dose limits on other types of sexual dysfunction drugs. You pay 50% of the cost of the medication per prescription unit. These drugs must be medically necessary and pre-authorized by PacifiCare.

Note: PacifiCare reserves the right to require the prior authorization of any drug product to assure adherence to FDA approved indications and national practice standards.

Pre-authorization for All Non-Formulary and Selected Formulary Drugs

All non-Formulary drugs and selected Formulary drugs must be pre-authorized by PacifiCare in order to be covered. Pre-authorization requests may be initiated by Member's PacifiCare Participating Physician. PacifiCare's pre-authorization review process for selected Formulary drugs is to ensure that the drugs are Medically Necessary and being utilized according to treatment guidelines consistent with good professional practice. For a list of the selected Formulary medications that require PacifiCare's pre-authorization, please contact PacifiCare's Customer Service Department. Non-Formulary drugs which are not otherwise excluded from coverage will be pre-authorized in the following instances:

- No Formulary alternative is appropriate and the drug is Medically Necessary for patient care, as determined by PacifiCare, consistent with professional practice.
- The Formulary alternative has failed after therapeutic trial. Member's Participating Physician will be asked to provide a copy of the medical chart notes specifically stating treatment failure with the Formulary alternative.
- The Formulary alternative is not appropriate as determined by a review of physician chart notes.
- The Member has been under treatment and remains stable on a non-Formulary prescription drug and conversion to a Formulary drug would be medically inappropriate.
- The Member experiences typical allergic reaction or established adverse effects relating to the pharmacological properties of the Formulary drug which are attributed to formulations or differences in absorption, distribution or elimination.
- Member's Participating Physician provides evidence in the form of documents, records or clinical trials which establishes that use of the requested non-Formulary drug over the Formulary drug is Medically Necessary, as determined by PacifiCare.

Dispensing Quantity Limitations

The amount of the drug that may be dispensed per prescription or refill will be one Prescription Unit as consistent with good professional practice. Prescriptions requiring greater amounts will be completed on a refill basis, except as explained below.

Maintenance Drug Dispensing

Maintenance drugs may be dispensed for up to a three (3) month supply through the PacifiCare Mail Service Center. These products include, but are not limited to:

- Antiarthritics
- Antiasthmatics
- Anti-clotting drugs
- Antiepileptic drugs
- Antihypertensive drugs
- Antiparkinsons drugs
- Cardiac drugs
- Cholesterol and lipid lowering agents
- Diuretics
- Gastrointestinal drugs
- Glucose test strips
- Hormones
- Insulin and Insulin syringes
- Oral contraceptives
- Oral hypoglycemics
- Prenatal vitamins
- Thyroid suppressants or replacements

Pharmacy Locations

To ensure that members can conveniently fill prescription drugs, PacifiCare's Participating Pharmacy network includes most major pharmacy and supermarket chains and many independent pharmacies. Below is a list of participating PacifiCare pharmacies.

- Albertsons Food & Drug
- Bel Air Pharmacies
- Cardinal Health Pharmacies
- CBC Pharmacies
- Drug Emporium
- Family Care Network
- Friendly Hills Pharmacy
- Gemmel Pharmacy Group
- Horton and Converse
- K-Mart Pharmacies
- Longs Drug Stores
- Lucky
- Major Value Pharmacies
- Managed Pharmacy Care
- Medicine Shoppe Pharmacies
- Medi-Save Pharmacies
- Merrill's Pharmacies
- Network Pharmacies
- OPEN Independent Pharmacies
- PCN Independent Pharmacies
- PCP Independent Pharmacies
- Pharmacy Factors
- Plus Care Pharmacies
- Price/Costco Pharmacies
- Raley's Drug Center
- Rite Aid Pharmacies (Thrifty/Payless)
- Safeway Pharmacies
- Save Mart Pharmacies
- Sav-On Drugs
- Sharp Rees-Stealy Pharmacies
- Shopko
- Talbert Pharmacies
- Target Pharmacy
- UniMed Pharmacies
- United Drug Stores
- UPNI Contracted Pharmacies
- Valu-Rite Pharmacies
- Vons Food & Drug/ Pavilions
- Wal-Mart Pharmacies
- Selected independent pharmacies

You can also access the most up-to-date information on our web site at www.pacificare.com.

If a PacifiCare Participating Pharmacy is Not Available

The Drug Benefit is honored only at PacifiCare Participating Pharmacies. You are eligible for direct reimbursement only if a PacifiCare Participating Pharmacy was not available or accessible. In this situation you will be required to pay the price of the prescription and should file for reimbursement. For direct reimbursement, you must send to PacifiCare the following information:

1. Your prescription receipts from the pharmacy showing the name of the drug, date filled, pharmacy name, and name of Member for whom the prescription was written and proof of payment.
2. A statement describing why a Participating Pharmacy was not available to the Member.
3. The above information should be sent to the following address:

   PacifiCare Pharmacy Department
   P.O. Box 6037
   Cypress, CA 90630

If request for reimbursement is determined to be appropriate, payment will be forwarded to you.

Should you have any questions regarding your PacifiCare Prescription Drug Benefit, please call PacifiCare's Customer Service Department.

PacifiCare Mail Service Program

Mail Service:
$10 Generic Formulary
$20 Brand Name Formulary Copayment

PacifiCare offers a Mail Service Pharmacy Program to members using maintenance medications (medications that are taken on an ongoing basis). With the Mail Service Program, you get the same high quality prescriptions dispensed by registered pharmacists, without ever leaving your home. Our mail service pharmacists are backed by a sophisticated computerized quality control system to prevent possible drug interactions and duplicate therapy.

- If your doctor prescribes an ongoing medication for you, tell him or her you would like to use the Mail Service Pharmacy. Ask for a 90-day prescription with refills.
- Complete the prescription mail order form enclosed with your benefit materials, which you can also obtain from PacifiCare's web site or by calling PacifiCare Customer Service.
- Refer to your Schedule of Benefits for your Mail Service Copayment.

If you have any questions about the Mail Service Program, please call Customer Service.

Prescription Drug Exclusions and Limitations

Prescription drug benefits will not be provided for any prescription covering or prescribed for the following:

- Drugs or medicines not on the PacifiCare Formulary, unless pre-authorized by PacifiCare.
- Drugs or medicines purchased and received prior to the Member's effective date or after the Member's termination.
- Therapeutic devices or appliances including hypodermic needles, syringes (except insulin syringes), support garments and other non-medicinal substances.
- All non-prescription (over-the-counter) contraceptive jellies, ointments, foams and devices.
- Medications to be taken or administered to the eligible Member while he or she is a patient in a hospital, rest home, nursing home, sanitarium, etc.
- Drugs or medicines delivered or administered to the Member by prescriber or the prescriber's staff.
- Dietary supplements including vitamins (except prenatals) and fluoride supplements, health or beauty aids and anorexiants (i.e., diet pills).
- Medication for which the cost is recoverable under any workers' compensation or occupational disease law, any state or government agency, or medication furnished by any other drug or medical service for which no charge is made to the patient.

- Medications prescribed for experimental or investigational therapies, unless required by an external, independent review panel pursuant to California Health and Safety Code Section 1370.4.
- Medications prescribed for experimental or non-FDA-approved indications unless prescribed in a manner consistent with a specific indication in *Drug Information for the Health Care Professional*, published by the United States Pharmacopeial Convention, the *American Medical Association Drug Evaluation*, the *American Hospital Formulary Services edition of Drug Information*, or any other source which reflects community practice standards; medications limited to investigational use by law.
- Medications available without a prescription (over-the-counter) or for which there is a non-prescription equivalent available, even if ordered by a physician.
- Drugs, medicines or cosmetic aids prescribed to primarily improve or otherwise modify the Member's external appearance.
- Medications prescribed by non-participating physicians (except for prescriptions required as a result of an Emergency or Urgently Needed Service for the acute condition).
- Smoking cessation products (other than those available by participating in PacifiCare's StopSmoking Program) including, but not limited to, nicotine gum and nicotine nasal spray. Benefit limited to three times as a PacifiCare Member not to exceed once per twelve (12) month period. Each course of treatment limited to a ninety (90) day supply.
- Injectable drugs (except as listed under Covered Benefits).

Please refer to "Understanding Health Care Terms" for definitions of terms used in this section.

Welcome to PacifiCare Behavioral Health of California (PBHC). Our mission is to give our members quality behavioral health care. We are happy to have you as a member.

- We offer you direct 24-hour access to our services.
- We coordinate and pay for all behavioral health care in your benefit plan.
- You may have some copayments or coinsurance amounts.

What is Behavioral Health?

Behavioral health is a new name for the:

- Treatment of mental health conditions such as depression and anxiety, and
- Treatment of alcohol and drug problems.

What does PacifiCare Behavioral Health of California Do?

PBHC arranges behavioral health care services for our members. We have a large group of participating providers, including:

- Psychiatrists,
- Psychologists,
- Clinical Social Workers,
- and Marriage, Family and Child Counselors.

PBHC arranges all your behavioral health care. You may have some copayments or deductibles – it depends on your benefit plan. Please refer to your Schedule of Benefits for covered services and exclusions and limitations.

Do I need a referral from my Primary Care Physician to get Behavioral Health Services?

No. You can call PBHC by dialing the toll-free number, 1-800-999-9585.

How do I get PBHC services?

Step 1

To get PBHC services, you must call PBHC first. Just dial the toll-free number, 1-800-999-9585.

Step 2

A PBHC staff member will make sure you are an eligible plan member.

Step 3

The PBHC staff member will also ask some questions, such as:

- What are the problems or symptoms you are having?
- Do you already have a participating provider you want to see?
- What kind of provider do you prefer?

Step 4

You will then be given the name and telephone number of a participating provider near your home or work that meets your needs.

Step 5

You call the provider's office to make an appointment.

Step 6

After your first visit, your provider will get approval for any additional services you need that are in the plan. You do not need to call PBHC again.

PBHC staff will check with your participating provider to make sure you are getting the care that you need.

What if I want to change my PBHC provider?

Simply call your PBHC toll-free number at 1-800-999-9585.

If I see a provider who is not part of PBHC's provider network, will it cost me more?

Yes. If you are enrolled in this plan and choose to see a provider who is not part of our network, you will have to pay for the entire cost of the treatment (except in an emergency) with no reimbursement from PBHC. Please refer to your Schedule of Benefits for covered services and exclusions and limitations.

Can I call in the evening or at night?

Yes. If you need behavioral health care after normal business hours, please call your PBHC toll-free number at 1-800-999-9585 for help. A staff member is always there to help.

What is an Emergency?

An emergency is, for example, when a person is suddenly very sick due to a mental illness or a drug or alcohol problem – and this person must be kept from hurting himself/herself or others.

What Happens In An Emergency?

Step 1

In an emergency, get help or treatment immediately. This means you should call 911 if you have to.

Step 2

Then, as soon as reasonably possible, you, or someone acting for you, must call your PBHC toll-free number at 1-800-999-9585. This is important.

Step 3

PBHC will arrange follow-up Behavioral Health Services after an emergency. PBHC may move you to one of its participating providers, as long as the move would not harm your health.

If I am out of state or traveling, am I still covered?

Yes, but only in an emergency. Get treatment immediately. Then, as soon as reasonably possible, call your PBHC toll-free number at 1-800-999-9585 to ensure your emergency treatment is covered. This is important.

Your PBHC toll-free number works anywhere in the United States. From other countries, you can reach PBHC by calling (818) 782-1100.

PBHC will coordinate all follow-up Behavioral Health Services after an emergency. PBHC may move you to one of its participating providers, as long as the move would not harm your health.

About Our Participating Providers

Call your PBHC toll-free number at 1-800-999-9585 for:

- information on PBHC participating providers.
- their office hours,
- background information on all providers such as their education, years of experience, and areas of specialization,
- a copy of the PacifiCare Behavioral Health of California Provider Directory, or
- how to get referrals for specialists in behavioral health.

You can also view a listing of PBHC participating providers, by area, on PBHC's Internet web site at www.pbhi.com

Who are PacifiCare Behavioral Health's Participating providers?

PBHC's Participating providers include hospitals, outpatient drug and alcohol treatment programs, group practices and individual professionals. All participating providers are carefully screened and must meet PBHC licensing and program standards.

What About New Treatments?

PBHC's Medical Director and other professionals meet at least once a year to look at new treatments and programs in behavioral health. These new programs are available to members only after PBHC feels they are safe and effective. You will not be asked to be in any research studies or experiments.

Concurrent Reviews

To determine continuing Medical Necessity for your treatment, concurrent review will occur on a regular basis. During such reviews the PBHC Clinician monitors the course of treatment to determine its effectiveness, appropriate level of care, and continued Medical Necessity. The PBHC Clinician must authorize all extended lengths-of-stay and transfers to different levels of care as well as any related additional services.

Continuing Treatment for New Members

If you:

- were not offered an Out-of-Network option or did not have the option to continue with your previous health plan when you enrolled in this Plan;
- have been eligible and enrolled in this Plan for less than thirty (30) days;
- are under treatment by a non-Participating Provider at time of enrollment for a condition with a DSM-IV diagnosis; and
- have a condition where an immediate change in Practitioner could present a risk of harm to you or others,

these Behavioral Health Services may be covered by PBHC for the purpose of transitioning you to a Participating Provider. If these services are approved, PBHC may cover them to the extent that the services would be covered by a Participating Provider.

For outpatient services, you will be eligible for up to three (3) visits with the non-Participating Provider in order to transition you to a Participating Provider. You must contact PBHC within the first thirty days of PBHC coverage and use these visits within the first 60 days of coverage For inpatient services, PBHC will conduct a full inpatient assessment by a licensed PBHC case manager. If the Behavioral Health Services meet PBHC's Emergency Services criteria, the PBHC case manager will authorize care at the non-participating facility and/or Participating Provider until you are medically stable and able to transfer to a Participating Facility. If the services do not meet PBHC's Emergency Services criteria, PBHC will authorize two (2) days at the non-participating facility and arrange for you to be transferred to a Participating Facility.

What If My Participating Provider is Terminated From the Network?

In the event that your participating provider is terminated by us for reasons other than a medical disciplinary cause, fraud or other criminal activity, you may be eligible to continue receiving care from that provider following the termination, providing the terminated provider agrees to the terms and conditions of the contract. Continued care from the terminated provider may be for up to (90) days if Medically Necessary for chronic, serious or acute conditions, if you are receiving mental health counseling and are in a crisis period, or until your care can be safely transferred to another provider. This continuation will not be applicable if your provider has voluntarily left our network or is no longer part of a Participating Provider Group.

If you have any questions, or would like a copy of our Continuity of Care Policy, you may call our Customer Service Department at 1-800-999-9585.

What If I Get a Bill?

You should not get a bill from your PBHC participating provider. PBHC's participating providers send all their bills to us for payment. You may have to pay a copayment to the providers each time you receive services.

You could get a bill from an emergency room provider if you used emergency care. If this happens, send PBHC a copy of the bill or claim within 90 days of the date of service. If you can't get the bill to us in 90 days, PacifiCare will not deny the claim, provided the claim was submitted as soon as reasonably possible. In any case, PBHC will not pay for bills or claims given to us that are more than one year old.

Mail bills or claims to:

PacifiCare Behavioral Health of California, Inc.
Claims Department
23046 Avenida de la Carlota, Ste. 700
Laguna Hills, CA 92653

PBHC will reimburse non-participating providers of emergency treatment at the applicable percentage of usual and customary charges, as determined by PBHC, less any of your required Copayments. You are responsible for any charges for emergency treatment provided by a non-participating provider that exceed the usual and customary amount.

Non-Emergency Treatment provided by non-Participating Providers and Facilities is not covered by PBHC.

Payment for PBHC Participating Providers

PacifiCare Behavioral Health of California typically contracts with individual Practitioners and behavioral health groups to provide Behavioral Health Services to its Members. In addition, PBHC contracts with Facilities to provide inpatient Behavioral Health Services.

Most of the individual contracted practitioners and facilities receive a discounted fee-for-service payment to provide services to PBHC Members. The behavioral health groups receive a case rate payment from PBHC after the Member's initial visit to the behavioral health group. This case rate payment covers all Behavioral Health Services provided to the Member (within the benefit limits) during the entire treatment year.

Your Financial Responsibilities

PacifiCare will pay for Pre-Authorized Services as outlined in the Schedule of Benefits and as described below.

Copayment

You and your Dependents are responsible for the Copayment amounts specified in the Schedule of Benefits. The Copayment amount may be a specific dollar amount or a percentage of the Participating Provider's charge depending on the service provided.

Deductible

Please refer to your Schedule of Benefits for any applicable deductibles.

Payment for Non-Participating Providers

In the event that PacifiCare Behavioral Health determines the services of a non-participating provider do not meet the definition of Emergency services, the Member may be responsible for the non-participating provider's fees.

Participating Provider Payments

PacifiCare Behavioral Health of California payments are made directly to the Participating Provider according to the Schedule of Benefits.

CALIFORNIA LAW PROVIDES THAT ENROLLEES ARE NOT LIABLE FOR ANY AMOUNT OWED BY PACIFICARE BEHAVIORAL HEALTH OF CALIFORNIA TO ANY PARTICIPATING PROVIDER IN THE EVENT PACIFICARE BEHAVIORAL HEALTH DOES NOT PAY FOR PRE-AUTHORIZED SERVICES.

Second Opinions

You or your Participating Provider may request a second opinion by submitting a request for a second opinion either orally or in writing to PacifiCare Behavioral Health of California. The request will be reviewed and evaluated by a PBHC licensed clinician based on Medical Necessity, the nature of the recommended treatment plan and your current symptoms.

All decisions regarding second opinions will be given within the following time limits:

- Urgent/Emergent treatment within twenty-four (24) hours
- All other treatment within fourteen (14) calendar days

Second opinions may only be rendered by providers qualified to review and treat the condition in question. Request for referrals to non-participating providers for second opinions will be considered only in the event that the services requested are not available within the contracted network of Participating Providers. If your request for a second opinion is denied you may appeal the denial by following the procedures outlined in the Appeals Process section.

Second opinions requested by either you or your treating participating provider and authorized by PBHC will be deducted from your available benefit plan and you will incur the applicable Copayment amount. If a second opinion is requested by PBHC, you will not be required to pay a Copayment and your benefits will not be reduced.

Termination of Benefits

Conditions for Termination

If you threaten the life or well-being of personnel of PBHC or a Participating Provider, or any Member, your coverage will terminate. Please reference the "Ending Coverage" section of this brochure for other conditions for termination.

Whom to Call If You Have a Question or Complaint

Questions or Complaints

If you have a question or problem with PBHC's services or benefits, simply call us at 1-800-999-9585. You may also talk with your employer or union, or check this brochure.

If you wish to file a formal complaint, you may do so over the phone by calling 1-800-999-9585. You can also file a complaint in writing to:

PacifiCare Behavioral Health of California
Appeals Department
P.O. Box 55307
Sherman Oaks, CA 91413-0307

These complaints will be referred to the PBHC Quality Improvement Manager for review and action. All questions and complaints are answered personally and individually. If you disagree with a PBHC decision about an authorization for coverage and/or claim, please call us at the PBHC toll-free Member Service number, or please see "Appeals Process" in this section of this brochure.

Appeals Process

Level 1

After receipt of the complaint, the appeals coordinator shall conduct a review, consult the appropriate parties, including case managers and relevant providers. Cases needing immediate decisions will be reviewed within 72 hours. Upon receipt of your appeal, PBHC will send you an acknowledgement letter indicating who you may contact at PBHC regarding your appeal. Within thirty (30) days of the receipt of the complaint from you, PBHC shall send a written initial determination to you.

Level 2

If you are dissatisfied with the initial determination, you may request a review by the Director of Clinical Services by submitting a written request within fifteen (15) days of the receipt of the initial determination. If you are unable to contact PBHC within fifteen (15) days due to the nature of your illness or because you are undergoing inpatient treatment in a psychiatric hospital, this timeframe may be adjusted accordingly. The Director of Clinical Services shall review your complaint and you will receive a written redetermination within fifteen (15) days of the day the request was received by the Director of Clinical Services.

Level 3

If you are dissatisfied with the determination by the Director of Clinical Services, you may request a hearing before the Customer Satisfaction Committee. Your request for a hearing must be submitted within thirty (30) days from the redetermination. An informal hearing shall be held within thirty (30) days of your request for the hearing. You shall be notified of the hearing time, date and location at least fifteen (15) days prior to the hearing date. You have the option of: (a) attending the hearing in person; (b) submitting a written response to the Customer Satisfaction Committee; or (c) attending the hearing via teleconferencing. A PBHC Clinician will be made available to assist you in your presentation, if you so desire. You shall be notified of the findings of the Customer Satisfaction Committee within thirty (30) days of the hearing.

Level 4

If you are still dissatisfied, you may submit a request to PBHC to submit the complaint to binding arbitration before an arbitration association. Pursuant to California law any claim of up to $200,000 must be decided by a single neutral arbitrator who shall be chosen by the parties and who shall have no jurisdiction to award more than $200,000. However, PBHC and you may agree in writing to waive the requirement to use a single arbitrator and instead use a tripartite arbitration panel that includes the two party-appointed arbitrators or a panel of three neutral arbitrators or another multiple arbitrator system mutually agreeable to the parties. You shall have three (3) business days to rescind the waiver agreement unless the agreement has also been signed by your attorney, in which case the waiver cannot be rescinded.

In cases of extreme hardship, PBHC may assume all or part of your share of the fees and expenses of the neutral arbitrator provided you have submitted a hardship application with the arbitration association. The approval or denial of a hardship application shall be determined by the arbitration association.

If your request is not submitted to the arbitration association within sixty (60) days from the date of receipt of notice from the Customer Satisfaction Committee, the decision of the Customer Satisfaction Committee shall be final and binding. However, if you have legitimate health or other reasons which would prevent you from electing binding arbitration within sixty (60) days, you will have as long as necessary to accommodate your special needs in order to elect binding arbitration.

Further, if you seek review by the Department of Corporations within sixty (60) days of the Customer Satisfaction Committee's redetermination, you will have an additional sixty (60) days from the date of the final resolution of the matter by the Department of Corporations to elect binding arbitration.

Upon submission of a dispute to the arbitration association, both you and PBHC agree to be bound by the rules of procedure and decision of the arbitration Association. Full discovery shall be permitted in preparation for arbitration pursuant to California Code of Civil Procedure, Section 1285.05.

BY ENTERING INTO THIS AGREEMENT, YOU AND YOUR DEPENDENTS AGREE TO GIVE UP YOUR CONSTITUTIONAL RIGHTS TO HAVE ANY DISPUTE DECIDED IN A COURT OF LAW BEFORE A JURY AND INSTEAD ACCEPT THE USE OF ARBITRATION FOR RESOLVING DISPUTES WITH PACIFICARE BEHAVIORAL HEALTH OF CALIFORNIA.

Review by Commissioner of Corporations

The California Department of Corporations (DOC) is responsible for regulating health care service plans. The DOC's Health Plan Division has its own toll-free telephone number **(1-800-400-0815)** to receive complaints regarding health plans. The hearing and speech impaired may use the California Relay Service's toll-free telephone numbers **(1-800-735-2929 (TTY)** or **1-888-877-5378 (TTY))** to contact the department. The Department's internet website **(http://www.corp.ca.gov)** has complaint forms and instructions online.

If you have a grievance against PBHC, you should first telephone PBHC at **1-800-999-9585** and use our grievance process before contacting the Health Plan Division of the DOC. If you need help with a grievance involving an emergency or urgently needed services, a grievance that has not been satisfactorily resolved by PBHC, or a grievance that has remained unresolved for more than 60 days, you may call the Health Plan Division of the DOC for assistance. PBHC's grievance process and the Health Plan Division for assistance. PBHC's grievance process and the DOC's Health Plan Division's complaint review process are in addition to any other dispute resolution procedures that may be available to you, and your failure to use these processes does not preclude your use of any other remedy provided by law.

Quality Review Process

All complaints that involve quality of care issues are referred to the Quality Improvement Manager for review. Complaints that affect the immediate condition of you or your dependent will receive immediate review. You will be notified within five (5) business days of receipt of the complaint of PBHC's procedures for reviewing quality of care complaints. In any case, PacifiCare Behavioral Health of California will investigate your complaint, consulting with PBHC Clinicians, Participating Providers and reviewing medical records as necessary. Upon completion of the review, you will be notified in writing within thirty (30) days. The results of the quality review process are confidential and cannot be shared with you.

Information You Can Request from PBHC

PBHC wants you to have all the information you need to make informed decisions about your care. You may request the following information:

- Provider List, by area.
- Member Rights and Responsibilities.
- Clinical Practice Guidelines.
- Member Satisfaction Survey Results.
- Quality Improvement Program.
- Quality Improvement Evaluation.

Please call PBHC Customer Service if you would like to request information on the topics listed here.

Covered Services

PBHC will pay for the following covered Behavioral Health Services furnished in connection with the treatment of a Mental Health and/or a Chemical Dependency problem. Covered services must be:

(1) incurred while Member is eligible for PBHC benefits;

(2) pre-authorized by a PBHC Clinician; and

(3) rendered by a PBHC Participating Provider, except in the case of Emergency Treatment.

Payments are subject to Copayments as described in the Schedule of Benefits.

Covered Behavioral Health Services include:

- Individualized evaluation of the Member's needs, referral into treatment and monitoring by a PBHC Clinician.
- Behavioral Health Services and supplies Medically Necessary for the treatment of the Member, as authorized by a PBHC Clinician.
- Behavioral Health Services provided by a PBHC Participating Provider, which are received at a PBHC contracted Facility.

- Behavioral Health Services provided at Inpatient Treatment, Residential Treatment and Day Treatment.
- Chemical Dependency Services provided by a PBHC Participating Provider, which are received at a PBHC contracted Facility.
- Chemical Dependency Services provided at Inpatient Treatment, Residential Treatment and Day Treatment.
- Routine Detoxification, as defined in this brochure.
- Outpatient Mental Health Treatment services.
- Outpatient Treatment for Chemical Dependency services.
- Nursing by a Registered Nurse (RN), a Licensed Practical Nurse (LPN), or a Licensed Vocational Nurse (LVN) when Medically Necessary to accompany services provided by a PBHC Participating Provider.
- Practitioner services for individual, group and/or family therapy provided by a Participating Provider.
- Local ambulance service to and from a Facility in the event of an Emergency will be paid at usual and customary rates.
- Laboratory services authorized by a PBHC Clinician related to an approved Treatment Plan.
- Physical examination and intake history which are indicated and Medically Necessary as determined by the PBHC Clinician.
- Psychological testing when pre-authorized by a PBHC Clinician and provided by a licensed psychologist under contract with PBHC.
- Emergency Treatment as defined in this Combined Evidence of Coverage and Disclosure Form.
- Outpatient treatment for an eating disorder, as defined by the DSM-IV, when pre-authorized by a PBHC Clinician.

Exclusions and Limitations

No payment will be made for any of the following:

- Medical Detoxification, as defined in this Evidence of Coverage. (Medical detoxification is covered under the medical plan; see section titled "Benefits Available on an Inpatient Basis.")
- Any confinement, treatment, service or supply not authorized by a PBHC Clinician or his/her designee, except for Behavioral Health Emergency Treatment.
- Any confinement, treatment, service or supply not provided for the treatment authorized by a PBHC Clinician.
- Services which are provided by non-participating providers, except in an Emergency.
- Services, treatment and/or supplies that are provided as a result of workers' compensation law or similar law.
- Services, treatments and/or supplies obtained through or required by any governmental agency or program or any subdivision thereunder including but not limited to services required for treatment of disabilities acquired in the course of military service.
- Services which are predominantly for assistance in the activity of daily living, custodial or domiciliary in nature.
- Weight control programs; treatment for addiction to or dependency on tobacco or nicotine; treatment for caffeine dependency or dependency on any food substance.
- Services, treatments, and/or supplies deemed to be Experimental or Investigational by PBHC's Medical Director or his/her designee.
- Treatment or psychological testing for any reading or learning disorder, mental retardation, autism or other developmental disability. (See Attention Deficit Disorder in the section titled "Benefits Available on an Outpatient Basis" for specific medical coverage.)

- Counseling for adoption, custody, family planning or pregnancy in the absence of a DSM-IV diagnosis.
- Counseling in preparation for, or associated with, a sex change operation.
- Sexual therapy, including without limitation, therapy for sexual addiction, use of sexual surrogate, sexual treatment of sexual offenders or perpetrators of sexual violence.
- Pastoral or Spiritual counseling.
- Dance, poetry, music or art therapy, except as part of a treatment program.
- Non-organic therapies including but not limited to the following: bioenergetic therapy, confrontation therapy, crystal healing therapy, educational remediation, EMDR, guided imagery, marathon therapy, primal therapy, rolfing, sensitivity training, training analysis (tuitional, orthodox), transcendental meditation, Z therapy.
- Organic therapies including but not limited to the following: aversion therapy, carbon dioxide therapy, environmental ecological treatment or remedies, herbal therapies, hemodialysis for schizophrenia, vitamin or orthomolecular therapy, narcotherapy with LSD, and sedative action electrostimulation therapy.
- Private rooms and/or private duty nursing unless Medically Necessary as determined by a PBHC Medical Director or his/her designee.
- All non-prescription and prescription drugs, except when prescribed by a PBHC Participating Provider in connection with a Member's treatment as an inpatient at a Participating acute care Facility. Additional drug coverage is available under the "Outpatient Prescription Drug" benefit as described in this brochure.
- Surgery or acupuncture.
- Services required by court order as a condition of parole or probation, or in lieu of incarceration which are not Medically Necessary.
- Services which are not Medically Necessary for the treatment of Behavioral Health Disorders or Chemical Dependency Disorders.
- Long-term, insight-oriented psychotherapies designed to regress the Member emotionally or behaviorally.
- Personal enhancement or self-actualization development and other programs.
- Services provided by a non-licensed provider.
- Neurological services and tests, including but not limited to, EEGs, PET scans, beam scans, MRIs, skull X-rays and lumbar punctures.
- Treatments which do not meet national standards for mental health professional practice.
- Treatment sessions provided by telephone or computer Internet services.
- Methadone maintenance or treatment.
- Durable medical goods.
- Evaluation or treatment for education or professional training, investigational purposes related to employment, fitness for duty evaluations and career personnel counseling.

50% coinsurance per device
Maximum: $2,000 every 36 months

Hearing aid expenses for members are covered as follows:

Benefits

Hearing Aid Benefits include but are not limited to:

- An audiometric examination by an audiologist when authorized through the Member's Participating Medical Group. The associated office visit copayment applies.
- Hearing aids or ear molds – One appliance per ear as listed above per Member, every 36 months when Medically Necessary to provide functional improvement and when authorized through the Member's Participating Medical Group and obtained from a participating PacifiCare provider. No more than $2,000 will be paid every 36 months for all covered hearing aids combined.

Limitation

Coverage expenses relating to hearing aids are limited to the usual and customary charge of a basic hearing aid to provide functional improvement.

Exclusions

Certain hearing aid services are not covered, including but not limited to the following:

- Replacement of a hearing aid that is lost, broken or stolen within 36 months of receipt.
- Repair of the hearing aid and related services.
- Surgically implanted hearing devices.
- Services or supplies for which a Member is entitled to receive reimbursement under any applicable Workers' Compensation law.
- Services or supplies rendered to a Member after cessation of the coverage on his or her account, except that, if a hearing aid is ordered while coverage is in force on account of such Member and such a hearing aid is delivered within 60 days after the date of such cessation, such hearing aid will be considered a covered hearing aid expense.
- Services or supplies which are not necessary according to professionally accepted standards of practice, or which are not recommended or authorized by the Member's Participating Medical Group.
- An eyeglass-type hearing aid or additional charges for a hearing aid designed specifically for cosmetic purposes.

Understanding Health Care Terms

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

Medical Health Terms

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

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

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

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

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

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

Emergency Services are Medically Necessary Medical or Hospital Services required as a result of a medical condition manifesting itself the sudden onset of symptoms of sufficient severity, which may include severe pain, such that a layperson, who possesses an average knowledge of health and medicine could reasonably assume that the condition requires immediate medical treatment and could expect the absence of immediate medical attention to result in (1) placing the Member's health in serious jeopardy, (2) serious impairment to bodily functions or (3) serious dysfunction of any bodily part.

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

Experimental or Investigational Treatment is defined under "Exclusions and Limitations of Benefits."

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

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

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

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

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

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

Medically Necessary refers to Medical or Hospital Services which are determined by PacifiCare or the Participating Medical Group's Utilization Review Committee to be:

1. Rendered for the treatment or diagnosis of any injury or illness.
2. Appropriate for the symptoms, consistent with diagnosis, and otherwise in accordance with generally accepted medical practice and professionally recognized standards.
3. Not furnished primarily for the convenience of the Member, the attending physician, or other provider of services.
4. Furnished in the most cost-effective manner which may be provided safely and effectively to the member. Hospital inpatient services are Medically Necessary only if they require an overnight setting and could not be provided in a physician's office, the outpatient department of a hospital or in another appropriate facility without adversely affecting the Member's condition or the quality of medical care rendered.

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

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

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

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

Physician includes any licensed allopathic or osteopathic physician.

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

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

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

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

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

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

Reasonable and Customary charges refers to the commonly charged or prevailing fees for health services within a geographic area. A fee is considered to be reasonable if it falls within the parameters of the average or commonly charged fee for the particular service within that specific community.

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

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

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

Skilled Care refers to skilled nursing services or physical therapy services which are Medically Necessary, ordered by Member's Participating Medical Group, required to be provided by a licensed nurse or a licensed physical therapist and above the level of Custodial Care.

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

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

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

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

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

Outpatient Prescription Drug Benefit Terms

Formulary means a continually updated list of prescription medications that are approved by the PacifiCare Pharmacy and Therapeutics ("P&T") Committee, which is comprised of physicians and pharmacists. The Formulary contains both brand-name drugs and generic drugs, all of which have Food and Drug Administration ("FDA") approval.

Participating Pharmacy means a pharmacy that has contracted with PacifiCare to provide outpatient prescription drugs to Members at negotiated costs.

Non-Participating Pharmacy means a pharmacy that has not contracted with PacifiCare.

Pre-authorization means the review process whereby PacifiCare determines the Medical Necessity of a prescription drug prior to the Member receiving such prescription drug from a pharmacy.

Prescription Unit means the maximum amount (quantity) of medication that may be dispensed per single Copayment. For most oral medications, a Prescription Unit represents a thirty (30) day supply of medication. A Prescription Unit may be set at a smaller quantity for the Member's protection and safety, as determined by the manufacturer's package insert.

Selected Brands List means the brand-name drugs included on the PacifiCare Formulary in lieu of their generic equivalents.

Behavioral Health Terms

Alternative Levels of Care refers to the least restrictive level of care used to return Member to the pre-Crisis level of function. Alternative Levels of Care, including partial day and day treatment, are used in lieu of inpatient hospitalization.

Assessment Process is the process by which a PacifiCare Behavioral Health Clinician gathers information to determine Medical Necessity. The Member is asked a series of questions about the current life circumstances that are contributing to his/her behavioral health Crisis. The interview includes specific questions about areas of emotional duress and to what degree there is an impairment of functioning at the member's work, leisure and daily activities. The information is quantified numerically to determine the severity of the Member's condition and the appropriate level of care, and to monitor the effectiveness of treatment.

Behavioral Health Services are services rendered or made available to a Member for treatment of Chemical Dependency or Mental Disorders.

Behavioral Health Treatment Program is a structured treatment program aimed at the treatment and alleviation of Chemical Dependency or Mental Disorders.

Behavioral Health Treatment Plan is a written clinical presentation of the Participating Providers diagnostic impressions and therapeutic intervention plans. The Behavioral Health Treatment Plan is submitted routinely to the PBHC Clinician for review as part of the concurrent review monitoring process.

Calendar Year is the period of time commencing at 12:01 a.m. on January 1 and ending at 12:01 a.m. on the next January 1. Each succeeding like period will be considered a new Calendar Year.

Chemical Dependency is an addictive relationship between a Member and any drug, alcohol or chemical substance that can be documented according to the criteria in the DSM-IV. Chemical Dependency does not include addiction to or dependency on (1) tobacco in any form, or (2) food substances in any form.

Chemical Dependency Services are Behavioral Health Services for the treatment of Chemical Dependency.

Copayments are fees payable pursuant to this Agreement by the Member at the time of provision of Behavioral Health Services to a Participating Provider which are in addition to the Premiums paid by the Employer Group. Such fees may be a specific dollar amount or a percentage of total fees as specified herein, depending on the type of services provided.

Crisis is the sudden onset of severe behavioral symptoms and impairment of functioning due to a Mental Disorder or Chemical Dependency that in the absence or delay of medical attention and/or Behavioral Health Services would result in:

- serious injury to life or limb, and/or
- serious and permanent dysfunction to the Member.

Customer Service Department (for Supplemental Behavioral Health Services) is the department designated by PacifiCare Behavioral Health to whom oral or written Member issues may be addressed. The Customer Service Department may be contacted by telephone at 1-800-999-9585 or in writing at:

Customer Service Department
PacifiCare Behavioral Health of California, Inc.
5990 Sepulveda Blvd., Suite 400
Van Nuys, CA 91411.

Day Treatment Center is a Facility which provides a specific Behavioral Health Treatment Program on a full or part-day basis pursuant to a written treatment plan approved and monitored by a Practitioner, and which Facility is also licensed, certified or approved as such by the appropriate state agency.

Diagnostic and Statistical Manual (DSM-IV) – The fourth edition of the Diagnostic and Statistical Manual of Mental Disorders, which is published by the American Psychiatric Association and which contains the criteria for diagnosis of Chemical Dependency and Mental Disorders.

Emergency or **Emergency Services** Medically Necessary Behavioral Health circumstances which manifest themselves by acute symptoms of sufficient severity such that a layperson, who possesses an average knowledge of health and medicine could reasonably assume that the condition requires immediate medical treatment and could expect the absence of immediate Behavioral Health Services to result in:

- immediate harm to self or others;
- placing the Member's health in serious jeopardy;
- serious impairment of the Member's functioning; or
- serious and permanent dysfunction of the Member.

Emergency Facility is the medical acute facility, clinic emergency room or Inpatient Treatment Center.

Emergency Treatment is the immediate and unscheduled screening, examination, and evaluation of a Member by a Practitioner at a Facility to determine if an Emergency exists. If an Emergency is found to exist, Emergency Treatment will include the care and treatment by the Practitioner and Facility necessary to relieve or eliminate the Emergency Condition, within the capability of the Facility.

Experimental or Investigational Treatment is an investigatory or an unproven procedure or treatment regimen that does not meet the generally-accepted standards of usual professional medical practice in the general medical community.

Facility is a facility which is duly licensed by the state in which it operates to provide inpatient, day treatment, partial hospitalization or outpatient care for the diagnosis and/or treatment of Chemical Dependency or Mental Disorders.

Group Therapy is goal-oriented Behavioral Health Service provided in a group setting (6-12 participants) by a PBHC Participating Practitioner. Group Therapy can be made available to the Member in lieu of individual outpatient therapy when appropriate.

Inpatient Treatment Center is an acute care Facility which provides Behavioral Health Treatment Services in an acute, inpatient setting, pursuant to a Behavioral Health Treatment plan approved and monitored by a Practitioner, and which Facility also:

1. provides a 24-hour nursing and medical supervision;
2. has established a written referral relationship with a local hospital for patients beyond its scope of treatment capability; and
3. is licensed, certified or approved as such by the appropriate state agency.

Maximum Benefit is the lifetime maximum amount which PBHC will pay for any authorized Behavioral Health Services provided to Members by Participating Providers under the PBHC plan.

Medical Detoxification is treatment for an unstable or acute medical condition exacerbated by the withdrawal from chemical substances including drugs or alcohol, including, but not limited to, diabetes mellitus, hypertension or serious withdrawal complications, such as delirium tremens or seizures, which is provided at an Emergency Facility or Inpatient Treatment Center. Such treatment includes a complete history and physical examination and medical supervision of Member's medical records. Medical Detoxification is NOT covered under Mental Health benefits but is covered under the PacifiCare medical plan.

Medically Necessary refers to Behavioral Health Services or supplies for treatment of a Mental Disorder or Chemical Dependency which have been established in accordance with the generally accepted professional standards and PBHC's Medical Director or designee. The following standards have been established to determine if a service or supply is Medically Necessary.

- Rendered for the treatment and diagnosis of a severe Mental Disorder and Chemical Dependency, as defined by the DSM-IV and limited to severe impairment of a Member's mental, emotional or behavioral functioning.
- Appropriate for the severity of symptoms, consistent with diagnosis, and otherwise in accordance with generally accepted medical practice and professionally recognized standards;
- Not furnished primarily for the convenience of the Member, the attending physician, or other provider of service; and
- Furnished at the most appropriate level which may be provided safely and effectively to the Member.

Mental Disorder is a mental or nervous condition, diagnosed by a licensed Practitioner according to the criteria in the DSM-IV and limited to the impairment of a Member's mental, emotional or behavioral functioning on a daily basis.

Mental Health Services are Behavioral Health Services for the treatment of Mental Disorders.

Non-Crisis Therapy is therapy provided in those situations in which the Member's condition is stabilized and/or his or her condition is such that there is no reasonable expectation of improvement with Crisis Intervention.

Outpatient Treatment Center is a licensed or certified Facility which provides a Behavioral Health Treatment Program in an outpatient setting.

PBHC Clinician is a person licensed as a psychiatrist, psychologist, clinical social worker, marriage, family and child counselor, nurse or other licensed health care professional with appropriate training and experience in Behavioral Health Services, who is employed or under contract with PBHC, to perform case management services.

Participating Facility is a Facility which has contracted with PBHC to furnish Behavioral Health Services to Members and has agreed to accept the provisions of the applicable agreement, including the facility-specific compensation, plus any applicable Copayment, as the total charge.

Participating Practitioner is a Practitioner who has contracted with PBHC to provide Behavioral Health Services to Members and who has agreed to accept the provisions of the applicable agreement, including the contractually agreed upon compensation plus any applicable Copayments, as the total charge.

Practitioner is a psychiatrist, psychologist, registered nurse, licensed clinical social worker or a marriage, family and child counselor who is duly-licensed or certified under the laws of the State of California and who provides Behavioral Health Services.

Preferred Group Practice (PGP) Behavioral Health Group is a provider group or independent practice association duly organized and licensed under the laws of the State of California to provide Behavioral Health Services through agreements with individual behavioral health care providers, each of whom is qualified and appropriately licensed to practice his or her profession in the State of California.

Routine Detoxification is routine treatment and stabilization for symptoms resulting from withdrawal from chemical substances, including drugs or alcohol, which is provided at a PBHC Participating Provider without the necessity of intensive nursing, monitoring or procedures such as intravenous fluids. In order to obtain Routine Detoxification services, the Member must first obtain medical clearance from his or her Primary Care Physician under his or her medical or health plan.

Schedule of Benefits is the schedule of Behavioral Health Services, which is provided to a Member under this Supplemental Benefit.

Short-Term Inpatient Treatment is inpatient admission for Behavioral Health treatment for Mental Disorders and Chemical Dependency that are responsive to short-term treatment and are not chronic or organic in nature.

Short-Term Outpatient Treatment is Outpatient Behavioral Health treatment for Mental Disorders and Chemical Dependency Disorders that are responsive to short-term treatment and are not chronic or organic in nature.

Treatment Episode is a structured course of treatment authorized by a PBHC Clinician and for which a Member has been admitted to a Facility, received Behavioral Health Services and been discharged.

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

Visit is an outpatient session with a Participating Practitioner conducted on an individual or group basis during which Behavioral Health Services are delivered.

You means Subscriber and/or any covered dependents.

Schedule of Benefits

Medical Schedule of Benefits

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

DEDUCTIBLE	**–0–**
MAXIMUM BENEFITS	**UNLIMITED**
ANNUAL COPAYMENTS MAXIMUM	**$800/INDIVIDUAL** **$2,400/FAMILY**
OFFICE VISITS	$5 copayment
HOSPITALIZATION	**PAID IN FULL**
EMERGENCY SERVICES	$35 copayment *Waived if admitted as an inpatient*
URGENTLY NEEDED SERVICES (Medically Necessary Services required outside your Service Area)	$35 copayment *Waived if admitted as an inpatient*
PRE-EXISTING CONDITIONS	All conditions covered provided they are covered benefits.

Benefits Available While Hospitalized as an Inpatient

ALCOHOL, DRUG, OR OTHER SUBSTANCE ABUSE OR ADDICTION (Detoxification only)	**PAID IN FULL**
HOSPICE CARE (Up to one-hundred eighty (180) days in a Facility or on an outpatient or home care hospice basis per lifetime)	**PAID IN FULL**
INPATIENT HOSPITAL BENEFITS (Autologous (self-donated) blood up to $120.00 per unit)	**PAID IN FULL**
INPATIENT PHYSICIAN CARE	**PAID IN FULL**
INPATIENT REHABILITATION CARE	**PAID IN FULL**
MATERNITY CARE	**PAID IN FULL**
NEWBORN CARE	**PAID IN FULL**
SKILLED NURSING CARE (Up to one-hundred (100) calendar days following a new qualifying condition)	**PAID IN FULL**
VOLUNTARY INTERRUPTION OF PREGNANCY	
▮ 1st trimester	**PAID IN FULL**
▮ 2nd trimester (12-20 weeks)	**PAID IN FULL**
▮ After 20 weeks	Not covered*

* Voluntary interruption of pregnancy after the 20th week will be covered only when the mother's life is in jeopardy.

Benefits Available on an Outpatient Basis

ALCOHOL, DRUG, OR OTHER SUBSTANCE ABUSE OR ADDICTION (Detoxification only)	$5 copayment
ALLERGY TESTING/TREATMENT (Serum is included)	$5 copayment
AMBULANCE	**PAID IN FULL**
ATTENTION DEFICIT DISORDER (Medical Management)	$5 copayment
DURABLE MEDICAL EQUIPMENT CORRECTIVE APPLIANCES AND PROSTHETICS	**PAID IN FULL**
ELIGIBLE MATERIALS AND SUPPLIES	**PAID IN FULL**
FAMILY PLANNING/VOLUNTARY INTERRUPTION OF PREGNANCY	
▮ Vasectomy	$5 copayment
▮ Tubal ligation	$5 copayment
▮ Insertion/removal of intra-uterine device (IUD)	$5 copayment
▮ Intra-uterine device (IUD)	Not covered
▮ Insertion/removal of Norplant	$5 copayment
▮ Norplant device	$200 copayment/course of treatment
▮ Depo-Provera injection	$5 copayment
▮ Depo-Provera medication	Not covered
▮ Voluntary interruption of pregnancy	
1st trimester	$5 copayment
2nd trimester (12-20 weeks)	$5 copayment
After 20 weeks	Not covered*
HEALTH EDUCATION SERVICES	**PAID IN FULL**
HEARING SCREENING	$5 copayment
HEMODIALYSIS	$5 copayment
HOME CARE	**PAID IN FULL**
HOSPICE CARE – OUTPATIENT BASIS AND IN-HOME VISITS (Up to one-hundred eighty (180) days in a Facility or on an outpatient basis per lifetime)	**PAID IN FULL**
IMMUNIZATIONS (For children under two years of age, refer to Well-Baby Care)	$5 copayment
INFERTILITY SERVICES	50% copayment
LABORATORY AND RADIOLOGY	**PAID IN FULL**
MATERNITY CARE, TESTS AND PROCEDURES	**PAID IN FULL**
MEDICAL SOCIAL SERVICES	**PAID IN FULL**
MENTAL HEALTH SERVICES • For additional benefits, See "Behavioral Health Benefits." • Up to twenty (20) visits for crisis intervention only during each calendar year following your initial date of eligibility. • A copayment may be charged for missed scheduled appointments.	$20 copayment per visit

* Voluntary interruption of pregnancy after the 20th week will be covered only when the mother's life is in jeopardy.

Schedule of Benefits

ORAL SURGERY	**PAID IN FULL**
OUTPATIENT REHABILITATION THERAPY	$5 copayment
OUTPATIENT SURGERY	**PAID IN FULL**
PERIODIC HEALTH EVALUATIONS Physician, laboratory, radiology and related services as recommended by the American Academy of Pediatrics (AAP) and U.S. Preventive Services Task Force and authorized through 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.	$5 copayment
PHYSICIAN CARE	$5 copayment
VISION REFRACTIONS	$5 copayment
VISION SCREENING	$5 copayment
WELL-BABY CARE Preventive health service, including immunizations, recommended by the American Academy of Pediatrics (AAP) 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.	**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.	$5 copayment

Except in the case of Medically Necessary Emergency or an Urgently Needed Service (outside your Service Area), each of the above noted benefits are covered when authorized by your Primary Care Physician in your Participating Medical Group. Where the recommended service involves hospital admission or referrals, your Physician's recommendation may receive a second opinion review by a Utilization Review Committee. The committee is designed to promote the efficient use of resources while maintaining quality care for a Member.

Outpatient Prescription Drug Program Schedule of Benefits

RETAIL	
Generic and Selected Brand Name Drugs	$5 copayment
Brand Name Drugs	$10 copayment
MAIL SERVICE (UP TO 90 DAY SUPPLY)	
Generic and Selected Brand Name Drugs	$10 copayment
Brand Name Drugs	$20 copayment

Hearing Aid Benefit Schedule of Benefits

HEARING AIDS	50% coinsurance per device
MAXIMUM BENEFIT	$2,000 every 36 months

Behavioral Health Schedule of Benefits

MENTAL HEALTH SERVICES	
Deductible	None
Inpatient and Alternative Levels of Care*	**PAID IN FULL**
Outpatient Treatment	$20 Copayment Per Visit
SUBSTANCE ABUSE REHABILITATION	
Deductible	None
Inpatient and Alternative Levels of Care*	**PAID IN FULL**
Outpatient Treatment	$5 copayment per visit

*Alternative levels of care include Residential Treatment Centers and Day Treatment Centers.
Please note that medical detoxification is covered under the medical plan and is directed by your Primary Care Physician.

Index of Terms

For a complete description of the Covered Services and Exclusions and Limitations for the Medical Benefits, Outpatient Prescription Drug Program, Behavioral Health Benefits and Hearing Aid Benefits, please refer to the appropriate sections of this brochure. For a list of Copayments required for Covered Services, please refer to the "Schedules of Benefits" section.

Answering Questions

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

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

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

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

Contacting us:

PacifiCare of California
5701 Katella Avenue/P.O. Box 6006
Cypress, California 90630-5028

www.pacificare.com
800-624-8822; M-F, 8 a.m. to 8 p.m.
800-442-8833 (TDHI)

PacifiCare®

CM-999-12231.25
PC2314 Rev. 9/99