

YOUR HEALTH CARE BENEFITS HMO



CALIFORNIA

University of California
Combined Evidence of Coverage & Disclosure Form

PacifiCare[®]



Introducing 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.

Questions? Call the Customer Service Department at 1-800-624-8822.

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Summary of 2003 Plan Changes

Benefit Changes Effective January 1, 2003

Hospice days will now be covered when Member has a prognosis of life of one year or less.

Cancer Clinical Trials when certain criteria are met.

Transgender Benefits limited to psychotherapy and hormone therapy as described in the Harry Benjamin International Gender Dysphoria Association's (HBIIGDA) Standards of Care for Gender Identity Disorder.

Secure Horizons Medicare + Choice Plan

Maximum Supplemental pharmacy benefit is limited to \$2000 per Calendar Year.

Getting Started



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. The University establishes its own medical plan eligibility, enrollment and termination criteria based on the University of California Group Insurance Regulations ("Regulations"). Portions of the regulations are summarized below.

Subscriber

Employee: You are eligible if you are appointed to work at least 50% time for twelve months or more or are appointed at 100% time for three months or more or have accumulated 1,000 hours while on pay status in a twelve (12)-month period. To remain eligible, you must maintain an average regular paid time* of at least 17.5 hours per week. If your appointment is at least 50% time, your appointment form may refer to the time period as follows: "Ending date for funding purposes only; intent of appointment is indefinite (for more than one year)."

* For any month, your average regular paid time is the average number of regular paid hours per week (excluding overtime, stipend or bonus time) worked by you in the preceding twelve (12)-month period.

- a. A month with zero regular paid hours which occurred during your furlough or approved leave without pay will not be included in the calculation of the average. If such absence exceeds eleven (11) months, the averaging will be restarted.
- b. A month with zero regular paid hours which occurred during a period when you were not on furlough or approved leave without pay will be included in the calculation of the average. After two consecutive such months, the averaging will be restarted.

For a partial month of zero regular paid hours due to furlough, leave without pay or initial employment, the following will apply.

- a. If you worked at least 43.75% of the regular paid hours available in the month, the month will be included in the calculation of the average.
- b. If you did not work at least 43.75% of the regular paid hours available in the month, the month will not be included in the calculation of the average.

Annuitant

Annuitant is a former University Employee receiving monthly benefits from a University-sponsored defined benefit plan.

Survivor Annuitant

A deceased Employee or Annuitant's family member receiving monthly benefits from a University-sponsored defined benefit plan.

You may continue University medical plan coverage as an Annuitant when you retire or start collecting retirement or disability benefits from a University-sponsored defined benefit plan, or as a Survivor Annuitant when you start collecting survivor benefits from a University-sponsored defined benefit plan. You must also meet the following requirements:

1. You meet the University's service credit requirements for Annuitant medical eligibility;
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); and
3. You elect to continue coverage at the time of retirement;

If you are eligible for Medicare, see "Effect of Medicare on Annuitant Enrollment" below.

Eligible Dependents (Family Members)

When you enroll any Family Member, your signature on the enrollment form or the confirmation number on your electronic enrollment attests that your Family Member meets the eligibility requirements outlined below. The University and/or PacifiCare reserves the right to periodically request documentation to verify eligibility of Family Members. Documentation could include a marriage certificate, birth certificate(s), adoption records, or other official documentation. In addition, 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 Family Member and your signature) to the University to verify income tax dependency for those categories where it is a condition of eligibility.

Spouse

Your Legal Spouse. (Note: if you are a Survivor Annuitant, you may not enroll your legal spouse.)



Getting Started

Child

All eligible children must be under the limiting age (18 for legal wards, 23 for all others), unmarried, and may not be emancipated minors. The following categories are eligible:

- a. Natural, legally adopted children or children placed in your home by a recognized county or private agency for purposes of adoption;
- b. Stepchildren (natural or legally adopted children of your Spouse), if living with you, who are dependent on you or your spouse or same-gender Domestic Partner for at least 50% of their support and who are your, or your spouse's or same-gender Domestic Partner's Dependents for income tax purposes.
- c. Grandchildren of you or your spouse or same-gender Domestic Partner, if living with you, who are Dependent upon you, your spouse or your same-gender Domestic Partner for at least 50% of their support and who are your, your spouse's or same-gender Domestic Partner's Dependents for income tax purposes.
- d. Children for whom you are the legal guardian if living with you, who are dependent on you for at least 50% of their support and who are your dependents for income tax purposes.

Children who are totally self-supporting are not eligible dependents (example: are employed and do not live with you).

Any child described above (except a legal ward) who is incapable of self-support due to a physical or mental handicap may continue to be covered past age 23 provided the:

- a. Incapacity began before age 23, the child was enrolled in a group medical plan before age 23 and coverage is continuous; and
- b. Child is dependent you for at least 50% of his or her support and is your dependent for income tax purposes, and
- c. The child lives with you.

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).

Other Eligible Dependents (Family Members)

You may enroll an adult dependent relative or same-gender domestic partner and their eligible children as set forth in the University of California Group Insurance Regulations.

However, you may enroll only one adult family member: legal spouse, or adult dependent relative or same-gender domestic partner. For example, you may not enroll your adult dependent relative if you have enrolled your legal spouse or if your legal spouse remains eligible through PacifiCare under your plan. For information on who qualifies and on the requirements to enroll an adult dependent relative or same-gender domestic partner, please contact your local Benefits Office.

No Dual Coverage

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 or same-gender domestic partner are eligible, each may enroll separately or one may cover the other as a Dependent. If you enroll separately, neither may enroll the other as a Dependent. Eligible children may be enrolled under either parent's coverage, but not under both.

Qualified Medical Child Support Orders

A person having legal custody of a child or a custodial parent who is not a PacifiCare member may ask about obtaining dependent coverage as required by a court or administrative order, including a Qualified Medical

Getting Started



Child Support Order, by calling PacifiCare's Customer Service department at 1-800-624-8822 or 1-800-442-8833 (TDHI). A copy of the court or administrative order must be included with the enrollment application. Information including, but not limited to, the identification card, *Combined Evidence of Coverage and Disclosure Form* or other available information including notice of termination will be provided to the custodial parent, caretaker and/or District Attorney. Coverage will begin on the first of the month following receipt by PacifiCare of an enrollment form with the court or administrative order attached. PacifiCare will help facilitate your enrollment through the University of California's Benefits Office.

Enrollment

For information about enrolling yourself or an eligible Family Member, see the person at your location who handles benefits. If you are an Annuitant, contact the University's Customer Service Center. Enrollment transactions may be by paper form or electronic, according to current University practice. To complete the enrollment transaction, paper forms must be received by the local Accounting or Benefits office or by the University's Customer Service Center by the last business day within the applicable enrollment period; electronic transactions must be completed by midnight of the last day of the enrollment period.

During a Period of Initial Eligibility (PIE)

A PIE ends 31 days after it begins.

If you are an Employee, determined eligible by University for health plan benefits, you may enroll yourself and any eligible Family Members (Dependents) during your Period of Initial Eligibility (PIE). Your PIE starts the day you become an eligible Employee, as described above in "Employee", or on the day you acquire a newly eligible Dependent.

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

- a. For your new spouse, eligibility begins on the date of marriage, unless you have already enrolled another adult dependent. Survivor Annuitants may not add new spouses to their coverage.
- b. For your biological child, eligibility begins on your 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 your newly placed child for adoption is not enrolled during the PIE beginning on that date, there is an additional PIE beginning on the date that the adoption becomes final.

- d. Where there is more than one eligibility requirement, the date all requirements are satisfied.

If you decline enrollment for yourself or your eligible Dependents because of other group medical plan coverage and you lose that coverage involuntarily, you may 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, 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 yourself and your eligible Dependents in another University medical plan. Your PIE begins with the effective date of the move or the date you leave the PacifiCare 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.

At Other Times

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.

If you have two or more Dependents enrolled in the Plan, you may add a newly eligible Dependent at any time. See "Effective Date" below.

If you are an Annuitant, you may continue coverage for yourself and your enrolled Dependents in the same plan you were enrolled in immediately before retiring. You must elect to continue enrollment before the effective date of retirement (or the date disability or survivor benefits begin).



When Coverage Begins

Effective Date

The following effective dates apply, provided the appropriate enrollment transaction (paper form or electronic) has been completed within the applicable enrollment period.

If you enroll during a PIE, coverage for you and your Dependents is effective the date the PIE starts.

If you are an Annuitant continuing enrollment in conjunction with retirement, coverage for you and your Dependents are effective on the first of the month following the first full calendar month of retirement income.

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

For enrollees who complete a 90-day waiting period, coverage is effective on the 91st consecutive calendar day after the date the enrollment transaction is completed.

When you already have two or more covered Dependents and you add a newly eligible Dependent to your existing family coverage after the PIE, coverage may be retroactive with the effective date limited to the later of:

- a. a maximum of 60 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.

Change in Coverage

In order to change from individual to two-party coverage and from two-party to family coverage, or to add another Dependent to existing family coverage, contact the Benefit Representative who handles benefits at your campus or lab (or the **University's Customer Service Center at 1-800-888-8267**, if you are an Annuitant).

Medicare Enrollment

If you are an Annuitant and you and/or an enrolled Dependent is or who becomes eligible for Medicare Part A (Hospital Insurance) as primary coverage, then that individual must also enroll in and remain in Medicare Part B (Medical Insurance). Once Medicare coverage is established, coverage in both Part A and Part B must be continuous. This includes anyone who

is entitled to Medicare benefits through their own or their spouse's non-University employment. Individuals enrolled in both Part A and Part B are then eligible for the Medicare premium applicable to this plan.

Annuitants and their Dependents who are eligible for Medicare Part A, but decline to enroll in Part B of Medicare, will be assessed a monthly offset fee by the University to cover increased costs. The University will bill you directly for this on a monthly basis.

Annuitants or Dependents who are not eligible for Part A will not be assessed an offset fee. A notarized affidavit attesting to their ineligibility for Medicare Part A will be required. Affidavits may be obtained from the University's Customer Service Center.

(Annuitants/Dependents who are not entitled to Social Security and Medicare Part A will not be required to enroll in Part B.)

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.

Upon Medicare eligibility, you or your Dependent must complete a University of California Medicare Declaration Form. This notifies the University that you are covered by Part A and Part B of Medicare. The University's Medicare Declaration Forms are available through the University's Customer Service Center. Completed forms should be returned to the Annuitant Insurance unit at the Office of the President.

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.

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.

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Termination of Coverage

The termination of coverage provisions that are established by the University of California in accordance with its Regulations are described below. Additional Plan provisions apply and are described elsewhere in the document.

De-enrollment Due to Loss of Eligible Status

If you are an Employee and lose eligibility, your coverage and that of any enrolled Family Member stops at the end of the last month in which premiums are taken from earnings based on an eligible appointment.

If you are an Annuitant or Survivor Annuitant and your annuity terminates, your coverage and that of any enrolled Dependent stops at the end of the last month in which you are eligible for an annuity.

If your Dependent loses eligibility, you must complete the appropriate transaction to delete him or her within 60 days of the date the Dependent is no longer eligible. Coverage stops at the end of the month in which he or she no longer meets all the eligibility requirements. For information on de-enrollment procedures, contact the person who handles benefits at your location (or the University's Customer Service Center if you are an Annuitant).

De-enrollment Due to Fraud

Coverage for you or your Dependents may be terminated for fraud or deception in the use of the services of the Plan, or for knowingly permitting such fraud or deception by another. Such termination shall be effective upon the mailing of written notice to the Subscriber (and to the University if notice is given by the Plan). A Dependent who commits fraud or deception will be permanently de-enrolled, while any other Dependent and the Subscriber will be de-enrolled for 18 months. If a Subscriber commits fraud or deception, the Subscriber and any Dependents will be de-enrolled for 18 months.

Leave of Absence, Layoff or Retirement

Contact your local Benefits Office for information about continuing your coverage in the event of an authorized leave of absence, layoff or retirement.

Optional Continuation of Coverage

If your coverage or that of a Dependent ends, you and/or your Dependent may be entitled to elect continued coverage under the terms of the federal Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended and if that continued

coverage ends, specified individuals may be eligible for further continuation under California law. The terms of these continuation provisions are contained in the University of California notice "Continuation of Group Insurance Coverage," available from the UCbencom Web site (www.ucop.edu/bencom). The notice is also available from the person in your department who handles benefits and from the University's Customer Service Center. You may also direct questions about these provisions to your local Benefits Office or the University's Customer Service Center if you are an Annuitant.

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 those documents apply if information in this document is not the same. The University of California Group Insurance Regulations will take precedence if there is a difference between its provisions and those of this document and/or the Group Hospital and Professional Service Agreement. What is written in this document 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 booklet. 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

Annuitants may also direct questions to the University's Customer Service Center at the above phone number.



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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
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 under 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. Plan benefits are not accrued or vested benefit entitlements. The right to terminate or amend applies to all Employees, Annuitants and plan beneficiaries. The amendment or termination shall be carried out by the President or his or her delegates. The University of California will also determine the terms of the Plan, such as benefits, premiums and what portion of the premiums the University will pay. The portion of the premiums *that University pays is determined by UC and may change or stop altogether, and may be affected by the state of California's annual budget appropriation.*

Financial Arrangements

The benefits under the Plan are provided by PacifiCare under a Group Service Agreement. The cost of the premiums is currently shared between you and the University of California.

Agent for Serving of Legal Process

Legal process may be served on PacifiCare at the address listed above.

Your Rights under the Plan

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

1. Examine, without charge, at the Plan Administrator's office and other specified sites, all Plan documents, including the Group Service Agreement, at a time and location mutually convenient to the participant and the Plan Administrator.
2. Obtain copies of all Plan documents and other information for a reasonable charge upon written request to the Plan Administrator.

Claims under the Plan

To file a claim or to appeal a denied claim, refer to page 18 of this document.

Nondiscrimination Statement

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

Please send inquiries regarding the University's affirmative action and equal opportunity policies for staff to:

Director Mattie Williams
University of California Office of the President
300 Lakeside Drive
Oakland, CA 94612

and for faculty to:

Executive Director Sheila O'Rourke
University of California Office of the President
1111 Franklin Street
Oakland, CA 94607.

Accessing Care



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

Choosing a 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 Primary Care 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.

Reproductive Health Disclosure

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

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.

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

Continuity of Care for Terminating Physicians

In the event your contracting physician is terminated by PacifiCare or your Participating Medical Group for reasons other than a medical disciplinary cause, fraud or other criminal activity, you may be eligible to continue receiving care from your physician following the termination, providing the terminated provider agrees to the terms and conditions of the contract. Continued care from the terminated physician may be provided for up to ninety (90) days or a longer period if Medically Necessary for chronic, serious or acute conditions or through postpartum 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

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- 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 ReferralsSM program is available through a select network of Participating Medical Groups. With Express ReferralsSM, 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 ReferralsSM, please contact PacifiCare's Customer Service department or refer to your PacifiCare HMO *Provider Directory* or visit our Web site at www.pacificare.com.

Authorization, Modification and Denial of Health Care Services

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

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

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

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

Decisions to approve, modify, or deny requests for authorization of health care services, based on Medical Necessity, will be made in a timely fashion appropriate for the nature of the Member's condition, not to exceed five (5) business days from PacifiCare's or the Participating Medical Group's receipt of the information reasonably necessary to make the decision.

If the Member's condition poses an imminent and serious threat to their health including, but not limited to, potential loss of life, limb, or other major bodily function, or lack of timeliness would be detrimental in regaining maximum function, the decision will be rendered in a timely fashion appropriate for the nature of the Member's condition, not to exceed seventy-two (72) hours after PacifiCare's receipt of the information reasonably necessary and requested by PacifiCare to make the determination.

If the decision cannot be made within these time frames because (i) PacifiCare or the Participating Medical Group is not in receipt of all of the information reasonably necessary and requested, or (ii) PacifiCare or the Participating Medical Group requires consultation by an expert reviewer, or (iii) PacifiCare or the Participating Medical Group has asked that an additional examination or test be performed upon the Member, provided the examination or test is reasonable and consistent with good medical practice, PacifiCare or the Participating Medical Group will notify the provider and the Member, in writing, that a decision cannot be made within the required time frame. The notification will specify the information requested but not received or the additional examinations or tests required and the anticipated date on which a decision may be rendered. Upon receipt of all information reasonably necessary and requested by PacifiCare or the Participating Medical Group, PacifiCare or the Participating Medical Group shall approve, modify or deny the request for authorization within the time frames specified above as applicable.

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



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

Second Medical Opinions

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

The request for a second medical opinion will be approved or denied by the Participating Medical Group (or a PacifiCare Medical Director as applicable) in a timely fashion appropriate for the nature of the Member's condition. When the Member's condition is such that the Member faces an imminent and serious threat to his or her health, including, but not limited to, the potential loss of life, limb, or other major bodily function, or lack of timeliness that would be detrimental to the Member's ability to regain maximum function, the second opinion shall be rendered in a timely fashion appropriate for the nature of the Member's condition, not to exceed 72 hours after the Participating Medical Group's (or PacifiCare's as applicable) receipt of the request, whenever possible. When the Member's condition does not create an imminent and serious threat to his or her health, the second opinion shall be rendered in a timely fashion appropriate for the nature of the Member's condition, not to exceed five (5) business days after receipt of the

request by the Participating Medical Group or PacifiCare, as applicable. Second medical opinions will be rendered by an appropriately qualified health care professional. An appropriately qualified health care professional is a primary care physician or a specialist who is acting within his or her scope of practice and who possesses the clinical background related to the illness or condition associated with the request for a second medical opinion.

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

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

If a Member's request for a second medical opinion is denied, PacifiCare will notify the Member in writing of the reasons for the denial. The Member may appeal the denial by following the procedures outlined in the Appeals Process section of this *Combined Evidence of Coverage and Disclosure Form*. If the Member obtains

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a second medical opinion without prior authorization from his or her Participating Medical Group or PacifiCare, the Member will be financially responsible for the costs of such services.

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

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

Arranging Hospitalization

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

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

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

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

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

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

What To Do When You Require Emergency Services

If you believe that you need Emergency Services you should:

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

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

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

Urgently Needed Services

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

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

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

What To Do When You Require Urgently Needed Services

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

If possible, call, or have someone on your behalf call, your Primary Care Physician or Participating Medical Group. The telephone numbers for your Primary Care Physician and Participating Medical Group are on the front of your PacifiCare ID card. Assistance is available 24 hours a day, seven days a week.

Identify yourself as a PacifiCare Member and ask to speak to a physician. If you are calling during nonbusiness 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.

Using Emergency or Urgently Needed Services



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

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

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

Post Stabilization and Follow-Up Care

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

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

Receiving Medical Care "After Hours"

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

Non-Qualifying Services

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

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

What If I Get a Bill? (Reimbursement)

If for some reason you are billed for covered services, please call our Customer Service department at 1-800-624-8822, Monday through Friday, 7:00 a.m. to 9:00 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 noncovered 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.

Bills From Participating Providers

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

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

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

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

Bills From Nonparticipating Providers

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

Payment Responsibility



You Must File Claims With PacifiCare Within 90 Days of the Date You Receive the Services or Supplies.

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

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

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

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

Member Liability (Choice of Physician and Providers)

When covered services are received under the direction of your Participating Medical Group or 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.)
- Noncovered 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.
- If you are eligible for Medicare but fail to enroll in Medicare, your PacifiCare coverage will be reduced by the amount you could have received from Medicare.

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

Non-Duplication of Benefits With Workers' Compensation

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

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

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

Reimbursement of Third-Party Medical Expenses

If you receive medical services under your PacifiCare coverage after being injured through the actions of another person (a third party) for which you receive a monetary recovery, you will be required to reimburse PacifiCare, or its nominee, to the extent permitted under California Civil Code Section 3040 and federal law, for the cost of such medical services and benefits provided and the reasonable costs actually paid to perfect any lien.

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

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

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

General Information



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

If you are receiving benefits as a result of other automobile, accident or liability coverage, PacifiCare will not duplicate those benefits.

It is your responsibility to take whatever action is necessary to receive payment under automobile, accident, or liability coverage when such payments can reasonably be expected, and to notify PacifiCare of such coverage when available.

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

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

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

Extraordinary Circumstances

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

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

Changes In Coverage

Ending Coverage (Termination of Benefits)

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. If your family member loses eligibility, you must complete the appropriate transaction to delete him or her within 60 days of the date the family member is no longer eligible.

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

- Failure to pay required copayments, premiums or fees for noncovered 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 Managed Health Care.

For more information, please contact our Customer Service department.



General Information

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

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- 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 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 pre-existing conditions provisions, and (b) eligibility under HIPAA for individual coverage in any applicable State portability program. Individuals may receive credit for coverage under most medical plans. Employer health plans (for two or more employees) must recognize this 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.

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

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

Certification of Creditable Coverage

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

If additional information is needed to properly track your coverage history, including employer imposed waiting periods or HMO affiliation periods, you may need to contact your Employer to obtain this information. This Certificate may help you 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.
- Stop-loss insurance protects Participating Medical Groups and hospitals from large financial expenses. PacifiCare provides stop-loss protection to our Participating Medical Groups and hospitals that receive the monthly payments described above.

If any providers do not obtain stop-loss protection from PacifiCare, they must obtain stop-loss insurance from an insurance carrier acceptable to PacifiCare.

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

Public Policy Participation

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

Assessment of New Technology

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

Responding to Your Concerns

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

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

PacifiCare of California
Appeals 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 including an explanation of the reasons for the determination will be sent to the Member within thirty (30) days of PacifiCare's receipt of the Member's appeal. For appeals involving the delay, denial or modification of health care services, PacifiCare's written response will describe the criteria or guidelines used and the clinical reasons for its decision, including all criteria and clinical reasons related to Medical Necessity.

For determinations delaying, denying, or modifying health care services based on a finding that the services are not Covered Services, the response will specify the provisions in the plan contract that exclude that coverage. If the complaint is related to quality of care, the complaint will be reviewed through the procedure described in the section of this *Combined Evidence of Coverage and Disclosure Form* captioned Quality Management Review.

2. If the Member is dissatisfied after the determination by the Health Services Department, the Member may request a review by the Appeals and Grievance Committee by submitting a request within thirty (30) days of the receipt of the Health Services Department's determination. A hearing before the Appeals and Grievance Committee will be scheduled within thirty (30) days of the Member's request for a hearing. The Member's participation at the Appeals and Grievance Committee hearing is encouraged.

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3. If the Member is dissatisfied with the redetermination, the Member may, within sixty (60) days, submit or request that PacifiCare submit the appeal to voluntary mediation or binding arbitration before Judicial Arbitration and Mediation Services, Inc. (JAMS).
 - i. Voluntary Mediation – In order to initiate mediation, the Member or the agent acting on behalf of the Member shall submit a written request for voluntary mediation. If the parties mutually agree to mediation, the mediation will be administered by JAMS in accordance with its JAMS Comprehensive Arbitration Rules and Procedures, unless otherwise agreed to by the parties. Expenses for mediation shall be borne equally by the parties. The Department of Managed Health Care shall have no administrative or enforcement responsibilities in connection with the voluntary mediation process.
 - ii. Binding Arbitration – With the exception of claims brought pursuant to the Plan’s Quality Review Process, any claim, controversy dispute or disagreement between PacifiCare and Member which arises out of or is related to this Agreement that is not resolved by the above appeals and dispute resolution processes shall be resolved by binding arbitration by a single arbitrator. If the amount of the claim is less than \$200,000, then the arbitrator shall have no jurisdiction to award more than \$200,000. JAMS or such other neutral administrator as PacifiCare shall designate shall administer the arbitration. The JAMS Comprehensive Arbitration Rules and Procedures (Rules) in effect at the time demand for arbitration is made will be applied to the arbitration. The parties will endeavor to mutually agree to the appointment of the arbitrator, but if such agreement cannot be reached within thirty (30) days following the date demand for arbitration is made, the arbitrator appointment procedures in the Rules will be utilized. Arbitration hearings shall be held at the neutral administrator’s offices in Los Angeles, California, or at such other location as the parties may agree in writing. Civil discovery may be taken in such arbitration as provided by California law and civil procedure. The arbitrator(s) selected shall have the power to control the timing, scope and manner of the taking of discovery and shall further have the same powers to enforce the parties’ respective duties concerning discovery as would a Superior

Court of California including, but not limited to, the imposition of sanctions. The arbitrator(s) shall have the power to grant all remedies provided by California law. The arbitrator(s) shall prepare in writing an award that includes the legal and factual reasons for the decision. The parties shall divide equally the fees and expenses of the arbitrator(s) and the neutral administrator except that in cases of extreme hardship, PacifiCare may assume all or part of a Member’s share of the fees and expenses of the arbitrator(s), provided the Member has submitted a hardship application with JAMS or such other neutral administrator designated by PacifiCare. The approval or denial of a hardship application shall be determined by such administrator. The arbitrator(s) shall not have the power to commit errors of law or legal reasoning, and the award may be vacated or corrected pursuant to California law. The Federal Arbitration Act, 9 U.S.C. §§ 1-4, shall also apply to the arbitration.

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

Quality Management Review

All complaints that involve quality of care issues are referred to PacifiCare’s Health Services Department for review. Complaints that affect a Member’s immediate condition will receive immediate review. PacifiCare will investigate the complaint, 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,



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will be immediately referred to the PacifiCare Medical Director for expedited review, regardless of whether such complaints are received orally or in writing.

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

Experimental or Investigational Treatment

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

Independent Review of Denied Experimental or Investigational Treatment Eligibility Criteria

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

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

and

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

How To Request an Independent Review

Within five business days of a decision to deny coverage for an Experimental or Investigational therapy for a Member who has a life-threatening or seriously debilitating condition, PacifiCare will send the Member written notice of the denial and of the right to request an independent review if the physician certification and evidence requirements listed in Items 2 & 3 above

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are met. The denial notice from PacifiCare will include an application form, along with a pre-addressed envelope, to be used to request an independent review from the Department of Managed Health Care (DMHC). PacifiCare also will include a physician certification form that must be completed by the Member's physician for the Member to be eligible for an independent review. A Member who has a life-threatening or seriously debilitating condition and receives written notice from PacifiCare of its denial of coverage for a requested Experimental or Investigational therapy may request an independent review by completing the application form provided to the Member by PacifiCare and mailing the form to the DMHC in the pre-addressed envelope provided by PacifiCare. The Member's physician must provide the physician certification and evidence listed in Items 2 & 3 above. The Member may include the completed physician certification with the Member's application mailed to the DMHC, or the Member's physician may mail or fax the physician certification and evidence directly to the DMHC. The DMHC fax number is (1-916-229-0465). The DMHC may also be reached by calling (1-888-HMO-2219).

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

Independent Review Procedures

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

If the Member requests an independent review, PacifiCare will provide the following documents to the IRO designated by the DMHC within three (3) business days of PacifiCare's receipt of notification from the DMHC that a Member has applied for an independent review of PacifiCare's denial of Experimental or Investigational therapy: (a) the relevant medical

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

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

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

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

If the proposed therapy has not been provided and the Member's provider or the DMHC certifies in writing that an imminent and serious threat to the health of the Member may exist, including, but not limited to, serious pain, the potential loss of life, limb or major

bodily function, or the immediate and serious deterioration of the health of the Member, the analyses and recommendations of the experts must be expedited and rendered within three (3) days of the receipt of the Member's application and supporting information.

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

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

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

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

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

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

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

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

Coverage for the proposed therapy or treatment will be provided subject to the terms and conditions generally applicable to all other benefits under the Member's PacifiCare Health Plan Members or Physicians who want additional information about California's independent review process for denied Experimental or Investigational therapy for Members with life-threatening or seriously debilitating conditions may request a copy of PacifiCare's information packet by calling PacifiCare's Customer Service department.

Independent Medical Review of Grievances Involving a Disputed Health Care Service

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

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

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

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

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

In most cases, the IMR organization designated by the DMHC must provide its determination within 30 days of receipt of your application and supporting

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

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

Review By Department of Managed Health Care

The California Department of Managed Health Care is responsible for regulating health care service plans. The Department has a toll-free telephone number **(1- 888-HMO-2219)** to receive complaints regarding health plans. The hearing and speech impaired may call the California Relay Service's toll-free telephone numbers **(1-800-735-2929** or **1-888-877-5378 TTY)**. The Department's Internet Web site (<http://www.hmohelp.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 Department.

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 thirty (30) days, you may call the Department for assistance. The plan's grievance process and the Department's complaint review process are in addition to any other dispute resolution procedures that may be available to you, and your failure to use these processes does not preclude your use of any other remedy provided by law.

Complaints Against Participating Medical Groups, Providers, Physicians and Hospitals

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



General Information

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.

General Information



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

Annuitant may also direct questions to the University's Customer Service Center at the above phone number. 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

Please send inquiries regarding the University's affirmative action and equal opportunities policies for staff to:

Director Mattie Williams
University of California Office of the President
1111 Franklin Street
Oakland, CA 94607.

and for faculty to:

Executive Director Sheila O'Rourke
University of California Office of the President
1111 Franklin Street
Oakland, CA 94607.

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.

Nondiscrimination Statement

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



Medical Benefits

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).

\$250 per admit.

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.

\$250 per admit.

Cancer Clinical Trials

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

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

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

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

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

- Drugs or devices that have not been approved by the federal Food and Drug Administration and that are associated with the clinical trial.
- Services other than health care services, such as travel, transportation, housing, companion expenses and other nonclinical expenses that you may require as a result of the treatment being provided for purposes of the clinical trial.

Medical Benefits



- Any item or service that is provided solely to satisfy data collection and analysis needs and that is not used in the clinical management of your care.
- Health care services that, except for the fact that they are being provided in a clinical trial, are otherwise specifically excluded from coverage under PacifiCare.
- Health care services customarily provided by the research sponsor free of charge.

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

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

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

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

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

Any additional expenses you may have to pay beyond PacifiCare's negotiated rate as a result of using a

nonparticipating Provider do not apply to your annual Copayment maximum.

Members must pay all applicable Copayments at the time each service is rendered. Please consult your *Schedule of Benefits* for Copayment information or call Customer Service for more information.

Paid at contracting rate. Balance (if any) is the responsibility of the Member.

Hospice Services

Hospice Services are covered for Members with a terminal illness, defined as a medical condition resulting in a prognosis of life of one (1) year or less, if the disease follows its natural course. Hospice Services are provided as determined by the plan of care developed by the Member's interdisciplinary team, which includes, but is not limited to, the Member, the Member's Primary Care Physician, a registered nurse, a social worker and a spiritual caregiver. Hospice Services are provided in an appropriately licensed hospice facility when the Member's interdisciplinary team has determined that the Member's care cannot be managed at home because of acute complications or the temporary absence of a capable primary caregiver.

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

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

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

\$250 per admit.



Medical Benefits

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.

\$250 per admit.

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.

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.

\$250 per admit.

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.

\$250 per admit.

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.

This 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

Medical Benefits



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.

\$250 per admit.

Newborn Care

Complete prenatal and postnatal Hospital Services including circumcision (if desired) and special care nursery are covered. Coverage for newborn children of the Subscriber begins at birth. 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. 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.

\$250 per admit (baby under mother's admit fee).

Reconstructive Surgery

Inpatient Reconstructive Surgery is covered when performed to:

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

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

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

\$250 per admit.

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.

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

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 the Behavioral Health Benefits section of this brochure).

\$10 Copayment.

Allergy Testing

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

\$10 Copayment.

Allergy Treatment

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

\$10 Copayment.



Medical Benefits

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 nonemergency 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.

\$10 Copayment.

Breast Cancer Screening, Diagnosis and Treatment

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

\$10 Copayment.

Cancer Clinical Trials

Please refer to the benefit described above under Inpatient Cancer Clinical Trials. Outpatient services Copayments, Coinsurance or Deductibles apply.

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

Paid at contracting rate. Balance (if any) is the responsibility of the Member.

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.

Dental Treatment Anesthesia

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

- The Member is under seven (7) years of age; or
- The Member is developmentally disabled, regardless of age; or
- The Member's health is compromised and for whom general anesthesia is Medically Necessary.

Paid in Full.

Diabetes Management and Treatment

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

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

Blood glucose monitors; glucose monitors designed to assist the visually impaired; strips; lancets and lancet puncture devices; pen delivery systems (for the administration of insulin); insulin pumps and all

Medical Benefits



related necessary supplies; ketone urine testing strips; insulin syringes; and podiatry services and devices to prevent or treat diabetes related complications. Visual aids are covered for Members determined to have a visual impairment that would prohibit proper dosing of insulin.

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

\$10 Copayment.

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), and injection of Depo-Provera. 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.

\$10 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.)

\$10 Copayment



Medical Benefits

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 Services

Hospice Services are covered for Members with a terminal illness, defined as a medical condition resulting in a prognosis of life of one (1) year or less, if the disease follows its natural course. Hospice Services are provided pursuant to the plan of care developed by the Member's interdisciplinary team, which includes, but is not limited to, the Member, the Member's Primary Care Physician, a registered nurse, a social worker and a spiritual caregiver.

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

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

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

Paid in Full up to a maximum of one calendar year 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.

\$10 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 intrauterine 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.

Medical Benefits



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 postpartum 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.

\$10 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 myofascial 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.

\$10 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



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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.

\$10 Copayment.

Phenylketonuria (PKU) Testing and Treatment

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

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

Food products naturally low in protein are not covered.

\$10 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.)

\$10 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.

\$10 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.

\$10 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.

\$10 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)

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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 nonparticipating 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 noncovered 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 noncovered 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, unless required by an external, independent, review panel pursuant to California Health and Safety Code Section 1370.4.

Chiropractic Care

Care and treatment provided by a chiropractor is not covered.

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

Dental Care, Dental Appliances

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

Dental Treatment Anesthesia

General anesthesia provided or administered in a dentist's office is not covered. Charges for the dental procedure(s) itself including, but not limited to,



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professional fees of the dentist or oral surgeon, X-ray and laboratory fees or related dental supplies provided in connection with the care, treatment, filling, removal or replacement of teeth or structures directly supporting the teeth are not covered (except for services covered by PacifiCare under the outpatient benefit captioned Oral Surgery Services).

Developmental Disorders

Services that are primarily oriented toward treating a social, developmental or learning problem rather than a medical problem, 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 nonprescribed 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.

Emergency and Urgently Needed Services

Emergency and Urgently Needed Services are covered in a non-contracting facility only as long as the emergent or urgent condition exists and a transfer would be medically inappropriate. Routine follow-up care including treatments, procedures, X-rays, lab work, physician visits, rehabilitation and Skilled Nursing Care will not be covered without the

Participating Medical Group's authorization once it is medically reasonable for the Member to obtain these services from the Participating Medical Group. The fact that the Member is outside the Service Area and that it is inconvenient for the Member to obtain the required services from the Participating Medical Group will not entitle the Member to coverage.

Experimental or Investigational Treatment

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

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.

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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.

Nonlicensed Professionals

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

Nursing – Private Duty

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

Off-Label Drug Use

Off-Label Drug Use means that the Provider has prescribed a drug approved by the Food and Drug Administration (FDA) for a use that is different than for which the FDA approved the drug. PacifiCare excludes coverage for Off-Label Drug Use, including Off-Label self-injectable drugs, except as described in this *Combined Evidence of Coverage and Disclosure Form*. If the self-injectable drug prescribed is for Off-Label Use, the drug and its administration will be covered only when the following criteria are met: (1) The drug is approved by the FDA. (2) The drug is prescribed by a participating licensed health care professional for the treatment of a Life-Threatening condition or for a chronic and seriously debilitating condition. (3) The drug is Medically Necessary to treat the condition and (4) The drug has been recognized for treatment of the Life-Threatening or chronic and Seriously Debilitating condition by one of the following: The American Medical Association Drug Evaluations, The American Hospital Formulary Service Drug Information, The United States Pharmacopoeia Dispensing Information,

Volume I, or in two articles from major peer reviewed medical journals that present data supporting the proposed Off-Label Drug Use or uses as generally safe and effective. (5) The drug is administered as part of a core medical benefit as determined by PacifiCare. Nothing in this section shall prohibit PacifiCare from use of a formulary, copayment, technology assessment panel, or similar mechanism as a means for appropriately controlling the utilization of a drug that is prescribed for a use that is different from the use for which that drug has been approved for marketing by the FDA. Denial of a drug as Investigational or Experimental will allow the Member to use the Independent Medical Review System as outlined in the *Combined Evidence of Coverage and Disclosure Form*.

Organ Donor Services

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

Organ Transplants

Organ transplants not Medically Necessary and organ transplants considered Experimental or Investigational as defined herein are not covered. 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. Out-of-Area follow-up care includes, but is not limited to:

Routine follow-up care to Emergency or Urgently Needed Services, such as treatments, procedures, X-rays, lab work and doctor's visits, as well as Rehabilitation Services, Skilled Nursing Care, Custodial Care or home care.

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

Physical Examinations

Routine physical examinations for insurance, licensing, employment, school, camp, recreational or organizational activities are not covered. Physical examinations for appearances at hearings or court



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proceedings, examinations precedent to engaging in travel, or other non-preventive purposes or for premarital and preadoption 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, or medications and supplies related to surgical 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.

Weight Alteration Programs (Inpatient or Outpatient)

Weight loss or weight gain programs including, but not limited to, dietary evaluations and counseling, exercise programs, behavioral modification programs, surgery, laboratory tests, food and food supplements, vitamins and other nutritional supplements associated with weight loss or weight gain, are not covered. Surgical treatment for morbid obesity will be covered only when criteria are met as recommended by the National Institute of Health (NIH).

Outpatient Prescription Drug Program



Retail:

\$10 Generic Formulary/Selected Brands Copayment

\$20 Brand-Name Formulary Copayment

\$35 Non-Formulary Copayment

PacifiCare covers outpatient prescription drugs when ordered by a PacifiCare Participating Physician and filled at a PacifiCare Participating Pharmacy.

How To Use the Program

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

PacifiCare's Formulary

Your PacifiCare Prescription Drug Benefit uses a Formulary. However, under the Buy-Up Option Plan, non-Formulary drugs are generally covered by PacifiCare without prior authorization.

What You Will Pay

You will need to make the required Copayment each time a prescription is filled. You should never be required to pay more than your Copayment amount for Covered Prescription Drugs at a PacifiCare Participating Pharmacy.

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) Copayments.

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

You may also purchase the prescription drugs not on the PacifiCare Formulary for the non-Formulary Copayment listed above per one-month supply when ordered by a PacifiCare Participating Physician and filled at a PacifiCare Participating Pharmacy.

What Is Covered

When Medically Necessary, the prescription benefit will be provided for the following medications 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, EpiPens[®], Ana-Kits[®].**
- **Federal Legend oral contraceptives, prescription diaphragms.**
- **Generic Drugs:** Comparable generic drugs will be substituted for brand-name drugs.
- **Specified smoking cessation products** when a Member meets nicotine dependency criteria and is enrolled and continues to participate in PacifiCare's StopSmokingSM 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 preauthorized by PacifiCare.
- **Hormone drugs** subject to the Harry Benjamin International Gender Dysphoria Association's (HBI-GDA) Standards of Care for Gender Identity Disorder.

Preauthorization for Selected Drugs

Coverage for selected drugs will require PacifiCare's preauthorization. PacifiCare's preauthorization review process is to ensure that the selected drugs are Medically Necessary and being utilized according to treatment guidelines consistent with good professional practice. For a list of the selected medications that require PacifiCare's preauthorization, please contact PacifiCare's Customer Service department.



Outpatient Prescription Drug Program

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 receipt from the pharmacy showing the name of the drug, date filled, pharmacy name, 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:

Prescription Solutions® Claims
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 Customer Service.

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 Service 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 and periodically updates the PacifiCare Formulary.

In general, updates to the PacifiCare Formulary occur quarterly. However, in certain situations, drugs may be added or deleted 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.

Outpatient Prescription Drug Program



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.

Dispensing Quantity Limitations

The amount of drug which 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 described under Maintenance Drug Dispensing.

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
- Antihypertensives
- Antiparkinson 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

PacifiCare Mail Service Program

Mail Service:

\$20 Generic Formulary/Selected Brands Copayment

\$40 Brand-Name Formulary Copayment

\$70 Non-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 on 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.

Participating Pharmacy Network

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 PacifiCare Participating Pharmacies.

- Albertsons Food & Drug
- Bel Air Pharmacies
- Cardinal/Leadernet Independent Network
- Costco Pharmacies
- Drug Emporium
- EPN Independent Network
- Family Care Network
- Friendly Hills Pharmacy
- Gemmel Pharmacy Group
- Good Neighbor/PlusCare Pharmacies



Outpatient Prescription Drug Program

- Horton & Converse Pharmacies
 - K-Mart Pharmacies
 - Longs Drug Stores
 - Major Value Pharmacies
 - Managed Pharmacy Care
 - Medicap Pharmacies
 - Medicine Shoppe Pharmacies
 - Network Pharmacies
 - OPEN Independent Pharmacies
 - PCP Independent Pharmacies
 - Raley's Drug Center
 - Ralphs Pharmacies
 - Rite Aid Pharmacies
 - Safeway Pharmacies
 - Save Mart Pharmacies
 - Sav-On Drugs
 - Sharp Rees-Stealy Pharmacies
 - Talbert Pharmacies
 - Target Pharmacy
 - UniMed Pharmacies
 - United Drug Stores
 - UPNI Contracted Pharmacies
 - Valu-Rite/McKesson Drug Co.
 - Vons/Pavilions (A Safeway Company)
 - Wal-Mart Pharmacies
- Medications to be taken or administered to the eligible Member while he/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 prenatales), fluoride supplements, health or beauty aids and anorexiant (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 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 Pharmacopoeial 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 nonprescription equivalent available, even if ordered by a physician.
 - Drugs, medicines or cosmetic aids prescribed primarily to improve or otherwise modify the Member's external appearance.
 - Medications prescribed by nonparticipating physicians (except for prescriptions required as a result of an Emergency or Urgently Needed Service for an acute condition).
 - Smoking cessation products (other than those available by participating in PacifiCare's StopSmokingSM Program) including, but not limited to nicotine gum and nicotine nasal spray.
 - Injectable drugs (except as listed under Covered Benefits).

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

Exclusions and Limitations

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

- 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 nonmedicinal substances.
- All nonprescription (over-the-counter) contraceptive jellies, ointments, foams and devices.

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

How Your Behavioral Health Care Benefits Work



Welcome to PacifiCare Behavioral Health of California (PBHC). Our mission is to provide our Members with quality behavioral health care.

We offer you direct 24-hour access to our services.

We coordinate and pay for all behavioral health care as provided under your Plan, provided you use our Participating Providers.

You may have some Copayments or Coinsurance amounts.

What Does PacifiCare Behavioral Health of California Do?

PBHC arranges Behavioral Health Services for our Members. All services covered under this benefit plan will be provided by a PBHC Participating Provider and must be preauthorized by PBHC, except in the case of an Emergency. Simply call the PBHC Customer Service department at 1-800-999-9585 at any time of the day or night to learn more about your benefits. Our staff is always there to assist you with understanding your benefits, authorizing services, helping you select a provider, or anything else related to your benefits under this Plan.

PBHC authorizes an appropriate number of visits based on PBHC's treatment guidelines for your behavioral health condition. These guidelines are available to you upon request and have been distributed to all Participating Providers in our network.

What Is Behavioral Health?

Behavioral health is the name for the treatment of:

Mental health conditions, including treatment for the Severe Mental Illness of an adult or child and/or the Serious Emotional Disturbance of a child, and alcohol and drug problems, also known as Chemical Dependency.

What Is a Severe Mental Illness?

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

- Anorexia Nervosa
- Bipolar Disorder
- Bulimia Nervosa
- Major Depressive Disorder
- Obsessive-Compulsive Disorder
- Panic Disorder

- Pervasive Developmental Disorder or Autism
- Schizoaffective Disorder
- Schizophrenia

What Is the Serious Emotional Disturbance of a Child?

The Serious Emotional Disturbance (SED) of a child is defined as a child who:

- Has one or more mental disorders as defined by the Diagnostic and Statistical Manual (DSM-IV), other than a primary substance use disorder or developmental disorder, that results in behavior inappropriate to the child's age according to expected developmental norms; and
- Is under the age of eighteen (18) years old.

Furthermore, the child must meet one or more of the following criteria:

- As a result of the mental disorder, the child has substantial impairment in at least two of the following areas: self-care, school functioning, family relationships, or ability to function in the community; and either of the following occur:
 - i. the child is at risk of removal from home or has already been removed from the home,
 - ii. the mental disorder and impairments have been present for more than six months or are likely to continue for more than one year without treatment; or
- The child displays one of the following: psychotic features, risk of suicide or risk of violence due to a mental disorder; or
- The child meets the special education eligibility requirements under Chapter 26.5, commencing with Section 7570 of Division 7 of Title 1 of the Government Code of the State of California.

Do I Need a Referral From My Primary Care Physician To Get Behavioral Health Services?

No. You can call PBHC directly to obtain Behavioral Health Services. If you would like us to, we will help coordinate the care you receive from your PBHC Participating Provider and the services provided by your Primary Care Physician (PCP). This may be very important when you have both medical and behavioral health problems. PBHC will obtain the appropriate consents before information is released to your PCP.

You may call PBHC Customer Service at any time to start this process.



How Your Behavioral Health Care Benefits Work

How Do I Get Behavioral Health Services?

Step 1

To get Behavioral Health Services, you must call PBHC first, except in an Emergency. Just call PBHC Customer Service at 1-800-999-9585. A PBHC staff member will make sure you are an eligible Plan Member and answer any questions you may have about your benefits. The PBHC staff member will conduct a brief telephone screening by asking you questions, such as:

- What are the problems or symptoms you are having?
- Are you already seeing a Participating Provider?
- What kind of provider do you prefer?

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

Step 2

You call the PBHC Participating Provider's office to make an appointment.

Step 3

After your first visit, your PBHC Participating Provider will get approval for any additional services you need that are covered under the Plan. You do not need to call PBHC again.

What If I Want To Change My Participating Provider?

Simply call the PBHC Customer Service toll-free number at 1-800-999-9585 to select another PBHC Participating Provider.

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 the PBHC network, the services will be excluded and you will have to pay for the entire cost of the treatment with no reimbursement from PBHC, except in an Emergency.

In addition, such charges will not be considered part of the Plan's Appeal Process, quality improvement process or any other process provided for under the terms of this coverage. Please refer to your PBHC *Schedule of Benefits*, Covered Services and Exclusions and Limitations found later in this EOC for additional information.

Can I Call PBHC In the Evening or On Weekends?

Yes. If you need services after normal business hours, please call PBHC's Customer Service department. A staff member is always there to help.

Emergency Treatment

What Is an Emergency?

An Emergency is a condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson would expect the absence of immediate Behavioral Health Services could result in any of the following:

- Immediate harm to self or others;
- Placing your health in serious jeopardy;
- Serious impairment of your functioning; or
- Serious dysfunction of any bodily organ or part.

A situation will be considered an Emergency if you or your Dependent are temporarily outside of California, experience a situation which requires Behavioral Health Services, and a delay in treatment by a PBHC Participating Provider in California would result in a serious deterioration to your health.

What Happens In an Emergency?

Step 1: In an Emergency, get help or treatment immediately.

This means you should call 911 or go directly to the nearest medical facility for treatment if you have to.

Step 2: Then, within 48 hours of your Emergency, or as soon as is reasonably possible after your condition is stable, you or someone acting on your behalf, needs to call us at 1-800-999-9585. This is important.

Emergency Services are covered only as long as the condition continues to be an Emergency. Once the condition is under control and you can be safely transferred or discharged, additional charges incurred through the emergency care facility will not be covered.

Step 3: PBHC will arrange follow up services for your condition after an Emergency. PBHC may move you to a Participating Provider in our network, as long as the move would not harm your health.

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

In a situation which you consider Urgent, but not life threatening, call our Customer Service department for assistance in finding a provider near your location. If a Participating Provider cannot be located, you may be sent to a provider outside of our PBHC network.

It is very important that you follow the steps outlined above. If you do not, you may be financially responsible for services received.

If I Am Out of State or Traveling, Am I Still Covered?

Yes, but only in an Emergency or Urgent situation. If you think you are experiencing an Emergency or require Urgently Needed Services, get treatment immediately. Then, as soon as reasonably possible, call the PBHC Customer Service department to ensure your Emergency Treatment is covered. This is important.

If you are traveling outside of the United States, you can reach PBHC by calling 1-818-782-1100 for additional instructions on what to do in the case of an Emergency or Urgent situation.

Provider Information

About Our Participating Providers

Call the PBHC Customer Service department for:

- Information on PBHC Participating Providers,
- Provider office hours,
- Background information such as their areas of specialization,
- A copy of the PacifiCare Behavioral Health of California *Provider Directory*, or
- Information on how to get referrals for behavioral health specialists.

You can also view a listing of PBHC Participating Providers on our Internet Web site at www.pbhi.com.

Who Are PacifiCare Behavioral Health's Participating Providers?

PBHC's Participating Providers include hospitals, group practices and individual professionals. All Participating Providers are carefully screened and must meet strict PBHC licensing and program standards.

How Are Participating Providers Compensated By PBHC?

Our Participating Providers are paid on a discounted fee-for-service basis for the services they provide to you. This means that our Participating Providers have agreed to provide services to you at the normal fee they charge, minus a discount. PacifiCare Behavioral Health of California does not compensate its providers based on their utilization patterns.

If you would like to know more about fee-for-service reimbursement, you may request additional information from the PBHC Customer Service department or your PBHC Participating Provider.

What If I Am Seeing a Participating Provider and He or She Is Terminated From the Network?

In the event your Participating Provider is no longer a part of the PBHC provider network 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 continue to provide services under the terms and conditions of the contract they had with PBHC at the time their contract ended. Continued care from the terminated provider may be up to ninety (90) days or longer if Medically Necessary for chronic, serious or acute conditions, if you are receiving Behavioral Health Services and are in a crisis period, or until your care can be safely transferred to another PBHC Participating Provider.

If you have any questions about this provision or would like a copy of our Continuity of Care Policy, you may call our Customer Service department.

Continuing Treatment for New Members

Continuing Treatment is for Members who:

- were not offered an out-of-network option or did not have the option to continue with their previous health plan at the time of enrollment under this Plan;
- have been eligible and enrolled in this Plan for less than thirty (30) days;
- had no other health plan choice other than through PacifiCare's arrangement with PBHC;
- are under treatment by a nonparticipating provider at the time of enrollment for a condition listed in the DSM-IV;
- the treatment is a covered Behavioral Health Service or benefit under this Plan; and



How Your Behavioral Health Care Benefits Work

- have a condition where an immediate change in Practitioner could present a risk of harm to self or others.

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

Outpatient Treatment

For outpatient treatment, the Member may be eligible for the appropriate number of visits necessary to treat the condition with the existing nonparticipating provider in order to safely transition the Member to a PBHC Participating Provider.

Inpatient Treatment

If you are receiving inpatient services, a PBHC Clinician will complete a comprehensive clinical assessment first. If the Behavioral Health Services meet our inpatient guidelines, the PBHC Clinician will approve care at the non-PBHC facility.

If the inpatient services do not meet PBHC's guidelines for inpatient care, we will approve the number of days necessary in order to move you safely to a Participating Provider with as little disruption as possible, provided such a request is authorized by PBHC. PBHC will authorize an appropriate number of days in consideration of the potential clinical effect that a change of provider would have on you for the treatment of your acute condition. Call or have your provider call us to discuss this with a PBHC Clinician or Customer Service Associate.

If approved, the Member and provider will receive immediate authorization via telephone and a letter of confirmation via certified mail. PBHC will pay the nonparticipating provider at the same benefit level for approved services as they would to a Participating Provider.

If a Member is denied authorization for continuing benefits and would like to appeal the denial decision, they may refer to the Appeals Process found later in this EOC.

Public Policy Participation

PBHC affords its Members the opportunity to participate in establishing its public policy. One third of PBHC's Board of Directors is comprised of PBHC Members. If you are interested in participating in the establishment of PBHC's public policy, please call the PBHC Customer Service department for more details.

New Treatments

PBHC's Medical Director and other professionals meet at least once a year to review new behavioral health treatments and programs. These new treatment programs are available to Members only after PBHC determines they are safe and effective.

Concurrent Reviews

Concurrent review will occur on a regular basis to determine continuing Medical Necessity for your treatment. During such reviews, a PBHC Clinician, in conjunction with your Participating Provider, monitors the course of treatment to determine its effectiveness, appropriate level of care, and continued Medical Necessity. A PBHC Clinician must authorize all extended lengths of stays and transfers to different levels of care as well as any related additional services.

What If I Get a Bill?

You should not get a bill from your PBHC Participating Provider because PBHC's Participating Providers have been instructed to send all their bills to us for payment. You may however, have to pay a Copayment to the Participating Provider each time you receive services. You could also get a bill from an emergency room provider if you use Emergency care. If this happens, send PBHC the original bill or claim as soon as possible and keep a copy for yourself. You are responsible only for the amount of your Copayment, as described in the *Schedule of Benefits* in this EOC.

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, Suite 700
Laguna Hills, CA 92653

Non-Emergency Treatment provided by nonparticipating providers and facilities is not covered by PBHC.

Termination of Benefits

Conditions for Termination

Please refer to the Termination of Benefits section of your PacifiCare of California Medical *Combined Evidence of Coverage and Disclosure Form*

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Your Financial Responsibilities

Please refer to the Payment Responsibility Section of your PacifiCare of California Medical *Combined Evidence of Coverage and Disclosure Form*.

Confidentiality of Information

PBHC protects the confidentiality of all Member information in its possession, including treatment records and personal information. If you would like a copy of our Confidentiality policy, you may call our Customer Service department at 1-800-999-9585.

Authorization and Denial of Behavioral Health Care Services

PBHC uses Medical Necessity criteria or guidelines to determine whether to approve, delay, modify or deny Behavioral Health Services to its Members. The criteria used to delay, modify or deny requested services in the Member's specific case will be disclosed to the PBHC Participating Provider and to the Member. The public is also able to receive specific criteria or guidelines, based on a particular diagnosis, upon request.

PBHC qualified physicians, other appropriate qualified licensed health care professionals, and PBHC Participating Providers make decisions to deny, delay, or modify requests for authorization of Behavioral Health Services, based on Medical Necessity, within the following time frames as required by California State Law:

Decisions appropriate for the nature of the Member's condition, not to exceed five (5) business days from PBHC's receipt of information reasonably necessary to make the decision.

If the Member's condition poses an imminent and serious threat to their health, including, but not limited to, severe pain, potential loss of life, limb, or other major bodily function, or lack of timeliness would be detrimental in regaining maximum function, the decision will be rendered in a timely fashion appropriate for the nature of the Member's condition, not to exceed seventy-two (72) hours after PBHC's receipt of the information reasonably necessary and requested by PBHC to make the determination.

If the decision cannot be made within these time frames because (i) PBHC is not in receipt of all the information reasonably necessary and requested, or (ii) PBHC requires consultation by an expert reviewer, or (iii) PBHC has asked that an additional examination or test be performed upon the Member, provided the examination or test is reasonable and consistent with good medical practice, PBHC will notify the

Participating Provider and the Member, in writing, that a decision cannot be made within the required time frame. The notification will specify the information requested but not received or the additional examinations or tests required, and the anticipated date on which a decision may be rendered. Upon receipt of all information reasonably necessary and requested by PBHC, PBHC shall approve or deny the request for authorization within the time frames specified above as applicable.

PBHC notifies requesting Participating Providers of decisions to approve, modify or deny requests for authorization of Behavioral Health Services for Members within twenty-four (24) hours of the decision. Members are notified of decisions, in writing, within two (2) business days of the decision, including a description of the reasons for the decision, the criteria or guidelines used, the clinical reasons for decisions regarding Medical Necessity, and information about how to file an appeal of the decision with PBHC.

If you would like a copy of PBHC's description of the processes utilized for authorization, modification or denial of Behavioral Health Services, or the criteria or guidelines related to a particular condition, you may contact the PBHC Customer Service department

Experimental and Investigational Therapies

PBHC also provides an external, independent review process to review its coverage decisions regarding Experimental or Investigational therapies for PBHC Members who meet all of the following criteria:

You have a Life-Threatening or Seriously Debilitating condition, as defined below, which meets the criteria listed in items #2, #3, #4 and #5 below:

"Life-Threatening" means either or both of the following: (i) diseases or conditions where the likelihood of death is high unless the course of the disease is interrupted; (ii) diseases or conditions with potentially fatal outcomes, where the end point of clinical intervention is survival.

"Seriously Debilitating" means diseases or conditions that cause major irreversible morbidity.

Your PBHC Participating Provider certifies that you have a Life-Threatening or Seriously Debilitating condition, as defined above, for which standard therapies have not been effective in improving your condition, or for which standard therapies would not be medically appropriate for you, or for which there is no more beneficial standard therapy covered by PBHC than the therapy proposed pursuant to paragraph (3); and



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Either (a) your PBHC Participating Provider has recommended a treatment, drug, device, procedure or other therapy that he or she certifies in writing is likely to be more beneficial to you than any available standard therapies, and he or she included a statement of the evidence relied upon by the Participating Provider in certifying his or her recommendation; or (b) you, or your non-contracting physician who is a licensed, board-certified or board-eligible physician or provider qualified to practice in the area of practice appropriate to treat your condition, has requested a therapy that, based on two documents from medical and scientific evidence, as defined in the California Health and Safety Code Section 1370.4(d), is likely to be more beneficial for you than any available standard therapy. Such certification must include a statement of the evidence relied upon by the physician in certifying his or her recommendation. PBHC is not responsible for the payment of services rendered by non-contracting providers that are not otherwise covered under the Member's PBHC benefits; and a PBHC Medical Director or designee has denied your request for a drug, device, procedure or other therapy recommended or requested pursuant to paragraph (3); and

The treatment, drug, device, procedure or other therapy recommended pursuant to paragraph (3) above would be a covered service, except for PBHC's determination that the treatment, drug, device, procedure or other therapy is Experimental or Investigational.

Please refer to the Independent Medical Review of Disputed Health Care Services section found later in this EOC for more information.

Second Opinions

A Member, or his or her treating PBHC Participating Provider, may submit a request for a second opinion to PBHC either in writing or verbally through the PBHC Customer Service department. Second opinions will be authorized for situations, including but not limited to, when: (i) the Member questions the reasonableness or necessity of recommended procedures; (ii) the Member questions a diagnosis or plan for care for a condition that threatens loss of life, loss of limb, loss of bodily functions, or substantial impairment, including but not limited to a chronic condition; (iii) the clinical indications are not clear or are complex and confusing, a diagnosis is in doubt due to conflicting test results, or the treating provider is unable to diagnose the condition and the Member requests an additional diagnosis; (iv) the Treatment Plan in progress is not

improving the medical condition of the Member within an appropriate period of time given the diagnosis and plan of care, and the Member requests a second opinion regarding the diagnosis or continuance of the treatment; or (v) the Member has attempted to follow the plan of care or consulted with the initial provider concerning serious concerns about the diagnosis or plan of care.

The request for a second opinion will be approved or denied by PBHC's Medical Director or designee in a timely fashion appropriate for the nature of the Member's condition. Second opinions can only be rendered by a provider who possesses the clinical background related to the illness or condition associated with the request for a second opinion. If you are requesting a second opinion about care received from your PBHC Participating Provider, the second opinion will be provided by a provider of your choice within the PBHC Participating Provider network.

A second opinion will be documented by a consultation report which will be made available to you. If the Provider giving the second opinion recommends a particular treatment, diagnostic test or service covered by PBHC, and it is determined to be Medically Necessary by your Participating Provider, the treatment, diagnostic test or service will be provided or arranged by the Member's Participating Provider. However, the fact that a Participating Provider, furnishing a second opinion, recommends a particular treatment, diagnostic test or service does not necessarily mean that the treatment, diagnostic test or service is Medically Necessary or a covered service under your PBHC Plan. You will be responsible for paying any Copayment, as set forth in your *Schedule of Benefits*, to the PBHC Participating Provider who renders the second opinion.

If the Member's request for a second opinion is denied, the Member may appeal the denial by following the procedures outlined in the PBHC Appeals Process described below.

Responding To Your Concerns – the PBHC Appeals Process

Our first priority is to meet your needs, and that means providing responsive service. If you ever have a question or problem, your first step is to call the PBHC Customer Service department for resolution.

If you feel the situation has not been addressed to your satisfaction, you may submit a formal complaint over the telephone by calling the PBHC toll-free number. You can also file a complaint in writing:

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PacifiCare Behavioral Health of California, Inc.
Post Office Box 55307
Sherman Oaks, CA 91413-0307
Attn: Appeals Department

Appeals Process

All Members have the right to appeal any claim denial or denial of treatment authorization. Members, or their authorized representatives including their treating providers, may initiate the Appeal Process either verbally or in writing, however, it may be necessary for PBHC to request written clinical or other information in order for the appeal to be reviewed. All Member appeals shall be reviewed and responded to in writing within thirty (30) calendar days of receipt of all information necessary for review by PBHC.

PBHC Appeal Process

A Member or authorized Member representative may initiate the Appeal Process either verbally by calling the Customer Service department toll-free telephone number, or in writing to the address indicated above. Within five (5) days of receipt of written appeals, acknowledgment letters are sent to the individual initiating the appeal.

The appeal is reviewed by the PBHC Director of Clinical Services or designee. The Member is notified in writing of the determination within thirty (30) business days of receipt of the appeal and provided with instructions for initiating the next level of appeal as well as the opportunity to use our External Review Process, if applicable. All determinations and rationale for determinations are documented in writing to the provider and Member. If PBHC is unable to review the appeal within thirty (30) business days of receipt of the appeal, the individual who initiated the appeal will be notified of the delay, the specific reason for the delay, and the expected date of completion of the review.

Further, the Member may seek assistance or review by the Department of Managed Health Care (DMHC) at any time after participating in the PBHC Appeal Process for more than thirty (30) days. If this occurs, the Member will have an additional sixty (60) days from the date of the final resolution of the matter by the DMHC to elect binding arbitration.

Expedited Review Process

Appeals involving an imminent or serious threat to the health of the Member, including but not limited to, severe pain, potential loss of life, limb, or other major bodily function will be immediately referred to the PBHC Medical Director for expedited review, regardless

of whether such appeal is received orally or in writing. If an appeal has been sent to the PBHC Medical Director for immediate expedited review, PBHC will immediately inform the Member, in writing, of his or her right to notify the DMHC of the appeal. PBHC will provide the Member and the DMHC with a written statement of the disposition or pending status of the expedited review no later than three (3) days from receipt of complaint.

Independent Medical Review of a Disputed Health Care Service

You may request an Independent Medical Review (IMR) of disputed health care services from the Department of Managed Health Care if you believe that health care services have been improperly denied, modified, or delayed by PBHC or one of its Participating Providers.

A “disputed health care service” is any health care service eligible for coverage under your subscriber contract that has been denied, modified, or delayed by PBHC or one of its Participating Providers, in whole or in part because the service is not Medically Necessary. Be sure to check the IMR Eligibility section below to see if your grievance qualifies for an IMR.

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

IMR Eligibility: Your application for an IMR will be reviewed by the DMHC to confirm that:

- Your provider has recommended a health care service as Medically Necessary; or
- You have received Urgent care or Emergency services that a provider determined was Medically Necessary; or
- You have been seen by a PBHC Participating Provider for the diagnosis and treatment of the medical condition for which you seek independent review;
- The disputed health care service has been denied, modified, or delayed by PBHC or one of its Participating Providers, based in whole or in part on a decision that the health care service is not Medically Necessary; and



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- You have filed a grievance with PBHC and the disputed decision is upheld or the grievance remains unresolved after thirty (30) days. If your grievance requires expedited review you may bring it immediately to the DMHC's attention. The DMHC may waive the preceding requirement that you follow PBHC's grievance process in extraordinary and compelling cases.

If your case is eligible for an IMR, the dispute will be submitted to a medical specialist who will make an independent determination of whether or not the care is Medically Necessary. You will receive a copy of the assessment made in your case. If the IMR determines the service is Medically Necessary, PBHC will provide the health care service.

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

For more information regarding the IMR process, or to request an application form, please call PBHC's Customer Service department at 1-800-999-9585.

Binding Arbitration and Voluntary Mediation

If the Member is dissatisfied with the determination of the Independent Medical Review, the Member may, within sixty (60) days, submit or request that PBHC submit the appeal to binding arbitration or voluntary mediation before the Judicial Arbitration and Mediation Services, Inc. Systems (JAMS).

Upon submission of a dispute to JAMS, the Member and PBHC agree to be bound by the rules of procedure and the decision of JAMS. Full discovery shall be permitted in preparation for arbitration pursuant to California Code of Civil Procedure, Section 1283.05.

PBHC AND THE MEMBER UNDERSTAND THAT BY ENTERING INTO THIS AGREEMENT, THEY WAIVE THEIR CONSTITUTIONAL RIGHT TO HAVE ANY SUCH DISPUTE DECIDED IN A COURT OF LAW BEFORE A JURY AND INSTEAD ARE ACCEPTING THE USE OF ARBITRATION.

If the Member is requesting voluntary mediation, in order to initiate mediation, the Member or agent acting on behalf of the Member, shall submit a written request for voluntary mediation. If the parties mutually

agree to mediation, the mediation will be administered by JAMS in accordance with its Commercial Mediation Rules, unless otherwise agreed by the parties. Expenses for mediation shall be borne equally by both parties. The Department of Managed Health Care shall have no administrative or enforcement responsibilities in connection with the voluntary mediation process.

If the Member elects binding arbitration, with the exception of claims brought pursuant to The PBHC Quality Review Process section below, any claim, controversy, dispute or disagreement between PBHC and the Member which arises out of or is related to this Agreement that is not resolved by the above appeals process shall be resolved by binding arbitration by a single arbitrator.

If the amount of the claim is less than \$200,000, then the arbitrator shall have no jurisdiction to award more than \$200,000.

JAMS, or other neutral administrator as PBHC shall designate, will administer the arbitration. The Comprehensive Arbitration Rules and Procedures (Rules) in effect at the time demand for arbitration is made will be applied to the arbitration. The parties will endeavor to mutually agree to the appointment of the arbitrator, but if such agreement cannot be reached within thirty (30) days following the date demand for arbitration is made, the arbitrator appointment procedures in the Rules will be utilized.

Arbitration hearings shall be held at the neutral administrator's offices in Los Angeles, California or at such other location as the parties may agree to in writing. Civil discovery may be taken in such arbitration as provided by California law and civil procedure. The arbitrator(s) selected shall have the power to control the timing, scope and manner of the taking of discovery and shall further have the same powers to enforce the parties' respective duties concerning discovery as would a Superior Court of California, including but not limited to, the imposition of sanctions. The arbitrator(s) shall have the power to grant all remedies provided by California law. The arbitrator(s) shall prepare, in writing, an award that includes the legal and factual reasons for the decision.

The parties shall divide equally the fees and expenses of the arbitrator(s) and the neutral administrator except that in cases of extreme hardship, PBHC may assume all or part of a Member's share of the fees and expenses of the arbitrator(s) provided the Member has submitted a hardship application with JAMS or such other neutral administrator designated by PBHC. The approval or denial of a hardship application shall be

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determined by such administrator. The arbitrator(s) shall not have the power to commit errors of law or legal reasoning, and the award may be vacated or corrected pursuant to California law. The Federal Arbitration Act, 9 U.S.C. Sections 1-4, shall also apply to the arbitration.

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

THE PBHC Quality Review Process

The Quality Review Process is a Member-initiated internal review process that addresses Member concerns regarding the quality or appropriateness of services provided by PBHC Participating Providers that has the potential for an adverse effect on the Member. Upon receipt of the Member's concern, the concern is referred to the Quality Improvement Department for investigation.

PBHC takes great pride in the quality of our Participating Providers. That is why complaints specifically about the quality of the care you receive from your Participating Provider are handled in an expedited fashion. Quality of care complaints that affect a Member's current treatment shall be immediately evaluated and if necessary, other appropriate PBHC personnel and the PBHC Participating Provider will be consulted.

The Quality Improvement Specialist or designee will be responsible for responding to questions the Member may have about his or her complaint and about the Quality Review process. In appropriate instances, the Quality Improvement Specialist may arrange a meeting between the Member and the Participating Provider.

The relevant medical records will be obtained from the appropriate providers and reviewed by the PBHC Quality Improvement Specialist or designee. If necessary, a letter is sent to the Participating Provider, as appropriate, requesting further information. Additional information will be received and reviewed by the Quality Improvement Specialist or his or her designee. After reviewing the medical records, the case is referred to the Peer Review Committee for review and recommendation of corrective action against the PBHC Participating Provider involved, if appropriate.

If the Member has submitted a written complaint, the Member shall be notified of the completion in writing within thirty (30) days. The oral and written communications involving the Quality Review Process

and the results of the review shall remain confidential and cannot be shared with the Member. Nor can the outcome of the Quality Review Process be submitted to voluntary mediation or binding arbitration as described above under the PBHC Appeals Process. The Quality Improvement Specialist will follow-up to ensure that any corrective actions against a Participating Provider are carried out.

Review By the Department of Managed Health Care

The California Department of Managed Health Care is responsible for regulating health care service plans. The Department has a toll free number **(1-800-HMO-2219)** to receive complaints regarding health plans. The hearing and speech impaired may use the California Relay Service's toll-free telephone numbers **(1-877-688-9891 TDD)** to contact the Department. The Department's Internet Web site (<http://www.hmohelp.ca.gov>) has complaint forms and instructions online. If a Member has a grievance against PBHC, the Member should first telephone PBHC at **1-800-999-9585** and use PBHC's Appeal Process outlined in this EOC.

If the Member needs help with a grievance involving an Emergency, a grievance that has not been satisfactorily resolved by PBHC, or a grievance that has remained unresolved for more than thirty (30) days, the Member may call the Department's toll-free telephone number for assistance. PBHC's Appeals Process and the Department's complaint review process are in addition to any other dispute resolution procedures that may be available to the Member, and the Member's failure to use these processes does not preclude the Member's use of any other remedy provided by law.

Covered Services

Behavioral Health Services must be:

- Incurred while the Member is eligible for PacifiCare benefits;
- Preauthorized by a PBHC Clinician as Medically Necessary; and
- Rendered by a PBHC Participating Provider, except in the case of an Emergency.

PBHC will pay for the following Behavioral Health Services furnished in connection with the treatment as outlined in the *Schedule of Benefits*, provided the criteria above are met.



How Your Behavioral Health Care Benefits Work

Inpatient Hospital Benefits/Acute Care and Partial Hospital Benefits – Inpatient hospital services provided at a PBHC Participating Facility, except in an Emergency.

Inpatient Physician Care – Services of physicians while the Member is hospitalized on an inpatient basis.

Physician Care – Diagnostic and treatment services including consultation and treatment.

Ambulance – Use of an ambulance (land or air) for Emergencies, including but not limited to, ambulance or ambulance transport services provided through the 911 emergency response system is covered without prior authorization when the Member reasonably believes that the behavioral health condition requires Emergency Services that require ambulance transport services. Use of an ambulance for a nonemergency is covered when specifically authorized by PBHC.

Laboratory Services – Diagnostic and therapeutic laboratory services are covered when related to the approved Behavioral Health Treatment Plan.

Inpatient Prescription Drugs – Inpatient Prescription Drugs are covered only when prescribed by a PBHC Participating Provider for Behavioral Health Services.

Outpatient Prescription Drugs – Outpatient Prescription Drugs are covered only if an Outpatient Prescription Drug Supplemental Benefit Rider is attached to the PacifiCare of California Agreement and the prescription drugs were prescribed by a PBHC Participating Provider for a Behavioral Health diagnosis.

Injectable Psychotropic Medications – Injectable psychotropic medications are covered if prescribed by a PBHC Participating Provider for a Behavioral Health diagnosis.

Psychological Testing – When preauthorized by a PBHC Clinician and provided by a licensed psychologist under contract with PBHC.

Exclusion and Limitations

All exclusions and limitations listed in the PacifiCare of California Group Subscriber Agreement and EOC under the Exclusions and Limitations Section.

Treatment for any learning or reading disorder, mental retardation, motor skills disorder, and communication disorder.

Treatments which do not meet national standards for mental health professional practice.

Non-organic therapies, including but not limited to, the following: bioenergetics therapy, confrontation therapy, crystal healing therapy, educational remediation, EMDR, guided imagery, marathon therapy, primal therapy, rolfing, sensitivity training, transcendental meditation, Lovaas' Discrete Trial Training, Facilitated Communication, and EEG biofeedback (neurofeedback).

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, and rapid anesthesia opiate detoxification.

Treatments designed to regress the Member emotionally or behaviorally.

Personal enhancement or self-actualization therapy and other treatments.

Routine, custodial, convalescent care, long term therapy and/or rehabilitation. Individuals should be referred to appropriate community resources such as school districts and/or regional centers for these services.

Services provided by nonlicensed providers for the treatment of any illness or injury.

Pastoral or spiritual counseling.

Dance, poetry, music or art therapy except as part of a Behavioral Health Treatment Program.

Thought field therapy.

School counseling and support services, home based behavioral management, household management training, peer support services, recreation, tutor and mentor services, independent living services, supported work environments, job training and placement services, therapeutic foster care, wraparound services, emergency aid to household items and expenses, and services to improve economic stability and interpretation services.

Genetic counseling.

Community care facilities that provide 24-hour non-medical residential care.

IN ORDER TO FULLY UNDERSTAND YOUR BENEFIT PLAN, THIS PBHC COMBINED EVIDENCE OF COVERAGE AND DISCLOSURE FORM IS TO BE USED IN CONJUNCTION WITH YOUR PACIFICARE OF CALIFORNIA MEDICAL PLAN COMBINED EVIDENCE OF COVERAGE AND DISCLOSURE FORM. PLEASE READ BOTH DOCUMENTS CAREFULLY.

Hearing Aid Benefits



50% coinsurance per device

Maximum: \$2,000 every 36 months

Hearing aid expenses for members are covered as follows:

- An eyeglass-type hearing aid or additional charges for a hearing aid designed specifically for cosmetic purposes.

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.



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

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

Case Management is a 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 Medical Condition is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence

of immediate medical attention could reasonably be expected by the Member to result in any of the following:

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

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

Enrollment is the execution of a PacifiCare Enrollment Form, or a nonstandard 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.

Understanding Health Care Terms



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 Nonparticipating 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.

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

Physician includes any licensed allopathic or osteopathic physician.

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

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

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

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



Understanding Health Care Terms

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

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

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

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

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

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

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.

Nonparticipating Pharmacy means a pharmacy that has not contracted with PacifiCare.

Preauthorization 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

The following definitions apply to your Behavioral Health benefits. These are in addition to the definitions provided in the PacifiCare of California Medical Plan *Combined Evidence of Coverage and Disclosure Form*. Please refer to the *Schedule of Benefits* to determine which definitions apply to your benefits.

Alternative Levels of Care. The least restrictive level of care used to return the 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.

Behavioral Health Services. Chemical Dependency and Mental Health Services, including services for the treatment of SMI and SED of a child, collectively, to be provided to Members.

Understanding Health Care Terms



Behavioral Health Treatment Plan. A written clinical presentation of the Participating Provider's 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.

Behavioral Health Treatment Program. A structured treatment program aimed at the treatment and alleviation of Severe Mental Illness, Serious Emotional Disturbances of a child, Chemical Dependency and/or Mental Disorders.

Benefit Plan Design. The specific behavioral health benefit plan design for a PacifiCare Medical Plan which describes the coverage, pertinent terms and conditions for rendering Behavioral Health Services and the exclusions or limitations applicable to the covered Behavioral Health Services.

Chemical Dependency. 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 Inpatient Treatment Program. A structured medical and behavioral inpatient program aimed at the treatment and alleviation of Chemical Dependency.

Chemical Dependency Services. Services provided for the treatment of Chemical Dependency.

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

Crisis. 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.

Custodial Care. Personal services required to assist the Member in meeting the requirements of daily living. Custodial Care is not covered under this PBHC Behavioral Health Plan unless specifically listed in the *Schedule of Benefits*. Such services include, without limitation, assistance in walking, getting in or out of

bed, bathing, dressing, feeding, or using the lavatory, preparation of special diets and supervision of medication schedules. Custodial Care does not require the continuing attention of trained medical or paramedical personnel.

Customer Service Department. The department designated by PBHC 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:

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

Day Treatment Center. A Participating 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 PBHC Participating Provider, and which is also licensed, certified or approved as a Facility by the appropriate state agency.

Diagnostic and Statistical Manual (or 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. A behavioral health condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the prudent layperson would expect the absence of immediate Behavioral Health Services to result in any of the following:

- Immediate harm to self or others;
- Placing one's health in serious jeopardy;
- Serious impairment of one's functioning; or
- Serious dysfunction of any bodily organ or part.

If you or your Dependent are temporarily outside of California, experience a situation which requires Behavioral Health Services and a delay in treatment from a PBHC Participating Provider in California would result in a serious deterioration to your health, the situation will be considered an Emergency.

Emergency Treatment. Medically Necessary ambulance and ambulance transport services provided through the 911 (or alternative emergency response system) and medical screening, examination and evaluation by a Practitioner, to the extent permitted by applicable law and within the scope of their licensure



Understanding Health Care Terms

and clinical privileges, to determine if an Emergency for a Behavioral Health condition exists, and if it does, the care and treatment by a Practitioner necessary to relieve or eliminate the Emergency within the capabilities of the Facility.

Experimental and Investigational. Please refer to the Experimental and Investigational Therapies section of this EOC.

Facility. A health care 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 Behavioral Health Services.

Group. An employer, organization, association or other entity to whom the PBHC Group Agreement has been issued.

Group Agreement. The Agreement for the provision of Behavioral Health Services between the Group and PBHC.

Group Therapy. Goal-oriented Behavioral Health Services provided in a group setting (of usually about 6 to 12 participants) by a PBHC Participating Provider. Group Therapy can be made available to the Member in lieu of individual outpatient therapy when appropriate.

Inpatient Treatment Center. An acute care Participating Facility which provides Behavioral Health Services in an acute, inpatient setting, pursuant to a written Treatment Plan approved and monitored by a PBHC Participating Provider and which also:

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

Maximum Benefit. The lifetime or annual maximum amount shown in the PBHC *Schedule of Benefits* which PBHC will pay for any authorized Behavioral Health Services provided to Members by PBHC Participating Providers, if applicable.

Medical Detoxification. 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 this PBHC Benefit Plan.

Medically Necessary (or Medical Necessity). Services which are determined by PBHC to be:

- a. Rendered for the treatment or diagnosis of a Behavioral Health condition as defined by the DSM-IV;
- b. Appropriate for the symptoms, consistent with diagnosis, and otherwise in accordance with professionally recognized standards, which shall include the consideration of scientific evidence;
- c. Not furnished primarily for the convenience of the Member, the attending Physician, or other provider of services; and
- d. If more than one service, supply or level of care meets the requirements, of (a) through (c) above, furnished in the most cost-effective manner which may be provided safely and effectively to the Member.

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

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

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

Participating Facility. A health care or residential facility which is duly licensed in the State of California to provide inpatient, residential, day treatment, partial hospitalization or outpatient care for the diagnosis and/or treatment of covered Behavioral Health Services, and which has entered into a written agreement with PBHC.

Participating Practitioner. A psychiatrist, psychologist or other allied behavioral health care professional who is qualified and duly licensed or certified to practice his or her profession under the laws of the State of California, and who has entered into a written agreement with PBHC to provide covered Behavioral Health Services to Members.

Understanding Health Care Terms



Participating Preferred Group Practice. 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.

Participating Providers. Participating Practitioners, Participating Preferred Group Practices and Participating Facilities, collectively, each of which has entered into a written agreement with PBHC to provide covered Behavioral Health Services to Members.

PBHC Clinician. 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.

Residential Treatment Center. A Participating Facility which provides Behavioral Health Services on a full or part-day basis, pursuant to a written Treatment Plan approved and monitored by a Practitioner, and which also:

1. provides 24-hour nursing and medical supervision; and
2. is licensed, certified or approved as such by the appropriate state agency.

Routine Detoxification. 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 for unstable medical problems exacerbated by withdrawal from chemical substances including, but not limited to, diabetes mellitus, hypertension or serious withdrawal complications which may necessitate Medical Detoxification.

Schedule of Benefits. The schedule of Behavioral Health Services, which is provided to a Member under this Plan. Also see the *Schedule of Benefits* under the PacifiCare of California Medical Plan.

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

- Has one or more mental disorders as defined by the Diagnostic and Statistical Manual (DSM-IV), other than a primary substance use disorder or developmental disorder, that results in behavior inappropriate to the child's age according to expected developmental norms; and
- Is under the age of eighteen (18) years old.

Furthermore, the child must meet one or more of the following criteria:

- As a result of the mental disorder, the child has substantial impairment in at least two of the following areas: self-care, school functioning, family relationships, or ability to function in the community; and either of the following occur:
 - i. the child is at risk of removal from home or has already been removed from the home,
 - ii. the mental disorder and impairments have been present for more than six months or are likely to continue for more than one year without treatment; or
- The child displays one of the following: psychotic features, risk of suicide or risk of violence due to a mental disorder; or
- The child meets special education eligibility requirements under Chapter 26.5 commencing with Section 7570 of Division 7 of Title 1 of the California Government Code.

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

- Anorexia Nervosa
- Bipolar Disorder
- Bulimia Nervosa
- Major Depressive Disorder
- Obsessive-Compulsive Disorder
- Panic Disorder
- Pervasive Developmental Disorder or Autism
- Schizoaffective Disorder
- Schizophrenia



Understanding Health Care Terms

Treatment Episode/Plan. 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.

Urgent or Urgently Needed Services. 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. An outpatient session with a PBHC Participating Practitioner conducted on an individual or group basis during which Behavioral Health Services are delivered.

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

General Features

Deductible	-0-
Maximum Benefits	Unlimited
Annual Copayments Maximum	\$1,000/Individual \$3,000/Family
Office Visits	\$10 Copayment
Hospitalization	\$250 per admission
Emergency Services <i>(Waived if admitted as an inpatient)</i>	\$50 Copayment
Urgently Needed Services <i>(Medically Necessary Services required outside your Service Area)</i> <i>(Waived if admitted as an inpatient)</i>	\$50 Copayment
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 <i>(Detoxification only)</i>	\$250 per admission
Bone Marrow Transplant <i>(Donor searches limited to \$10,000 or 50 searches per lifetime)</i>	\$250 per admission
Cancer Clinical Trials ¹	Paid at contracting rate. Balance (if any) is the responsibility of the member
Hospice Care <i>(Up to one calendar year lifetime maximum)</i>	\$250 per admission
Hospital Benefits <i>(Autologous (self-donated) blood up to \$120.00 per unit)</i>	\$250 per admission
Mastectomy/Breast Reconstruction <i>(After a mastectomy and complications from a mastectomy)</i>	\$250 per admission
Maternity Care	\$250 per admission
Newborn Care <i>(After birth, if readmitted)</i>	\$250 per admission
Physician Care	Paid In Full
Rehabilitation Care	\$250 per admission
Skilled Nursing Care <i>(Up to one-hundred (100) calendar days from the first treatment per disability)</i>	Paid In Full
Voluntary Interruption Of Pregnancy	
- 1st trimester	Paid In Full
- 2nd trimester (12-20 weeks)	Paid In Full
- After 20 weeks <i>(*Voluntary interruption of pregnancy after the 20th week will be covered only when the mother's life is in jeopardy)</i>	Not covered*

Benefits Available On an Outpatient Basis

Alcohol, Drug, Or Other Substance Abuse Or Addiction <i>(Detoxification only)</i>	\$10 Copayment
Allergy Testing/Treatment <i>(Serum is included)</i>	\$10 Copayment
Ambulance	Paid In Full
Attention Deficit Disorder <i>(Medical Management)</i>	\$10 Copayment
Breast Cancer Screening, Diagnosis And Treatment	\$10 Copayment
Cochlear Implants	Paid In Full

Benefits Available On an Outpatient Basis (continued)

Dental Treatment Anesthesia	Paid In Full
Diabetes Management And Treatment	\$10 Copayment
Durable Medical Equipment	Paid In Full
Cancer Clinical Trials ¹	Paid at contracting rate. Balance (if any) is the responsibility of the member
Corrective Appliances And Prosthetics	Paid In Full
Eligible Materials And Supplies	Paid In Full
Family Planning/Voluntary Interruption Of Pregnancy	
– Vasectomy	\$10 Copayment
– Tubal ligation ²	\$10 Copayment
– Insertion/removal of Intra-Uterine Device (IUD)	\$10 Copayment
– Intra-Uterine Device (IUD)	50% Copayment
– Removal of Norplant	\$10 Copayment
– Depo-Provera injection	\$10 Copayment
– Depo-Provera medication (Limited to one Depo-Provera injection every 90 days)	\$35 Copayment
– Voluntary interruption of pregnancy	
– 1st trimester	\$10 Copayment
– 2nd trimester (12 – 20 weeks)	\$10 Copayment
– After 20 weeks	Not covered*
<i>(*Voluntary interruption of pregnancy after the 20th week will be covered only when the mother's life is in jeopardy)</i>	
Health Education Services	Paid In Full
Hearing Screening	\$10 Copayment
Hemodialysis	\$10 Copayment
Home Care	Paid In Full
Hospice Care – Outpatient Basis And In-Home Visits (Up to one calendar year per lifetime)	Paid In Full
Immunizations (For children under two years of age, refer to Well-Baby Care)	\$10 Copayment
Infertility Services	50% Copayment
Laboratory And Radiology	Paid In Full
Maternity Care, Tests And Procedures	Paid In Full
Medical Social Services (Voluntary interruption of pregnancy after the 20th week will be covered only when the mother's life is in jeopardy)	Paid In Full
Mental Health Services	\$10 Copayment per visit
– For additional benefits, See Behavioral Health Benefits.	
– Up to twenty (20) visits for crisis intervention during each calendar year following your initial date of eligibility.	
– A Copayment may be charged for missed scheduled appointments.	
Oral Surgery	Paid In Full
Outpatient Rehabilitation Therapy	\$10 Copayment
Outpatient Surgery	Paid In Full
Periodic Health Evaluations <i>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.</i>	\$10 Copayment
Phenylketonuria (PKU) Testing and Treatment	\$10 Copayment
Physician Care (For children under two years of age, refer to Well-Baby Care)	\$10 Copayment
Vision Refractions	\$10 Copayment
Vision Screening	\$10 Copayment
Well-Baby Care <i>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.</i>	Paid In Full

Well-Woman Care <i>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.</i>	\$10 Copayment
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¹ Services require preauthorization from PacifiCare.

² This Copayment applies regardless of whether this service is performed as an inpatient or on an outpatient basis. If this service is performed on an inpatient basis, you will also be required to pay the applicable inpatient Copayment for your benefit plan, if any.

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 Formulary Drugs	\$10 Copayment
Brand-Name Formulary Drugs	\$20 Copayment
Non-Formulary Drugs	\$35 Copayment

Mail Service (Up to 90 day supply)

Generic and Selected Brand-Name Formulary Drugs	\$20 Copayment
Brand-Name Formulary Drugs	\$40 Copayment
Non-Formulary Drugs	\$70 Copayment

HEARING AID BENEFIT SCHEDULE OF BENEFITS

General Features

Hearing Aids	50% Coinsurance per device
Maximum Benefit	\$2,000 every 36 months

Preauthorization is required for all Mental Health Services, Chemical Dependency Services and Severe Mental Illness (SMI) Benefits. You do not need to go through your Primary Care Physician, but you must obtain prior authorization through PacifiCare Behavioral Health of California (PBHC), an affiliate of PacifiCare that specializes in mental health and chemical dependency benefits. PBHC is available to you toll-free, 24 hours a day, 7 days a week, at 1-800-999-9585.

Mental Health Services

Inpatient Deductible	None
Inpatient per Admittance	\$250 per admission
Inpatient, Residential and Day Treatment <i>Unlimited days (Based upon Medical Necessity)</i>	\$250 per admission
Outpatient Treatment <i>Unlimited visits (Based upon Medical Necessity)</i>	\$10 Copayment per visit
Emergency and Urgently Needed Services ¹ <i>(Copayment waived if admitted as inpatient)</i>	Same as medical plan Copayment for Emergency and Urgently Needed Services ¹ .

Chemical Dependency Health Services

Inpatient Deductible	None
Inpatient Treatment	\$250 per admission
Outpatient Treatment	\$10 Copayment per visit
Emergency and Urgently Needed Services ¹ <i>(Copayment waived if admitted as inpatient)</i>	Same as medical plan Copayment for Emergency and Urgently Needed Services ¹ .

Serious Mental Illness Benefit²

Inpatient Deductible	None
Inpatient per Admittance	\$250 per admission
Inpatient, Residential and Day Treatment <i>Unlimited days (Based upon Medical Necessity)</i>	\$250 per admission
Outpatient Treatment <i>Unlimited visits (Based upon Medical Necessity)</i>	\$10 Copayment per visit
Emergency and Urgently Needed Services ¹ <i>(Copayment waived if admitted as inpatient)</i>	Same as medical plan Copayment for Emergency and Urgently Needed Services ¹ .

¹ Urgently Needed Services are Medically Necessary Services required outside 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, including severe pain, such that treatment cannot be delayed until the Member returns to the Service Area.

² Severe Mental Illness Diagnoses include: Schizophrenia, Schizoaffective Disorder, Bipolar Disorder, Major Depressive Disorder, Panic Disorder, Obsessive-Compulsive Disorder, Pervasive Developmental Disorders (Autism), Anorexia and Bulimia Nervosa. In addition, the Severe Mental Illness Benefit includes coverage of Serious Emotional Disturbance of Children (SED).

You do not need to go through your Primary Care Physician, but you must obtain prior authorization through PacifiCare Behavioral Health of California (PBHC), an affiliate of PacifiCare that specializes in mental health and chemical dependency benefits. PBHC is available to you toll-free, 24 hours a day, 7 days a week, at 1-800-999-9585.

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.

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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.

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.

PacifiCare's Customer Service –

We're Here for You

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

Count on Us for Efficient Service

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

We'll Expedite Your Requests

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

We're Here To Answer Your Questions

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

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

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

Concerns, Comments, Suggestions?

That's what we're here for.

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

Monday – Friday
7:00 a.m. – 9:00 p.m.

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Secure Horizons Medicare+Choice Plan

Effective January 1, 2003 Through December 31, 2003

Evidence of Coverage & Disclosure Information

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

Reference Page



Please fill this out for your reference:

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

Your Effective Date of enrollment

Your Rights Under The Plan:

As a participant in a University of California medical plan, you are entitled to certain rights and protections. All Plan participants shall be entitled to: Examine, without charge, at the Plan Administrator's office, or instead of or in addition to, at other locations that may be specified by the Plan Administrator, all Plan documents, including the Group Service Agreement. Obtain copies of all Plan documents and other information for a reasonable charge upon written request to the Plan Administrator.

Questions? Problems? Need help?

Call or write Secure Horizons Member Service, 1-800-228-2144, Telecommunications Device for the Hearing-Impaired (TDHI): 1-800-685-9355, 7:00 a.m. to 8:00 p.m. weekdays, or P. O. Box 489, Cypress, California 90630.

This Combined Evidence of Coverage and Disclosure Form contains the terms and conditions of coverage with Secure Horizons Medicare+Choice (M+C) Plan 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.

To receive additional information about the benefits of the Secure Horizons Medicare+Choice Plan, please contact 1-800-228-2144, Telecommunications Device for the Hearing-Impaired (TDHI): 1-800-685-9355.

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

This Combined Evidence of Coverage and Disclosure Information constitutes only a summary of Secure Horizons Medicare+Choice (M+C) Plan. This document will be mailed to you annually at the beginning of the Calendar Year or shortly thereafter upon state and federal regulatory approval. This document is effective for the Calendar Year January 1, 2003 through December 31, 2003.

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

Nondiscrimination Statement:

In conformance with applicable law and University policy, the University is an affirmative action/equal opportunity employer. Please send inquiries regarding the University's affirmative action and equal opportunity policies for staff to Director Mattie Williams and for faculty to Executive Director Sheila O'Rourke, both at this address: University of California Office of the President, 1111 Franklin Street, Oakland, CA 94607.



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Welcome To Secure Horizons Medicare+Choice Plan

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

This document and your Retiree Benefit Summary are an explanation of your rights, benefits and responsibilities as a Member of the Secure Horizons M+C Plan, a “Medicare+Choice” (M+C) Plan offered by PacifiCare of California, a Health Maintenance Organization, with a Medicare+Choice contract. It also explains Secure Horizons M+C Plan responsibilities to you. Your agreement with Secure Horizons M+C Plan consists of this combined Evidence of Coverage and Disclosure Information, which includes your Retiree Benefit Summary, your Election Form and any current or future amendments.

This combined Evidence of Coverage and Disclosure Information, which includes your Retiree Benefit Summary, contains important information regarding your health care coverage. Your Retiree Benefit Summary provides the details of your particular benefit plan, including any Copayments that you should pay when receiving a covered benefit. Together, these documents explain your health care coverage. Please read them carefully. All capitalized terms are defined in Section 1. Keep it in a safe place, available for quick reference.

Secure Horizons M+C Plan is not an insurance policy that merely pays Medicare deductibles and Coinsurance charges (commonly called a “Medigap” or “Medicare supplement” policy and regulated by the State insurance department). Instead, Secure Horizons M+C Plan has entered into a contract with the Centers for Medicare & Medicaid Services (CMS), the Federal government agency that administers Medicare. This contract authorizes Secure Horizons M+C Plan to arrange for health services for persons who are entitled to Original Medicare benefits and who choose to enroll in Secure Horizons M+C Plan. When you join Secure Horizons M+C Plan, you usually do not pay Original Medicare deductibles and Coinsurance and instead pay

Plan Premiums, Copayments and Coinsurance. Secure Horizons M+C Plan covers all services and supplies offered by Original Medicare, plus some additional services and supplies not covered by Original Medicare.

PacifiCare of California has signed a contract with CMS agreeing to cover you for one full year at a time. Secure Horizons M+C Plan costs and benefits may change from year to year, and we would notify you before any changes were made. In addition, either CMS or PacifiCare of California may choose to renew all or a portion of the contract. If the contract is not renewed, your Medicare coverage will be switched to Original Medicare unless you decided to enroll in another Medicare managed care plan. If either we or CMS decide not to renew the contract at the end of the year, we will send you a letter at least ninety (90) days before the end of the contract. If CMS ends the contract in the middle of the year, you will get a letter in the middle of the year. You will get a letter at least thirty (30) days before the end of the contract. Either letter would explain your options for health care coverage in your area and give you information about your right to get Medicare supplemental insurance (“Medigap”) coverage.

By enrolling in Secure Horizons M+C Plan, you have made a decision to receive your health care from Contracting Medical Providers and facilities. Of course, if you need Emergency Services or Urgently Needed Services for unforeseen medical conditions anywhere in the world, or out-of-area and routine travel renal dialysis in the United States at a Medicare certified facility, those services will be covered. You are required to follow all plan Member rules, such as obtaining Referrals and Prior Authorizations, when necessary.

However, if you receive services from Non-Contracting Medical Providers with-out Prior Authorization, neither Secure Horizons M+C Plan nor Medicare will pay for those services, except for:

Welcome To Secure Horizons Medicare+Choice Plan



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

Call Secure Horizons Member Service Whenever You Need Information

We strive to provide you with the information you need about Secure Horizons M+C Plan when you need it.

We have specially trained Secure Horizons Member Service Representatives you can call when you have questions or concerns about:

- Covered Services
- Making address or phone number changes (Please send us your new address in writing to Member Service, P.O. Box 489, Mail Stop CY24-476, Cypress, California 90630. Please refer to Section 8 for more information.)
- Contracting Primary Care Physician changes or to request a *Provider Directory*
- Enrollment or Disenrollment
- Appeal and Grievance rights
- Medical care when you are traveling
- The quality of care you are receiving
- Any other questions or concerns regarding Secure Horizons M+C Plan.

Updating Your Membership Records

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

Please report any changes in name, address or phone number to Secure Horizons Member Service immediately. Please also report any changes in health insurance coverage you have from your employer or your spouse's employer as well as any liability claims, eligibility under workers' compensation, and Medicaid eligibility.

You Can Tell Us How We're Doing

From time to time, we will be asking your thoughts on Secure Horizons M+C Plan through our Member satisfaction surveys. These surveys help us measure the performance of our Contracting Medical Groups and other Contracting Medical Providers, as well as the quality of our member service.

Your responses and comments help identify our strengths as well as areas for needed improvement.

Of course, you can call or write to us at any time with helpful comments, questions and observations. Your personal input is always welcome.



Section 1 – Health Care Terms

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

Acute Inpatient Rehabilitation

Acute Inpatient Rehabilitation is an interdisciplinary process comprising a number of medical specialties and allied health disciplines under the direction of a contracting physician, intended to assist the physically, mentally or respiratory impaired to achieve or regain their maximum functional potential for mobility and self-care. Acute Inpatient Rehabilitation includes physical therapy, occupational therapy, and speech pathology services.

Appeal

Any of the procedures that deal with the review of adverse Organization Determinations on the health care services a Member is entitled to receive or any amounts that the Member must pay for a Covered Service. These procedures include reconsiderations by the Medicare+Choice Organization, review by an independent review entity, hearings before Administrative Law Judges (of the Social Security Administration), review by the Departmental Appeals Board, and judicial review.

Basic Benefits

All health care services that are covered under the Medicare Part A and Part B programs (except Hospice services), additional services that we use Medicare funds to cover, and other services for which you may be required to pay a Plan Premium. All Members of Secure Horizons M+C Plan receive the Basic Benefits of their specific benefit plan.

Benefit Period

A Benefit Period is a way of measuring your use of services under Medicare Part A. This is used to determine “Original” Medicare coverage, and coverage under Secure Horizons M+C Plan. A Benefit Period begins with the first day of a Medicare-covered inpatient Hospital stay and ends with the close of a period of sixty (60) consecutive

days during which you were neither an inpatient of a Hospital nor of a Skilled Nursing Facility (SNF).

Calendar Year

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

Center for Health Dispute Resolution (The Center)

An independent review entity under contract with CMS that reviews Appeals by members of Medicare managed care plans, including Secure Horizons M+C Plan.

Centers for Medicare & Medical Services (CMS)

The Federal agency responsible for administering Medicare.

Coinsurance

The percentage of the Medicare-allowable amount that you have to pay. With Secure Horizons M+C Plan, the Coinsurance payment is a percentage of the Medicare-allowable amount for the service.

Contracting Hospital

A Hospital that has a contract with Secure Horizons M+C Plan or, in some limited circumstances, your Contracting Medical Group to provide medical services and/or supplies to you.

Contracting Medical Group

Physicians organized as a legal entity for the purpose of providing medical care. The Contracting Medical Group has a written agreement with Secure Horizons M+C Plan to provide or arrange for the provision of medical services to Members. Additionally, an Independent Physicians Association (IPA), which is an organized or affiliated group of physicians that delivers or arranges for the delivery of health services, functions as a Contracting Medical Group with the physicians practicing out of their own independent medical offices.

Section 1 – Health Care Terms



Contracting Medical Provider

A health professional, a supplier of health items, or a health care facility having an agreement with Secure Horizons M+C Plan or a Contracting Medical Group to provide or coordinate medical services to Members. Contracting Medical Providers are independent contractors and are not the employees or agents of Secure Horizons M+C Plan.

Contracting Pharmacy

A pharmacy that has an agreement with Secure Horizons M+C Plan to provide you with medication(s) prescribed by your Contracting Medical Provider in accordance with Secure Horizons M+C Plan.

Contracting Primary Care Physician (PCP)

The Secure Horizons M+C Plan contracting physician you choose associated with a Contracting Medical Group or directly contracting with Secure Horizons M+C Plan. Your Contracting Primary Care Physician is responsible for providing or authorizing Covered Services while you are a Member of Secure Horizons M+C Plan. Contracting Primary Care Physicians may be physicians of Internal Medicine, Family Practice, General Practice or Obstetrics/Gynecology, who have agreed to be Contracting Primary Care Physicians.

Coordination of Benefits

A process whereby Secure Horizons M+C Plan coordinates payment for services or procedures with other insurance (including but not limited to employer-sponsored health insurance) you may have. Coordination of Benefits is more fully discussed in Section 11 of this Evidence of Coverage.

Copayment

The fee you pay at the time you receive medical services in accordance with Secure Horizons M+C Plan.

Covered Services

Those medical benefits, services and supplies listed in the Retiree Benefit Summary which are:

- Services provided or furnished by Contracting Providers or authorized by Secure Horizons M+C Plan or its Contracting Providers.
- Emergency Services and Urgently Needed Services, for which you do not need Prior Authorization and which may be provided by Non-Contracting Providers. (Please refer to Section 6 for more information about Emergency Services and Urgently Needed Services.)
- Post stabilization services furnished by Non-Contracting Providers or Facilities that are authorized by us or were not pre-approved because Secure Horizons M+C Plan or your Contracting Medical Group did not respond to a request for preauthorization for such services within one hour of the request (or because we could not be contacted for preauthorization).
- Out-of-area and routine travel renal dialysis services provided while you are temporarily outside the Service Area (at a Medicare-certified facility located in the United States).
- Any services for which we provide Prior Authorization or pre-approval. Those benefits, services and supplies, which we must furnish or pay for under Secure Horizons M+C Plan for plan Members.
- Covered Services include Basic Benefits and Optional Supplemental Benefits, if you choose to enroll in an Optional Supplemental Benefit Plan available to you.

Custodial Care

Care furnished for the purpose of meeting non-Medically Necessary personal needs which could be provided by persons without professional skills or training, such as



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assistance in mobility, dressing, bathing, eating, preparation of special diets, and taking medication. Custodial Care is not covered by Secure Horizons M+C Plan or Original Medicare unless provided in conjunction with Skilled Nursing Care and/or skilled rehabilitation services.

Disenroll or Disenrollment

The process of ending your membership in Secure Horizons M+C Plan. (Please refer to Section 8 for more information.)

Durable Medical Equipment (DME)

Equipment that can withstand repeated use; is primarily and usually used to serve a medical purpose; is generally not useful to a person in the absence of illness or injury; and is appropriate for use in the home. Durable Medical Equipment is covered when it is designed to assist in the treatment of an injury or illness of the Member and the equipment is primarily for use in the home.

Routine DME will not be covered when the Member has exhausted the 100 day Skilled Nursing Facility benefit and remains in an institution or distinct part of an institution meeting the basic requirements of a Hospital or Skilled Nursing Facility. DME includes items such as oxygen equipment, wheelchairs, hospital beds and other items that are determined Medically Necessary **and covered** in accordance with Medicare law, regulations and guidelines. (Please refer to the Retiree Benefit Summary for more information on DME.)

Effective Date

The date your Secure Horizons M+C Plan coverage begins. You will receive written notification of your Effective Date from Secure Horizons M+C Plan.

Election Form

The enrollment application a Medicare beneficiary or legal representative must complete in order to be enrolled in Secure Horizons M+C Plan. Each Medicare beneficiary, or beneficiary representative,

must sign and date the Election Form. The Election Form is part of your agreement with Secure Horizons M+C Plan. An **Abbreviated Election Form** (or short enrollment form) is used by Members or beneficiary representative to elect another benefit plan offered by Secure Horizons M+C Plan. (Please refer to Section 2 for more information.)

Emergency Medical Condition

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

Emergency Services

Covered inpatient or outpatient services that are: 1) furnished by a provider qualified to furnish Emergency Services; and 2) needed to evaluate or stabilize an Emergency Medical Condition.

Evidence of Coverage and Disclosure Information (EOC)

This document explains Covered Services and defines your rights and responsibilities as a Member and those of Secure Horizons M+C Plan. Your Retiree Benefit Summary provides the details of your particular benefit plan, including any Copayments and Coinsurance that you should pay when receiving a covered benefit. Your Retiree Benefit Summary is part of this combined Evidence of Coverage and Disclosure Information. Together, these documents explain your health care coverage.

Exclusion

Items or services that are not covered under this combined Evidence of Coverage and Disclosure Information, which includes the

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Retiree Benefit Summary; Exclusions are disclosed in the Retiree Benefit Summary. You are responsible for paying for excluded items or services.

Experimental Procedures and Items

Items and procedures determined by Secure Horizons M+C Plan and Original Medicare not to be generally accepted by the medical community. When deciding if a service or item is experimental, Secure Horizons M+C Plan will follow CMS Medicare Carriers Manual and Coverage Issues Manual or Medicare guidelines. With the exception of procedures and items under clinical trials, experimental procedures and items are not covered under this Evidence of Coverage.

Fee-for-Service Medicare

A payment system by which doctors, hospitals and other providers are paid for each service performed (also known as traditional and/or Original Medicare).

Grievance

Any complaint or dispute other than one involving an Organization Determination. Examples of issues that involve a complaint that will be resolved through the grievance rather than the appeal process are: waiting times in physician offices, quality of care or services, rudeness or unresponsiveness of staff.

Group Retiree Members

Medicare-eligible retired employees and their Medicare-eligible dependents who meet the eligibility requirements of the University of California for enrollment in the University of California sponsored group retiree health plan available through Secure Horizons M+C Plan.

Health Education Services

Health Education Services are educational programs including educational counseling, classes and materials, on subjects such as diabetes control, provided by Secure Horizons M+C Plan, Member's Contracting Medical Group or its designee.

Home Health Agency

A Medicare-certified agency which provides intermittent Skilled Nursing Care, evaluation, and other therapeutic services in your home when Medically Necessary, when you are homebound and when authorized by your Contracting Physician.

Hospice

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

Hospice Care

A method for caring for a terminally ill Member by a Medicare-approved Hospice when a Member no longer elects to pursue aggressive medical treatment. Hospice care emphasizes supportive services, such as home care and pain control, rather than cure-oriented services. Hospice Care also provides counseling to the individual's family members. Medicare defines a terminally ill individual as someone with a life expectancy of six (6) months or less if the illness runs its normal course.

Hospital

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

Hospitalist

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



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Lock-In Feature

An arrangement that all Covered Services (with the exception of Emergency Services, Urgently Needed Services, or out-of-area and routine travel dialysis) must be provided or authorized by your Contracting Medical Group or your Contracting Primary Care Physician. If you receive services from a Non-Contracting Medical Provider including, but not limited to, a Specialist, Facility or a Contracted Medical Provider without Prior Authorization from Secure Horizons M+C Plan or your Contracting Medical Group, except for Emergency Services or Urgently Needed Services or out-of-area and routine travel dialysis, neither Secure Horizons M+C Plan nor Original Medicare will pay for that care.

Medical Director

A licensed physician who is an employee of either Secure Horizons M+C Plan or a Contracting Medical Group and is responsible for monitoring the quality of care to our Members.

Medi-Cal or Medicaid

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

Medically Necessary (Medical Necessity)

An intervention will be covered under Secure Horizons M+C Plan if it is an otherwise covered category of service, not specifically excluded, and Medically Necessary. An intervention may be medically indicated yet not be a covered benefit or meet the

definition of Medical Necessity. An intervention is Medically Necessary if, as recommended by the treating physician and determined by the Medical Director of Secure Horizons M+C Plan or the Contracting Medical Group, it is (all of the following):

- a. A health intervention for the purpose of treating a medical condition;
- b. The most appropriate supply or level of service, considering potential benefits and harms to the Member;
- c. Known to be effective in treating the medical condition. For existing interventions, effectiveness is determined first by scientific evidence, then by professional standards, then by expert opinion. For new interventions, effectiveness is determined by scientific evidence; and
- d. If more than one health intervention meets the requirements of (a) through (c) above, furnished in the most cost-effective manner which may be provided safely and effectively to the Member.

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

- (i) A **health intervention** is an item or service delivered or undertaken primarily **to treat** (that is, prevent, diagnose, detect, treat, or palliate) a medical condition or to maintain or restore functional ability. A **medical condition** is a disease, illness, injury, genetic or congenital defect, pregnancy, or a biological condition that lies outside the range of normal, age-appropriate human variation. A health intervention is defined by the intervention itself, the medical condition and the patient indications for which it is being applied.
- (ii) **Effective** means that the intervention can reasonably be expected to produce the intended results and to have expected benefits that outweigh potential harmful effects.

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

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

decisions about such new interventions should be based on convincing expert opinion.

(v) An intervention is considered **cost-effective** if the benefits and harms relative to costs represent an economically efficient use of resources for patients with this condition.

Medicare (Original Medicare)

The Federal government health insurance program established by Title XVIII of the Social Security Act.

Medicare Part A

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

Medicare Part A Premium

Part A is financed by part of the Social Security payroll withholding tax paid by workers and their employers and by part of the Self-Employment Tax paid by self-employed persons. If you are entitled to benefits under either the Social Security or Railroad Retirement systems or worked long enough in Federal, State, or local government employment to be insured, you do not have to pay a monthly Part A premium. If you do not qualify for premium-free Part A benefits, you may buy the coverage if you are at least 65 years old and meet certain requirements. You may also buy Part A through Social Security if you are under age 65 and are entitled to Medicare under the disability provisions.

Medicare Part B

Supplementary medical insurance that is optional and requires a monthly premium. Part B covers physician services (in both Hospital and non-hospital settings) and services furnished by certain non-physician Practitioners. Other Part B services include lab testing, Durable Medical Equipment, diagnostic tests, ambulance services, prescription drugs that cannot be self-



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administered, certain self-administered anti-cancer drugs, some other therapy services, certain other health services, and blood not covered under Part A.

Medicare Part B Premium

A monthly premium paid to Medicare (usually deducted from your Social Security check) to cover Part B services. You must continue to pay this premium to Medicare to receive Covered Services.

Medicare Allowable Cost

The amount that Medicare pays for the drug or device. This may not necessarily reflect the actual cost to PacifiCare of California.

Medicare+Choice (M+C) Coordinated Care Plans

These are Medicare+Choice Plans that use a network of providers that are under contract or arrangements with a Medicare+Choice Organization to provide covered benefits. These consist of Health Maintenance Organizations (HMOs), Provider-Sponsored Organizations (PSOs), and Preferred Provider Organizations (PPOs).

Medicare+Choice (M+C) Organization

A public or private entity organized and licensed by the State as a risk-bearing entity that is under contract with CMS to provide Covered Services. M+C Organizations can offer one or more M+C Plans. PacifiCare of California is an M+C Organization.

Medicare+Choice (M+C) Plan

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

Member

The Medicare beneficiary entitled to receive Covered Services, who has voluntarily elected to enroll in Secure Horizons M+C Plan and whose enrollment has been confirmed by CMS.

Network

Providers, facilities and Hospitals that have been contracted by Secure Horizons M+C Plan to deliver the Covered Services provided in this Evidence of Coverage and Retiree Benefit Summary.

Non-Contracting Medical Provider or Facility

Any professional person, organization, health facility, Hospital, or other person or institution licensed and/or certified by the State or Medicare to deliver or furnish health care services; and who is neither employed, owned, operated by, nor under contract with Secure Horizons M+C Plan to deliver Covered Services to you.

Office Visit

A visit to your Contracting Primary Care Physician, Specialist, other Contracting Medical Provider or Non-Contracting Medical Provider upon Referral.

Organization Determination

In general, a decision by Secure Horizons M+C Plan, or a person acting on Secure Horizons behalf, to approve or deny a payment for a service or a request for provision of service made by you or on your behalf.

Outpatient Medical Rehabilitation Therapy

Outpatient Medical Rehabilitation Therapy are services provided by physical, speech or occupational therapists determined to be Medically Necessary.

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PacifiCare – PacifiCare of California, dba Secure Horizons M+C Plan

A California corporation that is organized and licensed by the State as a risk-bearing entity that is certified by CMS as meeting Medicare+Choice Plan requirements.

PacifiCare is a Medicare+Choice Organization.

Peer Review Organization (PRO)

An independent contractor paid by CMS to review Medical Necessity, appropriateness and quality of medical care and services provided to Medicare beneficiaries. Upon request, the PRO also reviews Hospital discharges for appropriateness and quality of care complaints.

Plan Premium

The monthly payment to Secure Horizons M+C Plan, if applicable, along with the Part B Premiums paid to Medicare and if applicable, Medicare Part A Premiums, that entitles you to the Covered Services outlined in this Evidence of Coverage.

Practitioner

A contracting physician or other health care professional that provides health care services to the Member.

Prescription Unit

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

Prior Authorization

A system whereby a Member/Provider must receive approval from a Contracting Medical Group or Secure Horizons M+C Plan before you receive certain health care services.

Provider

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

Referral

A formal recommendation by your Contracting Primary Care Physician or his/her Contracting Medical Group that you receive health care from a Specialist, Contracting Medical Provider or Non-Contracting Medical Provider.

Retiree Benefit Summary

This document provides the details of your particular health plan, including any Copayments and/or Coinsurance that you should pay when receiving a covered benefit. Together with this Evidence of Coverage and Disclosure Information document, the Retiree Benefit Summary explains your health care coverage. Group Retiree Members receive the Retiree Benefit Summary as their *Schedule of Benefits*.

Second Medical Opinion

A review of the efficacy of a proposed treatment or service by a Provider, other than the Provider recommending the treatment or service. Secure Horizons M+C Plan or its Contracting Medical Group will assume financial responsibility for the Second Medical Opinion only when the Member obtains a Referral for a Second Medical Opinion from Secure Horizons M+C Plan or its Contracting Medical Group, before seeking the Second Medical Opinion. If the Second Medical Opinion recommends a particular treatment or service covered by Secure Horizons M+C Plan and the treatment or service is authorized by Secure Horizons M+C Plan or the Member's Contracting Medical Group, the treatment or service shall be either provided or arranged by the Member's Contracting Medical Group. The fact that a Provider, while furnishing a Second Medical Opinion, recommends a particular treatment, service,



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or treatment setting does not necessarily mean that the treatment or service is Medically Necessary or a covered benefit under the Member's Secure Horizons M+C Plan or that the treatment or service will be provided at the recommended setting.

Secure Horizons M+C Plan

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

Secure Horizons Member Service Department

A department of Secure Horizons M+C Plan dedicated to answering your questions concerning your membership, benefits, Grievances and Appeals. A Secure Horizons Member Service representative is available by calling the number below or by writing to P.O. Box 489, Cypress, California 90630.

Service Area

A geographic area approved by CMS within which a Medicare+Choice eligible individual may enroll in a particular Medicare+Choice Plan offered by Secure Horizons M+C Plan.

Skilled Nursing Care

Medically Necessary health care services that can only be performed by, or under the supervision of, licensed nursing personnel.

Skilled Nursing Facility

A facility which provides inpatient Skilled Nursing Care, rehabilitation services or other related health services and is State licensed and/or certified by Medicare. The term "Skilled Nursing Facility" does not include a convalescent nursing home, rest facility or facility for the aged which furnishes primarily Custodial Care, including training in routines of daily living. A "Home Skilled Nursing Facility" is defined as: (a) one in which the Member resided at the time of the Hospital admission that triggered eligibility for Skilled Nursing Facility care upon discharge; or (b) is the facility that is providing such services through the continuing care retirement community in which the Member resided at

the time of hospital admission; or (c) is the facility in which the Member's spouse is residing at the time of the Member's Hospital discharge. (Please see Section 5 for more information.)

Specialist

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

State

The State of California responsible for licensing and regulating the Secure Horizons M+C Plan.

Third Party Liability

In the case of injury to a Member caused by a third party, Secure Horizons M+C Plan or its nominee may seek reimbursement from the third party or from the Member (to the extent the Member has received monetary recovery for his or her injury) for Covered Services furnished by Secure Horizons M+C Plan. Third Party Liability is more fully discussed in Section 11 of this EOC.

Time-Sensitive

A situation where waiting for a standard decision for a determination on your request for services or an Appeal of a service denial could seriously jeopardize your life or health, or your ability to regain maximum function.

Urgently Needed Services

Covered Services provided when you are temporarily absent from the area served by your Contracting Primary Care Physician; in general, the area outside a 30-mile radius of the Contracting Primary Care Physician/Contracting Medical Group you have selected (or, under unusual and extraordinary circumstances, provided when

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you are in this area, but your Contracting Medical Group is temporarily unavailable or inaccessible) when such services are Medically Necessary and immediately required: 1) as a result of an unforeseen illness, injury, or condition; and 2) it is not reasonable given the circumstances to obtain the services through your Contracting Medical Group.

Utilization Management Committee

A committee used by Secure Horizons M+C Plan or a Contracting Medical Group to promote the quality of health care and the efficient use of resources. Duties of the Utilization Management Committee include prospective, current and retrospective review of medical services. This Committee may also be referred to as the Medical Management Committee.



Section 2 – Eligibility, Enrollment Periods and Effective Date

The University of California establishes its own medical plan eligibility criteria for Annuitants based on the University of California Group Insurance Regulations. Portions of these regulations are summarized below. If you reside in the Secure Horizons service area, and meet the University's and the Plan's eligibility criteria, you may enroll in the Plan.

To Enroll In Secure Horizons Medicare+Choice Plan, You Must:

1. Be entitled to Medicare Part A and enrolled in Medicare Part B.
2. Not currently have end stage renal disease or receive routine kidney dialysis. However, if either of these conditions should apply to you, you may still enroll if you are a current Member of Secure Horizons Medicare+Choice Plan either through an Employer Group Sponsored Health Plan or as an Individual. If you develop end stage renal disease while a Member of Secure Horizons Medicare+Choice Plan, you can continue your membership. Note: If you have received a transplant that has restored your kidney function and you no longer require a regular course of dialysis, you are not considered to have ESRD and you are eligible to enroll in Secure Horizons Medicare+Choice Plan.
3. Permanently reside in the Service Area as defined in Section 1.
4. Complete and sign an Individual Election Form. If another person assists you in completing the Individual Election Form, that person must also sign the form and state his/her relationship to you; and
5. Agree to abide by Secure Horizons Medicare+Choice Plan rules.

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

University of California Eligibility Provisions

Who Is Eligible

You may participate in the Plan if you are an eligible Annuitant and enrolled in both the Hospital (Part A) and the Medical (Part B) parts of Medicare. The same applies to your Dependents. Dependents who are covered by the PacifiCare plan, but not by both parts of Medicare, may continue in that Plan until they cease to be eligible. Anyone enrolled in a non-University Medicare+Choice contract is not eligible for this Plan.

Eligible Annuitants (Including Survivor Annuitants):

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

1. you meet the University's service credit requirements for Annuitant medical eligibility;
2. you were enrolled in a University medical plan immediately before retiring;
3. 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);
4. your medical coverage is continuous from the date employment ends;
5. your monthly benefits check is large enough to cover your portion of any of the medical plan premium; and
6. you elect to continue coverage at the time of retirement.

The following are the University of California's eligibility criteria for Dependent coverage. In order for Dependents to be enrolled in Secure Horizons, they must also meet the Secure Horizons eligibility criteria

Section 2 – Eligibility, Enrollment Periods and Effective Date



set forth in this section. Dependents who meet the University of California's eligibility criteria set forth below but do not meet Secure Horizons' eligibility criteria may be eligible for coverage through the PacifiCare Health Plan described in the < Section > of this *Combined Evidence of Coverage and Disclosure Form*.

Eligible Dependents:

SPOUSE: Your legal spouse, except if you are a Survivor Annuitant you may not enroll your legal spouse.

CHILDREN: 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 who 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 attests to these 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 above, (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 on you for at least 50% of his/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 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 continued coverage is not required. If the coverage handicapped child is not your natural or legally adopted child, the child must reside with you 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 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 the University of California's Member Service Center. 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 official documentation.



Section 2 – Eligibility, Enrollment Periods and Effective Date

Enrollment Provisions

Annuitants and their enrolled Dependents who become eligible for Medicare Hospital insurance (Part A) as primary coverage must enroll in and remain in both Hospital (Part A) and Medical (Part B) portions of Medicare. This includes those who are entitled to Medicare benefits through their 2.own or their spouse's non-University employment. Annuitants or Dependents who are eligible for, but decline to enroll in both parts of Medicare, will be assessed a monthly offset fee by the University to cover the increased costs of remaining in the non-Medicare plan. Annuitants or Dependents who are not eligible for Part A will not be assessed an offset fee. A notarized affidavit attesting to their ineligibility for Medicare Part A will be required. Forms for this purpose may be obtained from the University of California's Member Service Center at 1-800-888-8267. (Annuitants/Dependents who are not entitled to Social Security and Medicare Part A will not be required to enroll in Part B.)

You should contact Social Security three months before your 65th birthday to inquire about your eligibility and how you enroll in the Hospital (Part A) and Medical (Part B) parts of Medicare. If you qualify for disability income benefits from Social Security, contact a Social Security office for information about when you will be eligible for Medicare enrollment.

To enroll yourself and any eligible Dependents, you must complete a University of California Medicare Declaration form and Secure Horizons' own enrollment form. This notifies the University that you are covered by the Hospital (Part A) and Medical (Part B) parts of Medicare. Medicare Declaration forms and Secure Horizons' enrollment forms are available through the University of California Member Service Center and completed forms should be returned to them. Upon receipt by the University of confirmation of Medicare enrollment, the Annuitant/Dependent will be changed from the PacifiCare non-Medicare plan to PacifiCare's Secure Horizons for

Medicare enrollees. Annuitants and their Dependents are required to transfer to the plan for Medicare enrollees.

You may also enroll yourself and any eligible Dependents during your Period of Initial Eligibility (PIE) which begins on:

- a. the date you have an involuntary loss of other group medical coverage; or
- b. the date you move out of a University health maintenance organization (HMO) plan's service area on either a permanent basis, or for more than two months on a temporary basis.

If you are an Annuitant enrolled as a spouse on a University medical plan and become eligible for both parts of Medicare in your own right, you may enroll yourself on the earlier of:

- a. the date both parts of Medicare are in effect; or
- b. the effective date of retirement.

In addition, you and your eligible Dependents may enroll during a group open enrollment period established by the University.

To enroll your newly eligible Dependents, contact the University of California Member Service Center to obtain an enrollment form and return it during the Dependent's PIE.

You may enroll Dependents during a newly eligible Dependent's PIE. The PIE starts the day the Dependent becomes eligible for benefits. For a new spouse, eligibility begins on the date of marriage. Survivor Annuitants may not add new spouses to their coverage.

For a newborn child, eligibility begins on the child's date of birth. For newly adopted children, eligibility begins on the earlier of:

- a. the date the Annuitant or Annuitant's spouse has the legal right to control the child's health care; or
- b. the date the child is placed in the Annuitant's physical custody.

Section 2 – Eligibility, Enrollment Periods and Effective Date



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

You may also enroll your eligible Dependent during a PIE which begins on the date he or she has an involuntary loss of other group medical coverage.

A PIE ends 31 days after it begins (or on the preceding business day for the University of California Member Service Center if the 31st day is on a weekend or a holiday).

If your Dependent fails to enroll during the PIE or open enrollment period, you may enroll your dependent 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 University of California Member Service Center and ends 90 consecutive calendar days later.

An Annuitant 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's enrollment form is received by the University of California Member Service Center; or
- b. the date the Dependent became eligible.

Your Enrollment Form

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

When Your Secure Horizons Medicare+Choice Plan Coverage Begins

Effective Date Provisions Coverage for Annuitants Enrolling In Conjunction With Retirement:

Coverage for Annuitants and their Dependents is effective on the first of the month following the first full calendar month of retirement income, provided the continuation form is submitted to the University of California Member Service Center.

Coverage for Annuitants or Dependents Becoming Eligible for Medicare:

Coverage will be transferred from the PacifiCare plan for non-Medicare enrollees to the Secure Horizons plan for Medicare enrollees effective on the date determined by the carrier, based on processing the Secure Horizons enrollment form through the Centers for Medicare & Medical Services (CMS).

Other Situations:

Coverage for Annuitants and their Dependents enrolling during a PIE is effective on the first day of the PIE provided the enrollment form is received by the University of California Member Service Center during the PIE. There is one exception to this rule: coverage for a newly adopted child enrolling during the second PIE is effective on the date the adoption becomes final. For dependents 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 University of California Member Service Center. 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 obtain a change form from the University of California Member Service Center, complete and return it.



Section 2 – Eligibility, Enrollment Periods and Effective Date

Secure Horizons Medicare+Choice Plan will send you a letter that tells you when your coverage begins. From your Effective Date forward, you must receive all routine Covered Services from Contracted Medical Providers. Neither Secure Horizons Medicare+Choice Plan nor Medicare will pay for services received from Non-Contracted Medical Providers except for:

- **Emergency Services anywhere in the world;**
- **Urgently Needed Services;**
- **Out-of-Area renal dialysis services;**
- **Those services for which Secure Horizons Medicare+Choice Plan allows you to self-refer to Contracted Medical Providers; and**
- **Referrals that have received Prior Authorization.**

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

Liability of Secure Horizons Medicare+Choice Plan Upon Initial Enrollment

If your Effective Date occurs during an inpatient stay in a Hospital, Secure Horizons Medicare+Choice Plan is not responsible for the provisions or payment of any of the inpatient Hospital services under the Medicare Hospital Insurance Plan (Part A), beginning on your Effective Date and during your stay. Secure Horizons Medicare+Choice Plan must assume responsibility for payment or provision of inpatient Hospital services under the Medicare Hospital Insurance Plan (Part A) on the day after the day of discharge. PacifiCare is responsible for the full scope of Part B services required by Medicare beginning on your Effective Date.

About Your Medicare Supplement (Medigap) Policy

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

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

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

Section 2 – Eligibility, Enrollment Periods and Effective Date



- You were previously enrolled under a Medigap policy and terminated your enrollment to participate, for the first time, in Secure Horizons Medicare+Choice Plan and you disenroll during the first twelve (12) months. You will be entitled to purchase the same Medigap policy you had before, if it is still available for the same insurer. If it is not available, you will be entitled to purchase any Medigap Plan “A”, “B”, “C”, or “F” sold in your state.

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

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

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



Section 3 - Member Rights and Responsibilities

Member Rights and Responsibilities [Roles]

Statement for 2003

As a member of PacifiCare/Secure Horizons M+C Plan you have the right to receive information about, and make recommendations regarding, your rights and responsibilities [roles].

You have the right to:

Timely, Quality Care

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

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

Treatment with Dignity and Respect

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

Section 3 - Member Rights and Responsibilities



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

Information About PacifiCare/Secure Horizons M+C Plan and Their Contracting Medical Providers

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

Timely Problem Resolution

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

Protection of Privacy in All Settings

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



Section 3 - Member Rights and Responsibilities

- Review your medical records. If you would like to review, correct or copy your medical records, you should contact your Contracting Primary Care Physician or other health care provider who created the medical record directly.
- Know that PacifiCare/Secure Horizons may accommodate employer requests for information by providing de-identified aggregated data. Only as permitted by law, PacifiCare may release information to self-funded employers where needed to administer the provisions of the plan. If required to supply this information to self-funded employers, they agree to protect the individual's data from internal disclosure that would affect the individual.
- Ask your Contracting Primary Care Physician or PacifiCare/Secure Horizons questions regarding your care. If you would like information about Contracting Medical Providers or have a suggestion, complaint or payment issue, we recommend you call the PacifiCare/Secure Horizons Customer/Member Service department at 1-800-228-2144 or for the hearing impaired (TTY/TTD/TDHI) 1-800-685-9355. Our Member Service Associates are available Monday through Friday 7:00 a.m. to 8:00 p.m.

Your Responsibilities [Roles] are to:

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

Section 4 – How Your Secure Horizons M+C Plan Coverage Works



Your Secure Horizons M+C Plan Membership Card

Your Secure Horizons M+C Plan membership card provides information to assist you in receiving your Secure Horizons M+C Plan Covered Services. It is important to present your membership card to your health care Provider.

Carry your Secure Horizons M+C Plan membership card (and your Medicare card) with you at all times.

Although you never need to give up your Medicare card, you must now use your Secure Horizons M+C Plan card to receive Covered Services.

It is important that you use only your Secure Horizons M+C Plan Membership Card – NOT your Medicare card — for these reasons:

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

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

How the Lock-In Feature Works for You and Secure Horizons M+C Plan

As a Secure Horizons M+C Plan Member, your medical benefits (except for Emergency Services and Urgently Needed Services, indicated as follows) are provided and arranged by your Secure Horizons M+C Plan Contracting Primary Care Physician, a

personal physician you choose from our list of Contracting Medical Providers. You are “Locked-In” to this Provider who will provide and coordinate all your routine health care services.

The “Lock-In” feature is key to you and Secure Horizons M+C Plan. Secure Horizons M+C Plan is able to offer you this health plan because of our contract with the Centers for Medicare & Medicaid Services (CMS), the government agency that oversees Medicare. Under this contract, the Federal government agrees to pay us a fixed monthly dollar amount for each Member we serve. We use the monthly amount received from the Federal government to compensate Contracting Medical Groups, Hospitals and other health care Providers to arrange care for you. (Please refer to Section 13 for more information regarding provider compensation.)

If you receive services from Non-Contracting Medical Providers without Prior Authorization, neither Secure Horizons M+C Plan nor Medicare will pay for those services except for:

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



Section 5 – Working With Your Contracting Medical Providers

Choice of Physicians and Providers Your Contracting Primary Care Physician

Your relationship with your Contracting Primary Care Physician is an important one. That's why we strongly recommend you choose a Contracting Primary Care Physician close to your home.

Once you have chosen your Contracting Primary Care Physician, we recommend that you have all your medical records transferred to his/her office. This will give your Contracting Primary Care Physician access to your medical history, and make him or her aware of any existing health conditions you may have.

Ask to see your Contracting Primary Care Physician when you make an initial appointment. Your Contracting Primary Care Physician is now responsible for all your routine health care services, so he or she should be the first one you call with any health concerns. When you select a Contracting Primary Care Physician, it is important to remember that this limits you to the panel of Specialists and Hospitals affiliated with your Contracting Primary Care Physician's Contracting Medical Group.

You Can Change Contracting Primary Care Physicians

Changing Contracting Primary Care Physicians Within Your Contracting Medical Group

If you wish, you may request to change Contracting Primary Care Physicians within your Contracting Medical Group at any time if the Contracting Primary Care Physician is accepting additional Secure Horizons M+C Plan Members. Call Secure Horizons Member Service for assistance.

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

If you want to change to a Contracting Primary Care Physician who is affiliated with a

different Contracting Medical Group, you must contact Secure Horizons Member Service. If the Contracting Primary Care Physician is accepting additional Secure Horizons M+C Plan Members and your request is received on or before the 15th of the month, the transfer will become effective on the first day of the following month. If your request is received after the 15th, the transfer will become effective the first day of the month following the month of your request. For example, if Secure Horizons M+C Plan receives your change request on July 15, your change is effective on August 1. If Secure Horizons M+C Plan receives your change request on July 16, your change is effective on September 1. You will receive a new Secure Horizons M+C Plan membership card that shows this change.

Although we won't deny your request, for continuity of care reasons we recommend that you postpone a request to change your Primary Care Physician or Network if you are an inpatient in a Hospital, a Skilled Nursing Facility or other medical institution at the time of your request.

To help promote a smooth transition of your health care when you change your Contracting

Medical Group, please let us know if you are currently seeing a Specialist, receiving Home Health Agency services, or using Durable Medical Equipment. Secure Horizons Member Service can assist with the transfer of your care or equipment.

We will make a good faith effort to notify you within 30 days of the termination of any plan health care provider that affects you. We will assist you in selecting a new Contracting Primary Care Physician or provide access to all Covered Services in the plan's benefit package.

How to Schedule an Appointment With Your Contracting Primary Care Physician

Please call your Contracting Primary Care Physician's office and request an

Questions? Call the Customer Service Department at 1-800-624-8822.

Section 5 – Working With Your Contracting Medical Providers



appointment. Appointments are scheduled according to the type of medical care you are requesting. Medical conditions requiring more immediate attention are scheduled sooner. If you have difficulty obtaining an appointment with your Primary Care Physician, please contact Member Service.

The telephone number for your Primary Care Physician or Contracting Medical Group is listed on your membership card.

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

How To Receive Covered Services From a Specialist

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

Neither Secure Horizons M+C Plan nor Medicare will pay for your care if you receive services from a Specialist without a Referral or Prior Authorization from your Contracting Primary Care Physician or Contracting Medical Group.

Once your Contracting Primary Care Physician's Referral request is approved, you may make an appointment with the Specialist. Appointments are scheduled according to the type of medical care you are requesting. Medical conditions requiring more immediate attention are scheduled sooner. If for any reason you receive a bill from a Specialist, please forward it to Secure Horizons M+C Plan for payment resolution, unless this bill applies to your Copayment or is for services

that were non-authorized and require Prior Authorization. See Section 7 for where to send your claim.

From time to time, Specialists are involuntarily terminated from contracting with Secure Horizons M+C Plan. We will make a good faith effort to inform you of your right to maintain your treatment with the Specialist through other avenues which may include joining a different Medicare+Choice Coordinated Care Plan or returning to Original Medicare.

Standing Referrals To Specialists

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



Section 5 – Working With Your Contracting Medical Providers

period of time, you may receive a Referral to a contracting Specialist or specialty care center that has expertise in treating the condition or disease for the purpose of having the Specialist coordinate your health care with your Contracting Primary Care Physician. To receive an “extended specialty Referral” your Contracting Primary Care Physician must determine, in consultation with the Specialist or specialty care center and your Contracting Medical Group’s Medical Director or a Secure Horizons M+C Plan Medical Director, that this extended specialized medical care is Medically Necessary. The extended specialty Referral will be made according to a treatment plan approved by your Contracting Medical Group’s Medical Director or a Secure Horizons M+C Plan Medical Director, in consultation with your Contracting Primary Care Physician, the Specialist, and you. After the extended specialty Referral is made, the Specialist will serve as the main coordinator of your care, subject to the approved treatment plan. You may request an extended specialty Referral by asking your Contracting Primary Care Physician or Specialist.

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

You may obtain obstetrical and gynecological (OB/GYN) physician services directly from a contracting OB/GYN or contracting Family Practice Physician (designated by your Contracting Medical Group as providing OB/GYN physician services) affiliated with your Contracting Medical Group. This means that no Prior Authorization or Referral from your Contracting Primary Care Physician is required to obtain OB/GYN physician services from a contracting OB/GYN or Family Practice Physician affiliated with your Contracting Medical Group. However, if you directly access an OB/GYN or Family Practice Physician not affiliated with your Contracting 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 Prior Authorized in advance by your Contracting Medical Group or Secure Horizons M+C Plan.

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

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

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

You also have direct access to women’s routine and preventive health care services (as described in the Retiree Benefit Summary) by following the procedures outlined above.

Continuity of Care for Terminating Physicians

In the event your contracting physician is terminated by Secure Horizons M+C Plan or your Contracting 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 Secure Horizons M+C Plan or a Contracting Medical Group.

Section 5 – Working With Your Contracting Medical Providers



If you are receiving treatment for:

- an acute condition (such as open surgical wounds, or recent heart attack)
- serious chronic condition (such as chemotherapy or radiation therapy)
- a high-risk pregnancy (such as multiple babies where there is a high likelihood of complications)
- pregnancy in the second or third trimester
- and your physician is terminated, you may request permission to continue receiving treatment from the terminated physician beyond the termination date by calling Secure Horizons M+C Plan. Your Contracting Medical Group's Medical Director in consultation with your terminated physician will determine the best way to manage your ongoing care. **Secure Horizons M+C Plan must preauthorize services for continued care.** If you have any questions, or would like a copy of Secure Horizons' 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 Secure Horizons Member Service.

Access to Medical Records and Files

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

Authorization, Modification, Delay, and Denial of Health Care Services

Secure Horizons M+C Plan and its Contracting Medical Groups use processes to review, approve, modify, delay, or deny, based

on Medical Necessity, requests by Providers for authorization of the provision of health care services to Members.

Secure Horizons M+C Plan and Contracting Medical Groups may also use criteria or guidelines to determine whether to approve, modify, delay, or deny, based on Medical Necessity, requests by providers of health care services for Members. The criteria used as the basis of a decision to modify, delay, or deny requested health care services in a specific case under review will be disclosed to the Provider and the Member in that specific case. The criteria or guidelines used to determine whether to authorize, modify, delay, or deny health care services are available to the public upon request, limited to the criteria or guidelines for the specific procedure or condition requested.

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

Secure Horizons M+C Plan and its Contracting Medical Groups make these decisions within at least the time frames required by Federal law or regulation. Please see Section 9 of this Evidence of Coverage for specific information regarding the time frames by which Secure Horizons M+C Plan must make a determination (decision) on your request for payment or the provision of health care services.

If you would like a copy of Secure Horizons M+C Plan policies and procedures, a description of the processes utilized for authorization, modification, delay, or denial of health care services, or Secure Horizons M+C Plan criteria or guidelines, you may contact Secure Horizons Member Service.

Second Medical Opinions

You may request a Second Medical Opinion by submitting a request for a Second Medical Opinion regarding a recommended procedure or service to your Contracting Primary Care Physician. The request will be



Section 5 – Working With Your Contracting Medical Providers

evaluated by the Contracting Medical Group (or a Secure Horizons M+C Plan Medical Director as applicable) based on Medical Necessity. All decisions regarding Second Medical Opinions will be rendered within the following time limits: emergency procedures within twenty-four (24) hours; urgent procedures within seventy-two (72) hours; and elective procedures within fourteen (14) calendar days. Second Medical Opinions can only be rendered by a physician qualified to review and treat the medical condition in question. Referrals to Non-Contracting Medical Providers or Facilities will be approved only when the services requested are not available within the Contracting Medical Provider's (or Secure Horizons M+C Plan's as appropriate) network of Contracting Medical Providers. If the Provider giving the Second Medical Opinion recommends a particular treatment, diagnostic test or service covered by Secure Horizons M+C Plan and Medically Necessary, the treatment, diagnostic test or service will be provided or arranged by the Member's Contracting Medical Group. If you are denied a Second Medical Opinion, you may appeal the denial by following the procedures outlined in the Appeals Process Section.

Secure Horizons M+C Plan has approved procedures to identify, assess, and establish treatment plans (including direct access visits to Specialists) for Members with complex or serious medical conditions. In addition, Secure Horizons M+C Plan will maintain procedures to ensure that Members are informed of health care needs that require follow-up and receive training in self-care and other measures to promote their own health.

Health Care Facilities: Hospitalization and Skilled Nursing Care

If your Secure Horizons M+C Plan Contracting Primary Care Physician/Specialist determines that you require Hospitalization or Skilled Nursing Care, he or she will arrange these Covered Services for you.

Coverage for acute care (referred to in the Member materials as “inpatient Hospital

benefits”) consists of Medically Necessary inpatient Hospital services authorized by your Contracting Medical Group, including semi-private room, intensive care, definitive observation, isolation, operating room, recovery room, labor and delivery room, laboratory, diagnostic and therapeutic radiology, nuclear medicine, pharmacy, inhalation therapy, dialysis, EKG, EEG, EMG, blood and blood plasma, anesthesia supplies, surgically implanted devices and implanted breast prosthesis post-mastectomy, nursing services, professional charges by the hospital pathologist or radiologist, coordinated discharge planning and other miscellaneous Hospital charges for Medically Necessary care and treatment.

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

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

Secure Horizons M+C Plan covers inpatient Skilled Nursing Care and services that are provided in a Medicare-certified Skilled Nursing Facility under contract with Secure Horizons M+C Plan. Skilled Nursing Facility services include Skilled Nursing Care, room and board, and other customarily provided services. Skilled Nursing Care is covered if the Member requires Skilled Nursing Care services or skilled rehabilitation services on a daily basis and these skilled services can be provided only on an inpatient basis in a Skilled Nursing Facility.

With the exception of Emergency or Urgently Needed Services, you will only be admitted to those Hospitals, acute care, subacute care,

Section 5 – Working With Your Contracting Medical Providers



transitional inpatient care and Skilled Nursing Facilities that are authorized by your Contracting Medical Group and under contract with Secure Horizons M+C Plan. You may call Secure Horizons Member Service to request a copy of Secure Horizons M+C Plan's utilization review and Prior Authorization processes that apply to care provided in subacute care, transitional inpatient care and Skilled Nursing Facilities.

Secure Horizons M+C Plan covers post-hospitalization Skilled Nursing Care through a Member's "home Skilled Nursing Facility" if Secure Horizons M+C Plan has a contract with the facility or if the home facility agrees to accept substantially similar payment under the same terms and conditions that apply to similarly situated Skilled Nursing Facilities that are under contract with Secure Horizons M+C Plan. Home Skilled Nursing Facilities may refuse to accept a Member or to impose conditions on their acceptance of such a Member. The Member would receive coverage for Skilled Nursing Facility care at the home facility that is no less favorable than he or she would receive otherwise in another Skilled Nursing Facility that has a contract with Secure Horizons M+C Plan.

Please note: Secure Horizons M+C Plan will not pay Federal hospitals, e.g., Veteran's (VA) Hospitals, for Emergency and non-emergency items or services furnished to veterans, retired military personnel or eligible dependents. For Members who are not eligible for VA benefits, Secure Horizons M+C Plan will cover Emergency, Urgent and post-stabilization care provided by a VA facility; these services are considered to be out-of-network.

Please refer to your Retiree Benefit Summary for further details.

Organ Transplants

A Medicare-approved transplant center determines whether you are a candidate for a transplant. Covered transplants are limited to corneal, heart, intestinal, kidney, pancreas (when performed with or after a Medicare

covered kidney transplant), liver, lung, heart-lung, bone marrow and stem cell. The following transplants must be performed in a Medicare approved transplant center in order to be covered by Medicare: heart, intestinal, liver, lung, and heart-lung. Secure Horizons M+C Plan will arrange an organ transplant for you at a facility in its preferred transplant network, which is a network of transplant centers that are: licensed in the State of California; certified by Medicare as a transplant center for a specific organ transplant; designated by Secure Horizons M+C Plan as a transplant center for a specific organ program; and able to meet the reasonable access standards for organ transplantation based on the Regional Organ Procurement Agency statistics within the transplant center's geographic location. A Regional Organ Procurement Agency serves a geographic area designated by a State-licensed organ procurement organization for transplants in the State of California.

Ambulance

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

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



Section 5 – Working With Your Contracting Medical Providers

Home Health Care

If your Secure Horizons M+C Plan Contracting Primary Care Physician/Specialist determines that you require Home Health Care, he or she will arrange these Covered Services for you.

In order to qualify for Home Health benefits, an individual must be confined to his or her home, under a plan of treatment reviewed and approved by a physician and require a Medically Necessary qualifying skilled service.

Covered Home Health services for those who **qualify** may include:

Part-time or intermittent skilled nursing and home health aide services

- Physical and occupational therapy and speech pathology services
- Medical social services
- Medical supplies (Please see the Retiree Benefit Summary for more information.)
- Durable Medical Equipment (such as wheelchairs, hospital beds, oxygen, walkers) (Please see the Retiree Benefit Summary for more information.)

When you qualify for coverage of Home Health Services, Secure Horizons M+C Plan covers either part-time or intermittent Skilled Nursing and Home Health aide services. **Part-time** means any number of days per week up to 35 hours per week of Skilled Nursing and Home Health aide services combined for less than 8 hours per day, based upon the need for and reasonableness of such additional care.

Intermittent means up to 35 hours per week of Skilled Nursing and Home Health aide services combined which are provided on less than daily basis, based upon the need for and reasonableness of such additional care; or up to and including full-time (i.e., 8 hours per day) Skilled Nursing and Home Health aide services combined which are provided and needed 7 days per week for temporary, but not indefinite, periods of time up to 21 days with allowances for extensions in exceptional

circumstances where the need for care in excess of 21 days is finite and predictable.

A homebound Member has restricted ability, due to an illness or injury, to leave home without the assistance of another or the aid of a supportive device (such as crutches, a cane, a wheelchair, or a walker), or if leaving the home is medically contraindicated. You do not have to be bedridden in order to be considered confined to the home. However, your condition should be such that there exists a normal inability to leave the home and, consequently, leaving the home would require a considerable and taxing effort. If you leave the home, you may be considered homebound if the absences from the home are infrequent or for periods of relatively short duration, or to receive medical treatment, including regular absences for the purpose of participating in therapeutic, psychosocial, or medical treatment in an adult day-care program that is licensed or certified by the State of California, or to attend a religious service.

Home health services do not include the costs of housekeepers, food service arrangements, or full-time nursing care at home.

Hospice

In order to access Hospice care, Secure Horizons M+C Plan Members must elect Hospice care under Medicare. Upon making this election, all care related to the terminal illness will be provided by the Medicare-certified Hospice which is billed directly to Medicare. Secure Horizons M+C Plan will continue to provide for the covered basic medical services unrelated to the terminal illness which are also billed directly to Medicare. Secure Horizons M+C Plan will continue to cover and be financially responsible for supplemental benefits that Original Medicare does not cover. As a Secure Horizons M+C Plan Member, you have the right to get information about all available Medicare-certified Hospice Providers. For more information regarding electing Hospice care, including those Hospice facilities that

Section 5 – Working With Your Contracting Medical Providers



have an agreement with your Contracting Medical Group, please contact Secure Horizons Member Service.

Clinical Trials

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

When you enroll in a Clinical Trial, the providers are paid directly by Original Medicare for all the Covered Services you receive. The Clinical Trial providers do not have to be Secure Horizons M+C Plan contracting Providers.

This means that you do not need to get a Referral to join a Clinical Trial. However, you should tell us before you start a Clinical Trial. That way, we can still keep track of your health care services. You may remain enrolled in Secure Horizons M+C Plan even if you elect to participate in a Clinical Trial. Your care unrelated to the Clinical Trial can still be delivered by Secure Horizons M+C Plan.

Religious Non-medical Health Care Institutions (RNHCIs) Care

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

In order to be eligible for care in a RNHCI, members must have a condition that would allow them to receive inpatient hospital or extended care services. In addition, the member must make an election that they are conscientiously opposed to the acceptance of “Nonexcepted” medical treatment. “Excepted” medical treatment is medical care or treatment that you receive involuntarily or that is required under Federal, State or local law. “Nonexcepted” medical treatment is any other medical care or treatment.

Receiving Non-Emergency Care After Hours

If you need to talk to or see your Contracting Primary Care Physician after the office has closed for the day, call the 24-hour number located on the front of your Secure Horizons M+C Plan membership card. The physician on call will return your call and advise you on how to proceed.



Section 6 – Emergency and Urgently Needed Services

Emergency Services

Prior Authorization for treatment of Emergency Medical Conditions is not required.

In the event of an Emergency Medical Condition, go to the closest emergency room, or call 911 for assistance. It is appropriate for you to use the “911” emergency response system in your area for assistance when you have an Emergency Medical Condition that requires an emergency response. Secure Horizons M+C Plan will cover Emergency Services whether you are in or out of the Service Area. You should have someone telephone your Contracting Primary Care Physician or Secure Horizons M+C Plan at the number listed on your membership card as soon as reasonably possible. Secure Horizons M+C Plan offers worldwide emergency coverage.

Emergency Services are covered inpatient or outpatient services that are:

1. Furnished by a Provider qualified to furnish Emergency Services; and
2. Needed to evaluate or stabilize an Emergency Medical Condition.

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

1. Serious jeopardy to the health of the individual or, in the case of a pregnant woman, the health of the woman or her unborn child;
2. Serious impairment to bodily functions; or
3. Serious dysfunction of any bodily organ or part.

It is important to notify your Contracting Primary Care Physician or Secure Horizons M+C Plan of an Emergency Medical Condition so that your Contracting Primary

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

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

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

Post Stabilization Care

Medically Necessary, non-Emergency Services following receipt of emergency care to enable you to remain stabilized are covered when Secure Horizons M+C Plan or its Contracting Medical Group provides preauthorization for such services; or when Secure Horizons M+C Plan or its Contracting Medical Group does not respond within one hour to a request for preauthorization from a Non-Contracting Medical Provider or Facility; or when Secure Horizons M+C Plan or its Contracting Medical Group could not be contacted for preauthorization.

Coverage for Post Stabilization Care is effective until:

- you are discharged

Section 6 – Emergency and Urgently Needed Services



- a Contracting Medical Provider arrives and assumes responsibility for your care
- the Non-Contracting Medical Provider and Secure Horizons M+C Plan agree to other arrangements

Urgently Needed Services

Secure Horizons M+C Plan also covers Urgently Needed Services.

Urgently Needed Services are Covered Services provided when you are temporarily* absent from the area served by your Contracting Primary Care Physician; in general, the area outside a 30-mile radius of the Contracting Primary Care Physician/Contracting Medical Group you have selected (or, under unusual and extraordinary circumstances, provided when you are in this area, but your Contracting Medical Group is temporarily unavailable or inaccessible) when such services are Medically Necessary and immediately required:

- **As a result of an unforeseen illness, injury, or condition; and**
- **It is not reasonable given the circumstances to obtain the services through your Contracting Medical Group.**

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

If such a medical need arises, we request that you, if possible, first telephone your Contracting Primary Care Physician or Secure Horizons M+C Plan, then seek care from a local doctor. Should this be difficult, you may seek care from a Hospital emergency room or other medical facility.

If you must visit a Hospital for Urgently Needed Services when outside the Service Area, you should contact your Contracting Medical Group or Secure Horizons M+C Plan within forty-eight (48) hours or as soon as reasonably possible, so that we can be

involved in the management of your care. While we prefer that you return to the Service Area and receive follow-up care through your Contracting Primary Care Physician, follow-up care will be covered out of the Service Area when the care required continues to meet the above definition of Urgently Needed Services.

When You Need Urgent Care and You're in Your Service Area

All medical providers have a 24-hour emergency number. Your Secure Horizons M+C Plan Contracting Medical Providers may have on-site urgent care centers. Many of these centers have extended hours and do not require appointments. We encourage you to take advantage of this convenience in an urgent medical situation.

1. Call your Secure Horizons M+C Plan's Contracting Medical Group at the number listed on the front of your Secure Horizons M+C Plan membership card.
2. Identify yourself as a Secure Horizons M+C Plan Member and let them know that you feel you need immediate medical attention.
3. Follow any first aid instructions given (you may be advised to go to your medical Provider or to a nearby Hospital).

If, for any reason, you are unable to reach your medical Provider, follow the steps for out-of-area Urgently Needed Services as previously described.

Remember, follow-up medical care must be received or authorized by your Secure Horizons M+C Plan Contracting Medical Provider.

Remember, if you receive services from Non-Contracting Medical Providers without Prior Authorization, neither Secure Horizons M+C Plan nor Medicare will pay for those services, except for:

- **Emergency Services**
- **Urgently Needed Services**



Section 6 – Emergency and Urgently Needed Services

- **Out-of-area and routine travel renal dialysis** (in the United States at a Medicare-certified facility)

Covered Services for which Secure Horizons M+C Plan allows you to self-refer to Contracting Providers.

Reimbursement for Emergency, Urgently Needed Services or Out-of-Area and Routine Travel Renal Dialysis Paid by Member

Providers should submit bills to Secure Horizons M+C Plan for payment. However, if you paid for any Emergency Services, Urgently Needed Services or Out-of-Area and routine travel renal dialysis obtained from Non-Contracting Medical Providers, you should submit your bills to Secure Horizons M+C Plan for a payment determination. Please include your name, your Member number, and the bill, as well as medical documentation. No claim forms are required. Bills should be submitted to the following address:

Secure Horizons M+C Plan
Attention: Secure Horizons M+C Plan Claims
P. O. B o x 489
Cypress, California 90630

Right to Appeal

Secure Horizons M+C Plan provides you with a written notice when a service or payment is denied. If Secure Horizons M+C Plan has denied payment for services you think should have been covered, or if we refused to arrange for services that you believe are covered by Medicare, you have the right to appeal. If you think your health could be seriously harmed by waiting for a decision about authorization for a service, ask for an **Expedited Appeal**. See Section 9. If you have questions about any bills, contact Secure Horizons Member Service.

Section 7 – Premiums and Payment Options



As a Member of Secure Horizons M+C Plan, you have the following financial obligations: (Specific Copayment/Coinsurance and Premium amounts are listed in the Retiree Benefit Summary.)

Plan Premiums (“Prepayment Fees”)

- **Medicare Part B Premium** – A monthly premium paid to Medicare to cover Supplemental Medical Insurance (Part B). As a Secure Horizons M+C Plan Member, you must continue to pay your Medicare Part B Premium. If you receive a Social Security annuity check, this premium is automatically deducted from your check. Otherwise your premium is paid directly to Medicare by you or someone on your behalf (such as the California Department of Health Services, which administers the Medi-Cal program).

Financial Arrangements:

The benefits under this Plan are paid by PacifiCare under a Group Service Agreement. The cost of the premiums is currently paid entirely by the University of California.

Changes in Plan Premiums

Increases in Secure Horizons M+C Plan Individual Plan Premiums and/or decreases in the level of coverage are only permitted at the beginning of each contract year (which is usually the Calendar Year) and must be approved by CMS. You will receive written notice in the fall of each year of any benefit or Plan Premium changes that become effective the following January. Rate changes and benefit changes for Group Retiree Members enrolled through the University of California Group Retiree plan are subject to contractual arrangements between Secure Horizons M+C Plan and the University of California. The University of California is responsible for notifying you of any Secure Horizons M+C Plan Premium changes, contribution changes, or University of California -sponsored benefit changes 30 days before they become effective.)

Other Charges

All Copayments and Coinsurance are due and payable at the time of service to the provider of service. Specific Copayment and Coinsurance amounts are listed in the Retiree Benefit Summary enclosed.



Section 8 – Disenrollment From Secure Horizons Medicare+Choice Plan

Voluntary Disenrollment

In the event you choose to cancel your membership under the Secure Horizons M+C Plan Group Retiree Plan, re-enrollment may not be permitted until your next Open Enrollment Period. You should consult with your benefits administrator regarding the availability of other coverage before canceling your PacifiCare/Secure Horizons M+C Plan membership outside of the University of California Open Enrollment Period. Please note that Group Retiree Members may enroll in the Secure Horizons M+C Plan Individual Plan as individual members. Please refer to Section 2 for further information regarding enrollment. As an individual member of Secure Horizons M+C Plan, you will receive the benefit package approved by Centers for Medicare & Medicaid Services for your county of residence, which may cover less than the benefit package available through the University of California or union trust, and a plan premium may apply. For additional information regarding benefits and plan premiums related to individual members, please contact Secure Horizons Member Service at 1-800-228-2144, Telecommunications Device for the Hearing Impaired (TDHI): 1-800-685-9355.

Please contact your benefits administrator regarding their disenrollment and move notification policies and the possible impact to your retiree health care coverage options and other retirement benefits. Additionally, please contact either the University of California or Secure Horizons Member Service Department for more information regarding your disenrollment effective date.

How to Disenroll –If you want to leave Secure Horizons Medicare+Choice Plan and return to Original Medicare, you must Disenroll from our Plan and you will automatically be returned to Original Medicare. You may:

- Write a letter to us and send it to us. Please make sure you sign and date your letter. If you have any questions, please call the Member Service Department; or

- Call the national help line at 1-800-MEDICARE (1-800-633-4227), or the hearing impaired TTY/TDD access line 1-877-486-2048, to Disenroll via the phone; or
- You can contact your nearest Social Security office or, if you have Railroad Retirement benefits, you can contact the Railroad Retirement Board office.

After we receive your Disenrollment request, we will send you a letter that tells you when your Disenrollment effective date will be. As long as your Disenrollment request follows the new rules, it will be processed. If your Disenrollment request does not follow the new rules, we must reject your Disenrollment and you will remain a Secure Horizons Medicare+Choice Plan Member.

The Effective Date of Your Disenrollment

In most cases, a written Disenrollment request received by the end of the month will make your Disenrollment effective the 1st of the following month. For example, if your Disenrollment request were received on March 31, your Disenrollment from Secure Horizons Medicare+Choice Plan would be processed for an effective date of April 1, 2003. Please contact either the University of California or Secure Horizons Member Services for more information regarding your Disenrollment effective date.

Remember that while you are waiting for your membership to end, you are still a Member of Secure Horizons M+C Plan and must continue to receive all routine Covered Services from Contracted Medical Providers until the date your Disenrollment is effective. Secure Horizons M+C Plan will send you a letter that tells you when your Disenrollment is effective. Once your Disenrollment is effective, you can start using your red, white, and blue Medicare card to get services under Original Medicare. (You can call Social Security at 1-800-772-1213 if you need a new card.)

Section 8 – Disenrollment From Secure Horizons Medicare+Choice Plan



Moves or an Extended Absence From the Secure Horizons Medicare+Choice Plan Service Area

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

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

Secure Horizons Medicare+Choice Plans are currently offered in the following states: Arizona, California, Colorado, Nevada, Oklahoma, Oregon, Texas and Washington. If you are moving outside of your Service Area, you may be eligible to enroll in a Secure Horizons Medicare+Choice Plan in your new location. Plan Premiums, Copayments and Covered Services will vary from one area to another. Please contact the Member Service Department for information and assistance in completing any necessary paperwork. For information on other plans available in your area, you can call 1-800-MEDICARE (1-800-633-4227), or the hearing impaired TTY/TDD access line 1-877-486-2048, or visit the CMS Web site at www.medicare.gov.

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

If we leave the Medicare program or change our Service Area so that it no longer includes the area where you live, we will notify you in writing. If either of these things happen, you will be allowed to change the way you get Medicare coverage. Your choices will always include going to Original Medicare, and they may also include joining another Medicare managed care plan or a private fee-for-service plan if such plans are available in your area and are accepting new members.

PacifiCare of California, the company that offers Secure Horizons Medicare+Choice Plan, has a contract with the CMS. This contract renews each year. At the end of each year, the contract is reviewed, and either PacifiCare or CMS can decide to end it. It is also possible for our contract to end at some other time. If the contract is going to end, we will generally notify you at least 90 days in advance. Your advance notice may be as little as 30 days or even fewer days if CMS must end our contract in the middle of the year.

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

Coverage That Ends During an Inpatient Hospital Stay

If your coverage under Secure Horizons Medicare+Choice Plan ends while you are an inpatient in a Hospital (or Hospital unit), Secure Horizons Medicare+Choice Plan may be responsible for the inpatient services until



Section 8 – Disenrollment From Secure Horizons Medicare+Choice Plan

the date of your discharge. We have Member Service Representatives available who can tell you if we are responsible for your inpatient services.

Secure Horizons Medicare+Choice Plan is not responsible for services, other than inpatient Hospital services, furnished on or after the Effective Date of your Disenrollment.

Involuntary Disenrollment

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

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

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

1. If you give information on your Individual Election Form that is false or deliberately misleading, and it affects whether or not you can enroll in Secure Horizons Medicare+Choice Plan.
2. If you behave in a way that is unruly, uncooperative, disruptive, or abusive, and this behavior seriously affects our ability to arrange Covered Services for you or for others who are Members of Secure Horizons Medicare+Choice Plan. Before we can make you leave for this reason, we must get permission from the Centers for Medicare & Medicaid Services, the government agency that runs Medicare.
3. If you let someone else use your membership ID card to get Covered Services. Before we ask you to leave for this reason, we must refer your case to the Inspector General, and this may result in criminal prosecution.

4. If you do not pay the health Plan Premiums. We will tell you of a 90-day grace period during which you can pay the health Plan Premiums before you are required to leave Secure Horizons Medicare+Choice Plan. Should you decide later to reenroll in Secure Horizons Medicare+Choice Plan, you may pay any outstanding health Plan Premiums due from your previous enrollment. Please Note: Your health Plan Premiums are paid by the University of California.

University of California Rules Related to Fraud

Fraud

Coverage for an Annuitant or covered Dependent may be terminated for fraud or deception in the use of the services of the Plan, or for knowingly permitting such fraud or deception by another. Deception includes but is not limited to intentionally enrolling an ineligible individual. Such termination shall be effective upon the mailing of written notice by the Plan to the Annuitant and the University. A Dependent who commits fraud or deception will be permanently disenrolled while any other Dependent and the Annuitant will be disenrolled for 18 months. If an Annuitant commits fraud or deception, the Annuitant and any Dependents will be disenrolled for 18 months.

You Have the Right to Make a Complaint if We Ask You to Leave. If we do ask you to leave Secure Horizons Medicare+Choice Plan, we will tell you our reasons in writing and explain how you can file a Grievance if you want to.

Until we notify you in writing that you have been Disenrolled, you are still considered a Secure Horizons Medicare+Choice Plan Member and must continue to get routine Covered Services from Contracted Medical Providers. Neither Secure Horizons nor Medicare will pay for services received except for Urgently Needed Services; Emergency Services anywhere in the world; Out-of-

Section 8 – Disenrollment From Secure Horizons Medicare+Choice Plan



Area renal dialysis services; services for which Secure Horizons Medicare+Choice Plan allows you to self-refer to Contracted Medical Providers; and Referrals that have received Prior Authorization.

We Cannot Ask You to Leave Because of Your Health

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

If you ever feel that you are being encouraged or asked to leave Secure Horizons Medicare+Choice Plan because of your health, you should call the national Medicare help line at 1-800-MEDICARE or contact your Regional CMS Office:

Centers for Medicare & Medicaid Services
75 Hawthorne Street
San Francisco, CA 94105

Review of Termination and Reinstatement

No Member shall be Disenrolled because of the Member's health status or requirements for health care services other than as stated within this Section. Any Member who believes he/she was Disenrolled by Secure Horizons M+C Plan because of the Member's health status or requirements for health care services may request a review by the California Department of Managed Health Care pursuant to California Health and Safety Code, Section 1365, or contact your CMS Regional Office at 75 Hawthorne Street, San Francisco, California 94105, 1-415-744-3617. In the event the Department determines the Disenrollment was contrary to Section 1365, the Member shall be reinstated retroactively to the date of the Disenrollment.

COBRA Optional Continuation of Coverage Through the University of California Sponsored Health Plans

Under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended, enrolled persons who would lose coverage under the Secure Horizons 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 Dependents, it shall 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:

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:

1. because your employment ended for a reason other than gross misconduct; or
2. 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:

In the case of your eligible Dependent spouse, your spouse may continue coverage for himself or her-self and any enrolled Dependent children if your spouse's coverage would have ended because of any of the following Qualifying Events:

1. because your employment ended for a reason other than gross misconduct; or



Section 8 – Disenrollment From Secure Horizons Medicare+Choice Plan

2. because your work hours were reduced (including approved leave without pay or layoff); or
3. at your death; or
4. because you became entitled to Medicare benefits; or
5. when your spouse ceased to be an eligible Dependent as a result of a divorce, legal separation, or annulment.

If coverage ends under (5) immediately above, please see “Notice” below.

In 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:

1. because your employment ended for a reason other than gross misconduct; or
2. because your work hours were reduced (including approved leave without pay or layoff); or
3. at your death; or
4. because you became entitled to Medicare benefits; or
5. because of your divorce, legal separation, or annulment; or
6. when your eligible Dependent child ceased to be an Eligible Dependent under the rules of the plan.

If coverage for an eligible Dependent ends due to an event shown (5) or (6) immediately above, please see “Notice” below.

For the qualifying event (1) or (2), if you become 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 became 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 ceased 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 University of California Member Service Center 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 the 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, CA 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 provision (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 occurs:

Section 8 – Disenrollment From Secure Horizons Medicare+Choice Plan



1. With respect to yourself and any Qualified Beneficiaries, the day 18 months from the earlier of the date:
 - a. your employment ends for a reason other than gross misconduct, or
 - b. 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:
 - (i) the disability was determined to exist at the time, or during the first sixty (60) days, of the 18 months of COBRA coverage, and
 - (ii) 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.

1. With respect to your Qualified Beneficiaries (other than yourself), the day 36 months from the earliest of the date:
 - a. of your death; or
 - b. of your entitlement to Medicare benefits; or
 - c. of your divorce, annulment, or legal separation from your spouse; or
 - d. 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:

1. 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 the required payments.
2. The day the person becomes covered (after the day the person made the election for continuation of coverage) under any other group health plan, on an insured or uninsured basis. This item (4) 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.
3. The day the person becomes entitled to Medicare Benefits.
4. The day the employer no longer provides group health coverage to any of its employees.

California Continuation Coverage

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. The former spouse of the above former employee is entitled to California Continuation Coverage, provided the former spouse continued coverage under COBRA as a Qualified Beneficiary. This continuation does not apply to children of a former employee. The continuation will end on the earlier of:

1. the date the individual turns 65;
2. the date the University no longer maintains the group plan, including any replacement plan;



Section 8 – Disenrollment From Secure Horizons Medicare+Choice Plan

3. the date the individual is covered by a group medical plan not maintained by the University;
4. the date the individual becomes entitled to Medicare;
5. 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 18 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 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% anytime 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 California Continuation Coverage.

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

Please note: When your continuation of coverage ends, you may be able to convert your coverage to an individual Conversion Plan if you wish.

Group Retiree Members may enroll in the Secure Horizons M+C Plan Individual Plan as individual members. As an individual Member for Secure Horizons M+C Plan, you will receive the benefit package approved by CMS for your county of residence, which may cover less than the benefit package available through the University of California and a Plan Premium may apply.

Section 9 – Secure Horizons M+C Plan Appeal and Grievance Procedures



As a Secure Horizons M+C Plan Member, you are encouraged to let us know if you have concerns or experience any problems with Secure Horizons M+C Plan. Please contact Secure Horizons Member Service at the number below for more information.

The procedures described in the sections that follow may be used if you have an Appeal or Grievance that you want to submit to Secure Horizons M+C Plan for review and resolution. These procedures include:

- General Information on Secure Horizons M+C Plan Appeals Procedures
- Secure Horizons M+C Plan Organization Determination and Standard Appeals Process
- Peer Review Organization (PRO) Immediate Review of Hospital Discharges
- Medicare Expedited/72-Hour Determinations and Appeals Procedure
- Secure Horizons M+C Plan Grievance Procedure
- PRO Quality of Care Complaint Procedure

Secure Horizons M+C Plan will review your Appeal or Grievance and if the Appeal or Grievance 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 Grievance.

General Information on Secure Horizons M+C Plan Appeals Procedure

As a Member of Secure Horizons M+C Plan, you have the right to Appeal any decision about our payment for, or failure to arrange or continue to arrange for, what you believe are Covered Services under your Medicare+Choice Plan. These include:

- Payment for Emergency Services, Post-Stabilization Care, or Urgently Needed

Services, or Out-of-area and routine travel renal dialysis (in the United States at a Medicare-certified facility)

- Payment for any other health services furnished by a Non-Contracting Medical Provider or facility that you believe are covered under Original Medicare, or should have been arranged for or reimbursed by Secure Horizons M+C Plan
- Services you have not received, but that you believe are the responsibility of Secure Horizons M+C Plan to pay for or arrange
- Discontinuation of services that you believe are Medically Necessary Covered Services
- Failure of Secure Horizons M+C Plan to approve, furnish, arrange for or provide payment for health care services in a timely manner, or to provide you with a timely notice of an adverse determination, such that a delay would adversely affect your health

Use the Secure Horizons M+C Plan Grievance Procedure for complaints that are not denied claims or denied services (see “Secure Horizons M+C Plan Grievance Procedures” following “Secure Horizons M+C Plan Expedited/72-Hour Determination and Appeal Procedure”). If you have a question about which complaint process to use, please call Secure Horizons Member Service at 1-800-228-2144, TDHI: 1-800-685-9355.

Secure Horizons M+C Plan has a standard determination and Appeals procedure, and an expedited determination and Appeals procedure.

Who May File an Appeal

1. You may file an Appeal.
2. Someone else may file the Appeal for you on your behalf. You may appoint an individual to act as your representative to file the Appeal for you by following the steps:



Section 9 – Secure Horizons M+C Plan Appeal and Grievance Procedures

- a. Give us your name, your Medicare number and a statement, which appoints an individual as your representative. (Note: You may appoint a physician or a Provider.) For example: I [your name]_ appoint [name of representative] to act as my representative in requesting an Appeal from Secure Horizons M+C Plan and/or the Centers for Medicare & Medicaid Services regarding the denial or discontinuation of medical services.
 - b. You must sign and date the statement. If for any reason you are unavailable to sign and date the statement or to appoint a representative for the purposes of filing an Appeal, Secure Horizons M+C Plan will follow the instructions of any individual appointed by you in an Advance Directive, as explained in Section 10.
 - c. Your representative must also sign and date this statement unless he/she is an attorney.
 - d. You must include this signed statement with your Appeal.
3. A Non-Contracting Medical Provider may file a standard Appeal of a denied claim if he/she completes a waiver of payment statement, which says he/she will not bill you regardless of the outcome of the Appeal.

Support for Your Appeal

You are not required to submit additional information to support your request for a reconsideration (Appeal). Secure Horizons M+C Plan is responsible for gathering all necessary medical information. However, it may be helpful to include additional information to clarify or support your request. For example, you may want to include in your Appeal a request for information such as the denial letter issued, medical records or physician opinions in support of your request.

You have the opportunity to provide

additional information in person or in writing. In the case of an expedited decision or Appeal, you or your authorized representative may submit evidence, in person, by telephone, or in writing transmitted by facsimile (fax) at the address and telephone number referenced under the “Expedited/72-hour Review” procedure.

Assistance With Appeals

Regardless of whether you request either a standard or expedited Appeal, you can have a friend, lawyer or someone else help you. There are lawyers who do not charge a fee unless you win your Appeal. Groups such as lawyer referral services can help you find a lawyer. There are also groups, such as legal aid services, who will give you free legal services if you qualify. You may want to contact the Health Insurance Counseling and Advocacy Program (HICAP) at 1-800-434-0222.

Secure Horizons M+C Plan Standard Organization Determination and Appeals Process

If you specifically request a particular service from your Contracting Primary Care Physician or from a Specialist or other Provider you have been authorized to see, or if that Contracting Primary Care Physician or Specialist or other Provider specifically requests authorization for a service for you from Secure Horizons M+C Plan or your Contracting Medical Group, it is a request for an Organization Determination on the service. If you request in writing to Secure Horizons M+C Plan or your Contracting Medical Group that Secure Horizons M+C Plan or your Contracting Medical Group make payment for a service you have already received, it is a request for a Secure Horizons M+C Plan determination on the payment.

In the case of a standard determination, Secure Horizons M+C Plan must make a determination (decision) on your request for payment or provision of services within the following time frames:

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- **Request for Service.** If you request services or require Prior Authorization of a Referral, Secure Horizons M+C Plan must make a decision as expeditiously as your health care requires, but no later than fourteen (14) calendar days after receiving your request for service. An extension of up to fourteen (14) calendar days is permitted, if you request the extension or if Secure Horizons M+C Plan finds that additional information is needed and the extension of time benefits you; for example, if Secure Horizons M+C Plan needs additional medical records from Non-Contracting Medical Providers that could change a denial decision. Secure Horizons M+C Plan or your Contracting Medical Group will notify you promptly of the determination, but no later than upon expiration of the extension. When we take an extension, you will be notified of the extension in writing.
- **Requests for Payment.** If you request payment for services already received, Secure Horizons M+C Plan must make a decision on whether or not to pay the claim no later than sixty (60) calendar days from receiving your request.

Secure Horizons M+C Plan must notify you in writing of the decision within the time frames listed above. If the decision is a denial (partial or complete), the notice must state the reasons for the denial, inform you of your right to a reconsideration as well as the appeals process. Secure Horizons M+C Plan's written response will describe the criteria used and the clinical reasons for its decision, including all criteria and clinical reasons related to Medical Necessity. For determinations delaying, denying, or modifying health care services based on a finding that the services are not a covered benefit, the response will specify the provisions in the plan contract that exclude that coverage. If you have not received such a notice within fourteen (14) calendar days of your request for services, or within sixty (60)

days of a request for payment, you may assume the decision is a denial, and you may file an Appeal.

If you do not agree with the decision made by Secure Horizons M+C Plan, you may appeal. There are two kinds of Appeals you can file. There is a "Standard Appeal" and an "Expedited Appeal."

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

1. You must submit a written request for a reconsideration to the Secure Horizons M+C Plan Appeals Department at P.O. Box 489, Cypress, California 90630. You may also request a reconsideration through the Social Security Administration Office (or, if you are a railroad retirement beneficiary, through a Railroad Retirement Benefits Office). You must submit your written request within sixty (60) calendar days of the date of the notice of the initial decision.

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

2. Secure Horizons M+C Plan will conduct a reconsideration and notify you in writing of the decision, within the following time frames:
 - **Request for Service.** If the Appeal is for a denied service, Secure Horizons M+C Plan must notify you of the reconsideration decision as expeditiously as possible, but no later than thirty (30) calendar days from receipt of your request for reconsideration. Secure Horizons M+C Plan may extend this time frame by up to fourteen (14) calendar days if you request the extension, or if Secure Horizons M+C Plan finds that additional information is needed and the extension of time benefits you; for example, if Secure Horizons M+C Plan needs additional medical records from Non-Contracting Medical Providers that could change a denial decision.



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- **Request for Payment.** If the Appeal is for a denied claim, Secure Horizons M+C Plan must notify you of the reconsideration determination no later than sixty (60) days after receiving your request for a reconsideration determination.
 - Secure Horizons M+C Plan reconsideration decision will be made by a person(s) not involved in the initial decision. All reconsiderations of adverse Organization Determinations based on Medical Necessity must be made by a physician with expertise in the field of medicine that is appropriate for the service at issue. However, that physician need not be of the same specialty or subspecialty as the treatment physician. During the reconsideration, you or your authorized representative may present or submit relevant facts and/or additional evidence for review either in person or in writing.
1. If Secure Horizons M+C Plan decides to reverse the original adverse decision, we must authorize or provide your service as expeditiously as your health requires, but no later than thirty (30) calendar days from the date of determination; or we must pay your claim within sixty (60) calendar days of the determination.
 2. If Secure Horizons M+C Plan decides to uphold the original adverse decision (continue to deny services or withhold payment), either in whole or in part, or if we fail to provide you with a decision on your reconsideration within the relevant time frame, we will automatically forward the case to the Center for Health Dispute Resolution (The Center) for a new and impartial review and you will be notified. The Center is the CMS independent contractor for Appeal reviews involving Medicare+Choice managed care plans, like Secure Horizons M+C Plan. We must send The Center the file within thirty (30) days of a request for services and within sixty (60) days of a request for payment.

The Center will either uphold Secure Horizons M+C Plan's decision or issue a new decision. If we forward the case to The Center, we still must notify you of our decision within the relevant time frame discussed above.

3. For cases submitted to The Center for review, The Center will make a reconsideration decision and notify you directly in writing of their decision and the reasons for the decision.

If The Center decides in your favor and reverses our decision, the following must occur:

- **Request for Service.** If The Center decides in your favor, we must authorize the service under dispute within 72 hours from the time of The Center's notice reversing our decision, or provide the service under dispute as expeditiously as your health condition requires, but no later than 14 calendar days from the date of The Center's notice.
- **Request for Payment.** If The Center decides in your favor, we must pay the claim for the service no later than 30 calendar days from the date of The Center's notice.

If The Center does not rule fully in your favor, there are further levels of appeal:

1. You may request a hearing before an Administrative Law Judge (ALJ) by submitting a written request to Secure Horizons M+C Plan, The Center or the Social Security Administration within sixty (60) days of the date of The Center's notice that the reconsideration decision was not in your favor. This sixty (60) day notice may be extended for good cause. A hearing can be held only if the amount in controversy is one hundred dollars (\$100) or more as determined by the Administrative Law Judge. All hearing requests will be forwarded to The Center. The Center will then forward your request and your reconsideration file to the

Section 9 – Secure Horizons M+C Plan Appeal and Grievance Procedures



hearing office. Secure Horizons M+C Plan will also be made a party to the appeal at the Administrative Law Judge hearing.

2. If the Administrative Law Judge's decision is adverse, either you or Secure Horizons M+C Plan may request a review by the Departmental Appeals Board of the Social Security Administration, which may either review the decision or decline review.
3. If the amount involved is \$1,000 or more, either you or Secure Horizons M+C Plan may request that a decision made by the Departmental Appeals Board or the Administrative Law Judge, if the Departmental Appeals Board has declined review, be reviewed by a Federal district court.
4. Any initial or reconsidered decision made by Secure Horizons M+C Plan, The Center, the Administrative Law Judge or the Departmental Appeals Board can be reopened:
 - a. within twelve (12) months;
 - b. within four (4) years for just cause; or
 - c. at any time for clerical correction or in cases of fraud.
5. The reconsidered determination is final and binding upon Secure Horizons M+C Plan. The binding arbitration clause in your Individual Election Form does not apply to disputes subject to CMS Appeals process.

Peer Review Organization (PRO) Immediate Review of Hospital Discharges

When you are being discharged from the Hospital, you will receive a written notice of explanation called an "Important Message from Medicare." If you think you are being asked to leave the Hospital too soon, you have the right to request a review by the PRO. Such a request must be made by noon of the next working day after you receive the Important Message from Medicare. This document outlines your rights; you do have

to disagree with the non-coverage determination in order to receive it. You cannot be made to pay for your Hospital care until the PRO makes its decision. You have the right to receive all the Hospital care that is necessary for the proper diagnosis and treatment of your illness or injury. According to Federal law, your discharge date must be determined solely by your medical need.

You have the right to request a review by a Peer Review Organization (PRO) of any written Important Message from Medicare that you receive. PROs are groups of doctors who are paid by the Federal government to review Medical Necessity, appropriateness, and quality of Hospital treatment furnished to Medicare patients, including those enrolled in a managed care plan (like Secure Horizons M+C Plan). The phone number and address of the PRO for your area is:

California Medical Review
Incorporated at Citicorp Center
One Sansome Street, Suite 600
San Francisco, CA 94104
1-800-841-1602 or 1-415-677-2000

If you ask for immediate review by the PRO, you will be entitled to this process instead of the Secure Horizons M+C Plan Expedited Appeals process that is described in this combined Evidence of Coverage and Disclosure Information. Instead of PRO review, you may appeal the Important Message from Medicare within 60 days of the Notice by requesting that Secure Horizons M+C Plan reconsider its decision. The advantage of the PRO review is that you will get the results within three working days if you request the review on time. **Also, you are not financially liable for Hospital charges during the PRO review.**

Note: You may file an oral or written request for an expedited/72-hour Appeal only if you have missed the deadline for requesting the PRO review. Specifically state that you want an expedited Appeal or 72-hour Appeal, or that you believe your health could be seriously harmed by waiting for a Standard Appeal.



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Secure Horizons M+C Plan Expedited/72-Hour Determination and Appeal Procedure

You have the right to request and receive expedited decisions affecting your medical treatment in “Time-Sensitive” situations. A Time-Sensitive situation is a situation where waiting for a decision to be made within the time frame of the standard decision-making process could seriously jeopardize your life or health, or your ability to regain maximum function. If Secure Horizons M+C Plan decides, based on medical criteria, that your situation is Time-Sensitive, or if any physician calls or writes in support of your request for an expedited review, Secure Horizons M+C Plan will issue a decision as expeditiously as possible, but no later than seventy-two (72) hours after receiving the request. We may extend this time frame by up to fourteen (14) days if you request the extension, or if we need additional information and the extension of time benefits you; for example, if we or our Contracting Medical Group need additional medical records from Non-Contracting Medical Providers that could change a denial decision. Again, we must make a decision as expeditiously as your health requires, but no later than the end of any extension period.

Types of Decisions Subject to Expedited/72-Hour Review

- 1. Expedited Determinations.** If you believe you need a service and you believe it is a Time-Sensitive situation, you or a physician may request that the decision be expedited. Secure Horizons M+C Plan must make a decision as expeditiously as your health care requires, but no later than 72 hours after receiving your request. Secure Horizons M+C Plan will decide when your situation is Time-Sensitive. If any physician makes the request for you, or calls or writes in support of your request for an expedited determination, and your situation is time-sensitive, we will issue a decision as expeditiously as your health requires, but no later than 72
- 2. Expedited Appeals.** If you want to request a reconsideration (Appeal) of a decision by Secure Horizons M+C Plan to deny a service you requested or to discontinue a service you are receiving that you believe is a Medically Necessary Covered Service, and you believe it is a Time-Sensitive situation, you or your authorized representative may request that the reconsideration be expedited. If a physician wishes to file an expedited Appeal for you, you must give him or her authorization to act on your behalf. If Secure Horizons M+C Plan decides that it is a Time-Sensitive situation or if any physician states that it is one, Secure Horizons M+C Plan will make a decision on your Appeal on an expedited basis. Examples of service decisions which you may appeal on an expedited basis, when you believe it is a Time-Sensitive situation, include the following:
 - If you think you are being discharged from a Skilled Nursing Facility too soon
 - If you think your Home Health care is being discontinued too soon
 - If you think you are being discharged from a Hospital too soon and you have missed the deadline for a Peer Review Organization (PRO) review

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

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How to Request an Expedited/72-Hour Review

To request an expedited/72-hour review, you or your authorized representative may call, write, fax or visit Secure Horizons M+C Plan. Be sure to ask for an expedited/72-hour review when you make your request.

Call:

Secure Horizons M+C Plan
Expedited Review Line:
1-888-277-4232 (Toll Free)
Business Hours: Monday through Friday,
8:00 a.m. to 5:00 p.m.

Secure Horizons M+C Plan will document your request in writing.

Secure Horizons M+C Plan
Expedited Review Line TDHI:
1-800-685-9355

Business Hours: Monday through Friday,
8:00 a.m. to 5:00 p.m.

Secure Horizons M+C Plan will document your request in writing.

Write:

Expedited 72-Hour Review Unit
Secure Horizons M+C Plan

Appeals Department
P. O. Box 489, Mail Stop CY22-294
Cypress, CA 90630
Fax: (714) 226-8898
Attention: Expedited 72-Hour Review Unit

Business Hours: Monday through Friday,
8:00 a.m. to 5:00 p.m.

Walk-in:

Secure Horizons Member Service Center
5701 Katella Avenue
Cypress, California 90630

Business Hours: Monday through Friday,
8:00 a.m. to 5:00 p.m.

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

1. Upon receiving your reconsideration request, Secure Horizons M+C Plan will determine if your request meets the definition of Time-Sensitive.
 - If your request does not meet the definition, it will be handled within the standard review process. You will be informed by telephone whether your request will be processed through the expedited seventy-two (72) hour review or the standard review process. You will also receive a written confirmation within three (3) calendar days of the phone call. If you disagree with Secure Horizons M+C Plan decision to process your request within the standard time frame, you may file a Grievance with Secure Horizons M+C Plan. The written confirmation letter will include instructions on how to file a Grievance. If your request is Time-Sensitive, you will be notified of our decision within seventy-two (72) hours. You will also receive a follow-up letter within 3 calendar days of the phone call.
 - An extension up to fourteen (14) calendar days is permitted for a 72-hour Appeal, if the extension of time benefits you; for example, if you need time to provide Secure Horizons M+C Plan with additional information or if Secure Horizons M+C Plan needs to have additional diagnostic testing completed. Secure Horizons M+C Plan will make a decision as expeditiously as your health requires, but no later than the end of any extension period. If the time frame is extended, you will be notified of the reasons for the delay.



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2. Your request must be processed within seventy-two (72) hours if any physician calls or writes in support of your request for an expedited/72-hour review, and the physician indicates that applying the standard review time frame could seriously jeopardize your life, health, or your ability to regain maximum function.
 - If a Non-Contracting Medical Provider supports your request, Secure Horizons M+C Plan will have seventy-two (72) hours from the time all the necessary medical information is received from that Provider to make a decision. Medical records will be requested from the non-contracting medical provider within 24 hours of your request.
3. Secure Horizons M+C Plan will make a decision on your Appeal and notify you of it within 72-hours of receipt of your request. If Secure Horizons M+C Plan decides to uphold the original adverse decision, either in whole or in part, the entire file will be forwarded by Secure Horizons M+C Plan to The Center for review no later than 24 hours after our decision. The Center will send you a letter with their decision within seventy-two (72) hours of receipt of your case from Secure Horizons M+C Plan.

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

There are four possible dispositions to a request for Expedited Determination/Appeal. They are:

- Your request to expedite our determination/appeal decision is approved; we make a decision in seventy-two (72) hours and notify you that we will provide or continue the service.
- Your request to expedite our determination/appeal decision is approved; we make a decision in seventy-two (72) hours and notify you that we will not provide or continue the service, and we will send the case to The Center.
- Your request to expedite our determination/appeal decision is not approved, and we tell you that your request will be handled under the standard determination/appeal process.
- Your request to expedite our determination/appeal decision cannot be made in seventy-two (72) hours, and we let you know that we will need up to an additional fourteen (14) days to process your request.

When you request an expedited determination, if you do not hear from us within seventy-two (72) hours of your request, you can assume that your request has been denied. Our failure to notify you in a timely manner – within seventy-two (72) hours – constitutes a denial which you may appeal.

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

The Center Reopening

A reopening is not an Appeal right. The Center reopening is a re-evaluation by The Center of its reconsideration decision. Any of the parties to a reconsidered determination may request a reopening, however, granting reopening is solely at The Center’s discretion. The party requesting a reopening must clearly state in writing the basis on which the request is made.

All The Center determinations advise the parties of the standards for reopening the case file by The Center. A reopening may be requested by any party to the determination if the party believes one of the following grounds for reopening is applicable:

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

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

Secure Horizons M+C Plan Grievance Procedures

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

- Complaints about the quality of services that you receive
- Complaints regarding such issues as office waiting times, physician behavior, adequacy of facilities, or other similar Member concerns
- Involuntary Disenrollment situations (Please see Section 8 for more information.)
- If you disagree with Secure Horizons M+C Plan decision to process your Referral request under the standard 14-day time frame rather than expedited/72-hour time frame
- If you disagree with Secure Horizons M+C Plan decision to process your Appeal request under the standard 30-day time frame rather than the expedited/72-hour time frame

Secure Horizons M+C Plan will attempt to resolve any complaint that you might have. We encourage the informal resolution of complaints (i.e., over the telephone), especially if such complaints result from misinformation, misunderstanding or lack of information. However, if your complaint cannot be resolved in this manner, a more formal Member Grievance procedure is available.

To use the formal Grievance procedure, submit your Grievance in writing to Secure Horizons M+C Plan. Secure Horizons M+C Plan will write you to let you know how we have resolved your Grievance that does not

relate to quality of medical care issues within thirty (30) calendar days of receiving your written Grievance.

However, if your Grievance involves an imminent and serious threat to your health, Secure Horizons M+C Plan will review the Grievance on an expedited basis and notify you in writing of the resolution of the Grievance within no later than three (3) calendar days of receiving your Grievance. In some instances Secure Horizons M+C Plan will need additional time to address your concern. If additional time is needed, Secure Horizons M+C Plan will keep you informed regarding the status of your Grievance. Confidentiality of all parties will be observed. Whether you use the formal written or informal (telephone) Grievance procedure, we are required to track all Appeals and Grievances in order to report cumulative data to CMS and to our Members upon request.

The Secure Horizons M+C Plan Grievance Procedure is as follows:

1. You may notify Secure Horizons M+C Plan of your concern or submit a complaint to Secure Horizons M+C Plan either by telephone or in writing. You may call the Secure Horizons Member Service Department at 1-800-228-2144, TDHI: 1-800-685-9355, 7:00 a.m. to 8:00 p.m. weekdays; or write a letter to Secure Horizons at P.O. Box 489, Cypress, California 90630; or request a complaint form from the Secure Horizons Member Service Department or a Secure Horizons M+C Plan Contracting Medical Group and submit the completed complaint form to the Member Service Department. Your concern or complaint is then directed to the appropriate Secure Horizons M+C Plan department for investigation.
2. Secure Horizons M+C Plan will conduct an investigation of your complaint. Your complaint will be forwarded to the appropriate Secure Horizons M+C Plan department within five (5) working days of receipt. If the complaint is received by telephone and the person taking the call is



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unable to resolve your problem, Secure Horizons M+C Plan may request that you submit your complaint in writing and will assist you in writing down the complaint if you request. Secure Horizons M+C Plan will send you a letter acknowledging receipt of your complaint and explaining the Secure Horizons M+C Plan Grievance procedure within five (5) working days of receipt of your complaint. You may contact Secure Horizons M+C Plan at any time if you have any questions about the status of your complaint or the Secure Horizons M+C Plan Grievance procedure.

Complaints Involving Quality of Medical Care Issues

All complaints that involve quality of medical care issues are referred to Secure Horizons M+C Plan Health Services Department for review. Complaints that affect a Member's immediate condition will receive immediate review. Secure Horizons M+C Plan will investigate the complaint, consulting with the Member's Contracting Medical Group and appropriate Secure Horizons M+C Plan departments, and reviewing medical records as necessary. You may need to sign an authorization to release your medical records.

Secure Horizons M+C Plan will send you a written response regarding your complaint within thirty (30) days of receiving your complaint whenever possible, unless the complaint involves an imminent and serious threat to your health, in which case you will be notified in writing of the disposition of the complaint within five (5) days. The results of the Quality Management review are confidential.

Peer Review Organization Quality of Care Complaint Process

If you are concerned about the quality of care you have received, you may file a complaint with the Peer Review Organization (PRO) in your local area. (The name, address and telephone number of your local PRO are referenced in the previous section.)

Complaints That Do Not Relate to Quality of Medical Care Issues

Complaints that do not relate to quality of medical care issues are reviewed by Secure Horizons M+C Plan in consultation with appropriate Secure Horizons M+C Plan departments. Secure Horizons M+C Plan will investigate your complaint and send you a written response regarding the disposition of the complaint within thirty (30) calendar days of receiving the complaint whenever possible unless the complaint involves an imminent and serious threat to your health, in which case you will be notified in writing of the disposition of the complaint within no later than five (5) calendar days. If Secure Horizons M+C Plan is unable to complete its review within thirty (30) calendar days, you will be so notified within the thirty- (30) day period.

Arbitration

If you are dissatisfied with the resolution of the complaint through the grievance process, you may request that Secure Horizons M+C Plan submit the complaint to binding arbitration before a commercial arbitration association designated by Secure Horizons M+C Plan.

Arbitration does not apply to claims and service disputes subject to the Medicare reconsideration and Appeals process. Arbitration cases involving a 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, you and Secure Horizons may agree in writing to waive the requirement to use a single neutral arbitrator and instead use a three member panel that includes the two party-appointed arbitrators or a panel of three neutral arbitrators, or another combination of arbitrators which is mutually agreeable to the parties. You will have three 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.

Section 9 – Secure Horizons M+C Plan Appeal and Grievance Procedures



In cases of extreme hardship, Secure Horizons M+C Plan may assume all or part of your share of the fees and expenses of the neutral arbitrator, provided you have submitted a hardship application to a commercial arbitration association. The approval or denial of a hardship application will be determined by a commercial arbitration association.

If Secure Horizons M+C Plan does not receive a request for binding arbitration within sixty (60) days after your receipt of the decision, the decision will be final and binding. However, if you have a legitimate health or other reason preventing you from electing binding arbitration within sixty (60) days, you will have as long as is reasonably necessary to accommodate your special needs in order to elect binding arbitration.

Both you and Secure Horizons M+C Plan will agree to abide by the rules of procedure and decision made by a commercial arbitration association.

By enrolling as a Member of Secure Horizons M+C Plan, you agree to give up your constitutional rights to have any dispute decided in a court of law before a jury or in a court trial, and instead accept the use of binding arbitration for resolution of your disputes with Secure Horizons M+C Plan.

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

You or a person acting on your behalf may also request voluntary mediation with Secure Horizons M+C Plan with respect to a complaint, other than an Appeal subject to the Secure Horizons M+C Plan (Medicare) Appeal Procedure. In order to initiate mediation, you and Secure Horizons M+C Plan must voluntarily agree to mediation. Expenses for any mediation will be borne equally by you and Secure Horizons M+C Plan.



Section 10 – Advance Directives: Making Your Health Care Wishes Known

Secure Horizons M+C Plan is required by law to inform Members of their right to make health care decisions and to execute advance directives. An advance directive is a formal document written by you in advance of an incapacitating illness or injury. As long as you can speak for yourself, Contracting Medical Providers will honor your wishes. But, if you become so sick that you cannot speak for yourself, then this directive will guide your health care Providers in treating you and will save your family, friends and physicians from having to guess what you would have wanted. Federal law requires us to provide information on advance directives at the time of enrollment; that each Member's record shall include documentation regarding advance directives; and provide for staff and community education regarding advance directives.

An advance directive allows Members to state their choices about medical treatment or to name someone (their agent) to make decisions about their medical treatment if the Member should become too ill to make decisions on their own.

California law does not require you to fill out an advance directive and you will not be denied care if you do not have an advance directive. If you do complete one, it is necessary that you provide copies of your completed advance directive to your Contracting Primary Care Physician, your agent (if you have one), and your family. Be sure to keep a copy with you and take a copy to the Hospital when you are hospitalized for medical care.

The California Health Care Decision Law recognizes two types of advance directives: an "individual health care instruction" and a "power of attorney for health care." You can also just write down your wishes on a piece of paper, but it must be signed and witnessed.

California law allows you to register, amend or revoke the information in your advance directive with the California Secretary of State. This information can then be obtained by your health care providers, public guardians and other authorized individuals from the Secretary of State's office.

You may write the Special Filings Unit, California Secretary of State, P.O. Box 944225, Sacramento, CA 94244-2250 or call (916) 653-4984 to obtain the form or any information. You do NOT have to register the information with the Secretary of State for your advance health care directive to be valid.

You can also get more information about advance directives by calling Secure Horizons Member Service.

Section 11 – Coordinating Other Benefits You May Have and Third Party Liability



Who Pays First?

You are entitled to receive Covered Services through Secure Horizons M+C Plan. However, Medicare law gives Secure Horizons M+C Plan the right to recover payments from certain “third party” insurance companies or from you if you were paid by a “third party.” Because of this, we may ask you for information about other insurance you may have. If you have other insurance, you can help us obtain payment from the other insurer by promptly providing the information we request.

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

If you do not have end stage renal disease (ESRD) and have coverage under an employer group plan of an employer of twenty (20) or more employees, either through your own current employment or the employment of a spouse, you must use the benefits under that benefit plan prior to using your Secure Horizons M+C Plan benefits.

Similarly, if you do not have end stage renal disease (ESRD) but have Medicare based on disability and are covered under an employer group plan of an employer of one hundred (100) or more employees (or a multiple employer plan that includes an employer of one hundred or more employees) either through your own employment or that of a family Member, you must use the benefits under that plan prior to using your Secure Horizons M+C Plan benefits. In such cases you will only receive benefits not covered by your employer group plan through our contract with Medicare (and we will only be

paid an amount by Medicare to cover such “wrap around” benefits). A special rule applies if you have or develop end stage renal disease (ESRD).

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



Section 12 – Confidentiality and Release of Information

As new technologies give us a greater ability to share and access information, there is also increasing concern over the unauthorized use of confidential information. This is particularly true in health care, where Members' medical information is often sensitive. You'll be glad to know Secure Horizons M+C Plan is dedicated to protecting your confidential health care information.

Your Medical Record

Your personal and confidential health care information is maintained at your contracting doctor's office in the form of a medical record. These records include general information about you and documentation of the medical care you have received. Each time you see your contracting doctor, information about that visit is included in your medical record.

Your medical record plays a critical role in your receiving quality medical care. First, it provides the doctor treating you with your medical history. It also provides valuable information used by Secure Horizons M+C Plan to monitor quality of care. As a Member, you may access, inspect, amend and copy your medical records at your contracting doctor's office. There may be a charge for copying your medical records.

Protected by Law

Federal and State Law protects the confidentiality and privacy of Members' medical records and personal information. Secure Horizons M+C Plan does not jeopardize employee-employer relationships by releasing to employers information that is either explicitly or implicitly Member-identifiable. Secure Horizons M+C Plan takes measure to remove all identifiers when reporting medical and other data to employers, regardless of the level of risk assumed by the employer or Secure Horizons M+C Plan.

Routine Consent

When you joined Secure Horizons M+C Plan, you signed a statement that gives your routine consent for the release of protected information needed for your treatment, coordination of care, payment of claims, or administration of benefits. This consent also allows Secure Horizons M+C Plan to do research and measure quality using aggregated or unidentifiable data wherever possible. Secure Horizons M+C Plan collects and uses Members' medical information for the purpose of conducting quality assessments, utilization reviews, fraud detection and oversight reviews. However, your personal medical information cannot be released without your special consent, unless required by law. If you transfer to a new Contracting Primary Care Physician, for example, you will need to sign a medical release to transfer your records to the new doctor.

Protecting Privacy

Secure Horizons M+C Plan is doing several things to protect the privacy of your personal health information. We have developed organization-wide confidentiality policies and procedures that cover all areas of our business and are meeting national standards on confidentiality issues. Secure Horizons M+C Plan has an internal review committee that monitors Members' rights for privacy are being protected. This committee is responsible for reviewing policies and practices regarding the collection, use and disclosure of medical information.

We are also working to protect confidentiality in settings outside Secure Horizons M+C Plan by requiring medical groups and other providers with whom we contract to have confidentiality policies and procedures that meet State and Federal requirements. This would include physicians being prohibited from giving information to employers. Additionally, Secure Horizons M+C Plan performs annual assessments to monitor their compliance with these requirements.

Section 12 – Confidentiality and Release of Information



Special Consent

Requests for confidential information from any party(ies) regarding mental illness, substance abuse, genetic testing, HIV and AIDS cannot be released/re-released without a written consent from the Member. This special consent must specify the information at issue and permit the Member to revoke the consent at any time.

In addition, in the event that a Member lacks the ability to give informed consent for specific treatments, Secure Horizons M+C Plan works to obtain special consent. This is done in three ways: First, by obtaining a copy of the Member's completed Advance Directive, if available. Second, the Member's legal guardian, power of attorney, and/or next of kin is identified and contacted for consent. Third, lacking an individual authorized to give consent on behalf of the Member, an application for guardianship is submitted to the State Public Administrator.

If you have questions or concerns about the privacy of your health information, contact Secure Horizons Member Service.

Information from your medical records and such information from Providers or Hospitals shall be kept confidential. Except as is necessary in connection with administering the Medicare contract and fulfilling State and Federal requirements (including review programs to achieve quality medical care) or as permitted by State and Federal law, such information will not be disclosed without your written consent.

Additionally, any personal information that you provide in the course of your Enrollment is also protected and will remain confidential. This is to prevent unauthorized individuals from gaining access to or altering your records.



Section 13 – General Provisions

Governing Law

This combined Evidence of Coverage and Disclosure Information is subject to the laws of the State of California and the United States of America, including: the Health Maintenance Organization Act of 1973 and regulations promulgated thereunder by the Department of Health and Human Services of the United States, and Title XVIII of the Social Security Act and regulations promulgated thereunder by CMS. Any provisions required to be in this Evidence of Coverage by any of the above acts and regulations shall bind Secure Horizons M+C Plan and you, whether or not expressly provided in this document.

Your Financial Liability as a Secure Horizons M+C Plan Member

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

Secure Horizons M+C Plan Premium

Secure Horizons M+C Plan may Disenroll you for failure to pay Plan Premiums Your Plan Premiums are paid for by the University of California. However, prior to such action, Secure Horizons M+C Plan will:

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

Non-payment of Plan Premiums for the Plus Plan will result in the loss of your Plus Plan expanded benefits after a 90-day grace period.

Increases in Secure Horizons M+C Plan Individual Plan Premiums and/or decreases in the level of coverage are only permitted at the beginning of each contract year (which is usually the Calendar Year) and must be approved by CMS. You will receive written

notice by the fall before changes become effective. (Please note: Rate changes and the University of California -sponsored benefit changes for Group Retiree Members enrolled through the University of California are subject to contractual arrangements between Secure Horizons M+C Plan the University of California. The University of California is responsible for notifying you of any Secure Horizons M+C Plan premium changes, contribution changes, or the University of California -sponsored benefit changes 30 days before they become effective.)

Medicare Part A Premium

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

Medicare Part B Premium

As a Secure Horizons M+C Plan Member, you must continue to pay your Medicare Part B Premium. If you receive a Social Security Administration or Railroad Retirement Board annuity check, this Premium is automatically deducted from your check. Otherwise, your Premium is paid directly to Medicare by you or someone on your behalf (such as your Department of Health Services for Medi-Cal beneficiaries).

Copayments and Coinsurance All Copayments and Coinsurance specified in the Retiree Benefit Summary are due and payable to the contracting provider of service when the Covered Service is provided.

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Member Non-Liability

You are not responsible for any payments that Secure Horizons M+C Plan owes to, and fails to pay, a contracting provider. In the event the health plan fails to pay the contracted provider, the Member shall not be liable to the contracted provider for any sums owed by the plan.

However, you will be liable if you receive services from Non-Contracting Medical Providers without Prior Authorization. Neither Secure Horizons M+C Plan nor Medicare will pay for those services except for:

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

In addition, if you enter into a private contract with a Non-Contracting Medical Provider, neither Secure Horizons M+C Plan nor Medicare will pay for those services.

In the event a Contracting Medical Provider's contract with Secure Horizons M+C Plan is terminated while you are under his/her/its care, Secure Horizons M+C Plan will pay for the continuation of related Covered Services as long as you retain eligibility, until the Covered Services are completed, unless Secure Horizons M+C Plan makes a reasonable and medically appropriate arrangement for those services to be provided by another Contracting Medical Provider. A Secure Horizons M+C Plan Medical Director or designee shall determine when the Contracting Medical Provider's services are completed, and what is a reasonable and medically appropriate arrangement for the provision of the services by another Contracting Medical Provider. If you disagree with this determination, please refer to Section 9, Appeals and Grievance.

Reimbursement of Third-Party Medical Expenses

If you receive medical services under your Secure Horizons M+C Plan coverage after being injured through the actions of another person (a third party) for which you receive a monetary recovery, you will be required to reimburse Secure Horizons M+C Plan, or its nominee, to the extent permitted under California Civil Code Section 3040 and Federal law, for the cost of such medical services and benefits provided and the reasonable costs actually paid to perfect any lien.

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

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

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



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

If you are receiving benefits as a result of other automobile, accident or liability coverage, Secure Horizons M+C Plan will not duplicate those benefits.

It is your responsibility to take whatever action is necessary to receive payment under automobile, accident, or liability coverage when such payments can reasonably be expected, and to notify Secure Horizons M+C Plan of such coverage when available.

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

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

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

Acts Beyond the Control of Secure Horizons M+C Plan

If, due to a natural disaster, war, riot, civil insurrection, complete or partial destruction of a facility, ordinance, law or decree of any government or quasi-governmental agency, labor dispute (when said dispute is not within Secure Horizons M+C Plan control), or any other emergency or similar event not within the control of Secure Horizons M+C Plan, Secure Horizons M+C Plan or its Contracting Medical Providers may become unavailable to arrange or provide health services pursuant to

this combined Evidence of Coverage and Disclosure Information. Secure Horizons M+C Plan shall attempt to arrange for Covered Services insofar as practical and according to our best judgment. Neither Secure Horizons M+C Plan nor any Contracting Medical Group shall have any liability or obligation for delay or failure to provide or arrange for Covered Services if such delay is the result of any of the circumstances described above.

Contracting Providers Are Independent Contractors

The relationships between Secure Horizons M+C Plan and its Contracting Medical Groups and Contracting Hospitals are independent contractor relationships. None of the Contracting Medical Groups or Contracting Hospitals or their physicians or employees are employees or agents of Secure Horizons M+C Plan. An agent would be anyone authorized to act on Secure Horizons M+C Plan's behalf. Neither Secure Horizons M+C Plan nor any employee of Secure Horizons M+C Plan is an employee or agent of any Contracting Medical Group, Contracting Hospital or Contracting Medical Provider.

Secure Horizons M+C Plan Contracting Arrangements

In order to obtain quality service in an efficient manner, Secure Horizons M+C Plan pays its Contracting Medical Providers using various payment methods, including capitation, per diem, and incentive and discounted fee-for-service arrangements. **Capitation** means paying a fixed dollar amount per month for each Member assigned to the Provider. **Per diem** means paying a fixed dollar amount per day for all services rendered. **Incentive** means a payment which is based on appropriate medical management by the Provider. **Discounted fee-for-service** means paying the Provider's usual, customary and regular fee discounted by an agreed-to percentage.

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You are entitled to ask if we have special financial arrangements with our contracting physicians that can affect the use of Referrals and other services that you might need. To get this information, call our Secure Horizons Member Service and request information about our physician payment arrangements.

Physician-Patient Relationship

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

Secure Horizons M+C Plan does not prohibit or otherwise restrict a Provider, acting within the lawful scope of practice, from advising, or advocating on your behalf about:

1. Your health status, medical care or treatment options;
2. The risk, benefits, and consequences of treatment or nontreatment; or
3. The opportunity for you to refuse treatment and to express preferences about future treatment decisions.

Facility Locations

Medical services are provided to Secure Horizons M+C Plan Members through Contracting Medical Providers, Contracting Medical Groups, Contracting Hospitals, and Contracting Pharmacies. For a complete list of contracting Providers, please refer to the Secure Horizons M+C Plan *Provider Directory*. If you have any questions regarding contracting Providers listed in the directory or to request a directory, please call Secure Horizons Member Service or visit our web site at www.securehorizons.com.

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

Notices

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

If to Secure Horizons M+C Plan:
Secure Horizons M+C Plan
Attn: Member Service
P. O. B o x 489
Cypress, California 90630-0489

If to you, to your last address known to Secure Horizons M+C Plan.

Agent For Service of Legal Process:

Legal process may be served on PacifiCare at the following address: PacifiCare of California Joseph Konowiecki, 5995 Plaza Drive, Cypress, CA 90630-5028.

How Secure Horizons M+C Plan Contracting Providers Are Compensated

The following is a brief description of how Secure Horizons M+C Plan pays its contracting providers:

Secure Horizons M+C Plan typically contracts with medical groups to provide medical services and with hospitals to provide hospital services to Members. The Contracting Medical Groups, in turn, employ or contract with individual physicians.

Most of our Contracting Medical Groups receive an agreed upon monthly payment from Secure Horizons M+C Plan to provide services to Members. The monthly payment may be either a fixed dollar amount for each Member or a percentage of the Monthly Plan Premium received by Secure Horizons M+C Plan. The monthly payment typically covers professional services directly provided by the Contracting Medical Group, and may also cover certain Referral services. Some of Secure Horizons M+C Plan's Contracting Hospitals receive similar monthly payments in



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return for arranging Hospital services for Members. Other Hospitals are paid on a discounted fee-for-service or fixed charge per day of hospitalization.

At the beginning of each year, Secure Horizons M+C Plan and each Contracting Medical Group agree on a budget for the cost of services covered under the program for all Secure Horizons M+C Plan Members treated by the Contracting 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 Contracting Medical Group shares in the savings. The Contracting Hospital and Medical Group typically participate in programs for Hospital services similar to that described above.

Stop-loss insurance protects Contracting Medical Groups and Hospitals from large financial losses and ensures providers have resources to cover necessary treatment. Secure Horizons M+C Plan provides stop-loss protection to our Contracting Medical Groups and Hospitals that receive capitation payments. If any capitated providers do not obtain stop-loss protection from Secure Horizons M+C Plan, they must obtain stop-loss insurance from an insurance carrier acceptable to Secure Horizons M+C Plan. You may obtain additional information on compensation arrangements by contacting Secure Horizons Member Service or your Contracting Medical Group.

In addition, the Centers for Medicare & Medicaid Services (CMS) requires Secure Horizons M+C Plan to conduct a Member Satisfaction Survey, providing beneficiary requestors with a summary of survey results including information pertaining to physician incentives. If you would like a copy of the results of this survey, please contact Secure Horizons Member Service.

Additional Information

Technology Assessment

Secure Horizons M+C Plan regularly reviews new procedures, devices and drugs to determine whether or not they are safe and effective for Members. The Technology Assessment and Guideline Committee, consisting of staff experts, Contracting Primary Care Physicians, pharmacists and Specialists, conducts careful reviews of case studies, clinical literature, opinions of review organizations, e.g., ECRI Health Technology Assessment Information Service, HAYES New Technology Summaries or AHCPR (Agency for Health Care Policy and Research, Medicare, and Federal Drug Administration decisions).

Public Policy Participation

Secure Horizons M+C Plan affords its Members the opportunity to participate in establishing the public policy of Secure Horizons M+C Plan. One-third of PacifiCare of California's Board of Directors is comprised of PacifiCare/Secure Horizons M+C Plan Members. If you are interested in participating in the establishment of the PacifiCare/Secure Horizons M+C Plan public policy, please call or write Member Service.

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.

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Almost Anyone Can Be a Donor

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

Be Sure to Share Your Decision

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

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

How to Learn More

- To 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 at www.transweb.org
- Department of Health and Human Services at <http://www.organdonor.gov>
- Sign the donor card in your family’s presence
- Have your family sign as witnesses and pledge to carry out your wishes
- Keep the card with you at all times where it can be easily found

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

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

- General coverage and comparative plan information
- Utilization control procedures
- Statistical data on Appeals and Grievances
- The financial condition of Secure Horizons M+C Plan

You may call Secure Horizons Member Service or you may write to Secure Horizons M+C Plan at:

Secure Horizons M+C Plan
P. O. B o x 489
Cypress, California 90630-0489

Member Service
1-800-228-2144 or
TDHI 1-800-685-9355
7:00 a.m. to 8:00 p.m., weekdays

Sales Information
1-800-385-5588 or
TDHI 1-800-387-1074
P. O. B o x 489
Cypress, California 90630

Visit our web site at
www.securehorizons.com

Your Outpatient Prescription Drug Benefit

Many health problems require medication that must be prescribed by a Contracting Physician. This brochure contains important information for our members about the Secure Horizons outpatient prescription drug benefit. As a member, reading this material will help you understand your prescription drug coverage. It will also answer many questions, including:

- How are drugs prescribed by my Contracting Physician?
- What is a Prescription Drug Formulary (and how is it used)?



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- Where do I go to fill a prescription?
- What is the Mail Service Pharmacy Program?

We want our members to get the most from their prescription benefit plan so please read this Supplement to the Combined Evidence of Coverage and Disclosure Form

(“Supplement”) carefully. You need to become familiar with the terms used for explaining your coverage, because understanding these terms is essential to understanding your benefit. You’ll find important definitions in the back of this Supplement as well as in your medical Combined Evidence of Coverage and Disclosure Form. Also please see your Pharmacy *Schedule of Benefits* for specific information regarding your prescription drug benefit, such as copayment information and Secure Horizons Pre-authorization process for non-formulary and selected Formulary prescription drugs.

What is a Prescription Drug Formulary?

A prescription drug Formulary is the list of preferred drugs that are covered by your prescription drug benefit. Drugs on the Formulary can generally be prescribed by your Contracting Physician without pre-approval by Secure Horizons.

Secure Horizons prints its Formulary once a year and distributes it to all of our Contracting Physicians. Updates occur quarterly; however, in certain situations, drugs may be added or removed to the Formulary more frequently. (Our Formulary is also available year round to all our members. You can get a copy by calling our Member Service Department or visiting our Web site at www.securehorizons.com.)

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

How Do Drugs Get On Our Formulary?

All medications are added or removed from our Formulary after careful review by a committee of practicing doctors and pharmacists. The committee performs this review while considering the following criteria:

- Has the medication been approved by the Food and Drug Administration (FDA)?
- Is the medication safe?
- What is the quality of the medication?
- What is its effectiveness?
- What is the medication’s cost?

When we don’t include a medication, it’s usually because an approved alternative can be prescribed for the same condition. It’s also important to remember there may be other options available for treating a particular medical condition. It’s your Contracting Physician’s responsibility to decide when it is or isn’t appropriate to prescribe a drug.

If you are currently taking a drug for a specific medical condition and Secure Horizons removes that drug from the Formulary, Secure Horizons will not limit or exclude coverage for you for that drug provided that your Contracting Physician continues to prescribe the drug for your specific medical condition and provided that the drug is appropriately prescribed and continues to be considered safe and effective for treatment of your medical condition.

What is the Difference Between Generic and Brand Name Drugs? What is the Difference Between Generic and Brand Name Drugs? What is the Difference Between Generic and Brand Name Drugs?

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

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

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

NOTE: If you have a question about our Formulary or a particular drug, please contact Secure Horizons Member Service Department or visit Secure Horizons Web site at www.securehorizons.com.

Who Can Write My Prescription?

Generally, your prescription is written by a Contracting Physician. There are two exceptions to this rule. The first is when the prescription is written by a non-Contracting Physician that has been pre-approved by Secure Horizons for your treatment. The second exception is when a drug is prescribed in an emergency. (Please remember that an emergency is defined in your medical Evidence of Coverage.)

When I Fill a Prescription, How Much Medication Do I Receive?

How Are Drugs Dispensed and In What Quantities?

Typically, one Prescription Unit will be filled with each prescription. A Prescription Unit is the maximum quantity of medication that may be dispensed per single copayment.

For most oral medications, a Prescription Unit is up to a 30-day supply of medication. For drugs that can be habit-forming, the Prescription Unit is set at a smaller quantity for your protection.

How Are Maintenance Drugs Dispensed?

Maintenance Drugs are medications that members need to take on a regular basis. They may be dispensed for up to a 60-day supply at a Contracting Pharmacy. A 90-day supply may be ordered through the Secure Horizons Mail Service Pharmacy. (To learn more about this service, see "What is the Mail Service Pharmacy Program?")

Maintenance drugs include, but are not limited to:

- Antiarthritics
- Antiasthmatics
- Anticlotting drugs
- Antiepileptic drugs
- Antihypertensives
- Antiparkinson 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

Where Do I Fill My Prescription?

Where Do I Take My Prescription?

Secure Horizons has agreements with pharmacies throughout the state and selected outlets nationwide. Our Contracting Pharmacy network includes most major drug



Section 13 – General Provisions

stores and supermarket chains, along with many independent pharmacies. Secure Horizons Contracting Pharmacies include:

- Albertson's Food & Drug
- Bel Air Pharmacies
- Cardinal/Leadernet Independent Network
- Costco Pharmacies
- Drug Emporium
- EPN Independent Network
- Family Care Network
- Friendly Hills Pharmacy- Gemmel Pharmacy Group
- Good Neighbor/PlusCare Pharmacies
- Horton & Converse Pharmacies
- K Mart Pharmacies
- Long's Drug Stores
- Major Value Pharmacies
- Managed Pharmacy Care
- Medicap Pharmacies
- Medicine Shoppe Pharmacies
- Network Pharmacies
- OPEN Independent Pharmacies
- PCP Independent Pharmacies
- Raley's Drug Center
- Ralph's Pharmacies
- Rite Aid Pharmacies
- Safeway Pharmacies
- Save Mart Pharmacies
- Sav-On Drugs
- Sharp Rees-Stealy Pharmacies
- Talbert Pharmacies
- Target Pharmacy
- UniMed Pharmacies
- United Drug Stores
- UPNI Contracted Pharmacies

- Valu-Rite/McKesson Drug Co.
- Vons/Pavilions (A Safeway Company)
- Walgreen's
- Wal-Mart Pharmacies

You can get the most up-to-date list of pharmacies on our Web site at www.securehorizons.com. To take advantage of your benefit, always try to fill your prescription at one of these Contracting Pharmacies. If you go to a pharmacy outside our network, you will have to pay the entire cost of a prescription, then submit your payment for review. You will only be reimbursed if you meet the conditions explained in the next section.

What if a Secure Horizons Contracting Pharmacy Is Unavailable?

It's important to remember you should always take your prescription to a Contracting Pharmacy. An exception can be made in the event of an urgent or emergency situation, or when you're out of the service area. If you do go outside our network, you will need to pay the full price of the prescription and submit your bill for reimbursement review. To do this, you must send us the following information:

1. Copies of the receipts, etc., showing the name of the drug, date filled, pharmacy name, proof of payment and the name for whom the prescription was written.
2. A statement describing why one of our Contracting Pharmacies was not available.
3. The above information should be sent to: Secure Horizons Pharmacy Department, P.O. Box 6037, Cypress, CA 90630.

Remember: This should only be done when absolutely necessary. You must submit your bill for reimbursement review within 90 days from the date of service. Payment will be forwarded to you once your request for reimbursement is determined by Secure Horizons to be appropriate.

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What is the Mail Service Pharmacy Program?

Secure Horizons offers a Mail Service Pharmacy Program through Prescription Solutions. The Mail Service Pharmacy Program provides convenient service and savings on medications that you may take on a regular basis by allowing you to purchase certain drugs for receipt by mail.

If you use our Mail Service Pharmacy Program, you will generally get your medication within 10-14 working days of when the order is received. All orders are shipped in discreetly labeled envelopes for privacy and safety.

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

1. Call your Contracting Physician to obtain a new prescription for each medication. When you call, ask the physician to write the prescription for a 90-day supply with up to three additional refills. The doctor will tell you when to pick up the written prescription. (Note: Prescription Solutions must have a new prescription to process any new mail service request.)
2. After picking up the prescription, complete the Mail Service Form included in your enrollment materials. (To obtain additional forms, call Secure Horizons Member Service Department. You can also find the form at the Web site address www.rxsolutions.com.)
3. Enclose the prescription and appropriate copayment via check, money order, or credit card. Make the check or money order payable to: Prescription Solutions. No cash please.

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

IMPORTANT TIPS: If you are starting a new maintenance medication, please request two prescriptions from your Contracting Physician. Have one filled immediately at a Contracting Pharmacy while mailing the second prescription to Prescription Solutions. Once you receive your medication through Prescription Solutions, you should stop filling the prescription at the Contracting Pharmacy.

For more assistance in completing the form or determining the copayment, call Prescription Solutions at 1-800-562-6223 (AT&T's TDHI 1-800-735-2922).

How Do I Refill Prescriptions Through the Mail Service Pharmacy Program?

Refilling is also simple.

- By Mail

A reorder form and pre-addressed envelope are included with every prescription from Prescription Solutions. Complete the form, then mail it with the appropriate copayment in the pre-addressed envelope.

- By Phone (automated service)

Call the Prescription Solutions Automated Mail Service line at 1-800-562-6223. The prescription must indicate there are refills remaining.

or:

Talk to one of Prescription Solutions Customer Service representatives at 1-800-562-6223 (AT&T's TDHI 1-800-735-2922) 7:00 a.m. to 6:00 p.m., Monday through Friday, or Saturday, 8:00 a.m. to 5:00 p.m.

When Do I Reorder?

As explained earlier, it generally takes 10-14 workdays to deliver medications to our members. To prevent an interruption, reorder three weeks prior to running out of a medication. If you do run out, ask your Contracting Physician for a new 30-day prescription. This prescription needs to be filled at one of Secure Horizons Contracting Pharmacies.



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For questions regarding orders, call Prescription Solutions Customer Service representatives toll-free at 1-800-562-6223 (AT&T's TDHI 1-800-735-2922) 7:00 a.m. to 6:00 p.m., Monday through Friday, or Saturday, 8:00 a.m. to 5:00 p.m. A Customer Service representative or pharmacist will be happy to answer your questions.

Definitions

Formulary - A list of medications covered by Secure Horizons for use in the member's treatment, including prescription drugs.

Non-Contracting Pharmacy - A pharmacy that has NOT contracted with Secure Horizons to provide outpatient prescription drugs to our members.

Non-Contracting Physician - A physician that has NOT contracted with Secure Horizons to provide health care services to our members.

Contracting Pharmacy - A pharmacy that has contracted with Secure Horizons to provide outpatient prescription drugs to our members.

Contracting Physician - A physician that has contracted with Secure Horizons to provide health care services to our members.

Pre-authorization - Secure Horizons review process that determines the coverage of a prescription drug prior to the member receiving the prescription drug.

Prescription Unit - The maximum amount (quantity) of medication that may be dispensed per single Copayment. For most oral medications, a Prescription Unit represents up to a 30-day supply of medication. For drugs that could be habit-forming, the Prescription Unit is set at a smaller quantity for the protection and safety of the member.

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

What Is Covered

When Medically Necessary, the prescription benefit will be provided for the following medications 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, EpiPens®, Ana-Kits®.**
- **Federal Legend oral contraceptives, prescription diaphragms.**
- **Generic Drugs:** Comparable generic drugs will be substituted for brand-name drugs.
- **Specified smoking cessation products** when a Member meets nicotine dependency criteria and is enrolled and continues to participate in PacifiCare's StopSmokingSM 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 preauthorized by PacifiCare.
- **Hormone drugs** subject to the Harry Benjamin International Gender Dysphoria Association's (HBIIGDA) Standards of Care for Gender Identity Disorder.

SECTION 14 – Secure Horizons M+C Plan Service Area



Secure Horizons Medicare+Choice Plans are offered by PacifiCare®, that contracts with the federal government. Anyone with Medicare Parts A and B may apply. Members must continue to pay Medicare premiums and use contracting pharmacies and providers for routine care. Limitations and Copayments apply. Health Plan Premiums and benefits may vary by county. Pharmacy benefits are limited to a Covered Medications List that is subject to change without notice during the calendar year. Contact Secure Horizons for additional details.

Schedule of Benefits	Generic Formulary/ Selected Brands	Brand-Name Formulary	Non-Formulary
Retail Pharmacy Copayment	\$10	\$20	\$35

*An annual out-of-pocket maximum of \$2,000 for combined retail and mail order prescription drugs will apply.

What is My Schedule of Benefits?

This *Schedule of Benefits* is a companion to your prescription drug “*Supplement to the Combined Evidence of Coverage and Disclosure Form.*” It provides specific details about your prescription drug benefit, as well as its exclusions and limitations.

Along with your Supplement, please consult your medical “*Combined Evidence of Coverage and Disclosure Form*” for a description of your covered medical benefits, exclusions and limitations, as well as the terms and conditions of your coverage. You should also become familiar with the terms used for explaining your coverage. You’ll find important definitions in the Supplement as well as your medical *Combined Evidence of Coverage and Disclosure Form.*

How Do I Use My Prescription Drug Benefit?

Your prescription drug benefit helps to cover the cost for some of the medications prescribed by a Secure Horizons Contracting Physician. Using your benefit is simple.

- Present your prescription and Secure Horizons ID card at any Secure Horizons Contracting Pharmacy.
- Pay the copayment for a Prescription Unit or its retail cost, whichever is less.
- Receive your medication.

What Do I Pay When I Fill a Prescription?

You will pay only a copayment when filling a prescription at a Secure Horizons Contracting Pharmacy. You will pay a copayment every time a prescription is filled. Your benefits are as follows:

- When you fill or refill a prescription for a Formulary generic medication, your copayment is \$10.
- When you fill or refill a prescription for a Formulary brand name medication, your copayment is \$20.
- When you fill or refill a prescription for a non-Formulary generic or non-Formulary brand name medication, your copayment is \$35.

The copayment for specified smoking cessation products is \$20 per 30-day supply. There are selected brand name medications where you will have a copayment of just \$10. A copy of the selected brand list is available upon request from Secure Horizons Member Service Department.

When I Fill a Prescription, How Much Medication Do I Receive?

For a single copayment, Members receive either one Prescription Unit or up to a 30-day supply of a drug. For maintenance medications, you make a copayment for each Prescription Unit or every 30-day supply; however you can fill your prescription for two Prescription Units or up to 60 days.

If you use the Secure Horizons Mail Service Pharmacy Program, for the price of only \$20 for formulary generics, \$40 for formulary brands and \$70 for non-formulary drugs, you will receive up to a 90-day supply of maintenance medications. To learn more

about maintenance medications and the mail service program, please refer to your Supplement to the *Combined Evidence of Coverage and Disclosure Form*.

What Else Do I Need to Know?

You should become familiar with Secure Horizons Prescription Drug Formulary. **Any medication not on our Formulary and not excluded from coverage will be subject to the higher non-Formulary copayment except as described in the following paragraph.** For more on our Formulary, please refer to your Supplement to the *Combined Evidence of Coverage and Disclosure Form* or visit www.securehorizons.com.

Occasionally a non-formulary drug is Medically Necessary. You may choose to pay your non-Formulary copayment or you may request pre-authorization review. Pre-authorization requests may only be initiated by your Secure Horizons Contracting Physician and Secure Horizons will provide a determination of the request to your Contracting Physician within two business days. If the pre-authorization request is approved by Secure Horizons, you will pay the applicable Formulary brand name or generic copayment.

Additional Information

Medications Covered By Your Benefit

The following medications are included in the Secure Horizons managed Formulary and are available to your Contracting Physician. Your benefit also includes non-Formulary drugs for the non-Formulary copayment listed above when ordered by a Contracting Physician and filled at a Contracting 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 that may be dispensed by prescription only according to State law.

- Generic Drugs: Comparable generic drugs may be substituted for brand name drugs unless they are on Secure Horizons Selected Brands List. However, you may request that a prescription be filled with a brand-name drug that has one or more FDA-approved generic equivalent and is not included on the Selected Brands List by paying the applicable Non-Formulary Copayment. A copy of the Selected Brands List is available upon request from Secure Horizons Member Service Department.
- Federal Legend oral contraceptives and prescription diaphragms.
- Specified smoking cessation products when you meet nicotine dependency criteria and have enrolled participation in Secure Horizons StopSmokingSM Program.
- For the purposes of determining coverage, the following items are considered prescription drug benefits: glucagon, insulin, insulin syringes, inhaler extender devices, and anaphylaxis prevention kits (including, but not limited to, epipen, anakits, and anagard). See the medical benefit portion of the “*Combined Evidence of Coverage and Disclosure Form*” for coverage of other injectable medications.

Preauthorization for Selected Formulary and Non-Formulary Drugs

Selected Formulary & Non-Formulary drugs must be pre-authorized by Secure Horizons to determine that they are Medically Necessary and being prescribed according to treatment guidelines consistent with good professional practice.

For a list of the selected medications that require Secure Horizons preauthorization, please contact Secure Horizons Member Service Department at 1-800-228-2144, TDHI: 1-800-685-9355, Monday through Friday, from 7:00 a.m. to 7:00 p.m.

Exclusions and Limitations

While the prescription drug benefit covers most medications, there are some that are not covered:

- Drugs or medicines purchased and received prior to the Member's effective date or subsequent to 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, or devices.
- Medications to be taken or administered to the eligible Member while a patient in a hospital, rest home, nursing home, sanitarium, etc.
- Drugs or medicines delivered or administered to the Member by the prescriber or the prescriber's staff.
- Dietary supplements, including vitamins and fluoride supplements (except prenatal), health or beauty aids, herbal supplements and/ or alternative medicine.
- Compounded Medication: Any medicinal substance that has at least one ingredient that is Federal Legend or State Restricted in a therapeutic amount. All compounded medications are subject to Secure Horizons Prior Authorization process.
- Medication for which the cost is recoverable under any Workers' Compensation or Occupational Disease Law or any state or government agency, or medication furnished by any other drug or medical service for which no charge is made to the patient.
- Medication prescribed for experimental or investigational therapies, unless required by an external, independent review panel pursuant to California Health and Safety Code Section 1370.4. For non-Food and Drug Administration approved indications, see the following exclusion.
- Off-label drug use. Off-Label Drug Use means that the Provider has prescribed a drug approved by the Food and Drug Administration (FDA) for a use that is different than that for which the FDA approved the drug. Secure Horizons excludes coverage for Off-Label Drug Use, including Off-Label self-injectable drugs, except as described in the Subscriber Agreement and any applicable Attachments. If a self injectable drug prescribed for Off-Label Drug Use, the drug and its administration will be covered only if it satisfies the following criteria: (1) The drug is approved by the FDA. (2) The drug is prescribed by a Contracting licensed health care professional for the treatment of a life-threatening condition or for a chronic and seriously debilitating condition. (3) The drug is Medically Necessary to treat the condition. (4) The drug has been recognized for treatment of the life-threatening or chronic and seriously debilitating condition by one of the following: The American Medical Association Drug Evaluations, The American Hospital Formulary Service Drug Information, The United States Pharmacopoeia Dispensing Information or in two articles from major peer reviewed medical journals that present data supporting the proposed Off-Label Drug Use or uses as generally safe and effective. (5) The drug is administered as part of a core medical benefit as determined by Secure Horizons. Nothing in this section shall prohibit Secure Horizons from use of a formulary, copayment, technology assessment panel, or similar mechanism as a means for appropriately controlling the utilization of a drug that is prescribed for a use that is prescribed for a use that is different from the use for which that drug has been approved for marketing by the FDA. Denial of a drug as investigational or experimental will allow the Member to use the Independent Medical Review System as defined in this Evidence of Coverage.
- Medications available without a prescription (over-the-counter) or for which there is a non-prescription equivalent available, even if ordered by a physician.

- Elective or voluntary enhancement procedures, services, supplies and medications including but not limited to: weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging, and mental performance. Examples of these drugs include but are not limited to: Penlac“, Retin-A“, Renova“, Vaniqa“, Propecia“, Lustra“, Xenical“, or Meridia“.
- Medications prescribed by non-Contracting Physicians (except for prescriptions required as a result of an Emergency or Urgently Needed Service for an acute condition).
- Medications dispensed by a non-Contracting Pharmacy (except for prescriptions required as a result of an Emergency or Urgently Needed Service for an acute condition).
- Smoking cessation products (other than those available by participating in Secure Horizons StopSmokingSM Program) including, but not limited to, nicotine gum, nicotine patches, and nicotine nasal spray.
- Injectable drugs (except as listed under Medications Covered By Your Benefit)
- Drugs prescribed by a dentist or drugs used for dental treatment.
- Drugs used for diagnostic purposes.
- Disposable all-in-one pre-filled insulin pens, insulin cartridges and needles for non-disposable pen devices are covered when Medically Necessary in accordance with Secure Horizons pre-authorization process.
- Saline and irrigation solutions.
- MUSE suppositories.
- Outpatient prescription drugs to treat sexual dysfunction require prior authorization by Secure Horizons for coverage. If approved for coverage, you will pay the applicable non-formulary copayment per prescription unit. Quantity limits may apply.
- Replacement of lost, stolen, or destroyed medications.
- Secure Horizons reserves the right to expand the prior authorization requirement for any drug product to assure adherence to FDA-approved indications and national practice standards.

Vision benefits include but are not limited to the following:

Benefits	Copayment
Vision Examination A complete analysis of the eyes and related restructures to determine abnormalities <i>(One per Calendar Year)</i>	\$10

Benefits

- A. VISION EXAMINATION: A \$10 Copayment for a complete analysis, each calendar year, of the eyes and related restructures to determine abnormalities.
- B. LENSES: \$20 copayment for standard lenses. If lenses cost more than allowed the member will pay the addition charge. The doctor verifies the accuracy of the finished lenses.
- C. FRAMES: The plan offers a wide selection of frames, however, if the Member selects a frame which costs more than the amount allowed by the plan, there will be an additional charge. Frame allowance is \$75 every 24 months.
- D. CONTACT LENSES: Contact lenses are furnished under the VSP Plan when the VSP Panel Doctor secures prior approval for the following conditions:
 - a. Following cataract surgery
 - b. To correct extreme visual acuity problems that cannot be corrected with spectacle lenses
 - c. Anisometropia
 - d. Keratoconus

When VSP Panel Doctors receive approval for such cases, they are fully covered by VSP.

Exclusions

There is no benefit for professional services or materials connected with:

- A. Orthoptics or vision training and any associated supplemental testing.
- B. Plano lenses.
- C. Two pair of glasses in lieu of bifocals.
- D. Lenses and frames furnished under this program, which are lost or broken, will not be replaced except at the normal intervals when services are otherwise available.
- E. Medical or surgical treatment of the eyes.
- F. Any eye examination or any corrective eye wear, required by an employer as a condition of employment.
- G. If the covered person does not obtain the VSP benefit form in advance, but visits the Panel Doctor as a private patient, the Panel Doctor is not obligated to accept VSP fees as full payment for these services, but may elect to charge his usual and customary fees.

This benefit is provided through a contract between PacifiCare and California Vision Service Plan.

PART B

Benefits:

Hearing Aid Benefits include but are not limited to the following:

- A. A hearing examination by an audiologist when authorized through the Member's Participating Medical Group. The associated office visit Copayment applies.
- B. Hearing aids or ear molds — One appliance per ear, payable at usual and customary charges. The Hearing Aid Benefit renews every thirty-six (36) months from last date of service when Medically Necessary to provide functional improvement and when authorized through the Member's Participating Medical Group and obtained from a participating PacifiCare provider.

Exclusions:

Certain Hearing Aid services are not covered, including but not limited to the following:

- A. Replacement of a hearing aid that is lost, broken or stolen within thirty-six (36) months of receipt.
- B. Repair of the hearing aid and related services.
- C. Surgically implanted hearing devices.
- D. Services or supplies for which a member is entitled to receive reimbursement under any applicable Worker's Compensation Law.
- E. Services or supplies rendered to a Member after cessation of the coverage on his/her account, except that, if a Hearing Aid is ordered while coverage is in force on account of such Member and such Hearing Aid is delivered within sixty (60) days after the date of such cessation, such Hearing Aid shall be considered a Covered Hearing Aid Expense.
- F. 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.
- G. An eyeglass-type Hearing Aid or additional charges for a Hearing Aid designed specifically for cosmetic purposes.
- H. Services of which usual and customary payment exceeds the cost for all covered hearing aids combined and/or within 36 months of last receipt.

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

General Features

Deductible	-0-
Maximum Benefits	Unlimited
Annual Copayments Maximum	Three (3) Inpatient copayments per person per calendar year
Office Visits	\$10 Copayment
Hospitalization	\$250 per admission
Emergency Services <i>(Waived if admitted as an inpatient)</i>	\$50 Copayment
Urgently Needed Services <i>(Medically Necessary Services required outside your Service Area; Waived if admitted as an inpatient)</i>	\$50 Copayment
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 <i>(Detoxification only)</i>	\$250 per admission
Bone Marrow Transplant <i>(Donor searches limited to \$10,000 or 50 searches per lifetime)</i>	\$250 per admission
Hospice Care <i>(Up to one calendar year lifetime maximum)</i>	\$250 per admission
Hospital Benefits <i>(Autologous (self-donated) blood up to \$120.00 per unit)</i>	\$250 per admission
Mastectomy/Breast Reconstruction <i>(After a mastectomy and complications from a mastectomy)</i>	\$250 per admission
Physician Care	Paid In Full
Rehabilitation Care	\$250 per admission
Skilled Nursing Care <i>(Up to one-hundred (100) calendar days per Medicare benefit period)</i>	Paid In Full

Benefits Available On an Outpatient Basis

Alcohol, Drug, Or Other Substance Abuse Or Addiction <i>(Detoxification only)</i>	\$10 Copayment
Allergy Testing/Treatment <i>(Serum is included)</i>	\$10 Copayment
Ambulance	Paid In Full
Attention Deficit Disorder <i>(Medical Management)</i>	\$10 Copayment
Breast Cancer Screening, Diagnosis And Treatment	\$10 Copayment
Cochlear Implants	Paid In Full
Dental Treatment Anesthesia	Paid In Full
Diabetes Management And Treatment	\$10 Copayment
Durable Medical Equipment, Corrective Appliances And Prosthetics	Paid In Full
Eligible Materials And Supplies	Paid In Full
Health Education Services	Paid In Full
Hearing Screening	\$10 Copayment
Hemodialysis	\$10 Copayment

PART B

Benefits Available On an Outpatient Basis (continued)

Home Care	Paid In Full
Hospice Care – Outpatient Basis And In-Home Visits	Paid In Full as covered by Medicare
Immunizations	\$10 Copayment
Laboratory And Radiology	Paid In Full
Medical Social Services	Paid In Full
Mental Health Services	\$10 Copayment per visit
<ul style="list-style-type: none"> – For additional benefits, See Behavioral Health Benefits. – Up to twenty (20) visits for crisis intervention during each calendar year following your initial date of eligibility. – A Copayment may be charged for missed scheduled appointments. 	
Oral Surgery	Paid In Full
Outpatient Rehabilitation Therapy	\$10 Copayment
Outpatient Surgery	Paid In Full
Periodic Health Evaluations	\$10 Copayment
Phenylketonuria (PKU) Testing and Treatment	\$10 Copayment
Surgery	Paid In Full
Vision Refractions/Screening	\$10 Copayment
Vision Hardware	\$20 Copayment every 24 months
Well-Woman Care	\$10 Copayment
<i>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.</i>	

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 Formulary Drugs	\$10 Copayment
Brand-Name Formulary Drugs	\$20 Copayment
Non-Formulary Drugs	\$35 Copayment

Mail Service (Up to 90 day supply)

Generic and Selected Brand-Name Formulary Drugs	\$20 Copayment
Brand-Name Formulary Drugs	\$40 Copayment
Non-Formulary Drugs	\$70 Copayment

*Annual prescription drug out-of-pocket maximum of \$2,000 will be applied for combined retail and mail order prescription drugs.

HEARING AID BENEFIT SCHEDULE OF BENEFITS

General Features

Hearing Exam	\$10 Copayment
Hearing Aid Hardware	1 per ear every 36 months

Preauthorization is required for all Mental Health Services, Chemical Dependency Services and Severe Mental Illness (SMI) Benefits. You do not need to go through your Primary Care Physician, but you must obtain prior authorization through PacifiCare Behavioral Health of California (PBHC), an affiliate of PacifiCare that specializes in mental health and chemical dependency benefits. PBHC is available to you toll-free, 24 hours a day, 7 days a week, at 1-800-999-9585.

Mental Health Services

Inpatient Deductible	None
Inpatient per Admittance	\$250 per admission
Inpatient, Residential and Day Treatment <i>(Up to 190 days per lifetime as defined by Medicare)</i>	\$250 per admission
Outpatient Treatment <i>Unlimited visits (Based upon Medical Necessity)</i>	\$10 Copayment per visit
Emergency and Urgently Needed Services ¹ <i>(Copayment waived if admitted as inpatient)</i>	Same as medical plan Copayment for Emergency and Urgently Needed Services ¹

Chemical Dependency Health Services

Inpatient Deductible	None
Inpatient Treatment	\$250 per admission
Outpatient Treatment	\$10 Copayment per visit
Emergency and Urgently Needed Services ¹ <i>(Copayment waived if admitted as inpatient)</i>	Same as medical plan Copayment for Emergency and Urgently Needed Services ¹

Serious Mental Illness Benefit²

Inpatient Deductible	None
Inpatient per Admittance	\$250 per admission
Inpatient, Residential and Day Treatment <i>(Up to 190 days per lifetime)</i>	\$250 per admission
Outpatient Treatment <i>Unlimited visits (Based upon Medical Necessity)</i>	\$10 Copayment per visit
Emergency and Urgently Needed Services ¹ <i>(Copayment waived if admitted as inpatient)</i>	Same as medical plan Copayment for Emergency and Urgently Needed Services ¹

¹ Urgently Needed Services are Medically Necessary Services required outside 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, including severe pain, such that treatment cannot be delayed until the Member returns to the Service Area.

² Severe Mental Illness Diagnoses include: Schizophrenia, Schizoaffective Disorder, Bipolar Disorder, Major Depressive Disorder, Panic Disorder, Obsessive-Compulsive Disorder, Pervasive Developmental Disorders (Autism), Anorexia and Bulimia Nervosa. In addition, the Severe Mental Illness Benefit includes coverage of Serious Emotional Disturbance of Children (SED).

You do not need to go through your Primary Care Physician, but you must obtain prior authorization through PacifiCare Behavioral Health of California (PBHC), an affiliate of PacifiCare that specializes in mental health and chemical dependency benefits. PBHC is available to you toll-free, 24 hours a day, 7 days a week, at 1-800-999-9585.

**5701 Katella Avenue
P.O. Box 6006
Cypress, California 90630**

**Customer Service:
800-624-8822
800-442-8833 (TDHI)**

Visit our Web site @ www.pacificare.com