SecureHorizons®

Offered by PacifiCare

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

Effective January 1, 2000
Through December 31, 2000

This Document is Pending State Regulatory Approval

SecureHorizons®
Offered by PacifiCare

May 15, 2000

Dear Secure Horizons Member:

We thank you for your continued confidence in Secure Horizons and want to keep you up to date on new regulations which may impact your membership.

The Balanced Budget Refinement Act (BBRA) has changed effective dates for voluntary elections made during the Secure Horizons Open Enrollment Period. Beginning July 10, 2000, all voluntary enrollment forms and/or written disenrollment requests received by Secure Horizons by the 10th of the month are effective the first day of the next calendar month. Elections received by Secure Horizons after the 10th are effective the first day of the second calendar month after the election is made. These changes also apply to disenrollment requests received by your local Social Security Office or your Railroad Retirement Board office (if you are a railroad annuitant).

These changes are explained in detail in the enclosed Addendum to Your Year 2000 Member Handbook/Evidence of Coverage and Disclosure Information (EOC). We encourage you to review this information and keep it on file with your EOC and other member materials.

If you have any questions, please call Member Service from 7 a.m. to 7 p.m., Monday through Friday at 1-800-228-2144 or TDHI at 1-800-685-9355.

We appreciate your membership in Secure Horizons and look forward to continuing to serve you as your partner in good health.

Sincerely,

Kathy Feeny

Kathy Feeny
Senior Vice President, Secure Horizons

Attachment

PacifiCare®
SecureHorizons®

Group Retiree Plan℠

July 3, 2000

Dear Group Retiree Member:

Please find enclosed your Secure Horizons Evidence of Coverage and Retiree Benefits Summary. (*For spouses, dependents and early retirees who are not entitled to Medicare and enrolled in the PacifiCare Commercial Plan through your employer group's selection of the PacifiCare/Secure Horizons Group Retiree Plan, please refer to the PacifiCare Evidence of Coverage.*) Please retain this letter with your Evidence of Coverage.

As a Group Retiree Plan member ("a retiree"), the following components of the enclosed Evidence of Coverage may not pertain to you:

The Addendum to Your Year 2000 Evidence of Coverage (Section 2 - Eligibility, Enrollment and Effective Date).

Congress enacted new legislation called the Balanced Budget Refinement Act of 1999 which changes a Medicare beneficiary's Effective Dates for Enrolling and Disenrolling in a Medicare+Choice Plan. The implementation of this new law is explained in the Addendum. However, this new provision does not apply to Group Retiree members who enroll in an employer group plan when that plan is open for enrollment. For more information regarding your effective date, please contact either your former employer or union trust or Secure Horizons Member Services Department.

Section 7 - Premiums and Payments.

Your former employer or union trust may be responsible for making payment of any applicable plan premium directly to Secure Horizons on behalf of its enrolled retirees and the eligible dependent(s), unless you pay a monthly/quarterly plan premium directly to PacifiCare/Secure Horizons. Your former employer or union trust determines any retiree subscriber contribution toward plan premiums.

The discussion regarding the Health Care Financing Administration's (HCFA) approval of plan premium changes applies to the Secure Horizons Individual Plan, not the Group Retiree Plan. Rate changes for retirees enrolled through an employer group or union trust are subject to contractual arrangements between PacifiCare/Secure Horizons and your former employer or union trust. Your former employer or union trust is responsible for notifying you of any Secure Horizons plan premium changes or contribution changes 30 days before they become effective.

Changes in the level of coverage may occur at the beginning of each calendar year and/or your retiree group contract year. You will receive a written notice at least thirty (30) days prior to the date when such change shall become effective.

If you do not pay a plan premium directly to PacifiCare/Secure Horizons, disenrollment due to failure to pay plan premiums discussed in this section does not apply to you. However, if your former employer or union trust does not pay the plan premium, then you will be transferred to Secure Horizons' Individual Plan. Monthly plan premiums and benefits may vary by the member's county of residence.

The Addendum to Your Year 2000 Evidence of Coverage (Section 8 - Moves, Disenrollments).

In the event you choose to disenroll from your Secure Horizons Group Retiree Plan, re-enrollment in your group plan may not be permitted until your group's next Open Enrollment period. You should consult with your benefits administrator regarding the availability of other coverage before disenrolling from your PacifiCare/Secure Horizons membership outside of your former employer's or union trusts' Open Enrollment. Please note that Group Retiree Members may enroll in the Secure Horizons Individual Plan as individual members at any time. As an individual member of Secure Horizons, you will receive the benefit package approved by HCFA for your county of residence, which may cover less than the benefit package available through your former employer or union trust, and a plan premium may apply. For additional information regarding benefits and 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.

As referenced above, Congress enacted new legislation called the Balanced Budget Refinement Act of 1999 which changes a Medicare beneficiary's Effective Dates for Enrolling and Disenrolling in a Medicare+Choice Plan. The implementation of this new law for disenrollments is explained in the Addendum to Your Year 2000 Evidence of Coverage under the heading "Voluntary Disenrollment". However, this new provision does not apply to Group Retiree members who disenroll through their employer. For more information regarding your disenrollment effective date, please contact either your former employer or union trust or Secure Horizons Member Services Department.

Secure Horizons may disenroll you only under the conditions listed below. You will not be disenrolled due to your health status.

1. If you move permanently out of the Service Area and do not voluntarily Disenroll[A];

2. If your entitlement to Medicare Part A or enrollment in Part B benefits ends;

3. If you supply fraudulent information or misrepresentation on your group retiree election form which materially affects your eligibility to enroll in Secure Horizons[A,B];

4. If you are disruptive, unruly, abusive or uncooperative to the extent that your membership in Secure Horizons seriously impairs our ability to arrange Covered Services for you or other individuals enrolled in the plan. Involuntary Disenrollment on this basis is subject to prior approval by HCFAA;

5. You allow another person to use your Secure Horizons membership card to obtain Covered Services[A,B];

6. You and/or your employer group fail to pay the Plan Premiums, subject to the 90-day grace period for late payment[A]; or

7. The contract between Secure Horizons and HCFA under which Secure Horizons is offered is terminated[C], or the Secure Horizons Service Area is reduced.[C]

8. The PacifiCare/Secure Horizons Group Retiree Plan agreement between Secure Horizons and the employer group is terminated.[D] If the agreement between your employer group and PacifiCare/Secure Horizons is terminated, then you will be transferred from the Group Retiree Plan to Secure Horizons' Standard Individual Plan. **Your disenrollment from Secure Horizons Individual Plan will not occur until Secure Horizons receives a written disenrollment request from you as described in the attached Evidence of Coverage.** Please note that monthly plan premiums and benefits of the Secure Horizons Standard Individual Plan may vary by the member's county of residence.

Should Secure Horizons cancel your benefits for any of the reasons described in #1-7, Secure Horizons will not do so without notifying your employer group.

[A] Disenrollment on these grounds can only occur after you have been provided notice with an explanation of the reasons for the Disenrollment and information on Secure Horizons applicable grievance rights. HCFA must also be notified, if Disenrollment is due to reasons 3 - 5 above.;

[B] Requires a referral to the Inspector General and may result in criminal prosecution;

[C] The contract with HCFA is renewed on an annual basis. At the end of each contract year, the contract can be ended by either Secure Horizons or HCFA. If Secure Horizons ends the contract, you will receive a minimum ninety (90) day notification before the end of the contract. If HCFA ends the contract you will receive a minimum thirty (30) day notification. We will explain what your options are at that time. For example, there may be other health plans in the area for you to join, if you wish. Or you may wish to return to Original Medicare and possibly obtain supplemental health insurance. Whether you enroll in another Medicare+Choice Coordinated Care Plan or not, there would be no gap in Medicare coverage. Until returning to Original Medicare coverage or enrolling in another Medicare+Choice Coordinated Care Plan, you will still be a Member of Secure Horizons.

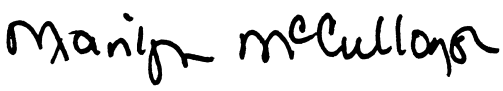
[D] The contract with the employer group is renewed upon the ending date of the contract period. At the end of each contract period, either Secure Horizons or the employer group can end the contract. Your employer will notify you regarding the options of your retiree health care coverage options.

Section 13 — Optional Supplemental Benefits.

Since your former employer or union trust may offer you additional supplemental or buy-up benefits, this section is not applicable to you. For information regarding your supplemental benefits, if applicable, please refer to the enclosed Retiree Benefits Summary document.

If you have any questions regarding this letter or the enclosed materials, please contact Secure Horizons Member Services at 1-800-228-2144, Telecommunications Device for the Hearing Impaired (TDHI): 1-800-685-9355.

Sincerely,



Marilyn McCullough
Vice President, Member Services

Addendum to Your Year 2000 Evidence of Coverage
Effective July 10, 2000

Section 2 – Eligibility, Enrollment and Effective Date

When Secure Horizons Coverage Begins

The Effective Date of enrollment in Secure Horizons will depend on when Secure Horizons receives your signed and completed individual election form. Secure Horizons will send you a letter that tells you when your coverage begins.

In general, completed individual election forms must be received by Secure Horizons no later than the 10th of the month to be effective the first of the next month. Completed election forms received after the 10th of the month will be effective the second month after your form is received by Secure Horizons. For example, if Secure Horizons receives your completed election form on June 10, your Effective Date would be July 1. If your form was received on June 11, your Effective Date would be August 1.

Exceptions* to this general rule include, but are not limited to, the following:

- Initial Election Period. In the case of an enrollment when you first become entitled to both Medicare Part A and Part B, your enrollment will be effective as of the first day of the month that you have coverage under both Medicare Part A and Part B.
- Annual Election Period. Enrollment-elections received during the Annual Election Period in November are usually effective on January 1. However, if Secure Horizons is "open" or has an Open Enrollment Period during the month of November, then completed election forms received between November 1 and November 10 can be effective December 1.

To obtain detailed information concerning these exceptions, please call Member Service at 1-800-228-2144 or TDHI at 1-800-685-9355.

Section 8 – Disenrollment From Secure Horizons

Voluntary Disenrollment

The date of your disenrollment will depend on when Secure Horizons receives your written request to disenroll. Secure Horizons will send you a letter that tells you when your disenrollment is effective.

In general, written requests to disenroll must be received by Secure Horizons no later than the 10th of the month to be effective the first of the next month. Written requests to disenroll that are received after the 10th of the month will be effective the second month after your request is received by Secure Horizons. For example, if Secure Horizons receives your disenrollment request on June 10, your Effective Date would be July 1. If your request was received on June 11, your Effective Date would be August 1.

There is an exception to this general rule. Disenrollment requests received between November 1 and November 10 are usually effective December 1. However, since the month of November is also the Annual Election Period, you can ask for a January 1 effective date.

** Please note that this addendum affects ONLY voluntary elections made during the Open Enrollment Period. Effective dates are not changed for the following: involuntary disenrollment, employer group retroactive enrollments and disenrollments, and the Special Election Periods (SEP) (including the SEP for Employer Group Health Plans and the SEP for Permanent Moves)*

Reference Page

Please fill this out for your reference:

_____

Your Secure Horizons membership number (located on your membership card)

_____ / _____ / _____

Your Effective Date of enrollment

Questions? Problems? Need help?

Call or write:

Secure Horizons Member Service Department, 1-800-228-2144, Telephonic Device for the Hearing Impaired (TDHI) 1-800-685-9355, 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 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 plan, please contact 1-800-228-2144, Telephonic 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 the Health Plan. This document will be mailed to you annually at the beginning of the contract year (Calendar Year) or shortly thereafter upon state and federal regulatory approval. This document is effective for the calendar year January 1, 2000, through December 31, 2000.

The contract between HCFA and PacifiCare of California to offer Secure Horizons must be consulted to determine the exact terms and conditions of coverage.

Federal law mandates that Secure Horizons 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 does not discriminate both in the employment of staff and in the provision of health care services on the basis of race, disability, religion, sex, sexual orientation, health, ethnicity, creed, age or national origin.

Table of Contents

Welcome To Secure Horizons

This document is an explanation of your rights, benefits and responsibilities as a Member of the Secure Horizons Plan, a "Medicare + Choice" (M+C) Plan offered by PacifiCare of California, a "Medicare + Choice" (M+C) Organization. It also explains Secure Horizons responsibilities to you. Your agreement with Secure Horizons consists of this combined Evidence of Coverage and Disclosure Information, your individual election form and any current or future amendments.

This combined Evidence of Coverage and Disclosure Information contains important information. Please read it carefully. All capitalized terms are defined in Section I. Keep it in a safe place, available for quick reference.

Secure Horizons is not an insurance policy that merely pays Medicare deductibles and coinsurance charges (commonly called a "Medigap" or "Medicare supplement" policy). Instead, Secure Horizons has entered into a contract with the Health Care Financing Administration (HCFA), the Federal Government agency that administers Medicare. This contract authorizes Secure Horizons to arrange for comprehensive health services to persons who are entitled to Medicare benefits and who choose to enroll in Secure Horizons. Secure Horizons covers all services and supplies offered by Medicare, plus additional services and supplies not covered by Medicare.

By enrolling in Secure Horizons, you have made a decision to receive all of 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, those services will be covered. **However, if you receive services from Non-Contracting Medical Providers without Prior Authorization neither Secure Horizons 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 allows you to self-refer to Contracting Provider**s

How You Can Learn More About Your Benefits

We encourage you to attend a Member Education meeting where you can learn more about Secure Horizons. A Secure Horizons representative will lead the meeting and answer questions you may have about Secure Horizons.

You'll also become familiar with the services and assistance available through the Secure Horizons Member Service Department. To find out the dates and times of the next Member Education meeting, call our Secure Horizons Member Service Department, 1-800-228-2144, (TDHI) 1-800-685-9355.

Call the Secure Horizons Member Service Department Whenever You Need Information

We strive to provide you with the information you need about Secure Horizons 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 your new address in writing to Secure Horizons Member Service Department, P.O. Box 489, Cypress, California 90630. Please refer to Section 8.)
- 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 care you are receiving
- Times and locations of Member Education Meetings
- Any other questions or concerns regarding your Health Plan.

You can reach the Secure Horizons Member Service Department at 1-800-228-2144, (TDHI) 1-800-685-9355, 7:00 a.m. to 7:00 p.m. weekdays.

Updating Your Membership Records

Your Secure Horizons 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 the Contracting Medical Group or IPA you selected upon enrollment. These records are very important because they identify you as an eligible Secure Horizons member and determine where you can receive services.

Please report any changes in name, address or phone number to Secure Horizons Member Service Department immediately. You should also report any changes in health insurance coverage you have from your employer or your spouse's employer. You should also report 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 through our Member Satisfaction surveys. These surveys help us measure the performance of our Contracting Medical Groups/ IPAs and 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 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 physiatrist, 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, an independent review entity, hearings before administrative law judges (of the Social Security Administration), review by the Board, and judicial review.

Benefit Period
A Benefit Period is a way of measuring your use of services under Medicare Part A. A Benefit Period begins with the first day of a Medicare-covered inpatient hospital stay and ends when you have been out of a hospital or other facility primarily providing Skilled Nursing or rehabilitation services for sixty (60) days in a row (including the day of discharge).

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 HCFA contractor that reviews Appeals for Medicare contracting managed care plans, including Secure Horizons.

Coordination of Benefits
A process whereby Secure Horizons 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 EOC.

Contracting Hospital
A Hospital that has a contract with Secure Horizons or, in some limited circumstances, your Contracting Medical Group or IPA to provide 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 to provide or arrange for the provision of medical services to Members.

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

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

Contracting Primary Care Physician
The Secure Horizons contracting physician you choose associated with a Contracting Medical group or IPA. Your Contracting Primary Care Physician is responsible for providing or authorizing Covered Services while you are a Member of Secure Horizons. 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.

Copayment
The fee you pay at the time of medical services in accordance with your Health Plan.

Covered Services
Those benefits, services and supplies which are:

- Services provided or furnished by Contracting Providers or authorized by Secure Horizons 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 or our Contracting Medical Group did not respond to a request for pre-authorization for such services within one hour of the request (or because we could not be contacted for pre-authorization).
- Out-of-area and routine travel dialysis services provided while you are temporarily outside the Service Area.
- 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 for plan Members.

Covered Services include Basic Benefits and Supplemental Benefits.

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 assistance in mobility, dressing, bathing, eating, preparation of special diets, and taking medication. Custodial Care is not covered by Secure Horizons or Medicare unless provided in conjunction with Skilled Nursing Care.

Disenroll or Disenrollment
The process of ending your membership in Secure Horizons.

Drug Formulary
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, many of which are Practitioners experienced in the diagnosis and treatment of various diseases. The Drug Formulary contains both brand name drugs and generic drugs, all of which have Food and Drug

Administration ("FDA") approval. Members who would like additional information about the Formulary should contact Secure Horizons Member Service at 1-800-228-2144, (TDHI) 1-800-685-9355, or visit our web site at www.securehorizons.com.

Durable Medical Equipment
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. To be covered, Durable Medical Equipment must be Medically Necessary and prescribed by a Contracting Medical Provider for use in your home, such as oxygen equipment, wheelchairs, hospital beds and other items that are determined Medically Necessary, in accordance with Medicare law, regulations and guidelines.

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

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.

Enrollment Period
A designated period of time in which you can elect an optional supplement benefit as an existing Member.

Evidence of Coverage and Disclosure Information
This document, which explains Covered Services and defines your rights and responsibilities as a Member and those of Secure Horizons.

Exclusion
Items or services which are not covered under this Evidence of Coverage; Exclusions are disclosed in the attached Comparison of Benefits.

Experimental Procedures and Items
As defined in Section 9, page 46 are not covered unless otherwise dictated by federal or state law.

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
A complaint that is not related to a denied claim or denied service; complaints regarding denied claims or services are treated as Appeals.

HCFA
The Health Care Financing Administration, the Federal Agency responsible for administering Medicare.

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, Subscriber's Contracting Medical Group/ IPA or its designee.

Health Plan
The Covered Services, Copayment requirements, limitations and Exclusions that are defined herein.

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 confined to your home and when authorized by your Contracting Primary Care 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.

Independent Physicians Association (IPA)

An organized or affiliated group of physicians who function as a Contracting Medical Provider/Group yet work out of their own independent medical offices.

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 IPA or your Contracting Primary Care Physician. If you receive services from a Non-Contracting Medical Provider without Prior Authorization, except for Emergency Services or Urgently Needed Services, neither Secure Horizons

nor Medicare will pay for that care.

Medical Director
A licensed physician who is an employee of either Secure Horizons or a Contracting Medical Group/IPA and is responsible for monitoring the quality of care to our members.

Medically Necessary
Medical or Hospital Services which are determined by a Medical Director of Secure Horizons or the Contracting Medical Group/IPA to be:

(a) Rendered for the treatment or diagnosis of an injury or illness;

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

(c) Not furnished primarily for the convenience of the Member, the attending Physician, or other provider of service; and

(d) If more than one service, supply or level of care meets the requirements of (a) through (c) above, furnished in the most cost-effective manner which may be provided safely and effectively to the Member.

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

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

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 + 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. 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 certified by HCFA as meeting M+C requirements. 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 is a Medicare + Choice Plan.

Member
You, the Medicare beneficiary entitled to receive Covered Services, who have voluntarily elected to enroll in Secure Horizons and whose enrollment has been confirmed by HCFA.

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 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.

Optional Supplemental Benefits
Additional non-Medicare covered benefits beyond the benefits included in the standard Secure Horizons plan. There is a Plan Premium associated with Optional Supplemental Benefits, these are referred to as high option plans. Members of Secure Horizons must voluntarily elect Optional Supplemental Benefits in order to receive them.

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

PacifiCare - PacifiCare of California
dba Secure Horizons. A California corporation that is organized and licensed by the State as a risk-bearing entity that is certified by HCFA as meeting Medicare + Choice requirements. PacifiCare is a Medicare + Choice Organization.

Peer Review Organization (PRO)
An independent contractor paid by HCFA 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, if applicable, along with the Part B Premiums paid to Medicare 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. 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, IPA or Secure Horizons 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.

Quality Improvement Committee
Quality Improvement Committee is a committee established and maintained by Secure Horizons, consisting of at least three (3) physician members from Contracting Medical Groups or IPAs, which performs quality assurance reviews.

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

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 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 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 and the treatment or service is authorized by Secure Horizons or the Member's Contracting Medical Group, the treatment or service shall be either provided or arranged by the Member's Contracting Medical Group/ IPA. The fact that a Provider, while furnishing a Second Medical Opinion, recommends a particular treatment or service does not necessarily mean that the treatment or service is Medically Necessary or a covered benefit under the Members Health Plan.

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

Secure Horizons Member Service
A department of Secure Horizons dedicated to answering your questions concerning your membership, benefits, Grievances and

Appeals. A Secure Horizons Member Service representative is available to assist you during regular business hours by calling, 1-800-228-2144, (TDHI) 1-800-685-9355 or by writing to P.O. Box 489, Cypress, California 90630.

Service Area
A geographic area approved by HCFA within which a Medicare + Choice eligible individual may enroll in a particular Medicare + Choice Plan offered by Secure Horizons.

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.

Specialist
Any duly licensed physician, osteopath, psychologist or other Practitioner (as defined by Medicare) 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.

Third Party Liability
In the case of injury to a Member caused by a third-party, Secure Horizons or its designee 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. Third Party Liability is more fully discussed in Section 14 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 Secure Horizons Service Area (or, under unusual and extraordinary circumstances, provided when you are in the Service Area but your Contracting Medical Group or IPA 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 or IPA.

Utilization Review Committee
A committee used by Secure Horizons or a Contracting Medical Group or IPA to promote the quality of health care and the efficient use of resources. Duties of the Utilization Review 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 and Effective Date

Who Is Eligible to Enroll in Secure Horizons?

You are eligible to enroll in Secure Horizons if:

1. You are entitled to Medicare Part A (see definition in Section 1) (Hospital Insurance) and enrolled in Medicare Part B (see definition in Section 1) (Medical Insurance). A person who was a Member on or before December 31, 1998 and who was on that day entitled only to Part B of Medicare was deemed to be an enrollee of Secure Horizons and is eligible to continue enrollment in Secure Horizons if that person continues to reside in the Service Area. (If you are later disenrolled from Secure Horizons, however, you are not eligible to enroll in Secure Horizons unless you satisfy the Plan's eligibility requirements. If you have Medicare Part B ONLY, please see Section 7 for more information;
2. You do not currently have end-stage renal disease (that is, permanent kidney failure which requires regular kidney dialysis) or have had a kidney transplant in the past thirty-six (36) months. (This does not apply if you are currently a non-Medicare member of PacifiCare). If you develop end-stage renal disease while a Member of Secure Horizons, you cannot be Disenrolled due to your health status;
3. You permanently reside in the Service Area as defined in Section 15;
4. You 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. You agree to abide by Secure Horizons rules.

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

Enrollment

There are a number of times at which an eligible individual may enroll in Secure Horizons. Eligible individuals can enroll in Secure Horizons at the following times:

- Initial Election Period. You may elect to enroll in a Medicare + Choice Plan when you first become entitled to both Part A and Part B of Medicare. The Initial Election Period begins on the first day of the third month before the date on which you are entitled to both Part A and Part B and ends on the last day of the month before the date on which you become eligible for both Parts of Medicare.
- Special Election Period. Special periods of time in which an enrollee can discontinue enrollment in a Medicare + Choice Plan and change his/her enrollment to another Medicare + Choice Plan or return to Original Medicare. In the event of the following circumstances, a Special Election Period is warranted: the Medicare + Choice Plan in which the Member is enrolled is terminated; the enrollee moves out of the service area of the Medicare + Choice Plan; the Medicare + Choice Organization

offering the Plan violated a material provision of its contract with the Member; or, the Member meets such other material conditions as HCFA may provide.

- Continuous Open Enrollment. If you are eligible, you may submit a completed Secure Horizons individual election form at any time.

A Secure Horizons individual election form must be complete in order to be processed. A completed individual election form is defined as having all the following information:

- Your signature and the date on the form and statement of understanding. (If someone else signs the election form for you, a power of attorney or other acceptable legal documentation is required along with a statement of their relationship to you.
- Your full name as it appears on your Medicare card or Social Security Administration awards letter.
- Your residential street address. (A "P.O. Box" is considered a mailing address and will not be accepted in lieu of a residential address.)
- Your Health Insurance Claim Number (HIC#) also known as the Medicare number.
- Your effective date(s) of Parts A and B.
- Your date of birth.
- Your response to the end stage renal disease (ESRD) question. (If yes, you must be a current PacifiCare member within same State in order for your application to be accepted.)

Your individual election form will be processed in the order received. Your enrollment in Secure Horizons will be effective the first day of the month following the date your signed and completed individual election form is received by Secure Horizons. Since Secure Horizons has continuous open enrollment, your, enrollment during November can be effective on December 1 or January 1, it's your choice. Your individual election form is submitted to HCFA for verification of eligibility in Secure Horizons. If for any reason an election form is rejected by HCFA, we'll contact you for additional information or provide instructions to follow regarding resubmission of the election form.

When Your Secure Horizons Coverage Begins

Your coverage with Secure Horizons begins on the first day of the month following the date your signed and completed individual election form is received by Secure Horizons, provided all entitlement requirements have been met. As noted above, enrollments received in the month of November can be effective on either December 1 or January 1. In the case of an enrollment when you first become entitled to both Medicare Part A and Part B, your enrollment will be effective as of the first day of the month that you have coverage under both Medicare Part A and Part B. Secure Horizons informs applicants of the Effective Date of their enrollment. From your Effective Date forward, all Covered Services, with the exception of Emergency Services or Urgently Needed Services, must be provided or authorized by your Contracting Medical Group or IPA or your Contracting Primary Care Physician.

If you receive services from Non-Contracting Medical Providers without Prior Authorization, neither Secure Horizons 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 allows you to self-refer to Contracting Providers**

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

Liability of Secure Horizons Upon Initial Enrollment

If your Effective Date occurs during an inpatient stay in a Hospital, paid for under the Medicare prospective payment system, Secure Horizons 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 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. Secure Horizons 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 has sent you written confirmation of your Effective Date. This is because premiums, copayments, or other amounts that Medicare + Choice Plans charge for Medicare covered services will not be reimbursed by Medigap policies. However, if you Disenroll from Secure Horizons, 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 for a reason that does not involve any fault on your part (e.g., you move out of the Secure Horizons Service Area or the Secure Horizons contract with HCFA terminates);
- You enrolled in Secure Horizons upon first reaching Medicare eligibility at age 65, but Disenroll from Secure Horizons within 12 months of your Effective Date;
- You were previously enrolled under a Medigap policy and terminated your enrollment to participate, for the first time, in Secure Horizons and you Disenroll during the first 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.

In any of these situations, you must apply for a Medigap policy within 63 days after your Secure Horizons coverage terminates and submit evidence of the date of your loss of coverage. For additional information regarding guaranteed Medicare supplemental policies, please call your State Health Insurance Program at 1-800-434-0222.

Should you choose to keep your Medicare supplement (Medigap) policy, you may not be reimbursed for services you receive from Non-Contracting 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, Original Medicare will not process any claims for medical services you receive.
- Secure Horizons has the financial responsibility for all Medicare-covered health services you need as long as you follow Secure Horizons procedures on how to receive medical services.

Section 3 – Secure Horizons Member Rights and Responsibilities

Secure Horizons is committed to the treatment of Secure Horizons Members in a manner that respects your personal rights and responsibilities regarding the health care coverage you receive.

As a member of Secure Horizons, you have the ***right*** to:

Timely, Quality Care

- Choice of quality contracted physicians, health care professionals and Providers. (Note: Selection choice may be limited by the contracting Provider's patient case load.)
- Candid discussion of appropriate or Medically Necessary treatment options for your condition, regardless of cost or benefit coverage.
- Timely access to your Contracting Primary Care Physician and Referrals to Specialists when Medically Necessary.
- Use Emergency Services when you, as a prudent layperson acting reasonably, believe that an Emergency Medical Condition exists. Payment will be made if you as a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: 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; serious impairment to bodily functions; or serious dysfunction of any bodily organ or part.
- Actively participate in decisions regarding your own health and treatment options.
- Receive Urgently Needed Services. Urgently Needed Services are Covered Services provided when you are temporarily absent from the Secure Horizons Service Area (or, under unusual and extraordinary circumstances, provided when you are in the Service Area, but your Contracting Medical Group or IPA 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 or IPA.

Treatment With Dignity and Respect

- Be treated with dignity and respect and to have your right to privacy recognized.
- Exercise these rights regardless of your race, disability, ethnicity, gender, sexual orientation, creed, age, religion or your national origin, cultural or educational background, or your economic or health status, English proficiency, reading skills or source of payment for your health care. Expect these rights to be upheld by both the Plan and Contracting Providers.
- Confidential treatment of all communications and records pertaining to your health care and the care of other patients. You have the right to access your

medical records. The plan must provide timely access to your medical records. To obtain information regarding how to access your medical records, contact the Secure Horizons Member Service department at the telephone number shown at the end of this statement. Written permission from you or your authorized medical representative shall be obtained before medical records can be made available to any person (including your employer if appropriate), who is not directly concerned with your health care or responsible for making payments for the cost of such care. Protection of confidential information covers all Secure Horizons internal departments, any contracted entities and research and treatment settings. (Please refer to Section 12 for more information regarding Confidentiality.)

- Extend your rights to any person who may have legal responsibility to make decisions on your behalf regarding your medical care.
- Refuse treatment or leave a medical facility, even against the advice of a physician, provided you accept the responsibility and consequences of the decision (however, your refusal in no way limits or otherwise precludes you from receiving other Medically Necessary Covered Services for which you consent).
- Complete an Advance Directive, Living Will or other directive to a Contracting Medical Provider.
- Receive the full set of the managed care organization's confidentiality policies upon request.
- Make recommendations regarding the Members' rights and responsibilities policies.

Health Plan Information

- Information about your health plan, Covered Services, and Member rights and responsibilities.
- Know the names and qualifications of physicians, health care professionals and Contracting Providers involved in your medical treatment.
- Receive information about an illness, the course of treatment and prospects for recovery in terms you can understand, including how medical treatment decisions are made by the Contracting Medical Group.
- Information about our contracted physician payment agreements, as well as explanations for any bills for noncovered services, regardless of payment source.
- Accept the financial responsibility associated with services received while under the care of a physician or while a patient at a facility.
- Information about your medications – what they are, how to take them and possible side effects.
- Receive as much information about any proposed treatment or procedure as you may need in order to give an informed consent or to refuse a course of treatment. Except in Emergencies, this information shall include a description of the procedure or treatment, the medically significant risks involved, any alternate

course of treatment or nontreatment and the risks involved in each, and the name of the person who will carry out the procedure or treatment.

- Reasonable continuity of care and to know the time, location of an appointment, the name of the physician providing care and to be informed of continuing health care requirements following discharge from inpatient or outpatient facilities.
- Be advised if a physician proposes to engage in Experimental or investigational procedures affecting your health care or treatment. You have the right to refuse to participate in such research projects.
- Examine and receive an explanation of any bills for non-covered services, regardless of payment sources.

Timely Problem Resolution

- Voice complaints and appeals about Secure Horizons or the care provided without discrimination and expect problems to be fairly examined and appropriately addressed.
- Responsiveness to reasonable requests made for services.

As a Member of Secure Horizons, you have the ***responsibility*** to:

- Provide to the extent possible, physicians, health care professionals and contracting Providers the information needed in order to care for you.
- Do your part to improve your own health condition by following treatment plans, instructions and care that you have agreed on with your physician(s).
- Participate, to the degree possible, in understanding your behavioral health problems and developing mutually agreed upon treatment goals.
- Accept the financial responsibility for any copayment or coinsurance associated with covered services received while under the care of a physician or while a patient at a facility.
- Review information regarding Covered Services, policies and procedures as stated in your Member Handbook or Evidence of Coverage booklet.
- Ask questions of your contracting physician or Secure Horizons. If you have a suggestion, concern or payment issue, call our Member Service department at 1-800-228-2144, (TDHI) 1-800-685-9355.

Section 4 – How Your Secure Horizons Coverage Works

Your Secure Horizons Membership Card

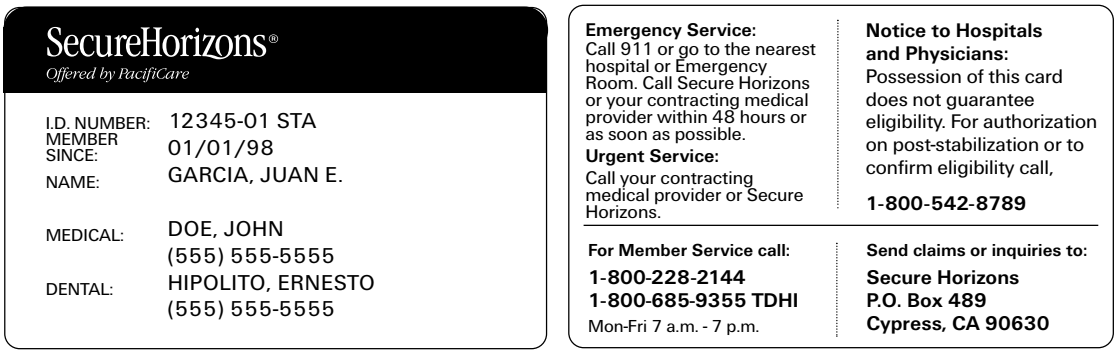
Your Secure Horizons Membership Card assists you in receiving all your Secure Horizons Covered Services. It is important to present your membership card to your health care Provider.

Carry your Secure Horizons membership card (and your Medicare card) with you at all times, using the special card holder we have provided – simply place your Medicare card in the holder opposite the membership card.

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

It is important that you use only your Secure Horizons 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 your Contracting Primary Care Physician or Secure Horizons as soon as possible so that Secure Horizons is involved in the management of your care, and
3. To prevent errors in billing. Secure Horizons pays the bills on behalf of Medicare. Medicare will not pay the bills while you are a Member of Secure Horizons.



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

As a Secure Horizons Member, all your medical benefits (except for Emergency Services and Urgently Needed Services) are provided and arranged by your Secure Horizons 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. Secure Horizons is able to offer you this Health Plan because of our contract with the Health Care Financing Administration (HCFA), 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 contract with Medical Groups, Hospitals and other health care Providers to arrange care for you.

Your Health Plan is affordable because of the "Lock-In" feature and is one of the reasons why Secure Horizons can arrange additional services not covered by Medicare.

If you receive services from Non-Contracting Medical Providers without Prior Authorization neither Secure Horizons 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 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. Having your Contracting Primary Care Physician nearby makes receiving medical care and developing a trusting and open relationship that much easier.

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.

Always ask to see your Contracting Primary Care Physician when you make an 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/IPA.

You Can Change Primary Care Physicians

Changing Contracting Primary Care Physicians Within Your Contracting Medical Group or IPA

If you wish, you may request to change Contracting Primary Care Physicians within your Contracting Medical Group or IPA at any time if the Contracting Primary Care Physician is accepting additional Secure Horizons Members.

Call Secure Horizons Member Service for assistance, 1-800-228-2144, (TDHI) 1-800-685-9355.

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

If you want to change to a Contracting Primary Care Physician who is affiliated with a different Contracting Medical Group or IPA, you must contact Secure Horizons Member Service. If the Contracting Primary Care Physician is accepting additional Secure Horizons 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. You will receive a new Secure Horizons Membership Card that shows this change.

Secure Horizons will review your request to change to a different Contracting Medical Group or IPA on a case-by-case basis. We recommend that you remain with your Contracting Medical Group if you are a patient in a Hospital, a Skilled Nursing Facility or other medical institution at the time of your request, you are a high-risk or third trimester obstetrical patient, or the change could have an adverse affect on the quality of your health care. We will not deny your request to change Contracting Medical Groups.

To help promote a smooth transition of your health care when you change your Contracting Medical Group or IPA, 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 15 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 ensure you have access to all Covered Services in the plan's benefit package.

How to Schedule an Appointment With Your Contracting Primary Care Physician

It's easy – simply call your Contracting Primary Care Physician's office and request an appointment. There are no special rules to follow. Appointments are scheduled according to the type of medical care you are requesting. Medical conditions requiring more immediate attention are scheduled sooner.

The telephone number for your PCP or Contracting Medical Group/IPA 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 Contracting 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 a Utilization Review Committee.

If you receive services from a Specialist without a Referral or Prior Authorization from your Contracting Primary Care Physician or Contracting Medical Group/IPA, neither Secure Horizons nor Medicare will pay for these services.

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, simply forward it to Secure Horizons for payment. See Section 6 for where to send your claim.

In the event your Specialist is involuntarily terminated from contracting with Secure Horizons, 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 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, 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 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 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 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/IPA 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.

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 ID 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 Comparison of Benefits) by following the procedures outlined above.

Continuity of Care for Terminating Physicians

In the event your contracting physician is terminated by Secure Horizons or your Participating Medical Group for reasons other than a medical disciplinary cause, fraud or other criminal activity, you may be eligible to continue receiving care from your physician following the termination, providing the terminated Provider agrees to the terms and conditions of the contract. Continued

care from the terminated physician may be provided for up to ninety (90) days or a longer period if Medically Necessary for chronic, serious or acute conditions or through post-partum for pregnancy related conditions or until your care can safely be transferred to another Provider. This does not apply to physicians who have voluntarily terminated their participation with Secure Horizons or a Contracting Medical Group.

If you are receiving treatment for:

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

and your physician is terminated, you may request permission to continue receiving treatment from the terminated physician beyond the termination date by calling Secure Horizons. 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 must provide Prior Authorization 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 Department at 1-800-228-2144, (TDHI) 1-800-685-9355.

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, by submitting a request for a Second Medical Opinion to your Contracting Primary Care Physician. The request will be evaluated by the Contracting Medical Group (or a Secure Horizons 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' as appropriate) network of contracting medical providers. If you are denied a Second Medical Opinion, you may appeal the denial by following the procedures outlined in the Appeals Process, Section 9 of this EOC.

Secure Horizons 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 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 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 or IPA, including semiprivate 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, and 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 or IPA 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, you will only be admitted to those hospitals, acute care, subacute care, transitional inpatient care and skilled nursing facilities that are authorized by your Contracting Medical Group or IPA and under contract with Secure Horizons. You may call Secure Horizons Member Service Department to request a copy of Secure Horizons' utilization review and prior authorization processes that apply to care provided in subacute care, transitional inpatient care and skilled nursing facilities.

Please refer to your Comparison of Benefits for further details.

Ambulance

Secure Horizons covers Medically Necessary ambulance services for Emergency or Urgent Needed Services or when authorized by Secure Horizons or its designee, according to Medicare guidelines. Secure Horizons **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/IPA, 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 contracted facility to another contracted facility unless the transfer is necessary to deliver medical services that are not available at the first facility.

Home Health Care

If your Secure Horizons Contracting Primary Care Physician/Specialist determines that you require Home Health Care, he or she will arrange these Covered Services for you. Please refer to your Comparison of Benefits for further details.

Hospice

In order to access Hospice care, Secure Horizons members must elect Hospice care under Medicare. Upon making this election, Medicare will be financially responsible for all medical and hospital services related to the terminal condition. Secure Horizons will remain financially responsible for Supplemental Benefits, such as routine vision care, that Original Medicare does not cover. As a Secure Horizons Member, you are entitled to impartial information regarding available Medicare-certified Hospice Providers. For more information regarding electing Hospice care, including those Hospice facilities that have an agreement with your Contracting Medical Group, please contact Secure Horizons Member Service at 1-800-228-2144, (TDHI) 1-800-685-9355 from 7:00 a.m. to 7:00 p.m. weekdays.

Receiving 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 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 to the nearest Contracting Hospital, 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 will cover Emergency Services whether you are in or out of the Service Area. You should have someone telephone your medical provider or Secure Horizons at the number listed on your membership card as soon as reasonably possible. Secure Horizons 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 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 medical provider or Secure Horizons of an Emergency Medical Condition so that your medical provider can be involved in the management of your health care and transfer can be arranged when your medical condition is stable (depending on the distance involved). Please contact your medical provider or Secure Horizons at the number located on your Secure Horizons 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. 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 must receive any follow-up care through your Contracting Primary Care Physician.

Post-Stabilization Care

Medically Necessary, non-Emergency Services following receipt of Emergency Care to enable you to remain stabilized is covered if Secure Horizons or its Contracting Medical Group

provides pre-authorization for such services or Secure Horizons or its Contracting Medical Group does not respond within one hour to a request for pre-authorization from a Non-Contracting Medical Provider or Facility or Secure Horizons or its Contracting Medical Group could not be contacted for pre-authorization. Coverage for Post-Stabilization Care is effective until:

- You are discharged;
- A Contracting Medical Provider arrives and assumes responsibility for your care; or
- The Non-Contracting Medical Provider and Secure Horizons agree to other arrangements.

Urgently Needed Services

Secure Horizons will also cover Urgently Needed Services.

Urgently Needed Services are Covered Services provided when you are temporarily* absent from the Secure Horizons Service Area (or, under unusual and extraordinary circumstances, provided when you are in the Service Area, but your Contracting Medical Group or IPA 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 or IPA.**

* *A temporary absence is an absence from the Service Area lasting not more than 12 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, 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/IPA or Secure Horizons 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

Here's what to do if you need urgent medical care within your Secure Horizons service area:

Several of Secure Horizons contracting medical providers have 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' Contracting Medical Group at the number listed on the front of your Secure Horizons membership card.
2. Identify yourself as a Secure Horizons 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).

All medical providers have a 24-hour emergency number. 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 contracting medical provider.

Remember, if you receive services from Non-Contracting Medical Providers without Prior Authorization neither Secure Horizons 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 allows you to self-refer to Contracting Providers.**

Reimbursement for Emergency or Urgently Needed Services Paid by Member

Providers should submit bills to Secure Horizons for payment. However, if you paid for any Emergency Services or Urgently Needed Services obtained from Non-Contracting Medical Providers, you should submit your bills to Secure Horizons for a payment determination. Please include your name, your member number, and the bill. No claim forms are required. Bills should be submitted to the following address:

Secure Horizons
Attn: Secure Horizons Claims
P.O. Box 489
Cypress, California 90630

If you have questions about any bills, contact Secure Horizons Member Service at: 1-800-228-2144, (TDHI) 1-800-685-9355.

Right to Appeal

Secure Horizons or your Contracting Medical Group provides you with a written notice every time a service or payment is denied. If Secure Horizons or your Contracting Medical Group 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. See Section 9.

Section 7 – Premiums and Payments

As a Member of Secure Horizons, you have the following financial obligations:

Premiums ("Prepayment Fees")

- **Medicare Part B Premium**
  As a Secure Horizons 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).
- **Medicare Part A Premium or Secure Horizons Part A "Equivalent" Benefit Premium**
  Most Medicare beneficiaries are automatically entitled to Medicare Hospital Insurance (Part A). If you are not entitled to Medicare Part A, and have purchased in the past an "Equivalent Part A benefit" from Secure Horizons, you **will** be allowed to continue to purchase a Part A equivalent benefit directly from Secure Horizons if your membership started prior to January 1, 1999. If you would like to purchase Medicare Part A from Social Security, please call your local Social Security Office or call 1-800-772-1213 toll-free. For the hearing impaired, the toll-free number to reach Social Security is 1-800-325-0778.

Note: If you are enrolled in Part B and not entitled to Part A and you Disenroll from Secure Horizons, you will not be eligible to reenroll in Secure Horizons or any other Medicare + Choice Coordinated Care Plan until you either purchase Part A from Social Security or become entitled to Part A. (Please see Section 1 for the definition of Medicare Part A Premium.)

For information regarding Plan Premiums for Optional Supplemental Benefits, please see Section 13.

Secure Horizons has the right to Disenroll you for failure to pay Plan Premiums (except for Plan Premiums which cover Optional Supplemental Benefits, see Section 13). However, prior to such action, Secure Horizons will:

(a) Contact you regarding the payment due;

(b) Advise you that failure to pay the Plan Premiums within a 90-day grace period will result in your disenrollment;

(c) Include an explanation of your rights under the Secure Horizons Grievance procedures.

Nonpayment of Secure Horizons Plan Premiums may return you to Original Medicare.

Until you are notified of your Disenrollment, you are still a Secure Horizons Member and must continue to use Contracting Medical Providers.

For further details on Disenrollment, please see Section 8.

Your Premium Payment Options

As a Secure Horizons Member, you have two options for paying your monthly Plan Premium ("prepayment fee"), or

any other premiums that may be associated with Optional Supplemental Benefits or your Secure Horizons Part A Equivalent benefit Plan Premium. These are the Easy Pay or coupon book methods.

With the convenient Easy Pay method, you can have your Plan Premium(s) automatically deducted from your personal bank account and electronically transmitted for payment. You will have no more checks to write, and can enjoy peace of mind knowing that your Plan Premium payments are taken care of – even if you are traveling.

For more information about this option, call 1-800-228-2144, (TDHI) 1-800-685-9355, select the option for Enrollment Services Department and then select the option for Premium Billing. If you're interested in the Easy Pay option, simply complete and return the Easy Pay application.

If you do not elect the Easy Pay method of payment, you will be automatically enrolled in the coupon book payment option. Using the coupon book payment method is simple. As Plan Premiums become due, remove the appropriate coupon from your coupon book, complete a check or money order for the amount shown on the coupon, and mail to Secure Horizons in the envelope provided. If you have any questions regarding your Plan Premium payment choices, please call 1-800-228-2144, (TDHI) 1-800-685-9355.

Premiums are due the first of each month and are considered late if received after the 10th of each month. The Secure Horizons High Option Dental Plan requires the payment of a premium in addition to any premium you may pay by county. Payment for the High Option Plan is due by the 1st of each month and is considered late if received after the 10th of each month.

Changes in Plan Premiums

Increases in 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 HCFA. You will receive written notice by October 15 of the year before changes that are not to your advantage become effective.

Other Charges

All **Copayments** shall be paid at the time of service. Specific Copayment amounts are listed in the Comparison of Benefits.

Section 8 – Moves, Extended Absences, and Disenrollment From Secure Horizons

Moves Within the Secure Horizons Service Area

If you are planning a move within the Secure Horizons Service Area, please notify Member Service prior to your move. It may be necessary to complete a form.

Moves or an Extended Absence From the Secure Horizons Service Area

If you are permanently moving out of the Service Area or plan an extended absence of more than 12 consecutive months, it is important to notify Secure Horizons in writing of the move or extended absence before you leave the Service Area.

Failure to notify Secure Horizons of a permanent move or an extended absence may result in your involuntary Disenrollment from Secure Horizons, since we are required to Disenroll you if you permanently move outside the service area. (An absence from the service area of more than 12 months is considered a permanent move. Please see Section 15.) 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 Secure Horizons Contracting Medical Providers (except for Emergency Services, Urgently Needed Services, and out-of-area and routine travel Dialysis Services in the United States at a Medicare certified facility). **You must return to the service area for all other covered services.**

Secure Horizons is currently offered in the following states: Arizona, California, Colorado, Nevada, Ohio, Oklahoma, Oregon, Texas and Washington. **If you are moving outside of your Service Area, you may be eligible to enroll in Secure Horizons in your new location, unless you have ESRD. All individuals will need to sign and complete a new enrollment form for submission to HCFA in their new state.** Plan Premiums, Copayments and Covered Services will vary from one area to another. Please contact Secure Horizons Member Service at 1-800-228-2144, (TDHI) 1-800-685-9355 for information and assistance in completing any necessary paperwork.

Voluntary Disenrollment

You may choose to end your membership in Secure Horizons for any reason. Write a letter or complete a Disenrollment form and send it to the Secure Horizons Member Service department. We must have your signature on the letter you write or the Disenrollment form in order to process your Disenrollment request. We will send you a copy of your written request to Disenroll.

The date of your Disenrollment will be effective the first day of the month following the month we receive your written request to Disenroll. Secure Horizons will send

you a letter confirming your Disenrollment date once we receive approval from HCFA.

You may also Disenroll through any Social Security office or Railroad Retirement Board office.

Even though you have requested Disenrollment, you must continue to receive all Covered Services from Secure Horizons Contracting Medical Providers until the date your Disenrollment is effective.

You will be covered by Original Medicare after you Disenroll from Secure Horizons, unless you have joined another Medicare + Choice Coordinated Care Plan.

Involuntary Disenrollment

Secure Horizons may Disenroll you only under the conditions listed below. You will not be Disenrolled due to your health status.

1. If you move permanently out of the Service Area and do not voluntarily Disenroll❶;
2. If your entitlement to Medicare Part A or enrollment in Part B benefits ends;
3. If you supply fraudulent information or misrepresentation on your individual election form which materially affects your eligibility to enroll in Secure Horizons❶❷;
4. If you are disruptive,unruly, abusive or uncooperative to the extent that your membership in Secure Horizons seriously impairs our ability to arrange Covered Services for you or other individuals enrolled in the plan. Involuntary Disenrollment on this basis is subject to prior approval by HCFA❶;
5. You allow another person to use your SecureHorizons membership card to obtain Covered Service❶❷;
6. You fail to pay the Plan Premiums, subject to the 90-day grace period for late payment❶; or
7. The contract between Secure Horizons and HCFA under which Secure Horizons is offered is terminated,❸ or the Secure Horizons Service Area is reduced.❸

❶ Disenrollment on these grounds can only occur after you have been provided notice with an explanation of the reasons for the Disenrollment and information on Secure Horizons applicable grievance rights. HCFA must also be notified, if Disenrollment is due to reasons 3–5 above;

❷ Requires a referral to the Inspector General and may result in criminal prosecution;

❸ The contract with HCFA is renewed on an annual basis. At the end of each contract year, the contract can be ended by either Secure Horizons or Medicare. If Secure Horizons ends the contract, you will receive a minimum ninety (90) day notification before the end of the contract. If HCFA ends the contract you will receive a minimum thirty (30) day notification. We will explain what your options are at that time. For example, there may be other health plans in the area for you to join, if you wish. Or you may wish to return to Original Medicare and possibly obtain supplemental health insurance. Whether you

enroll in another Medicare + Choice Coordinated Care Plan or not, there would be no gap in Medicare coverage. Until returning to Original Medicare coverage or enrolling in another Medicare + Choice Coordinated Care Plan, you will still be a Member of Secure Horizons.

Until you are notified in writing of your Disenrollment, you are still considered a Secure Horizons Member and must continue to receive Covered Services from Contracting Medical Providers. Neither Secure Horizons nor Medicare will pay for services received from Non-Contracting Medical Providers, except for:

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

Note: If you are in a Hospital on your effective date of Disenrollment, Secure Horizons may be responsible for paying for Medicare covered acute hospital services until you are discharged in accordance with Medicare guidelines. If you are otherwise undergoing treatment for a medical condition, other than acute Hospital services, on the effective date of your Disenrollment, your coverage under Secure Horizons will end.

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 alleges he/she was Disenrolled by Secure Horizons because of the Member's health status or requirements for health care services may request a review by the California Commissioner of Corporations pursuant to California Health and Safety Code, Section 1365 or contact your HCFA Regional Office. In the event the Commissioner determines the Disenrollment or was contrary to Section 1365, the Member shall be reinstated retroactively to the date of the Disenrollment.

Section 9 – Secure Horizons Appeal and Grievance Procedures

As a Secure Horizons Member you are encouraged to let us know if you have concerns or experience any problems with Secure Horizons or your Health Plan. We have representatives available to help you with your questions and concerns.

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 for review and resolution. These procedures include:

- Medicare Standard Appeals Procedure
- Medicare Expedited/72-Hour Determinations and Appeals Procedure
- Secure Horizons Grievance Procedure
- Peer Review Organization (PRO) Immediate Review of Hospital Discharges
- PRO Quality of Care Complaint Procedure
- Review by the Department of Managed Care

Secure Horizons will review your Grievance or Appeal and if the Grievance or Appeal 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.

Secure Horizons Appeals Procedure

As a Member of Secure Horizons, 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 (including Optional Supplemental Benefits) under your Medicare + Choice Plan. These include:

- Payment for Emergency Services, Post-Stabilization Care, or Urgently Needed Services;
- Payment for any other health services furnished by a Non-Contracting Medical Provider or Facility that you believe should have been arranged for, or reimbursed by Secure Horizons;
- Services you have not received, but that you believe are the responsibility of Secure Horizons to pay for or arrange; or
- Discontinuation of services that you believe are Medically Necessary Covered Services.

Use the Secure Horizons Grievance Procedure for complaints that are not denied claims or denied services (see "Secure Horizons Grievance Procedures" described below following "Secure Horizons Expedited/72-Hour Determination and Appeal Procedure"). If you have a question about which complaint process to use, please call Secure Horizons Member Service.

Secure Horizons 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 below:
   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 and/or the Health Care Financing Administration 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 will follow the instructions of any individual appointed by you in an advanced 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 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 request 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 FAX at the address and telephone number referenced below under the expedited/72-hour review procedure. (Please call Secure Horizons for additional information on the procedures for submitting evidence.)

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 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 Standard Appeals Procedure

Secure Horizons must make a determination (decision) on your request for payment or provision of services within the following time frames:

- Request for Service. If you request services or require Prior Authorization of a Referral, Secure Horizons 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 up to fourteen (14) calendar days after receiving your request for service. An extension up to fourteen (14) calendar days is permitted, if you request the extension or if Secure Horizons finds that additional information is needed and the extension of time benefits you; for example, if Secure Horizons needs additional medical records from Non-Contracting Medical Providers that could change a denial decision.
- Requests for Payment. If you request payment for services already received, Secure Horizons 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 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. 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 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 Appeals Department at P.O. Box 489, Cypress, California 90630. You may also request a reconsideration through the Social Security office (or, if you are a railroad retirement beneficiary, through a Railroad Retirement Board Office). You must submit your written request within sixty (60) calendar days [if applicable insert longer time period required by State law] 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 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 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 may extend this time frame by up to fourteen (14) calendar days if you request the extension or if Secure Horizons finds that additional information is needed and the extension of time benefits you; for example, if Secure Horizons

needs additional medical records from Non-Contracting Medical Providers that could change a denial decision.

- Request for Payment. If the Appeal is for a denied claim, Secure Horizons must notify you of the reconsideration determination no later than sixty (60) days after receiving your request for a reconsideration determination.

Secure Horizons reconsideration decision will be made by a person(s) not involved in the initial decision. 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 decides to reverse the original adverse decision, we will authorize your service as expeditiously as your health requires, but no later than thirty (30) calendar days of your request for an Appeal; or we will pay your claim within sixty (60) calendar days of your request for an Appeal.
2. If Secure Horizons decides to uphold the original adverse decision, either in whole or in part, 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 HCFA's independent contractor for Appeal reviews involving Medicare + Choice managed care plans, like Secure Horizons. 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 decision or issue a new decision.
3. For cases submitted to The Center for review, The Center will make a reconsideration decision and notify you in writing of their decision and the reasons for the decision. If The Center (or a higher appeal level) reverses Secure Horizons' decision, we will pay your claim or authorize your service as expeditiously as your health requires but not later than sixty (60) calendar days of receiving The Center's decision. If The Center maintains Secure Horizons' decision, their notice will inform you of your right to a hearing before an administrative law judge of the Social Security Administration.

If The Center does not rule fully in your favor, there are further levels of appeal:

4. You may request a hearing before an administrative law (ALJ) by submitting a written request with Secure Horizons, HCFA or the Social Security Administration within sixty (60) days of the date of The Center's notice of an unfavorable reconsideration decision. 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 hearing office. Secure Horizons will also be made a party to the appeal at the ALJ level.

5. If the administrative law judge's decision is adverse, either you or Secure Horizons may request a review by the Departmental Appeals Board of the Social Security Administration, which may either review the decision or decline review.
6. If the amount involved is $1,000 or more, either you or Secure Horizons may request that a decision made by the Departmental Appeals Board (DAB) or the administrative law judge, if the DAB has declined review, be reviewed by a Federal district court.
7. Any initial or reconsidered decision made by Secure Horizons, The Center, the administrative law judge or the Departmental Appeals Board can be reopened (a) within twelve months, (b) within four (4) years for just cause, or (c) at any time for clerical correction or in cases of fraud.
8. The reconsidered determination is final and binding upon Secure Horizons. The binding arbitration clause in your individual election form does not apply to disputes subject to HCFA's Appeals process.

Medicare 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 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 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 or IPA 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. If Secure Horizons decides that it is a Time-Sensitive situation or if any physician states that it is one, Secure Horizons will make a decision on your request for a service on an expedited/72-hour basis (subject to extension as discussed below).
2. Expedited Appeals. If you want to request a reconsideration (Appeal) of a decision by Secure Horizons 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 (Appeal) 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 decides that it is a Time-Sensitive situation or if any physician states that it is one, Secure Horizons will make a decision on your Appeal on an expedited/72-hour 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 received a denial of a service you requested;
- 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.

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. Be sure to ask for an expedited/72-hour review when you make your request.

Call: 1-888-277-4232 (Toll Free)
Business Hours:
Monday through Friday,
8:00 a.m. - 5:00 p.m.
Secure Horizons will document your request in writing.

(TDHI) 1-800-685-9355
Business Hours:
Monday through Friday,
8:00 a.m. - 5:00 p.m.
Secure Horizons will document your request in writing.

Write: Expedited 72-Hour Review Unit, Secure Horizons Appeals Department
P.O. Box 489, Mail Stop CY22-294, Cypress, CA 90630

Fax: 1-714-226-8898
Attention: Expedited 72-Hour Review Unit
Business Hours:
Monday through Friday,
8:00 a.m. - 5:00 p.m.

Walk-in: Secure Horizons Member Service Center
5701 Katella Avenue
Cypress, CA 90630
Business Hours:
Monday through Friday,
8:00 a.m. - 5:00 p.m.

How Your Expedited/72-Hour Review Request Will Be Processed

1. Upon receiving your reconsideration request, Secure Horizons 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 two (2) working days of the phone call. If you disagree with Secure Horizons decision to process your request within the standard time

frame, you may file a Grievance with Secure Horizons. 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 two (2) working 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 with additional information or if Secure Horizons needs to have additional diagnostic testing completed.

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 or health or your ability to regain maximum function.

- If a Non-Contracting Medical Provider supports your request, Secure Horizons will have seventy-two (72) hours from the time all the necessary medical information is received from that Provider to make a decision.

3. Secure Horizons will make a decision on your Appeal and notify you of it within 72-hours of receipt of your request. If Secure Horizons decides to uphold the original adverse decision, either in whole or in part, the entire file will be forwarded by Secure Horizons 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.

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.
- 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/ appeal, 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 at 1-800-228-2144, (TDHI) 1-800-685-9355.

Secure Horizons Grievance Procedures

As a Secure Horizons 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 (see Section 8);
- If you disagree with Secure Horizons 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 decision to process your Appeal request under the standard 30 day time frame rather than the expedited/72 hour time frame.

Secure Horizons 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 the Secure Horizons Appeals Department. Secure Horizons will write you to let you know how we have resolved your Grievance 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 will review the Grievance on an expedited basis and notify you in writing of the resolution of the Grievance within no later than five (5) calendar days of receiving your Grievance. In some instances Secure Horizons will need additional time to address your concern. If additional time is needed, Secure Horizons will keep you informed regarding the status of your Grievance. Confidentiality of all parties will be observed. We are required to track all appeals and grievances in order to report cumulative data to HCFA, and to our Members, upon request, beginning in early calendar year 2000.

The Secure Horizons Grievance Procedure is as follows:

1. You may notify Secure Horizons of your concern or submit a complaint to Secure Horizons 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,** or write a letter to the Secure Horizons Appeals Department at P.O. Box 489, Cypress, California 90630, or request a complaint form from the Secure Horizons Member Service Department or a Secure Horizons Contracting Medical Group or IPA and submit the completed complaint form to the Member Service Department. Your concern or complaint is then directed to the Secure Horizons Appeals Department for investigation.

2. An Appeals Coordinator will conduct an investigation of your complaint and forward your complaint to the appropriate Secure Horizons department within five (5) working days of receipt. If the complaint is received by telephone and the person taking the call is unable to resolve your problem, the Appeals Coordinator may request that you submit your complaint in writing and will assist you in writing down the complaint if you request. The Appeals Department will send you a letter acknowledging receipt of your complaint and explaining the Secure Horizons Grievance procedure within three (3) working days of receipt of your complaint. You may contact the Appeals Department at any time if you have any questions about the status of your complaint or the Secure Horizons Grievance procedure.

Complaints Involving Quality of Medical Care Issues

Complaints that involve quality of medical care issue(s) are directed to a clinical reviewer in the Secure Horizons Appeals Department for investigation and review. The clinical reviewer will investigate your complaint and send you a written response regarding the disposition or pending status of 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 clinical reviewer will request and review the relevant medical records and may request further information from your primary Contracting Medical Group/IPA or contracting physician or other contracting provider, as appropriate. The clinical reviewer will consult with a Secure Horizons Medical Director or his or her designee, if necessary. If a quality of care issue is identified, the clinical reviewer and the Secure Horizons Medical Director will take appropriate action or recommend a review by the PacifiCare/Secure Horizons Regional Peer Review Committee or refer the complaint to a Secure Horizons Medical Director for recommendation of appropriate action against the primary Contracting Medical Group/IPA, contracting physician or other provider involved.

If you are dissatisfied with the written response following the Quality Assurance Review, you may request an

additional review by the Secure Horizons Quality Improvement Committee. You must request the review by the Quality Improvement Committee within thirty (30) days of receiving the written response from the Clinical Review Department, unless you have extenuating circumstances. The Quality Improvement Committee will review your complaint and notify you of the completion of the review within thirty (30) days whenever possible. If the Quality Improvement Committee is unable to complete its review within thirty (30) days, you will be so notified within the thirty (30) day period. Quality of care complaints are not subject to further review under the Grievance Procedure.

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 the Secure Horizons Appeals Department, in consultation with other Secure Horizons departments when appropriate. The Appeals Department will investigate your complaint and send you a written response regarding the disposition or pending status 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 the Appeals Department is unable to complete its review within thirty (30) calendar days, you will be so notified within the thirty (30) day period.

If you are dissatisfied with the written response of the Appeals Department, you may request a hearing before the Member Satisfaction Committee. You must request the hearing within thirty (30) days of receiving the written response from the Appeals Department, unless you have extenuating circumstances. A hearing before the Member Satisfaction Committee will be scheduled within thirty (30) days or Secure Horizons' receipt of your request for a hearing. You will be notified of the hearing date and are encouraged to attend the hearing either in person or by teleconference.

If you are dissatisfied with the resolution of the complaint by the Member Satisfaction Committee, you may request within thirty (30) days a review by a Secure Horizons executive officer. The Secure Horizons executive officer will review the complaint and send you written notice of the decision within thirty (30) days of receiving the request for the review.

If you are still dissatisfied following the review by the Secure Horizons executive officer, you may request that Secure Horizons submit the complaint to binding arbitration before a commercial arbitration association designated by Secure Horizons. 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.

In cases of extreme hardship, Secure Horizons 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 does not receive a request for binding arbitration within sixty (60) days after your receipt of the decision of the Secure Horizons executive officer, the decision of the Secure Horizons executive officer 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. Further, if you seek review by the Department of Managed Care within sixty (60) days of receiving the Secure Horizons executive officer's decision, you will have an additional sixty (60) days from the date of the final resolution of the matter by the Department of Managed Care to elect binding arbitration.

Both you and Secure Horizons 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, 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.

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 must be appealed through the Secure Horizons Medicare Appeals Procedure (see above).

Peer Review Organization (PRO) Immediate Review of Hospital Discharges

If you are being discharged from the Hospital, you will receive a written notice of explanation called a "Notice of Discharge and Medicare Appeal Rights." Either Secure Horizons or the Hospital is required to issue this notice. 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 first workday after you receive the Notice of Coverage and Appeal Rights. 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 Notice of Discharge and Medicare Appeal Rights that you receive from Secure Horizons stating that it will no longer pay for your Hospital care. 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). The phone number and address of the PRO for your area is:

California Medical Review, Incorporated at Citicorp Center, One Sansom 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 standard Appeals process that is described in this Evidence of Coverage and Disclosure Information in Section 9. Instead of PRO review you may appeal Secure Horizons Notice of Discharge and Medicare Appeal Rights within 60 days of the Notice by requesting that Secure Horizons reconsider its decision. The advantage of the PRO review is that you will get the results within three 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.

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 section above.)

Review by the Department of Managed Care

The California Department of Managed Care is responsible for regulating health care service plans. The department has a toll-free telephone number (1-800-400-0815) to receive complaints regarding health plans. The hearing and speech impaired may use the California Relay Service's toll-free telephone numbers (1-800-735-2929 (TTY) or 1-800-877-5378 (TTY)) to contact the department. The department's Internet website (http://www.dmc.ca.gov) has complaint forms and instructions online. If you have a grievance against your health plan, you should first telephone your plan at (1-800-228-2144, TDHI: 1-800-685-9355) 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 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.

You or your appointed representative (including a Provider) may submit a complaint to the DMC only after you have either completed or participated in the Secure Horizons Grievance and Appeals Procedure for at least sixty (60) days. However, you may immediately file a complaint with the DMC if your complaint involves an imminent and serious threat to your health, including, but not limited to, potential loss of life, limb, or major bodily function, if Secure Horizons has not resolved your complaint within sixty (60) days of filing.

You or a person acting on your behalf may also request voluntary mediation with Secure Horizons with respect to a complaint, other than an Appeal subject to the Secure Horizons (Medicare) Appeal Procedure prior to exercising the right to submit a complaint to the DMC. In order to initiate mediation, you and Secure Horizons must voluntarily agree to mediation. Expenses for any mediation will be borne equally by you and Secure Horizons.

Conference Regarding Denial of Experimental or Investigational Treatment for Terminal Illness

If Secure Horizons or your Contracting Medical Group or IPA denies coverage or authorization for a treatment or services deemed Experimental or Investigational (as defined below) for a terminal illness, as recommended by a Contracting Medical Provider, Secure Horizons will provide you within five (5) business days of the denial all of the following information: (i) a statement of the specific medical and scientific reasons for the denial; (ii) a description of any alternative treatment covered by Secure Horizons; and (iii) a copy of the applicable Secure Horizons Grievance and Appeals Procedure and/or Secure Horizons Complaint Form explaining the opportunity to request a conference with Secure Horizons to review the denial. Within thirty (30) calendar days of receipt of your request for a conference, Secure Horizons will hold a conference which you may attend to review the denial and the basis for determining that the proposed treatment is experimental. The conference will be held within five (5) business days if the treating Contracting Medical Provider determines, in consultation with a Secure Horizons Medical Director, that the effectiveness of either the proposed treatment or any alternative treatment covered by Secure Horizons would be materially reduced if not provided at the earliest possible date.

Any drug, device, treatment or procedure shall be deemed Experimental or Investigational if, as determined solely by a Secure Horizons Medical Director or his or her designee based upon criteria established by Secure Horizons' Technology Assessment Committee, any one or more of the following criteria are met:

- It cannot be lawfully marketed without the approval of the United States Food and Drug Administration (FDA) and such approval has not been granted at the time of its use or proposed use;

- It is the subject of a current investigational new-drug or new-device application on file with the FDA;
- It is being provided pursuant to a Phase I or Phase II clinical trial or as the experimental or research arm of the Phase III clinical trial, as these Phases are defined in regulations and other official actions and publications issued by the FDA and the Department of Health and Human Services (HHS);
- It is being provided pursuant to a written protocol which describes among its objectives determinations of safety and/or efficacy as compared with the standard means of treatment;
- It is being delivered or should be delivered subject to the approval and supervision of an Institutional Review Board (IRB) as required and defined by federal regulations and other official actions and publications issued by the FDA and the HHS;
- The predominant opinion among experts as expressed in the published authoritative literature is that usage should be substantially confined to research settings;
- The predominant opinion among experts as expressed in the published authoritative literature is that further research is necessary in order to define safety, toxicity, effectiveness or effectiveness compared with conventional alternatives; or
- It is not Investigational or Experimental in itself pursuant to the above, and would not be Medically Necessary, but for the provision of a drug, device, treatment or procedure which is Investigational or Experimental.
- The exclusive sources of information to be relied upon by Secure Horizons in determining whether a particular treatment is Experimental or Investigational, and therefore not a covered benefit under this Evidence of Coverage, are limited to the following:
  - The Member's medical records;
  - The protocol(s) pursuant to which the drug, device, treatment or procedure is to be delivered;
  - Any consent document the Member, or his or her representative, has executed or will be asked to execute, in order to receive the drug, device, treatment or procedure;
  - The published authoritative medical or scientific literature regarding the drug, device, treatment or procedure at issue as applied to the Medical Condition at issue;
  - Opinions of other agency review organizations/ review organizations, e.g., ECRI Health Technology Assessment Information Service, HAYES New Technology Summaries or AHCPR (Agency for Health Care Policy and Research);
  - Expert medical opinion;
  - Regulations and other official actions and publications issued by the FDA and HHS.

Section 10 – Advance Directives: Making Your Health Care Wishes Known

Secure Horizons is required by law to inform you of your 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.

There may be several types of advance directives you can choose from, depending on state law. Most states recognize:

1. DPAHC (Durable Power of Attorney for Health Care);
2. Living Wills; and
3. Natural Death Act Declarations.

It is necessary that you provide copies of your completed directive to:

1. Your Primary Care Physician;
2. Your agent; and
3. Your family.

Be sure to keep a copy with you and take a copy to the Hospital when you are hospitalized for medical care.

You are not required to initiate an advance directive, and you will not be denied care if you do not have an advance directive.

If you believe your Provider has not complied with your Advanced Directive, you may file a complaint with the Department of Health Services.

The following questions and answers explain your rights to make health care decisions and how you can plan what should be done when you can't speak for yourself. We hope this information will help increase your control over your medical treatment.

Q. Who decides about my treatment?

A. Your doctors will give you information and advice about treatment. You have the right to choose. You can say "Yes" to treatment you want. You can say "No" to any treatment you don't want – even if the treatments might keep you alive longer.

Q. How do I know what I want?

A. Your doctor must tell you about your medical condition and about what different treatments have "side effects." Your doctors must offer you information about serious problems that medical treatment is likely to cause you.

Often, more than one treatment might help you – and people have different ideas about which is best. Your doctors can tell you which treatments are available to you, but your doctor can't choose for you. That choice depends on what is important to you.

Q. What if I'm too sick to decide?

A. If you can't make treatment decisions, your doctor will ask your closest available relative

or friend to help decide what is best for you. Most of the time, that works. But sometimes everyone doesn't agree about what to do. That's why it is helpful if you say in advance what you want to happen if you can't speak for yourself. There are several kinds of "advance directives" that you can use to say what you want and who you want to speak for you.

One kind of advance directive under California law lets you name someone to make health care decisions when you can't. This form is called a DURABLE POWER OF ATTORNEY FOR HEALTH CARE.

Q. Who can fill out this form?

A. You can if you are 18 years or older and of sound mind. You do not need a lawyer to fill it out.

Q. Who can I name to make medical treatment decisions when I'm unable to do so?

A. You can choose an adult relative or friend you trust as your "agent" to speak for you when you're too sick to make your own decisions.

Q. How does this person know what I would want?

A. After you choose someone, talk to that person about what you want. You can also write down in the DURABLE POWER OF ATTORNEY FOR HEALTH CARE when you would or wouldn't want medical treatment. Talk to your doctor about what you want and give your doctor a copy of the form. Give another copy to the person named as your agent. And take a copy with you when you go into a hospital or other treatment facility.

Sometimes treatment decisions are hard to make and it truly helps your family and doctors if they know what you want. The DURABLE POWER OF ATTORNEY FOR HEALTH CARE also gives them legal protection when they follow your wishes.

Q. What if I don't have anybody to make decisions for me?

A. You can use another kind of advance directive to write down your wishes about treatment. This is often called a "living will" because it takes effect while you are still alive but have become unable to speak for yourself. The California Natural Death Act lets you sign a living will called a DECLARATION. Anyone 18 years or older and of sound mind can sign one.

When you sign a DECLARATION it tells your doctors that you don't want any treatment that would only prolong your dying. All life-sustaining treatment would be stopped if you were terminally ill and your death was expected soon, or if you were permanently unconscious. You would still receive treatment to keep you comfortable, however.

The doctors must follow your wishes about limiting treatment or turn your care over to another doctor who will. Your

doctors are also legally protected when they follow your wishes.

Q. Are there other living wills I can use?

A. Instead of using the DECLARATION in the Natural Death Act, you can use any of the available living will forms. You can use a DURABLE POWER OF ATTORNEY FOR HEALTH CARE form without naming an agent. Or you can just write down your wishes on a piece of paper. Your doctors and family can use what you write in deciding about your treatment. But living wills that don't meet the requirements of the Natural Death Act don't give as much legal protection for your doctors if a disagreement arises about following your wishes.

Q. What if I change my mind?

A. You can change or revoke any of these documents at any time as long as you can communicate your wishes.

Q. Do I have to fill out one of these forms?

A. No, you don't have to fill out any of these forms if you don't want to. You can just talk with your doctors and ask them to write down what you've said in your medical chart. And you can talk with your family. But people will be more clear about your treatment wishes if you write them down. And your wishes are more likely to be followed if you write them down.

Q. Will I still be treated if I don't fill out these forms?

A. Absolutely. You will still get medical treatment. We just want you to know that, if you become too sick to make decisions, someone else will have to make them for you.

REMEMBER THAT A DURABLE POWER OF ATTORNEY FOR HEALTH CARE lets you name someone to make treatment decisions for you. That person can make most medical decisions – not just those about life-sustaining treatment – when you can't speak for yourself. Besides naming an agent, you can also use the form to say when you would and wouldn't want particular kinds of treatment. If you don't have someone you want to name to make decisions when you can't, you can sign a NATURAL DEATH ACT DECLARATION. This DECLARATION says that you do not want life-prolonging treatment if you are terminally ill or permanently unconscious.

Q. What is Secure Horizons' policy regarding advance directives?

A. As a member of Secure Horizons, you share our interest in preventive care and maintaining good health. Eventually, however, every family may face the possibility of serious illness in which important decisions must be made. We believe it is never too early to think about decisions that may be very important in the future, and to discuss these topics with family, friends and other interested people.

Secure Horizons has formal policies to ensure that your advance directive wishes will be respected. It is important to remember that not all treatment may be covered by your health benefit plan and you should always refer to your Comparison of Benefits to determine whether or not coverage is available.

Secure Horizons complies with California laws and court decisions on advance directives. We do not require any member to execute an advance directive. If you choose to complete an advance directive, it is your responsibility to provide a copy to your physician and to bring a copy with you when you check into a hospital or other health facility so that it can be kept with your medical records.

Q. How can I get more information about advance directives?

A. Simply call the Secure Horizons Member Service department at 1-800-228-2144 from 7:00 a.m. to 7:00 p.m. weekdays to request a list of community resources regarding advance directives.

The California Consortium on Patient self-determination prepared the preceding text, which has been adopted by the California Department of Health Services to implement Public Law 101-508.

Section 11 – Coordinating Other Benefits You May Have

Who Pays First?

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 plan prior to using your Secure Horizons 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 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 ESRD.

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 have (or develop) 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 ESRD. Medicare is the primary payer after this coordination period. (However, if your employer group plan coverage was secondary to Medicare when you developed ESRD because it was not based on current employment as described above, Medicare continues to be the primary payer.)

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 providing the information we request promptly.

Coordination of benefits protects you from higher Plan Premiums. The end result is more affordable health care.

Section 12 – Confidentiality and Release of Information

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. Unauthorized individuals cannot gain access to or alter your records.

Section 13 – Adding Optional Supplemental Benefits

Based on where you live, Secure Horizons may offer a High Option plan which provides additional dental benefits for an added monthly plan premium.

Secure Horizons High Option Dental Plan

Secure Horizons will have an Enrollment Period for the High Option Dental Plan from November through January of each calendar year. During this time – and only during this time – you may elect to enroll in the High Option Dental Plan by completing a change request form or a transfer form available through Member Services. New Members may elect to enroll in the High Option Dental Plan at the time of enrollment or within the first thirty (30) days of his/her effective date. If you choose to enroll in the High Option Dental Plan during the Enrollment Period or as a new Member, you can transfer back to the Standard Plan at any time but you may not re-enroll in a Secure Horizons High Option Plan until the next Enrollment Period.

Effective Date

Secure Horizons must receive your "Change Request Form" or "Transfer Form" no later than:

- December for a January effective date.
- January for a February effective date.

For more information regarding the Secure Horizons High Option Dental Plan premium and its availability in your Service Area, please refer to your Comparison of Benefits or contact Member Service Department at 1-800-228-2144, (TDHI) 1-800-685-9355. For new Members, who elect to enroll in the High Option Dental Plan, their effective date is the first day that their membership is effective with Secure Horizons.

Electing Optional Supplemental Benefits

To enroll in the Secure Horizons High Option Dental Plan you must submit a transfer form. Please call Secure Horizons Member Service at 1-800-228-2144, (TDHI) 1-800-685-9355 to obtain a transfer form.

Discontinuing Your Optional Supplemental Benefits

If you want to transfer from High Option Dental to Basic Dental, you must submit a transfer form. All transfer requests from the High Option Dental Plan to the Basic Dental Plan received by the sixth (6th) of the month will be effective the first (1st) day of the following month. Members will be responsible for their monthly plan premium payment if transfer request is received after the 6th of the month. Please call Secure Horizons Member Service at at 1-800-228-2144, (TDHI) 1-800-685-9355. Non-payment of Plan Premiums for Optional Supplemental Benefits will result in loss of your Optional Supplemental Benefits after a 90-day grace period and may result in your return to the standard plan. Should you decide later to re-enroll in Secure Horizons, you must pay any Plan Premiums, due from your previous Enrollment in the Plan.

Optional Supplemental Benefits are subject to the same Appeals process as any other benefits.

Section 14 – General Provisions

Governing Law

This Evidence of Coverage 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 HCFA. Any provisions required to be in this Evidence of Coverage by any of the above acts and regulations shall bind Secure Horizons and you whether or not expressly provided in this document.

Your Financial Liability As a Secure Horizons Member

As a Member of Secure Horizons, you have the following financial obligations:

Secure Horizons Plan Premium
Secure Horizons may Disenroll you for failure to pay Plan Premiums (except for premiums which cover Optional Supplemental Benefits). However, prior to such action, Secure Horizons will:

(a) contact you within 20 days after the date when the delinquent charges are due

(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, or transfer to the Secure Horizons zero premium standard plan, if available, and

(d) give you a written notice of Disenrollment, including an explanation of your right to a hearing under Secure Horizons grievance procedures.

Increases in 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) must be approved by HCFA. You will receive written notice by October 15 of the year before changes that are not to your advantage 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 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.) For instructions on how to purchase Medicare Part A, see Section 7.

Medicare Part B Premium

As a Secure Horizons 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

All Copayments specified in the Schedule of Benefits must be paid to Contracting Medical Provider at the time of service.

Member Non-Liability

By statute, you are not responsible for any payments that Secure Horizons owes to, and fails to pay, a contracting provider. In the event the health plan fails to pay the provider, the Member shall not be liable to the 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 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 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 nor Medicare will pay for those services. In the event a Contracting Medical Provider's contract with Secure Horizons is terminated while you are under his/her/its care, Secure Horizons will pay for the continuation of related Covered Services as long as you retain eligibility, until the Covered Services are completed, unless Secure Horizons makes a reasonable and medically appropriate arrangement for those services to be provided by another Contracting Medical Provider. A Secure Horizons 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.

Third Party Liability

In the case of injuries caused by any act or omission of a third party, and any complications incident thereto, all Covered Services shall be furnished by Secure Horizons to you. However, you agree to fully reimburse Secure Horizons or its designee, to the extent of any monetary recovery, for the cost of all such services and benefits provided or paid, immediately upon obtaining a monetary recovery, whether due to settlement or judgment, as a result of such injuries.

You agree to cooperate in protecting the interests of Secure Horizons under this provision. You shall not settle any claim, or release any person from liability, without the written consent of Secure Horizons, wherein such release or settlement will extinguish or act as a bar to Secure Horizons, right of reimbursement.

Acts Beyond the Control of Secure Horizons

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 control), or any other emergency or similar event not within the control of Secure Horizons, Secure Horizons 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 shall attempt to arrange for Covered Services insofar as practical and according to our best judgment. Neither Secure Horizons nor any Contracting Medical Group or IPA 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 and its Contracting Medical Groups and IPAs and Contracting Hospitals are independent contractor relationships. None of the Contracting Medical Groups or IPAs or Contracting Hospital or their physicians or employees are employees or agents of Secure Horizons. An agent would be anyone authorized to act on Secure Horizons behalf. Neither Secure Horizons nor any employee of Secure Horizons is an employee or agent of any Contracting Medical Group, or IPA or Contracting Hospital or Contracting Medical Provider.

Secure Horizons Contracting Arrangements

In order to obtain quality service in an efficient manner, Secure Horizons pays its Contracting Medical Providers using various payment methods, including capitation, per diem, 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.

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 Department at 1-800-228-2144, (TDHI) 1-800-685-9355 and request information about our physician payment arrangements.

Physician-Patient Relationship

You are responsible for selecting a Contracting Medical Group or IPA. The physician-patient relationship between you and your Contracting Medical Group or IPA shall be maintained by the Contracting Medical Group or IPA. Secure Horizons is not a health care Provider.

Secure Horizons 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 Members through Contracting Medical Providers, Contracting Medical Groups and IPAs, Contracting Hospitals, and Contracting Pharmacies. For a complete list of contracting Providers, please refer to the Secure Horizons Provider Directory. If you have any questions regarding contracting Providers listed in the directory or to request a directory, please contact Secure Horizons Member Services Department, 1-800-228-2144, (TDHI) 1-800-685-9355 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 Provider Directory or your Secure Horizons membership card.

Notices

Any notice required to be given under this Evidence of Coverage 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:
Secure Horizons
Attn: Member Service
P.O. Box 489
Cypress, CA 90630-0489

If to you, to your last address known to Secure Horizons.

How Secure Horizons Contracting Providers Are Compensated

The following is a brief description of how Secure Horizons pays its contracting providers:

Secure Horizons typically contracts with medical groups and IPAs to provide medical services and with hospitals to provide hospital services to members. The Contracting Medical Groups and IPAs, in turn, employ or contract with individual physicians.

Most of our Contracting Medical Groups and IPAs receive an agreed upon

monthly payment from Secure Horizons 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. The monthly payment typically covers professional services directly provided by the Contracting Medical Group or IPA, and may also cover certain referral services. Some of Secure Horizons' contracting hospitals receive similar monthly payments in return for arranging hospital services for Members. Other hospitals are paid on a discounted fee-for-service or fixed charge per day of hospitalization.

At the beginning of each year, Secure Horizons and each Contracting Medical Group or IPA agree on a budget for the cost of services covered under the program for all Secure Horizons Members treated by the 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 or IPA 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, IPAs, and hospitals from large financial losses and ensure providers have resources to cover necessary treatment. Secure Horizons provides stop-loss protection to our Contracting Medical Groups, IPAs, and hospitals that receive capitation payments. If any capitated providers do not obtain stop-loss protection from Secure Horizons, they must obtain stop-loss insurance from an insurance carrier acceptable to Secure Horizons. You may obtain additional information on compensation arrangements by contacting Secure Horizons Member Service Department at 1-800-228-2144, (TDHI) 1-800-685-9355 or your Contracting Medical Group or IPA.

In addition, the Health Care Financing Administration (HCFA) requires this health plan to conduct a Member Satisfaction Survey, providing beneficiary requesters 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 our Member Services Department at 1-800-228-2144, (TDHI) 1-800-685-9355.

Additional Information

Technology Assessment

Secure Horizons regularly reviews new procedures, devices and drugs to determine whether or not they are safe and effective for Members. The Technology Assessment Committee, consisting of staff experts, Contracting Primary Care Physicians, pharmacists and Specialists, conducts careful reviews of case studies, clinical literature, and Medicare and Federal Drug Administration decisions. If the proven benefits of a new treatment outweigh the risks, the new treatment is added to the Member's benefits and coverage is adjusted accordingly.

Public Policy Participation

PacifiCare/Secure Horizons 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 are

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 Secure Horizon's Member Service department.

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

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 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 & 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 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 Member, you have the right to request information on the following:

- General coverage and comparative plan information
- Utilization control procedures
- Statistical data on Grievances and Appeals
- The financial condition of PacifiCare/Secure Horizons.

Please contact Secure Horizons Member Service at 1-800-228-2144, (TDHI) 1-800-685-9355.

You may write to PacifiCare's Corporate Offices at: 3120 Lake Center Drive Santa Ana, CA 92704

Section 15 – Secure Horizons Service Area

You are eligible for enrollment and continued coverage as long as you reside in the area listed below:

Counties (subject to change)

Alameda, Butte, Contra Costa, Fresno, Kern,* Los Angeles,** Marin, Napa, Orange, Sacramento, San Francisco, San Joaquin, San Mateo, Santa Barbara, Santa Clara, Santa Cruz, Solano, Sonoma, Stanislaus, Ventura

* excluding 93527, Inyokern, 93528 and 93558, Johannesburg, 93554, Randsburg, and 93555 and 93556, Ridgecrest

** excluding 90704, Avalon, Catalina Island

You are also eligible for enrollment and continued coverage as long as you reside in one of the following zip codes in the counties listed below:

County: El Dorado

95614	95619	95623
95633	95634	95635
95636	95643	95651
95664	95667	95672
95682	95684	95709
95720	95726	95762

County: Imperial

92257	92274	92275

County: Madera

00020	93601	93604
93610	93614	93637
93638	93639	93643
93644	93645	93653
93669		

County: Placer

95602	95603	95604
95626	95631	95648
95650	95658	95661
95663	95668	95677
95678	95681	95703
95713	95717	95722
95736	95746	95747
95765		

County: Riverside

91718	91719	91720
91752	91760	92201
92202	92203	92210
92211	92220	92223
92230	92234	92235
92236	92239	92240
92241	92253	92254
92255	92258	92260
92261	92262	92263
92264	92270	92274
92276	92282	92292
92313	92320	92330
92337	92343	92344
92355	92360	92362
92367	92370	92380
92383	92387	92388
92390	92395	92396
92500	92501	92502
92503	92504	92505
92506	92507	92508
92509	92513	92514
92515	92516	92517
92518	92519	92521
92530	92531	92532
92536	92539	92543
92544	92545	92546
92548	92549	92551
92552	92553	92554
92555	92556	92557
92561	92562	92563
92564	92567	92570
92571	92572	92581
92582	92583	92584
92585	92586	92587
92589	92590	92591
92592	92593	92595
92596	92878	92880
92881	92883	95829
95867		

County: San Bernardino

91701	91708	91709
91710	91729	91730
91737	91739	91743
91758	91761	91762
91763	91764	91784
91785	91786	91798
92252	92256	92284
92285	92286	92301
92305	92307	92308
92309	92310	92311
92312	92313	92316
92318	92323	92324
92327	92329	92334
92335	92336	92337
92338	92339	92340
92342	92345	92346
92347	92350	92354
92356	92357	92358
92359	92364	92365
92366	92368	92369
92371	92372	92373
92374	92375	92376
92377	92382	92392
92393	92394	92397
92398	92399	92400
92401	92402	92403
92404	92405	92406
92407	92408	92409
92410	92411	92412
92413	92423	92427

County: San Diego

91901	91902	91903
91905	91906	91908
91909	91910	91911
91912	91913	91914
91915	91916	91917
91921	91931	91932
91933	91934	91935
91941	91942	91943
91944	91945	91946
91947	91948	91950
91951	91962	91963
91976	91977	91978
91979	91980	92003
92007	92008	92009
92013	92014	92018
92019	92020	92021
92022	92023	92024
92025	92026	92027
92028	92029	92030
92033	92037	92038
92039	92040	92046
92049	92050	92051
92052	92054	92055
92056	92057	92058
92059	92060	92061
92064	92065	92066
92067	92068	92069
92070	92071	92072
92073	92074	92075
92078	92079	92082
92083	92084	92085
92086	92088	92091
92092	92093	92096
92100	92101	92102
92103	92104	92105
92106	92107	92108
92109	92110	92111
92112	92113	92114
92115	92116	92117
92118	92119	92120
92121	92122	92123
92124	92126	92127
92128	92129	92130
92131	92132	92133
92134	92135	92136
92137	92138	92139
92140	92142	92143
92145	92147	92149
92150	92152	92153
92154	92155	92159
92160	92162	92163
92164	92165	92166
92167	92168	92169
92170	92171	92172
92173	92174	92175
92176	92177	92178
92182	92186	92188
92189	92190	92191
92192	92193	92194
92195	92196	92197
92198	92199	

County: San Luis Obispo

00032	93401	93402
93403	93404	93405
93406	93407	93408
93409	93410	93412
93420	93421	93424
93428	93430	93433
93435	93442	93443
93444	93445	93448
93449	93452	93453
93483		

County: Tulare

93201	93207	93208
93218	93219	93221
93247	93256	93257
93258	93260	93261
93265	93267	93270
93272	93673	

SecureHorizons®

Offered by PacifiCare

More than our name, it's our goal.℠

Member Service
1-800-228-2144 or
TDHI 1-800-685-9355

Sales Information
1-800-385-5588 or
TDHI 1-800-387-1074

P.O. Box 489
Cypress, California 90630

Visit our web site at
www.securehorizons.com

SHC-99-181.0-F
RO/2/00

SHR4000
SH-600-19179
Version B