

**2002
University of California**

**Combined Evidence of Coverage
& Disclosure Form**



Your Health Care Benefits



HMO

1

I N T R O D U C I N G

PacifiCare's HMO Plan

PacifiCare® offers you and your family an exciting choice in health care coverage.

As a Member you'll enjoy a wide range of benefits at an affordable cost. You will receive those benefits without claim forms and without paying costly deductibles.

Just pay the Copayment as referenced on your *Schedule of Benefits*. Then relax.

We'll take care of the rest.

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

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

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

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

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Summary of 2001 Plan Changes

BENEFIT CHANGES EFFECTIVE JANUARY 1, 2002

Outpatient office visit Copayments will now be \$10.

Inpatient hospital Copayment will be \$250 per admission (both medical and behavioral health admits).

Emergency room Copayment will be \$50 unless admitted.

Outpatient prescription drug Copayment will be \$10 Generic, \$20 Brand Name and \$35 non-Formulary.

Outpatient prescription drugs through mail service will be \$20 Generic, \$40 Brand Name and \$70 non-Formulary.

Annual Copayment Maximum will now be \$1,000/Individual, \$3,000/Family

Mental Health Services for crisis intervention Copayment will now be \$10.

Hospice days will now be covered up to one calendar year per lifetime.

ELIGIBILITY – COVERING YOUR FAMILY MEMBERS

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

Subscriber

Employee: You are eligible if you are appointed to work at least 50% time for one year or more or are appointed at 100% time for three months or more or have accumulated 1,000 hours while on pay status in a 12 month period. A person appointed at least 50% time with the following notation on their appointment form is eligible: "Ending date is for funding purposes only; intent of employment is indefinite (for more than one year)."

To remain eligible, employees must maintain an average regular paid time of at least 17.5 hours a week and maintain an eligible appointment of at least 50% time.

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

These conditions apply:

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

Family Members

Your Legal Spouse: Adult Dependent Relative or same-gender Domestic Partner except if you are a Survivor Annuitant then you may not add your legal spouse.

Child: Any of your natural or legally adopted children who are unmarried and under age 23 (18 for legal wards).

The following children are also eligible:

- a. Any unmarried stepchildren under age 23, who reside with you, who are dependent on you or your spouse or same-gender Domestic Partner for at least 50% of their support and who are you, or your spouse's or same-gender Domestic Partner's Dependents for income tax purposes.
- b. Any unmarried grandchildren under age 23, who reside with you, who are Dependent upon you, your spouse or your same-gender Domestic for at least 50% of their support and who are your, your spouse's or same-gender Domestic Partner's Dependents for income tax purposes.
- c. Any unmarried children under age 18 for whom you are the legal guardian, who reside with you, who are dependent upon you for at least 50% of their support and who are your dependents for income tax purposes. Children under 18 years of age who are totally self supporting, are not eligible dependents (e.g. do not live with you).

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

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

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

Getting Started

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

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

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

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

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

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

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

Qualified Medical Child Support Orders

A person having legal custody of a child or a custodial parent who is not a PacifiCare member may ask about obtaining dependent coverage as required by a court or administrative order, including a Qualified Medical Child Support Order, by calling PacifiCare's Customer Service department at 1-800-624-8822 or 1-800-442-8833 (TDHI). A copy of the court or administrative order must be included with the enrollment application. Information including, but not limited to, the identification card, *Combined Evidence Of Coverage and Disclosure Form* or other available information including notice of termination will be provided to the custodial parent, caretaker and/or District Attorney. Coverage will begin on the first of the month following receipt by PacifiCare of an enrollment form with the court or administrative order attached.

ENROLLMENT

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

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

- a. For a new spouse, eligibility begins on the date of marriage. Survivor Annuitants may not add new spouses to their coverage.
- b. For a newborn child, eligibility begins on the child's date of birth.
- c. For newly adopted children, eligibility begins on the earlier of:
 - i. the date the Employee or Employee's spouse has the legal right to control the child's health care, or
 - ii. the date the child is placed in the Employee's physical custody.

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

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

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

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

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

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

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

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

- a. a maximum of 60 days prior to the date your Dependent is enrolled (either by receipt of their enrollment form by the local Accounting or Benefits Office or by electronic enrollment), or
- b. the date the Dependent became eligible.

Medicare Enrollment

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

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

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

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

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

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

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

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

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

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

Getting Started

WHEN DOES COVERAGE BEGIN?

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

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

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

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

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

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

CHOOSING A PHYSICIAN

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

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

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

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

REPRODUCTIVE HEALTH DISCLOSURE

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

that does not provide family planning benefits and these benefits have been purchased by your employer, please call Customer Service for assistance.

Selecting A Physician for Your Newborn

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

SCHEDULING APPOINTMENTS

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

FACILITIES – PROVIDER LOCATIONS

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

GEOGRAPHIC AREA ("SERVICE AREA")

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

REFERRALS TO SPECIALISTS

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

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

This referral may also be reviewed by the Participating Medical Group's Utilization Review Committee. For more information regarding the role of the Utilization

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Review Committee, please refer to the definition of Utilization Review Committee. A Utilization Review Committee meets on a regular basis as determined by membership needs, special requests or issues and the number of authorization or referral requests to be addressed. Decisions may be made outside of a formal committee meeting to assure a timely response to emergency or urgently needed requests.

STANDING REFERRALS TO SPECIALISTS

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

EXTENDED REFERRAL FOR COORDINATION OF CARE BY SPECIALIST

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

Group's Medical Director or a PacifiCare Medical Director, in consultation with your Primary Care Physician, the specialist, and you, if a treatment plan is considered necessary. After the extended specialty referral is made, the specialist will serve as the main coordinator of your care, subject to the approved treatment plan. You may request an extended specialty referral by asking your Primary Care Physician or specialist.

DIRECT ACCESS TO OB/GYN PHYSICIAN SERVICES

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

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

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

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

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

CONTINUITY OF CARE FOR TERMINATING PHYSICIANS

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

If you are receiving treatment for:

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

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

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

AUTHORIZATION, MODIFICATION AND DENIAL OF HEALTH CARE SERVICES

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

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

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

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

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

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

If the decision cannot be made within these timeframes because (i) PacifiCare or the Participating Medical Group is not in receipt of all of the information reasonably necessary and requested, or (ii) PacifiCare or the Participating Medical Group requires consultation by an expert reviewer, or (iii) PacifiCare or the Participating Medical Group has asked that an additional examination or test be performed upon the Member, provided the examination or test is reasonable and consistent with

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good medical practice, PacifiCare or the Participating Medical Group will notify the provider and the Member, in writing, that a decision cannot be made within the required timeframe. The notification will specify the information requested but not received or the additional examinations or tests required, and the anticipated date on which a decision may be rendered. Upon receipt of all information reasonably necessary and requested by PacifiCare or the Participating Medical Group, PacifiCare or the Participating Medical Group shall approve, modify, or deny the request for authorization within the timeframes specified above as applicable.

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

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

SECOND MEDICAL OPINIONS

A Member, or his or her treating participating health professional, may submit a request for a second medical opinion to the Participating Medical Group (or in some cases PacifiCare, therefore Member should consult his or her Primary Care Physician). Second medical opinions will be provided or authorized when medically appropriate including, but not limited to, the following: (i) the Member questions the reasonableness or necessity of recommended surgical procedures; (ii) the Member questions a diagnosis or plan for care for a condition, that threatens loss of life, loss of limb, loss of bodily functions, or substantial impairment, including but not limited to a chronic condition; (iii) the clinical indications are not clear or are complex and confusing, a diagnosis

is in doubt due to conflicting test results, or the treating provider is unable to diagnose the condition and the Member requests an additional diagnosis; (iv) the treatment plan in progress is not improving the medical condition of the Member within an appropriate period of time given the diagnosis and plan of care, and the Member requests a second opinion regarding the diagnosis or continuance of the treatment; or (v) the Member has attempted to follow the plan of care or consulted with the initial provider concerning serious concerns about the diagnosis or plan of care.

The request for a second medical opinion will be approved or denied by the Participating Medical Group (or a PacifiCare Medical Director as applicable) in a timely fashion appropriate for the nature of the Member's condition. When the Member's condition is such that the Member faces an imminent and serious threat to his or her health, including, but not limited to, the potential loss of life, limb, or other major bodily function, or lack of timeliness that would be detrimental to the Member's ability to regain maximum function, the second opinion shall be rendered in a timely fashion appropriate for the nature of the Member's condition, not to exceed 72 hours after the Participating Medical Group's (or PacifiCare's as applicable) receipt of the request, whenever possible. When the Member's condition does not create an imminent and serious threat to his or her health, the second opinion shall be rendered in a timely fashion appropriate for the nature of the Member's condition, not to exceed five (5) business days after receipt of the request by the Participating Medical Group or PacifiCare, as applicable. Second medical opinions will be rendered by an appropriately qualified health care professional. An appropriately qualified health care professional is a primary care physician or a specialist who is acting within his or her scope of practice and who possesses the clinical background related to the illness or condition associated with the request for a second medical opinion.

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

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

If a Member's request for a second medical opinion is denied, PacifiCare will notify the Member in writing of the reasons for the denial. The Member may appeal the denial by following the procedures outlined in the Appeals Process section of this *Combined Evidence of Coverage and Disclosure Form*. If the Member obtains a second medical opinion without prior authorization from his or her Participating Medical Group or PacifiCare, the Member will be financially responsible for the costs of such services.

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

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

ARRANGING HOSPITALIZATION

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

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

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

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

Using Emergency or Urgently Needed Services

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

EMERGENCY SERVICES

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

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

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

WHAT TO DO WHEN YOU REQUIRE EMERGENCY SERVICES

If you believe that you need Emergency Services you should:

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

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

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

URGENTLY NEEDED SERVICES

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

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

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

WHAT TO DO WHEN YOU REQUIRE URGENTLY NEEDED SERVICES

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

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

Identify yourself as a PacifiCare Member and ask to speak to a physician. If you are calling during non-business hours and a physician is not immediately available, ask to have the physician-on-call paged. A physician should call you back shortly.

Explain your situation and follow the instructions provided.

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

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

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

POST-STABILIZATION AND FOLLOW-UP CARE

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

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

RECEIVING MEDICAL CARE "AFTER HOURS"

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

NON-QUALIFYING SERVICES

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

Payment Responsibility

PREMIUMS (PREPAYMENT FEES)

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

COPAYMENTS

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

ANNUAL COPAYMENT MAXIMUM

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

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

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

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

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

WHAT IF I GET A BILL? (REIMBURSEMENT)

If for some reason you are billed for covered services, please call our Customer Service department at 1-800-624-8822, Monday through Friday, 8:00 a.m. to 8:00 p.m.

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

Bills From Participating Providers

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

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

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

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

Bills From Non-Participating Providers

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

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

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

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

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

unlikely event that PacifiCare would be unable to pay them on your behalf, for instance, in the case of PacifiCare's insolvency or natural disaster. However, if you receive properly authorized covered services from an non-participating provider, or Emergency or Urgently Needed Services from a non-participating provider, you may be responsible for the amount of those bills in the unlikely event that PacifiCare is financially unable to pay them on your behalf. In the event you receive a bill because a non-participating provider refused to accept payment from PacifiCare, you may submit a claim for reimbursement as described above.

MEMBER LIABILITY (CHOICE OF PHYSICIAN AND PROVIDERS)

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

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

General Information

COORDINATING BENEFITS

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

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

Duplication of Benefits with Medicare

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

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

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

Non-Duplication of Benefits With Workers' Compensation

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

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

Reimbursement of Third-Party Medical Expenses

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

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

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

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

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

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

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

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

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

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

EXTRAORDINARY CIRCUMSTANCES

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

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

CHANGES IN COVERAGE

Ending Coverage (Termination of Benefits)

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

Employee

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

Dependents

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

A Dependent's coverage stops on the last day of the month in which he/she is no longer eligible. For spouses, this means the last day of the month when the divorce, legal separation or annulment is final. You are required to complete a new enrollment form when a Dependent is no longer eligible. If your family member loses eligibility, you must complete the appropriate transaction to delete him or her within 60 days of the date the family member is no longer eligible.

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

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

General Information

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

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

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

Notifying You of Changes In Your Plan

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

Notifying Us of Any Change In Your Status

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

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

Renewal or Reinstatement

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

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

CONTINUING COVERAGE

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

Optional Continuation of Coverage

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

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

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

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

2. In the case of your Eligible Dependent spouse, your spouse may continue coverage for himself or herself and for any enrolled dependent children if your spouse's coverage would have ended because of any of the following Qualifying Events:
 - a. because your employment ended for a reason other than gross misconduct; or
 - b. because your work hours were reduced (including approved leave without pay or layoff); or

- c. at your death; or
- d. because you became entitled to Medicare benefits; or
- e. when your spouse ceased to be an Eligible Dependent as a result of divorce, legal separation, or annulment.

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

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

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

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

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

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

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

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

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

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

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

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- the person gives PacifiCare written notice of the disability within sixty (60) days after the determination of disability is made and within 18 months after the date employment ended or work hours were reduced.

PacifiCare must be notified if there is a final determination under the United States Social Security Act that the person is no longer disabled. The notice must be provided within thirty (30) days after the final determination. The coverage will end on the first of the month that starts more than thirty (30) days after the determination.

- With respect to Qualified Beneficiaries (other than yourself), the day 36 months from the earliest of the date: (1) of your death; or (2) of your entitlement to Medicare benefits; or (3) of your divorce, annulment, or legal separation from your spouse; or (4) your dependent child ceases to be an Eligible Dependent under the rules of the Plan. The 36 months will be counted from the date of the earliest Qualifying Event.

With respect to any Qualified Beneficiary:

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

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

- the date the individual turns 65;
- the date the University no longer maintains the group plan, including any replacement plan;
- the date the individual is covered by a group medical plan not maintained by the University;
- the date the individual becomes entitled to Medicare;
- with respect to the spouse or former spouse only, the date five years from the date COBRA ends for the spouse or former spouse.

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

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

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

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

Creditable Coverage

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

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

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

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

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

Certification of Creditable Coverage

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

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

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

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

Individual Conversion

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

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

General Information

TOTAL DISABILITY

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

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

HOW PACIFICARE PARTICIPATING PROVIDERS ARE COMPENSATED

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

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

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

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

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

PUBLIC POLICY PARTICIPATION

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

ASSESSMENT OF NEW TECHNOLOGY

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

RESPONDING TO YOUR CONCERNS

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

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

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

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

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

Appeals Process

1. PacifiCare's Health Services Department will conduct a review, and an initial determination including an explanation of the reasons for the determination will be sent to the Member within thirty (30) days of PacifiCare's receipt of the Member's appeal. For appeals involving the delay, denial or modification of health care services, PacifiCare's written response will describe the criteria or guidelines used and the clinical reasons for its decision, including all criteria and clinical reasons related to medical necessity. For determinations delaying, denying, or modifying health care services based on a finding that the services are not Covered Services, the response will specify the provisions in the plan contract that exclude that coverage. If the complaint is related to quality of care, the complaint will be reviewed through the procedure described in the section of
2. If the Member is dissatisfied after the determination by the Health Services Department, the Member may request a review by the Appeals and Grievance Committee by submitting a request within thirty (30) days of the receipt of the Health Services Department's determination. A hearing before the Appeals and Grievance Committee will be scheduled within thirty (30) days of the Member's request for a hearing. The Member's participation at the Appeals and Grievance Committee hearing is encouraged.
3. If the Member is dissatisfied with the redetermination, the Member may, within sixty (60) days, submit or request that PacifiCare submit the appeal to voluntary mediation or binding arbitration before Judicial Arbitration and Mediation Services, Inc. (JAMS).
 - i. Voluntary Mediation – In order to initiate mediation, the Member or the agent acting on behalf of the Member shall submit a written request for voluntary mediation. If the parties mutually agree to mediation, the mediation will be administered by JAMS in accordance with its JAMS Comprehensive Arbitration Rules and Procedures, unless otherwise agreed to by the parties. Expenses for mediation shall be borne equally by the parties. The Department of Managed Health Care shall have no administrative or enforcement responsibilities in connection with the voluntary mediation process.
 - ii. Binding Arbitration – With the exception of claims brought pursuant to the Plan's Quality Review Process, any claim, controversy dispute or disagreement between PacifiCare and Member which arises out of or is related to this Agreement that is not resolved by the above appeals and dispute resolution processes shall be resolved by binding arbitration by a single arbitrator. If the amount of the claim is less than \$200,000, then the arbitrator shall have no jurisdiction to award more than \$200,000. JAMS or such other neutral administrator as PacifiCare shall designate shall administer the arbitration. The JAMS Comprehensive Arbitration Rules and Procedures (Rules) in effect at the time demand for arbitration is made will be applied to the arbitration. The parties will endeavor to mutually agree to the appointment of the arbitrator, but if such agreement cannot be reached within thirty (30) days following the date demand for

General Information

arbitration is made, the arbitrator appointment procedures in the Rules will be utilized. Arbitration hearings shall be held at the neutral administrator's offices in Los Angeles, California or at such other location as the parties may agree in writing. Civil discovery may be taken in such arbitration as provided by California law and civil procedure. The arbitrator(s) selected shall have the power to control the timing, scope and manner of the taking of discovery and shall further have the same powers to enforce the parties' respective duties concerning discovery as would a Superior Court of California including, but not limited to, the imposition of sanctions. The arbitrator(s) shall have the power to grant all remedies provided by California law. The arbitrator(s) shall prepare in writing an award that includes the legal and factual reasons for the decision. The parties shall divide equally the fees and expenses of the arbitrator(s) and the neutral administrator except that in cases of extreme hardship, PacifiCare may assume all or part of a Member's share of the fees and expenses of the arbitrator(s) provided the Member has submitted a hardship application with JAMS or such other neutral administrator designated by PacifiCare. The approval or denial of a hardship application shall be determined by such administrator. The arbitrator(s) shall not have the power to commit errors of law or legal reasoning, and the award may be vacated or corrected pursuant to California law. The Federal Arbitration Act, 9 U.S.C. §§ 1-4, shall also apply to the arbitration.

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

Quality Management Review

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

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

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

Expedited Review

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

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

Experimental or Investigational Treatment

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

Independent Review of Denied Experimental or Investigational Treatment Eligibility Criteria

PacifiCare provides the opportunity to seek an independent review under California's Independent Medical Review System pursuant to Health & Safety Code Section 1370.4 of its coverage decisions regarding

Experimental or Investigational therapies for PacifiCare Members who meet all of the following criteria:

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

and

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

4. A PacifiCare Medical Director has denied the Member’s request for a treatment or therapy recommended or requested pursuant to paragraph (3); and
5. The treatment or therapy recommended pursuant to paragraph (3) would be a covered service, except for PacifiCare’s determination that the treatment, drug, device, procedure or other therapy is Experimental or Investigational.

How To Request an Independent Review

Within five business days of a decision to deny coverage for an Experimental or Investigational therapy for a Member who has a life-threatening or seriously debilitating condition, PacifiCare will send the Member written notice of the denial and of the right to request an independent review if the physician certification and evidence requirements listed in Items 2 & 3 above are met. The denial notice from PacifiCare will include an application form, along with a pre-addressed envelope, to be used to request an independent review from the Department of Managed Health Care (DMHC). PacifiCare also will include a physician certification form that must be completed by the Member’s physician for the Member to be eligible for an independent review

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

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

General Information

Independent Review Procedures

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

If the Member requests an independent review, PacifiCare will provide the following documents to the IRO designated by the DMHC within three (3) business days of PacifiCare's receipt of notification from the DMHC that a Member has applied for an independent review of PacifiCare's denial of Experimental or Investigational therapy: (a) the relevant medical records within PacifiCare's possession; (b) any other relevant documents or information used by PacifiCare in determining whether the proposed therapy should be covered and any statement by PacifiCare explaining the reasons for its decision to deny coverage for the proposed therapy; and (c) all information provided to the Member by PacifiCare and any of its contracting providers concerning PacifiCare and provider decisions regarding the Member's condition and care (including a copy of PacifiCare's denial notice to the Member), and any materials that the Member or the Member's physician submitted to PacifiCare in support of the request for coverage of the Experimental or Investigational therapy. If there is any information or evidence the Member or the Member's physician wish to submit to the DMHC in support of the independent review that has not previously been provided to PacifiCare, the Member may include this information with the Member's application to the DMHC for the independent review. Also, the Member's physician must provide to the DMHC or the IRO, as required, copies of any relevant medical records and any newly developed or discovered relevant medical records and respond to any requests for additional medical records or other relevant information from the experts on the panel performing the independent review.

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

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

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

If the proposed therapy has not been provided and the Member's provider or the DMHC certifies in writing that an imminent and serious threat to the health of the Member may exist, including, but not limited to, serious pain, the potential loss of life, limb or major bodily function, or the immediate and serious deterioration of the health of the Member, the analyses and recommendations of the experts must be expedited and rendered within three (3) days of the receipt of the Member's application and supporting information.

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

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

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

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

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

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

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

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

Coverage for the proposed therapy or treatment will be provided subject to the terms and conditions generally applicable to all other benefits under the Member's PacifiCare Health Plan

Members or Physicians who want additional information about California's independent review process for denied Experimental or Investigational therapy for Members with life-threatening or seriously debilitating conditions may request a copy of PacifiCare's information packet by calling PacifiCare's Customer Service department.

Independent Medical Review of Grievances Involving a Disputed Health Care Service

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

General Information

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

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

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

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

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

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

REVIEW BY DEPARTMENT OF MANAGED HEALTH CARE

The California Department of Managed Health Care is responsible for regulating health care service plans. The Department has a toll-free telephone number **(1-888-HMO-2219)** to receive complaints regarding health plans. The hearing and speech impaired may call the Department's direct toll-free telephone number **(1-877-688-9891 (TDD))** or the California Relay Service's toll-free telephone numbers **(1-800-735-2929 or 1-888-877-5378 TTY)**. The Department's facsimile number is 1-916-229-4328. The Department's Internet Web site (<http://www.hmohelp.ca.gov>) has complaint forms and instructions online. If you have a grievance against your health plan, you should first telephone your plan at **1-800-624-8822** or **1-800-442-8833 (TDHI)** and use the plan's grievance process before contacting the Department. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your plan, or a grievance that has remained unresolved for more than thirty (30) days, you may call the Department for assistance. The plan's grievance process and the Department's complaint review process are in addition to any other dispute resolution procedures that may be available to you, and your failure to use these processes does not preclude your use of any other remedy provided by law.

Complaints Against Participating Medical Groups, Providers, Physicians and Hospitals

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

YOUR RIGHTS UNDER THE PLAN

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

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

IMPORTANT INFORMATION ABOUT ORGAN AND TISSUE DONATIONS

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

Almost Anyone Can Be a Donor

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

Be Sure To Share Your Decision

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

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

How To Learn More

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

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

PLAN ADMINISTRATION

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

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

Sponsorship and Administration of the Plan

The University of California is the plan sponsor and administrator for the plan described in this brochure.

If you have a question, you may direct it to:

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

Annuitant may also direct questions to the University's Customer Service Center at the above phone number. Claims under the plan are processed by PacifiCare at the following address and phone number:

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

Type of Plan

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

Plan Year

The Plan year is January 1 through December 31.

Continuation of the Plan

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

Agent for Serving Legal Process

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

Non-Discrimination Statement

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

Please send inquiries regarding the University's affirmative action and equal opportunities policies for staff to Director Mattie Williams and for faculty to Executive Director, Sheila O'Rourke, both at this address: University of California Office of the President, 1111 Franklin Street, Oakland, CA 94607.

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

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

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

BENEFITS WHILE HOSPITALIZED AS AN INPATIENT

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

Alcohol, Drug or Other Substance Abuse or Addiction

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

\$250 per admit

Bone Marrow Transplants

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

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

Experimental or Investigational bone marrow transplants are not covered.

\$250 per admit

Hospice Care

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

\$250 per admit

Hospital Benefits (Acute Care)

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

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

\$250 per admit

Physician Care

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

Paid in Full

Medical Benefits

Rehabilitation Care (Subacute Care)

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

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

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

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

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

\$250 per admit

Mastectomy/Breast Reconstruction After Mastectomy and Complications from Mastectomy

Surgery to perform a Medically Necessary mastectomy and lymph node dissection is covered, including prosthetic devices or reconstructive surgery to restore and achieve symmetry for the Member incident to the mastectomy. The length of a hospital stay is determined by the attending physician and surgeon in consultation with the Member, consistent with sound clinical principles

and processes. Coverage includes any initial and subsequent reconstructive surgeries or prosthetic devices for the diseased breast on which the mastectomy was performed and for a healthy breast if, in the opinion of the attending physician and surgeon, this surgery is necessary to achieve normal symmetrical appearance. Medical treatment for any complications from a mastectomy, including lymphedema is covered.

\$250 per admit

Maternity Care

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

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

\$250 per admit

Newborn Care

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

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

Reconstructive Surgery

Inpatient Reconstructive Surgery is covered when performed to:

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

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

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

\$250 per admit

Skilled Nursing Care/Transitional Care

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

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

Paid in Full

Voluntary Interruption of Pregnancy

Refer to your *Schedule of Benefits* for coverage.

BENEFITS AVAILABLE ON AN OUTPATIENT BASIS

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

Alcohol, Drug or Other Substance Abuse or Addiction

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

\$10 Copayment

Allergy Testing

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

\$10 Copayment

Allergy Treatment

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

\$10 Copayment

Ambulance

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

Paid in Full

Medical Benefits

Attention Deficit Disorder

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

\$10 Copayment

Breast Cancer Screening, Diagnosis and Treatment

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

\$10 Copayment

Cochlear Implants

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

Paid in Full

Dental Treatment Anesthesia

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

- The Member is under seven (7) years of age; or

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

Paid in Full

Diabetes Management and Treatment

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

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

Blood glucose monitors; glucose monitors designed to assist the visually impaired; strips; lancets and lancet puncture devices; pen delivery systems (for the administration of insulin); insulin pumps and all related necessary supplies; ketone urine testing strips; insulin syringes; and podiatry services and devices to prevent or treat diabetes related complications. Visual aids are covered for Members determined to have a visual impairment that would prohibit proper dosing of insulin.

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

\$10 Copayment

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

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

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

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

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

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

Paid in Full

Eligible Materials and Supplies

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

Paid in Full

Family Planning

The following services are covered when authorized by Member's Primary Care Physician in Member's Participating Medical Group: vasectomy, tubal ligation, voluntary interruption of pregnancy through the first twenty weeks (voluntary interruption of pregnancy after the 20th week will be covered only when the mother's life is in jeopardy), insertion of intra-uterine device (IUD), insertion of Norplant and the Norplant device and injection of Depo-Provera. For applicable copayments see the *Schedule of Benefits* at the end of this brochure.

Health Education Services

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

Paid in Full

Hearing Screening

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

\$10 Copayment

Hemodialysis

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

\$10 Copayment

Medical Benefits

Home Care

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

Paid in Full

Hospice Care

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

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

Immunizations

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

\$10 Copayment

Infertility Services

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

50% of Cost Copayment

Laboratory and Radiology

Diagnostic and therapeutic laboratory and radiology services are covered.

Paid in Full

Maternity Care, Tests and Procedures

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

Paid in Full

Medical Social Services

Referrals to licensed community agencies or social services are covered.

Paid in Full

Mental Health Services (Crisis Intervention Only)

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

Outpatient care for Crisis Intervention, up to a maximum of twenty (20) visits each calendar year, is covered when authorized by Member's Primary Care Physician in Member's Participating Medical Group. Crisis Intervention is defined as short-term Medically Necessary treatment required when Member suffers a sudden mental condition which interferes with Member's daily activities and from which Member is incapable of recovering without assistance. Sessions are covered only until Member is restored to Member's pre-crisis function level. Treatment may be provided by a psychiatrist, psychologist or other duly licensed counselor. Treatment may be limited to group therapy when group therapy is appropriate.

\$10 Copayment per visit

Oral Surgery Services

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

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

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

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

Paid in Full

Outpatient Medical Rehabilitation Therapy

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

\$10 Copayment

Outpatient Surgery

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

Paid in Full

Medical Benefits

Periodic Health Evaluations

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

\$10 Copayment

Phenylketonuria (PKU) Testing and Treatment

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

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

Food products naturally low in protein are not covered.

\$10 Copayment

Physician Care

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

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

\$10 Copayment

Vision Refractions

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

\$10 Copayment

Vision Screening

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

\$10 Copayment

Well-Baby Care

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

Paid in Full

Well-Woman Care

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

\$10 Copayment

EXCLUSIONS AND LIMITATIONS

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

General Exclusions

The following services are not covered by PacifiCare.

- A. (1) All services not specifically included in this packet, (2) services rendered without authorization from Member's Primary Care Physician in Member's Participating Medical Group (except for Emergency or Urgently Needed Services, or obstetrical and gynecological physician services obtained directly from an OB/GYN or Family Practice Physician (designated by your Participating Medical Group as providing OB/GYN services) affiliated with your Participating Medical Group), and (3) services prior to Member's start date of coverage or after the time coverage ends.
- B. PacifiCare is not responsible for the cost of services rendered by Non-Participating Providers when the Member has refused treatment provided or authorized through Member's Primary Care Physician in Member's Participating Medical Group.
- C. PacifiCare is not responsible for the cost of services which, in the judgment of the Health Plan, are not Medically Necessary or not required in accordance with professionally recognized standards of medical practice.
- D. PacifiCare is not responsible for the cost of services which are part of a plan of treatment for a non-covered service, including services and supplies to treat medical conditions which are recognized by the organized medical community in the State of California, in conformance with professionally recognized standards of practice, to be direct and predictable consequences of such non-covered services; provided, however, that the Health Plan shall not exclude coverage for Medically Necessary services required to treat medical conditions that may arise but are not predictable in advance, such as unexpected complications of surgery.

Specific Exclusions

Acupuncture, Acupressure, Biofeedback

Acupuncture, acupressure and biofeedback are not covered.

Alcoholism, Drug Addiction or Other Substance Abuse

Rehabilitation for chronic alcoholism, drug addiction or other substance abuse is covered through PacifiCare Behavioral Health and is described in the Behavioral Health Benefits section of this brochure.

Ambulance Service

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

Bone Marrow Transplants

Bone marrow transplants are not covered when they are Experimental or Investigational, unless required by an external, independent, review panel pursuant to California Health and Safety Code Section 1370.4.

Chiropractic Care

Care and treatment provided by a chiropractor is not covered.

Cosmetic or Reconstructive Surgery

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

- i. A proposed surgery when there is another more appropriate surgical procedure that has been offered to the member.
- ii. Services that offer only a minimal improvement in the member's appearance; or
- iii. Services performed without prior authorization by the Participating Medical Group.

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

Medical Benefits

Custodial Care

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

Dental Care, Dental Appliances

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

Dental Treatment Anesthesia

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

Developmental Disorders

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

Disabilities Connected to Military Services

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

Drugs and Prescription Medication

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

Durable Medical Equipment, Corrective Appliances and Prosthetics

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

Emergency and Urgently Needed Services

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

Experimental or Investigational Treatment

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

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

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

- A Member with a Life-Threatening or Seriously Debilitating condition may be entitled to an expedited hearing in cases in which a proposed treatment is denied as Experimental or Investigational, as provided in the *Subscriber Agreement* or pursuant to California Health and Safety Code Section 1370.4.
- It is the subject of a current investigational new-drug or new-device application on file with the FDA;
- It is being provided pursuant to a Phase I or Phase II clinical trial or as the experimental or research arm of the Phase III clinical trial, as these Phases are defined in regulations and other official actions and publications issued by the FDA and the Department of Health and Human Services (HHS);
- It is being provided pursuant to a written protocol which describes among its objectives determinations of safety and/or efficacy as compared with the standard means of treatment;
- It is being delivered or should be delivered subject to the approval and supervision of an Institutional Review Board (IRB) as required and defined by federal regulations and other official actions and publications issued by the FDA and the HHS;
- The predominant opinion among experts as expressed in the published authoritative literature is that usage should be substantially confined to research settings;
- The predominant opinion among experts as expressed in the published authoritative literature is that further research is necessary in order to define safety, toxicity, effectiveness or effectiveness compared with conventional alternatives; or
- It is not Investigational or Experimental in itself pursuant to the above, and would not be Medically Necessary, but for the provision of a drug, device, treatment or procedure which is Investigational or Experimental.

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

- The Member's medical records;
- The protocol(s) pursuant to which the drug, device, treatment or procedure is to be delivered;

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

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

Foot Care

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

Hearing Aids and Implantable Hearing Devices

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

Infertility Reversal

Reversal of voluntary sterilization is not covered.

Infertility Services

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

Medical Benefits

Institution Services and Supplies – Non-Eligible

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

Medicare Benefits for Medicare Retirees

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

Mental Disorders

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

Non-Licensed Professionals

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

Nursing-Private Duty

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

Off Label Drug Use

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

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

Organ Donor Services

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

Organ Transplants

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

Out-of-Area Services

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

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

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

Physical Examinations

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

Private Rooms and Comfort Items

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

Public Facility Care

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

Recreational, Educational or Hypnotic Therapy

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

Sex Transformations

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

Skilled Nursing Facility Care

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

Specialized Footwear for Foot Disfigurement

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

Vision Care

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

Weight Alteration Programs (Inpatient or Outpatient)

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

Outpatient Prescription Drug Program

Retail:

\$10 Generic Formulary/Selected Brands

Copayment

\$20 Brand-Name Formulary Copayment

\$35 Non-Formulary Copayment

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

HOW TO USE THE PROGRAM

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

PacifiCare's Formulary

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

What You Will Pay

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

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

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

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

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

WHAT IS COVERED

When Medically Necessary, the prescription benefit will be provided for the following medications when ordered by a PacifiCare Participating Physician and filled at a PacifiCare Participating Pharmacy.

- **Federal Legend Drugs:** Any medicinal substance which bears the legend: "Caution: Federal law prohibits dispensing without a prescription."
- **State Restricted Drugs:** Any medicinal substance which may be dispensed by prescription only according to State law.
- **Compounded Medication:** Any medicinal substance which has at least one ingredient that is Federal Legend or State Restricted in a therapeutic amount.
- **Insulin, insulin syringes, blood glucose test strips, lancets, inhaler extender devices, EpiPens[®], Ana-Kits[®].**
- **Federal Legend oral contraceptives, prescription diaphragms.**
- **Generic Drugs:** Comparable generic drugs will be substituted for brand-name drugs.
- **Specified smoking cessation products** when a Member meets nicotine dependency criteria and is enrolled and continues to participate in PacifiCare's StopSmokingSM Program.
- **Drugs to treat sexual dysfunction** are covered with a limitation. For oral medications, up to 8 pills may be covered per month. Contact the plan for dose limits on other types of sexual dysfunction drugs. You pay 50% of the cost of the medication per prescription unit. These drugs must be Medically Necessary and preauthorized by PacifiCare.

PREAUTHORIZATION FOR SELECTED DRUGS

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

IF A PACIFICARE PARTICIPATING PHARMACY IS NOT AVAILABLE

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

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

Prescription Solutions® Claims
P.O. Box 6037
Cypress, CA 90630

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

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

WHAT IS A PRESCRIPTION DRUG FORMULARY?

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

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

HOW DRUGS GET ON THE FORMULARY

The PacifiCare Formulary includes over 1,600 drugs, both brand name and generic, and has been developed to include medications that cover the majority of medical conditions. In most cases, when a medication is not included on the Formulary, it is because there is a Formulary alternative which can be prescribed for the same condition. The Formulary alternative may be either a brand name or a generic drug. A panel of pharmacists, medical directors, and physicians known as the Pharmacy and Therapeutics Committee developed and periodically updates the PacifiCare Formulary. In general, updates to the PacifiCare Formulary occur quarterly. However, in certain situations, drugs may be added or deleted more frequently. The Committee's criteria for including a drug on the PacifiCare Formulary is based on the following attributes of the drug:

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

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

GENERIC VS. BRAND-NAME DRUGS

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

Outpatient Prescription Drug Program

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

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

DISPENSING QUANTITY LIMITATIONS

The amount of drug which may be dispensed per prescription or refill will be one Prescription Unit as consistent with good professional practice. Prescriptions requiring greater amounts will be completed on a refill basis, except as described under Maintenance Drug Dispensing.

MAINTENANCE DRUG DISPENSING

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

- Antiarthritics
- Antiasthmatics
- Anti-clotting drugs
- Antiepileptic drugs
- Antihypertensives
- Antiparkinson drugs
- Cardiac drugs
- Cholesterol and lipid lowering agents
- Diuretics
- Gastrointestinal drugs
- Glucose test strips
- Hormones
- Insulin and Insulin syringes
- Oral contraceptives
- Oral hypoglycemics

- Prenatal vitamins
- Thyroid suppressants or replacements

PACIFICARE MAIL SERVICE PROGRAM

Mail Service:

\$20 Generic Formulary/Selected Brands Copayment

\$40 Brand-Name Formulary Copayment

\$70 Non-Formulary Copayment

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

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

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

PARTICIPATING PHARMACY NETWORK

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

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

- Good Neighbor/PlusCare Pharmacies
- Horton & Converse Pharmacies
- K-Mart Pharmacies
- Longs Drug Stores
- Major Value Pharmacies
- Managed Pharmacy Care
- Medicap Pharmacies
- Medicine Shoppe Pharmacies
- Network Pharmacies
- OPEN Independent Pharmacies
- PCP Independent Pharmacies
- Raley's Drug Center
- Ralphs Pharmacies
- Rite Aid Pharmacies
- Safeway Pharmacies
- Save Mart Pharmacies
- Sav-On Drugs
- Sharp Rees-Stealy Pharmacies
- Talbert Pharmacies
- Target Pharmacy
- UniMed Pharmacies
- United Drug Stores
- UPNI Contracted Pharmacies
- Valu-Rite/McKesson Drug Co.
- Vons/Pavilions (A Safeway Company)
- Wal-Mart Pharmacies

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

EXCLUSIONS AND LIMITATIONS

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

- Drugs or medicines purchased and received prior to the Member's effective date or after the Member's termination.
- Therapeutic devices or appliances including hypodermic needles, syringes (except insulin syringes), support garments and other non-medicinal substances.

- All non-prescription (over-the-counter) contraceptive jellies, ointments, foams and devices.
- Medications to be taken or administered to the eligible Member while he/she is a patient in a hospital, rest home, nursing home, sanitarium, etc.
- Drugs or medicines delivered or administered to the Member by prescriber or the prescriber's staff.
- Dietary supplements including vitamins (except prenatales), fluoride supplements, health or beauty aids and anorexiant (i.e. diet pills).
- Medication for which the cost is recoverable under any workers' compensation or occupational disease law, any state or government agency, or medication furnished by any other drug or medical service for which no charge is made to the patient.
- Medications prescribed for experimental or investigational therapies, unless required by an external, independent review panel pursuant to California Health and Safety Code Section 1370.4.
- Medications prescribed for non-FDA approved indications unless prescribed in a manner consistent with a specific indication in *Drug Information for the Health Care Professional*, published by the United States Pharmacopeial Convention, the American Medical Association *Drug Evaluation*, the American Hospital Formulary Services edition of *Drug Information*, or any other source which reflects community practice standards, medications limited to investigational use by law.
- Medications available without a prescription (over-the-counter) or for which there is a non-prescription equivalent available, even if ordered by a physician.
- Drugs, medicines or cosmetic aids prescribed primarily to improve or otherwise modify the Member's external appearance.
- Medications prescribed by non-participating physicians (except for prescriptions required as a result of an Emergency or Urgently Needed Service for an acute condition).
- Smoking cessation products (other than those available by participating in PacifiCare's StopSmokingSM Program) including, but not limited to nicotine gum and nicotine nasal spray.
- Injectable drugs (except as listed under Covered Benefits).

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

How Your Behavioral Health Care Benefits Work

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

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

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

You may have some Copayments or Coinsurance amounts.

WHAT DOES PACIFICARE BEHAVIORAL HEALTH OF CALIFORNIA DO?

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

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

WHAT IS BEHAVIORAL HEALTH?

Behavioral health is the name for the treatment of:

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

WHAT IS A SEVERE MENTAL ILLNESS?

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

Anorexia Nervosa

Bipolar Disorder

Bulimia Nervosa

Major Depressive Disorder

Obsessive-Compulsive Disorder

Panic Disorder

Pervasive Developmental Disorder or Autism

Schizoaffective Disorder

Schizophrenia

WHAT IS THE SERIOUS EMOTIONAL DISTURBANCE OF A CHILD?

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

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

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

- As a result of the mental disorder, the child has substantial impairment in at least two of the following areas: self-care, school functioning, family relationships, or ability to function in the community; and either of the following occur:
 - i. the child is at risk of removal from home or has already been removed from the home,
 - ii. the mental disorder and impairments have been present for more than six months or are likely to continue for more than one year without treatment; or

- The child displays one of the following: psychotic features, risk of suicide or risk of violence due to a mental disorder; or
- The child meets the special education eligibility requirements under Chapter 26.5, commencing with Section 7570 of Division 7 of Title 1 of the Government Code of the State of California.

DO I NEED A REFERRAL FROM MY PRIMARY CARE PHYSICIAN TO GET BEHAVIORAL HEALTH SERVICES?

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

HOW DO I GET BEHAVIORAL HEALTH SERVICES?

Step 1

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

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

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

Step 2

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

Step 3

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

WHAT IF I WANT TO CHANGE MY PARTICIPATING PROVIDER?

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

IF I SEE A PROVIDER WHO IS NOT PART OF PBHC’S PROVIDER NETWORK, WILL IT COST ME MORE?

Yes. If you are enrolled in this Plan and choose to see a provider who is not part of the PBHC network, the services will be excluded and you will have to pay for the entire cost of the treatment with no reimbursement from PBHC, except in an Emergency.

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

CAN I CALL PBHC IN THE EVENING OR ON WEEKENDS?

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

How Your Behavioral Health Care Benefits Work

EMERGENCY TREATMENT

What Is an Emergency?

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

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

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

What Happens In an Emergency?

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

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

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

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

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

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

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

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

IF I AM OUT OF STATE OR TRAVELING, AM I STILL COVERED?

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

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

PROVIDER INFORMATION

About Our Participating Providers

Call the PBHC Customer Service department for:

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

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

Who Are PacifiCare Behavioral Health's Participating Providers?

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

How Are Participating Providers Compensated By PBHC?

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

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

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

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

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

CONTINUING TREATMENT FOR NEW MEMBERS

Continuing Treatment is for Members who:

- were not offered an out-of-network option or did not have the option to continue with their previous health plan at the time of enrollment under this Plan;
- have been eligible and enrolled in this Plan for less than thirty (30) days;
- had no other health plan choice other than through PacifiCare's arrangement with PBHC;

- are under treatment by a non-participating provider at the time of enrollment for a condition listed in the DSM-IV;
- the treatment is a covered Behavioral Health Service or benefit under this Plan; and
- have a condition where an immediate change in Practitioner could present a risk of harm to self or others.

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

Outpatient Treatment

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

Inpatient Treatment

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

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

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

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

How Your Behavioral Health Care Benefits Work

PUBLIC POLICY PARTICIPATION

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

NEW TREATMENTS

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

CONCURRENT REVIEWS

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

WHAT IF I GET A BILL?

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

PBHC will not pay for bills or claims given to us that are more than one year old. Mail bills or claims to:

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

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

TERMINATION OF BENEFITS

Conditions for Termination

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

YOUR FINANCIAL RESPONSIBILITIES

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

CONFIDENTIALITY OF INFORMATION

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

AUTHORIZATION AND DENIAL OF BEHAVIORAL HEALTH CARE SERVICES

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

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

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

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

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

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

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

EXPERIMENTAL AND INVESTIGATIONAL THERAPIES

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

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

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

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

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

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

A PBHC Medical Director or designee has denied your request for a drug, device, procedure or other therapy recommended or requested pursuant to paragraph (3); and

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

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

How Your Behavioral Health Care Benefits Work

SECOND OPINIONS

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

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

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

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

RESPONDING TO YOUR CONCERNS – THE PBHC APPEALS PROCESS

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

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

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

Appeals Process

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

PBHC Appeal Process

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

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

the appeal within thirty (30) business days of receipt of the appeal, the individual who initiated the appeal will be notified of the delay, the specific reason for the delay, and the expected date of completion of the review.

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

Expedited Review Process

Appeals involving an imminent or serious threat to the health of the Member, including but not limited to, severe pain, potential loss of life, limb, or other major bodily function will be immediately referred to the PBHC Medical Director for expedited review, regardless of whether such appeal is received orally or in writing. If an appeal has been sent to the PBHC Medical Director for immediate expedited review, PBHC will immediately inform the Member, in writing, of his or her right to notify the DMHC of the appeal. PBHC will provide the Member and the DMHC with a written statement of the disposition or pending status of the expedited review no later than three (3) days from receipt of complaint.

Independent Medical Review of a Disputed Health Care Service

You may request an Independent Medical Review (IMR) of disputed health care services from the Department of Managed Health Care if you believe that health care services have been improperly denied, modified, or delayed by PBHC or one of its Participating Providers. A “disputed health care service” is any health care service eligible for coverage under your subscriber contract that has been denied, modified, or delayed by PBHC or one of its Participating Providers, in whole or in part because the service is not Medically Necessary. Be sure to check the IMR Eligibility section below to see if your grievance qualifies for an IMR.

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

to participate in the IMR process may cause you to forfeit any statutory right to pursue legal action against PBHC regarding the disputed health care service.

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

- Your provider has recommended a health care service as Medically Necessary; or
- You have received Urgent care or Emergency services that a provider determined was Medically Necessary; or
- You have been seen by a PBHC Participating Provider for the diagnosis and treatment of the medical condition for which you seek independent review;
- The disputed health care service has been denied, modified, or delayed by PBHC or one of its Participating Providers, based in whole or in part on a decision that the health care service is not Medically Necessary; and
- You have filed a grievance with PBHC and the disputed decision is upheld or the grievance remains unresolved after thirty (30) days. If your grievance requires expedited review you may bring it immediately to the DMHC’s attention. The DMHC may waive the preceding requirement that you follow PBHC’s grievance process in extraordinary and compelling cases.

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

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

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

How Your Behavioral Health Care Benefits Work

Binding Arbitration and Voluntary Mediation

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

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

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

If the Member is requesting voluntary mediation, in order to initiate mediation, the Member or agent acting on behalf of the Member, shall submit a written request for voluntary mediation. If the parties mutually agree to mediation, the mediation will be administered by JAMS in accordance with its Commercial Mediation Rules, unless otherwise agreed by the parties. Expenses for mediation shall be borne equally by both parties. The Department of Managed Health Care shall have no administrative or enforcement responsibilities in connection with the voluntary mediation process.

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

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

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

arbitration is made, the arbitrator appointment procedures in the Rules will be utilized.

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

The parties shall divide equally the fees and expenses of the arbitrator(s) and the neutral administrator except that in cases of extreme hardship, PBHC may assume all or part of a Member's share of the fees and expenses of the arbitrator(s) provided the Member has submitted a hardship application with JAMS or such other neutral administrator designated by PBHC. The approval or denial of a hardship application shall be determined by such administrator. The arbitrator(s) shall not have the power to commit errors of law or legal reasoning, and the award may be vacated or corrected pursuant to California law. The Federal Arbitration Act, 9 U.S.C. Sections 1-4, shall also apply to the arbitration.

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

THE PBHC Quality Review Process

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

PBHC takes great pride in the quality of our Participating Providers. That is why complaints specifically about the quality of the care you receive from your Participating Provider are handled in an expedited fashion. Quality of care complaints that affect a Member's current

treatment shall be immediately evaluated and if necessary, other appropriate PBHC personnel and the PBHC Participating Provider will be consulted.

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

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

If the Member has submitted a written complaint, the Member shall be notified of the completion in writing within thirty (30) days. The oral and written communications involving the Quality Review Process and the results of the review shall remain confidential and cannot be shared with the Member. Nor can the outcome of the Quality Review Process be submitted to voluntary mediation or binding arbitration as described above under the PBHC Appeals Process. The Quality Improvement Specialist will follow-up to ensure that any corrective actions against a Participating Provider are carried out.

REVIEW BY THE DEPARTMENT OF MANAGED HEALTH CARE

The California Department of Managed Health Care is responsible for regulating health care service plans. The Department has a toll free number **(1-800-HMO-2219)** to receive complaints regarding health plans. The hearing and speech impaired may use the California Relay Service's toll-free telephone numbers **(1-877-688-9891 TDD)** to contact the Department. The Department's Internet Web site (<http://www.hmohelp.ca.gov>.) has complaint forms and instructions online. If a Member has a grievance against PBHC, the Member should first telephone PBHC at **1-800-999-9585** and use PBHC's Appeal Process outlined in this EOC. If the Member needs help with a grievance involving an Emergency, a grievance that has not been satisfactorily

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

COVERED SERVICES

Behavioral Health Services must be:

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

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

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

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

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

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

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

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

How Your Behavioral Health Care Benefits Work

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

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

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

EXCLUSION AND LIMITATIONS

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

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

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

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

Organic therapies, including but not limited to, the following: aversion therapy, carbon dioxide therapy, environmental ecological treatment or remedies, herbal therapies, hemodialysis for schizophrenia, vitamin or orthomolecular therapy, and rapid anesthesia opiate detoxification.

Treatments designed to regress the Member emotionally or behaviorally.

Personal enhancement or self actualization therapy and other treatments.

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

Services provided by non-licensed providers for the treatment of any illness or injury.

Pastoral or spiritual counseling.

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

Thought field therapy.

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

Genetic counseling.

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

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

Hearing Aid Benefits

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

Hearing aid expenses for members are covered as follows:

BENEFITS

Hearing Aid Benefits include but are not limited to:

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

LIMITATION

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

EXCLUSIONS

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

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

Understanding Health Care Terms

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

MEDICAL HEALTH TERMS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Physician includes any licensed allopathic or osteopathic physician.

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

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

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

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

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

Understanding Health Care Terms

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

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

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

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

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

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

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

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

OUTPATIENT PRESCRIPTION DRUG BENEFIT TERMS

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

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

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

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

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

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

BEHAVIORAL HEALTH TERMS

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

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

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

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

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

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

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

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

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

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

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

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

Custodial Care. Personal services required to assist the Member in meeting the requirements of daily living. Custodial Care is not covered under this PBHC Behavioral Health Plan unless specifically listed in the *Schedule of Benefits*. Such services include, without limitation, assistance in walking, getting in or out of bed, bathing, dressing, feeding, or using the lavatory, preparation of special diets and supervision of medication schedules. Custodial Care does not require the continuing attention of trained medical or paramedical personnel.

Customer Service Department. The department designated by PBHC to whom oral or written Member issues may be addressed. The Customer Service department may be contacted by telephone at 1-800-999-9585 or in writing at:

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

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

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

Understanding Health Care Terms

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

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

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

Emergency Treatment. Medically Necessary ambulance and ambulance transport services provided through the 911 (or alternative emergency response system) and medical screening, examination and evaluation by a Practitioner, to the extent permitted by applicable law and within the scope of their licensure and clinical privileges, to determine if an Emergency for a Behavioral Health condition exists, and if it does, the care and treatment by a Practitioner necessary to relieve or eliminate the Emergency within the capabilities of the Facility.

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

Facility. A health care facility which is duly licensed by the state in which it operates to provide inpatient, day treatment, partial hospitalization or outpatient care for the diagnosis and/or treatment of Behavioral Health Services.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Routine Detoxification. Routine treatment and stabilization for symptoms resulting from withdrawal from chemical substances, including drugs or alcohol, which is provided at a PBHC Participating Provider without the necessity of intensive nursing, monitoring or procedures such as intravenous fluids. In order to obtain Routine Detoxification services, the Member must first obtain medical clearance from his or her Primary Care Physician under his or her medical or health plan for unstable medical problems exacerbated by withdrawal from chemical substances including, but not limited to, diabetes mellitus, hypertension or serious withdrawal complications which may necessitate Medical Detoxification.

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

Understanding Health Care Terms

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

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

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

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

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

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

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

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

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

Schedule of Benefits

MEDICAL SCHEDULE OF BENEFITS

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

| | |
|--|---|
| DEDUCTIBLE | -0- |
| MAXIMUM BENEFITS | UNLIMITED |
| ANNUAL COPAYMENTS MAXIMUM | \$1,000/INDIVIDUAL \$3,000/FAMILY |
| OFFICE VISITS | \$10 Copayment |
| HOSPITALIZATION | \$250 per admission |
| EMERGENCY SERVICES | \$50 Copayment <i>Waived if admitted as an inpatient</i> |
| URGENTLY NEEDED SERVICES (Medically Necessary Services required outside your Service Area) | \$50 Copayment <i>Waived if admitted as an inpatient</i> |
| PRE-EXISTING CONDITIONS | All conditions covered provided they are covered benefits. |

BENEFITS AVAILABLE WHILE HOSPITALIZED AS AN INPATIENT

| | |
|--|---|
| ALCOHOL, DRUG, OR OTHER SUBSTANCE ABUSE OR ADDICTION (Detoxification only) | \$250 per admission |
| BONE MARROW TRANSPLANT (Donor searches limited to \$10,000 or 50 searches per lifetime) | \$250 per admission |
| HOSPICE CARE (Up to one calendar year lifetime maximum) | \$250 per admission |
| HOSPITAL BENEFITS (Autologous (self-donated) blood up to \$120.00 per unit) | \$250 per admission |
| MASTECTOMY/BREAST RECONSTRUCTION (After a mastectomy and complications from a mastectomy) | \$250 per admission |
| MATERNITY CARE | \$250 per admission |
| NEWBORN CARE | \$250 per admission (After birth, if readmitted) |
| PHYSICIAN CARE | PAID IN FULL |
| REHABILITATION CARE | \$250 per admission |
| SKILLED NURSING CARE (Up to one-hundred (100) calendar days from the first treatment per disability) | PAID IN FULL |
| VOLUNTARY INTERRUPTION OF PREGNANCY | |
| ■ 1st trimester | PAID IN FULL |
| ■ 2nd trimester (12-20 weeks) | PAID IN FULL |
| ■ After 20 weeks | NOT COVERED* |

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

Schedule of Benefits

BENEFITS AVAILABLE ON AN OUTPATIENT BASIS

| | |
|---|-------------------------------------|
| ALCOHOL, DRUG, OR OTHER SUBSTANCE ABUSE OR ADDICTION (Detoxification only) | \$10 Copayment |
| ALLERGY TESTING/TREATMENT (Serum is included) | \$10 Copayment |
| AMBULANCE | PAID IN FULL |
| ATTENTION DEFICIT DISORDER (Medical Management) | \$10 Copayment |
| BREAST CANCER SCREENING, DIAGNOSIS AND TREATMENT | \$10 Copayment |
| COCHLEAR IMPLANTS | PAID IN FULL |
| DENTAL TREATMENT ANESTHESIA | PAID IN FULL |
| DIABETES MANAGEMENT AND TREATMENT | \$10 Copayment |
| DURABLE MEDICAL EQUIPMENT | PAID IN FULL |
| CORRECTIVE APPLIANCES AND PROSTHETICS ELIGIBLE MATERIALS AND SUPPLIES | PAID IN FULL |
| FAMILY PLANNING/VOLUNTARY INTERRUPTION OF PREGNANCY | |
| ■ Vasectomy | \$10 Copayment |
| ■ Tubal ligation | \$10 Copayment |
| ■ Insertion/removal of intra-uterine device (IUD) | \$10 Copayment |
| ■ Intra-uterine device (IUD) | 50% Copayment |
| ■ Insertion/removal of Norplant | \$10 Copayment |
| ■ Norplant device (Limited to one Norplant Device per 5-year period) | \$200 Copayment/course of treatment |
| ■ Depo-Provera injection | \$10 Copayment |
| ■ Depo-Provera medication (Limited to one Depo-Provera injection every 90 days) | \$35 Copayment |
| ■ Voluntary interruption of pregnancy | |
| 1st trimester | \$10 Copayment |
| 2nd trimester (12-20 weeks) | \$10 Copayment |
| After 20 weeks | Not covered* |
| HEALTH EDUCATION SERVICES | PAID IN FULL |
| HEARING SCREENING | \$10 Copayment |
| HEMODIALYSIS | \$10 Copayment |
| HOME CARE | PAID IN FULL |
| HOSPICE CARE – OUTPATIENT BASIS AND IN-HOME VISITS (Up to one calendar year per lifetime) | PAID IN FULL |
| IMMUNIZATIONS (For children under two years of age, refer to Well-Baby Care) | \$10 Copayment |
| INFERTILITY SERVICES | 50% Copayment |
| LABORATORY AND RADIOLOGY | PAID IN FULL |
| MATERNITY CARE, TESTS AND PROCEDURES | PAID IN FULL |
| MEDICAL SOCIAL SERVICES | PAID IN FULL |

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

MENTAL HEALTH SERVICES

\$10 Copayment per visit

- For additional benefits, See Behavioral Health Benefits.
- Up to twenty (20) visits for crisis intervention during each calendar year following your initial date of eligibility.
- A Copayment may be charged for missed scheduled appointments.

ORAL SURGERY**PAID IN FULL****OUTPATIENT REHABILITATION THERAPY**

\$10 Copayment

OUTPATIENT SURGERY**PAID IN FULL****PERIODIC HEALTH EVALUATIONS**

\$10 Copayment

Physician, laboratory, radiology and related services as recommended by the American Academy of Pediatrics (AAP) and U.S. Preventive Services Task Force and authorized through your Primary Care Physician in your Participating Medical Group to determine your health status. For children under two years of age, refer to Well-Baby Care.

PHENYLKETONURIA (PKU) TESTING AND TREATMENT

\$10 Copayment

PHYSICIAN CARE

\$10 Copayment

(For children under two years of age, refer to Well-Baby Care)

VISION REFRACTIONS

\$10 Copayment

VISION SCREENING

\$10 Copayment

WELL-BABY CARE**PAID IN FULL**

Preventive health service, including immunizations, recommended by the American Academy of Pediatrics (AAP) and U.S. Preventive Services Task Force and authorized through your Primary Care Physician in your Participating Medical Group for children under two years of age.

WELL-WOMAN CARE

\$10 Copayment

Includes Pap Smear (by your Primary Care Physician or an OB-GYN in your Participating Medical Group) and referral by the Participating Medical Group for screening mammography as recommended by the U.S. Preventive Services Task Force.

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

Schedule of Benefits

OUTPATIENT PRESCRIPTION DRUG PROGRAM SCHEDULE OF BENEFITS

RETAIL

| | |
|---|----------------|
| Generic and Selected Brand-Name Formulary Drugs | \$10 Copayment |
| Brand-Name Formulary Drugs | \$20 Copayment |
| Non-Formulary Drugs | \$35 Copayment |

MAIL SERVICE (UP TO 90 DAY SUPPLY)

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

HEARING AID BENEFIT SCHEDULE OF BENEFITS

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

BEHAVIORAL HEALTH SCHEDULE OF BENEFITS

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

MENTAL HEALTH SERVICES

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

CHEMICAL DEPENDENCY HEALTH SERVICES

| | |
|---|---|
| Inpatient Deductible | None |
| Inpatient Treatment | \$250 per admission |
| Outpatient Treatment | \$10 Copayment per visit |
| Emergency and Urgently Needed Services ¹ | Same as medical plan Copayment for emergency and urgently needed services ¹ . Copayment waived if admitted as inpatient. |

BEHAVIORAL HEALTH SCHEDULE OF BENEFITS (CONTINUED)

SERIOUS MENTAL ILLNESS BENEFIT²

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

¹ Urgently Needed Services are Medically Necessary Services required outside the Service Area to prevent serious deterioration of a Member's health resulting from an unforeseen illness or injury manifesting itself by acute symptoms of sufficient severity, including severe pain, such that treatment cannot be delayed until the Member returns to the Service Area.

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

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

Index of Terms

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

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ANSWERING QUESTIONS

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

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

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

PACIFICARE'S CUSTOMER SERVICE – WE'RE HERE FOR YOU

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

Count on Us for Efficient Service

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

We'll Expedite Your Requests

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

We're Here To Answer Your Questions

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

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

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

Concerns, Comments, Suggestions?

That's what we're here for.

**1-800-624-8822 or
1-800-442-8833 TDHI**

(Telecommunications Device for the Hearing Impaired)

Monday – Friday
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